



Topical theme

The Challenge of Managing Change: What Can we do Differently to Ensure Personalisation?

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ABSTRACT

This article questions whether traditional management approaches will be sufficient to deliver change when it comes to implementing personalisation, and outlines an alternative approach based on collaborative working in 'communities of practice'.

KEY WORDS

personalisation; implementation; collaboration; communities of practice; change management

Introduction

This article is about a new paradigm. Normally, I would start by telling you something of the latest policy developments.

In the UK, the policy landscape is in a state of transition. Assessment and Care Management, the centrepiece of the 1990 NHS and Community Care Act, is in demise. Personalisation (HM Government, 2007) is the new paradigm and self-directed support, self-assessment and co-production are the new language of social care.

I would then tell you why this new idea is unlikely to work in mainstream practice.

There is skepticism concerning the feasibility and likely impact of personalisation, given the inadequacy of the resource base of adult social care. (Lymbery, 2010)

There will be an evaluation. This will probably confirm that the policy is not delivering (for the reasons we anticipated) and things will carry on much as before until the next 'big idea' comes along.

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Many change initiatives in the past have introduced large-scale structural reforms. Whilst structural reforms are important and necessary, they have not always delivered their intended impact, with services for staff and service users often only changing a little. (Cameron & Quinn, quoted in Modernisation Agency, 2005a)

As researchers, we often hear and write about what this failure to implement policy means for service users and carers. Below (**Box 1**) is one such account which was told to me in a study

of hospital discharge. The study was carried out not that long ago. It is a tale of disappointment and sadness, and reads as the graveyard of so many well-intentioned policies – discharge planning, single assessment, comprehensive geriatric assessment, person-centred planning, falls prevention, dementia care, intermediate care, rehabilitation, choice, end of life care. All these policies are called for in the story, but they are just not there in practice.

To disseminate the findings of this particular study, which included the account above and many similar accounts like it, I attended a

Box 1: A TRUE STORY OF HOSPITAL DISCHARGE

I went in to the hospital in the morning and made a point of trying to speak to the Sister and saying 'We need to talk, what's going on?'. Nobody's told us anything, and it just happened that a junior doctor was next to me and said 'Oh, I would like to talk to you'. So I went back in the afternoon and spoke to her and she said 'Your father has had this water infection, we have treated it with antibiotics and he is fit for discharge'. I said he may be fit for discharge, but he is not coming home. It was at that point that they went to find a social worker. I saw the social worker once and that was when she brought the list of the nursing homes and the financial forms. She never actually sat down or discussed anything with me. I never saw anyone else, and nobody contacted us.

By now he must have been in hospital about three weeks. We found a nursing home and he should have gone to the home on the Monday. On the Friday was when they had the outbreak of the diarrhea. We lost the place in that nursing home. Then it turns out he has mentally declined anyway, or that he is more 'trying' than they had first assessed him. I kept saying all along that he wasn't being walked in hospital. They kept saying 'He is not safe to walk', but obviously as he got better from the water infection he was trying to get out of bed. He kept falling in hospital and then once he was found wandering from the hospital. One of the nurses said 'We didn't realise he could walk'. I said 'This is what I have been telling you. This is why he is in – because my mother cannot cope with him any more'. Before he went into hospital he was toileting himself, showering himself, he would be the first up, get up have his breakfast, make a cup of tea and take a cup of tea to mum. My mum said 'It might take him ages and I would be saying I wish that cup of tea would hurry up', but he used to do it, and that had been a routine all their lives and he had maintained that.

The only thing that anybody seemed bothered about was that when we chose the next home there was a top-up thing, a £16 top-up. My mother had to go in and sign forms and she came away and she said to me 'I have signed some forms but I don't know what they are about'.

Things didn't work out in the care home as Dad's needs were too high and the home manager suggested that we might want to consider finding a different home. Shortly after this, Dad was readmitted to hospital with a heart attack and died. [Researcher: 'How do you think your Dad was feeling about all this?'] Well, he was always fairly outspoken and would have been demanding to see the head man. But once he did say to me, in one of his more lucid moments, and this was the upsetting thing, 'There is no love or affection in this place'. He was aware – he just wanted stimulus. He wasn't ill. The nurses knew he wasn't ill but there was nothing there for him. Right to the end he was all set to come home again. But there you go.

meeting of what was at the time a local steering group charged with implementing the National Service Framework for Older People (NSFOP) (DH, 2001). Key tenets of the NSFOP were about promoting person-centred care and improving general hospital care, including discharge practices. The implementation group had been meeting for a number of years when the research was undertaken, and it was attended by managers from health and social care and a number of older people who were linked to the local older people's forum (a 'campaigning group'). The report was circulated to the group in advance and a presentation was given. After this, things moved on to the next agenda item, which was about the closure of beds at the local community hospital. I eagerly reported that the findings of the hospital discharge research suggested that these beds were desperately needed to prevent delayed discharges and improve care for older people. However, I was met with such hostility by the managers in attendance that I let the issue drop. After this meeting the report disappeared without a trace and, as far as I am aware, no action was ever taken to address any of the issues raised. Although the research did not set out to evaluate the NSFOP, the findings were a good indicator that in this particular hospital activity to implement the NSFOP was not affecting practice. Indeed, the mid-term review of the NSFOP confirmed lack of progress nationally with regard to developing person-centred planning for hospital discharge (Health Care Commission *et al*, 2006).

When it comes to policy implementation, how can we break this cycle of almost predictable failure? How can we tackle inertia and inaction in local systems of care? Is there anything we could do differently to ensure greater success? How can we prevent personalisation from ending up in the policy graveyard? Ultimately, how can we deliver change which is more tangible to service users and carers? If the story above were about you

and your family, how would you have felt? What would you have done?

The idea for this paper came out of a recent seminar hosted by the *Journal of Integrated Care*. It was apparent that, somewhere along the way, the record had got stuck and we were discussing the same old problems and the same old solutions over and over again. Surely there must be something else out there? Many in the room thought that the new paradigm was 'personalisation'. But I am not so sure. I suspect that yet another new policy may actually be part of the problem, and that it is high time for some deeper reflection on how we do 'service improvement'. This paper is an attempt to think through some of these issues, steering a course more towards the change management literature than the socio-political perspective which would see 'us' as part of the problem.

At a three-day seminar on ethics, a young man representing an organisation for people with learning disabilities in Denmark took to the floor. He told the 300 participants that the lectures and discussions had made him understand that ethics were seen and defined as problems that 'you have with us'. Like the child in Hans Christian Anderson's famous tale The Emperor's New Clothes, the young man had revealed a core problem... For he had drawn attention to how, with the best of intentions, professional ethics are used to control and discipline by means of setting the norm to which the 'others', the less professional, have to conform if they are to get any help. (Skaerbaek, 2010)

What's wrong with the way we manage policy implementation?

Writing from the perspective of a senior manager responsible for personalising health in West Sussex (a DH pilot area for the introduction of

personal health budgets), Sara Weech describes her commitment to fundamentally changing the relationship that services have with the public and how this commitment has been reinforced by stories of families and individuals who have had to 'battle' with services to get what they want.

This is not to say that our service providers intend to make life difficult – in fact I have never met a practitioner or manager who has ever wanted to make things worse for a patient, it is just that somehow we have designed a system that makes it easier for the system than for the customers we are trying to serve. (Weech, 2009)

To implement personalisation in West Sussex, Sara describes a change management approach which will be familiar to most managers working in health and social care. The first line of attack is to facilitate partnership working and to establish leadership and clear and strong governance. This is achieved here by setting up a 'joint commissioning board' (a senior executive board where the PCT and the County Council can work together).

As the [personal health budgets] programme develops [in West Sussex] it is intended that the governance be managed through the council's programme for social care transformation to ensure that the developments are fully aligned. There is a risk that if we do not do this families will have two different types of budget/payment mechanism – one for health and one for social care. (Weech, 2009)

As is apparent above, when it comes to implementing policies, local partnership working is often required because it has been absent at a higher level. For example, recent guidance on *Personalised and Integrated Care Planning*

(DH, 2009a) continues to see the *Common Assessment Framework* (DH, 2009b) as pivotal to the organisation and delivery of services for people with long-term conditions. Here, there is still commitment to a far more professionally led approach and there are questions as to how this will gel with 'self-assessment' and 'self-directed support'.

Following on from the individual budget pilots (Glendinning *et al*, 2008) there now seems less commitment to tackling what has historically been the biggest stumbling block of all when it comes to integrated care, namely separate funding streams (which will mean separate 'personal budgets') for health and social care (DH, 2009c). This is clearly at odds with the user perspective, given that we know service users do not distinguish between health and social care needs but see both as parts of overall support and personal care needs (Glasby & Duffy, 2007). Indeed, policy documents often fail to connect with one another, creating discontinuities of these kinds which can be very difficult to manage in practice. They also tend to gloss over some of the more controversial or tricky issues, leaving them to local managers to sort out. I would argue that this makes policy far less likely to succeed in practice. As a policy, personalisation is particularly 'holey' in this respect, which means that implementation is most likely to be a slow and painful process as local managers grapple with a myriad of thorny issues. For example, if you need assistance to have a bath, is that to be paid for out of your health budget or your social care budget? Are you allowed to pay for bubble bath out of your personal budget? Is this a frivolous luxury item or a form of aromatherapy which can boost mental health and well-being? As Mandelstam (2010) reminds us, personalisation is not yet underpinned by legislation, so the elements must fit within existing community care guidance, which is likely to cause even further complexity and uncertainty.

Returning to West Sussex, Sara acknowledges that implementing personalisation will be a marathon and that dogged determination and stamina will be needed to get there. To turn the task into an achievable one (and I suspect to demonstrate how some 'project funding' from the DH will be spent), Sara outlines the second line of attack familiar to most managers when it comes to implementing complex policy, namely to set up a new team or scheme, often conceptualising and delivering the work as a 'pilot project'.

It became clear that there was a need to prioritise a few areas that both make a difference and help test a new system and approach. Balancing the need to 'get on with it' and having a transparent process [it was agreed that we] should concentrate on areas that either addressed an existing problem/area of concerns, or had maximum opportunity for joint health and social care interface, were achievable and had capacity for change. (Weech, 2010)

Four project areas were subsequently chosen to pilot the use of personal health budgets: one looking at how to provide more timely support to carers of people with early signs of dementia, one targeting patients who repeatedly request GP appointments but who do not then have a need for a medical service, one for children with continence care needs, and one for people assessed as eligible for continuing care.

However, effecting change in these isolated and protected areas is unlikely to lead to change in mainstream services (Doyle & Cornes, 2006). In their article entitled 'Despite all we know about collaborative working, why do we still get it wrong?' Williams and Sullivan (2010) highlight that a key issue is that the 'rhetoric' of learning from pilot projects and other improvement initiatives is rarely translated into an explicit and

planned strategy for learning and knowledge transfer. As a result, in their study of collaborative care pilots they found that 'learning' tended to be concentrated in a relatively small cadre of individuals who happened to be associated with a particular collaborative project. The learning did not extend deeper into the wider system because when the individuals left they took the learning with them. There is reference to training and 'action learning sets' going beyond the pilots in West Sussex, but I am not sure that this will be enough to achieve the 'cultural transformation' that is aspired to.

*The whole personalisation journey depends on staff recognising and shifting the balance of power. This won't happen overnight, or just by telling them. It will require **concerted transformation of culture**, through workforce development, initial training and post-qualification support... To face the above challenges positively, we held a launch event bringing about 100 health and care staff together... We intend to build on this by developing 'action learning sets' of interested staff, both those actively involved in the projects and those in support services such as finance, commissioning, HR and IT. (Weech, 2009).*

Achieving cultural transformation – delivering personalisation

It might be argued that many policies fail quite simply because not enough people on the ground know enough about them to put them into practice. However:

There is so much knowledge around that we risk drowning in it. Learning about how things are interconnected is often more useful than learning about the pieces (Fraser & Greenhaugh, quoted in NHS Modernisation Agency, 2005b).

If we return to the account of hospital discharge presented at the beginning of this paper, we can see that when it comes to providing 'personalised' support to a person with multiple and complex needs the knowledge required is vast in terms of both clinical knowledge and policy literacy (discharge planning, single assessment, person-centred planning, falls prevention, dementia care, intermediate care, rehabilitation, choice, end of life care). Certainly, a 'personal budget' alone would not have delivered personalised care in this instance. What is required here is the interweaving of a whole range of resources, interventions and knowledge bases which are unlikely to be delivered by any single individual or professional group. Connor and Kissen (2010) get to the heart of the matter when they argue that, if we are to re-humanise the experience of being cared for, we need to re-humanise the experience of collegiate working in the service. This highlights the importance of seeing collaborative and interprofessional working not as policy initiatives for their own sake, but as the **bedrock** on which pretty much all other policy implementation must rest. As McGrath (quoted in CAIPE, 2007) points out:

Interprofessional working is not about fudging the boundaries between the professions and trying to create a generic care worker. It is instead about developing professionals who are confident in their own core skills and expertise, who are fully aware and confident in the skills of fellow health and care professionals, and who conduct their own practice in a non-hierarchical and collegiate way with other members of the working team, so as to continuously improve the health of their communities and to meet the real care needs of individual patients and clients.

The problem is, of course, that most interprofessional and collaborative working is itself confined to projects rather than being found in mainstream service provision. As Williams and Sullivan (2010) caution, collaborative working is not the first call on an organisation's core business but often a 'bolt-on' with few resources. They also alert us to lack of capacity in the system, which means that it is inappropriate to assume that managers and professionals who are competent in their mainstream job roles can be equally effective in collaborative settings.

Too often people are attached to collaborative initiatives by virtue of their seniority and status and contribute as organisational representatives rather than partners seeking to manufacture collaborative advantage.

It is significant that, faced with the prospect of public sector cuts, service improvement agencies such as the Care Services Improvement Partnership (CSIP) were quietly abolished, when in fact such organisations played a key role in 'boundary spanning' or laying the groundwork for policy implementation by networking to build collaborative cultures and to mediate between different cultures and the aspirations of diverse stakeholders (Cornes *et al*, 2010).

To ensure that 'service improvement' becomes embedded in the culture of the organisation, it is recommended that organisations aspire to become 'learning organisations' (RiPfa, 2006). Internationally, there is renewed interest in developing so-called collective capability and 'communities of practice' (Soubhi *et al*, 2010). These are noteworthy for those interested in developing 'learning organisations', because their aim is to achieve integration of 'learning and caring', in everyday practice for example, by broadening the scope of traditional case management/conferencing to include an element of reflective

'case-based' learning. Communities of practice do not therefore require massive investment of staff time and money (though facilitation and administrative support are helpful to get them up and running) but rather a subtle conceptual mind-shift among front-line practitioners with regard to a commitment to 'interprofessional learning in the trenches' (Soubhi *et al*, 2009). Communities of practice provide the social context in which this learning can take place, an arena where practitioners share clinical cases, listen, reflect and receive feedback on processes of care. They work to close 'performance gaps' by integrating different professional knowledge bases (for example ensuring that care provided to a person with a chronic condition is not provided as a 'unique event' but as a continual process requiring the cumulative integration of the knowledge of multiple care participants over time) and by ensuring effective integration of explicit knowledge (such as that documented by evidence-based research) with the intuitive and tacit knowledge, the 'knowing in practice', that professionals accumulate through daily application of their own values, intuition and judgment.

While explicit knowledge is visible through written documents and literature databases, tacit knowledge is made visible through non-linear approaches such as reflective practice and the collection and sharing of story narratives among professionals. These narratives can include success and failure stories, opinion about current practice facing the learning community, solutions to problems and feedback about tactics and methods. (Soubhi *et al*, 2010)

It is my suspicion that something akin to a 'community of practice' would have provided a far more effective dissemination pad for the aforementioned study of hospital discharge than

the 'local implementation group', because it would have enabled practitioners not only to 'hear' the user and carer perspectives but also to take responsibility and ownership for some of the issues it raised. To me, this is the essence of 'personalisation'.

Summary

This article has questioned whether traditional management approaches based on leadership, training and the 'piloting' of new teams and schemes will be sufficient to achieve personalisation and to deliver change which is tangible to service users and carers. It is suggested that a new approach to policy implementation is required which firmly locates 'service improvement' in the mainstream of service delivery, recognising that it is inherently a collaborative activity. It is concluded that only by taking ownership of the issues which arise in the front line of service delivery will personalisation be achieved, and that this will require a degree of organisational change to integrate 'learning and caring' in everyday practice. Indeed, given the Coalition government's commitment to less intervention from the centre and dismantling of whole layers of organisational architecture, shifting the responsibility for service improvement to the front line of service delivery may have particular appeal. Communities of practice may just be the launch pad on which this might take shape.

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