Innovation in the Public Sector

Innovation in the provision of home help services in the Southern Health Board area

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Case Study

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Content

Glossary of terms

ADPHN/AD –   Assistant Director of Public Health Nursing
HH –   Home Help Worker
HHO –   Home Help Organiser
PHN –   Public Health Nurse
SHB –   Southern Health Board – semi-autonomous sub-region of Irish public health service

Case Summary

The nature of the case

Introduction of an innovative system of communication and team working in relation to home help services for the elderly and the chronically ill is the focus of the case study. The aim of the Southern Health Board (SHB) in this innovation was to introduce an "improved structure of communications and participation for all stakeholders[1] designed to improve patient benefits, staff relations and worker satisfaction" (Vereker 03).

At its core, the innovation introduced a multi-disciplinary approach to service provision. This meant the involvement of the health professional (in this case the public health nurse), the service co-ordinator (home help organiser) and the actual service provider (the home help worker) in allocating actual service provision.

Following on the needs assessment in the new system, all three parties would be involved in determining the appropriate nature and level of service to be provided to the client. This innovation meant moving from a strongly demarcated and often disconnected process to an inclusive process where all members of the team had a timely opportunity to comment on the perceived needs of the client and the appropriate responses. It was also hoped that this innovative process would further encourage a multi-discipinary approach in the wider care of elderly clients, allow for regular feedback, and facilitate case management.

The context

This innovation took place in the Southern Health Board Region[2], as a pilot for the Irish health service at large. Its introduction was facilitated by a national partnership programme which underpinned wage agreements - known as Workplace Partnership. Workplace Partnership is an approach to negotiating both substantive and relationship changes, based on the introduction of formal structures for joint participation of trade unions, managers and staff in decision-making. Its goal is to develop shared understanding and joint problem solving approaches in the workplace at an early stage in decision-making, leading to solutions that take account of the needs of all workplace stakeholders.

A key element of this innovation was a move to interdisciplinary assessment and case work – to allow for participation in need assessment and decision-making by the home help workers who had previously been excluded from these processes. This case study produces a microcosm of service innovation in the public health service because it encapsulates the innovation process from inception to retrospection.

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[1] All the stakeholders were supply-side based – there was no consultation with service recipients.
[2] Now defunct – the health board system has been replaced in January 2005 by a new national matrix management system – the Health Service Executive. Under this system the corresponding area is now called Health Service Executive Southern Area.

Political context

At the time the innovation took place, the Irish public health service had been actively engaged in a major change process for a number of years. This change was driven partly by a number of critical reviews of Irish health care (Prospectus 2003, Brennan 2003). Both reports pointed to the absence of a single organisation responsible for managing the health service as a unified national system. Also both reports commented on the disconnection between budget and practice: "systems are not designed to develop cost consciousness" (Brennan). Both reports recommended strenuous reform. In addition, at the time of this case study, considerable budgetary pressure was put on health providers as significant savings were sought across the health service.

These changes parralled the changing sectoral environment in which clinical best practice had been evolving for twenty years and with it an increasing acceptance of the benefits, and some would say neccessity, of multi-disciplinary work. This was particularly the case in the long-term care of the elderly. Since June 2001, all those over 70 in Ireland have been entitled to free health care under the general medical scheme. This means that everyone in this age group is potentially eligible for home help support, since it is provided under the general medical scheme.

The partnership group sought to test innovations in service delivery to the elderly with a view to process improvement, effective deployment of resources, and ultimately an improved service for the client group. The stated objective was to examine "the provision of a more responsive service to elderly clients in their own homes, underpinned by the framework of Partnership within the health service."

Why this case?

This case was chosen because it offered opportunities to examine a service innovation from inception to evaluation, and because the outcomes of the innovation were expected to feed into national policy on the public sector provision of care to the elderly, through the Partnership system.

Context

Role of home support

In 1980, the World Health Organisation (WHO) stated that elderly people are better off in their own familiar environments and in their own homes because this will enable them to maintain their independence and ability to cope (WHO, 1980). Further, in a 2002 WHO report it also is recognised that older people prefer to be in their homes. WHO recommends that this preference be recognised as "a human right rather than an option for policy makers."

In Active Ageing: A Policy Framework (2002) WHO notes that in all countries, and in developing countries in particular, measures to help older people remain healthy and active are "a necessity, not a luxury". In particular, WHO identifies the need for domestic support (home help) for frail, elderly people that allow them to be maintained in their own homes. The WHO perceives the provision of such services as part of the signatory nations' obligation and commitment to healthy ageing.

Internationally, various policies exist aimed at maintaining elderly members of the community in their homes where possible. The Scottish administration, for example, is committed to the objective that people should have the choice to remain at home. In a 1998 policy document, it encouraged the development of "a 'tartan' of mixed, flexible provision to meet local needs." Emphased in this is the provision of home-help service. As with all parts of the United Kingdom, however, a strong emphasis is also placed in Scotland on value for money and other economic considerations. Lobbying groups in the United Kingdom, such as the National Council on Ageing, for example, note that economic concerns may well impact the quality of service offered to older people. "Although the government wants to ensure quality, there are unresolved tensions between providing services as cheaply as possible, rewarding good providers and encouraging staff training and retention." (2002)

Historically, in most developed countries, the care strategy for older people, who do not have the support of family or neighbours, emphasised institutional care either in long-stay hospital beds or old peoples' homes. Many OECD member countries have sought to reduce this emphasis and develop systems more in keeping with the general thrust of the WHO policy in the area. Denmark, France and Sweden have all experienced significant reductions in the proportion of elderly people in institutional care in tandem with an expansion in home care services. In Denmark and Sweden this decrease was supported by the development of benchmarks for the reduction of beds in more traditional institutions - which were felt to be overprovided at the expense of other services. Canada, the Netherlands and Norway have adopted similar policies and there has been a significant downward trend in the overall institutional provision. The Nordic countries are high service countries with the greatest extent of home care services provided to the elderly of any OECD country, excepting the Netherlands. Most OECD countries have been pursuing policies aimed at maintaining older people in their homes for as long as possible in recent years.

The OECD estimates, however, that provision of home help is almost non-existent or at best negligible (with 1 per cent or less receiving home help) in Greece, Italy, New Zealand, Portugal and Spain. In all the countries mentioned (except New Zealand) there are also very low levels of institutional care, and the differing approach may well reflect differing social structures and increased integration of older people into broad family groups.

In 1996, the OECD classed Ireland as having very modest levels of home-help (2-3 per cent) along with Austria, Canada, Germany and Japan. Many areas of the United States also fell into this category. The countries classed as having a significant level of provision were Belgium, France, the Netherlands and the United Kingdom. The report identified the Scandinavian countries especially Denmark and Finland as having a very high provision of home help (over 10 per cent of older people receiving home help).

The report goes on to discuss the development of other alternatives such as sheltered housing and "assisted living" concept. For example, in 1988 Denmark halted the building of traditional nursing homes and modified existing nursing homes into self-contained apartments. This concept has been expanded in some areas, including parts of the United States to include the availability of twenty-four hour support and services – often referred to as "assisted living". The report recognises that home-help services have developed in most countries as a gradual adaptation to demographic changes, in parallel with rather than as a substitute for institutions. This is mirrored in the development of Irish policy.

Irish Policy

The home-help system has formally existed in Ireland for thirty-three years, having been established by the Health Act 1970 and the subsequent circular (1972). One of the key motivations behind providing a legal basis for home-help was so that elderly people could continue to live at home as long as possible, and reduce the admission to institutional care. The wording of the Act made it clear that the service was predicated on the non-availability of family members or neighbours who would provide the support voluntarily. It is essentially intended to provide assistance with domestic chores and, where appropriate, personal care.

The foundations for the home-help service, as laid out in the 1972 circular, reflect the different social circumstances of the time and imply considerable continued reliance on families and the voluntary sector. Health Boards were empowered to provide Home Help, but not obliged to do so, and it was only to be organised where the voluntary organisations could not provide the service or where families and neighbours could not provide home support. Individual health boards throughout the country have different approaches and policies with regard to the provision of home-help service. Some boards define uniform maximum hours per client, whereas others work on a case-by-case basis.

The considerable social shift occurring in the intervening thirty years means that family-based support is less available due to increased economic pressure and

increased numbers of women in the workforce. A marked increase in the proportion of older people in the community is also evident. Irish social trends mirror those internationally: "Of concern though are recent demographic trends in a large number of countries indicating the increase in the proportion of childless women, changes in divorce and marriage patterns, and the overall much smaller number of children of future cohorts of older people, all contributing to a shrinking pool of support for older people (WHO 2002 referring to Wolf 2001)."

Historically, a strong emphasis also was placed on voluntary and religious organisations as support mechanisms for older people. Both groups, however, have suffered from the general erosion of social capital. The scenario in recent years, therefore, is of increasing needs paralleled by reduced availability of social capital.

Is Home Help Optional or Essential?

In a 1994 document, the then National Council for the Elderly states that the "bedrock of policy on the care of the elderly for many years has been to enable older people to continue living at home in their own locality for as long as they wish and are able to do so". A review of most discussion and policy documents in the area echoes this disposition and acknowledges that older people who remain in familiar surroundings usually have a higher quality of life. "As the proportion of older people increases in all countries, living at home into very old age with help from family members will become increasingly common. Home care and community services to assist informal caregivers need to be available to all, not just those who know about them or who can afford to pay for them.(WHO 2002)." That remaining at home allows for continued contact with familiar and significant surroundings, the maintenance of relationships with loved ones and the retention of a sense of independence and control is widely acknowledged in the literature.

WHO (2000) acknowledges that some policy makers fear that the provision of more formal care services will lessen the involvement of families. However, WHO refers to studies that have shown that this is not the case.The report states that when appropriate formal services are provided, informal care remains the key partner.

 Further, in a 1998 research report, Haslett, Ruddle and Hennessy found that many older people felt very strongly that even where they had families they should not have to rely on them for care. Many respondents expressed the view that older people wish to maintain their independence and not have to rely on family or neighbours. The Haslett et al report emphasised that independence from family and neighbours was a priority need for many elderly people. "They want to stay in their homes but they do not expect or even want their adult children and much less their neighbours, to have to care for them".

The wish of older people to retain their independence even from their family and to be maintained in their homes may be due in part to negative impressions of

institutional alternatives. An extensive King's Fund research report in 2002 gives the following example:

> "One woman expressed many of the fears – costs, quality and boredom: '*I've a horror of being stuck in residential care. I've been in hospital a lot. I didn't want to go … I've heard that much about homes. My brother-in-law was in a home £400 per week – he didn't like it. My sister is a home – very expensive. She doesn't like it. My other sister died in a home – she hated it….Her hair was never done, her eyes were crusted …You are sitting there all day waiting to be taken to the toilet. Half the people were just sitting. They sat around the television.'*"

This type of negative perception, combined with the perceived burden of cost and the prospect of being detached from family and community, makes institutional care unattractive to older people. That is not to suggest that home help from non-family members is universally welcomed – many older people do not wish to have their private space invaded by strangers and/or expect family members to provide care. Nor is it always possible for family members to care for older relatives due to geographic distance, working arrangements, other responsibilities, or even estrangement (Nov 2000)." Also, as noted earlier in the King's Fund report, older people may wish to maintain their independence even from family members. Furthermore, with the change in family structures and the greater volatility of families in general, the availability of family support is likely to reduce.

Needs Assessment

In the current Irish system, potential recipients of home health care are identified in one of three ways – by health professional – either public health nurse or doctor, by family member/neighbour, or self-nominated. Up until the late 1990s, recipients would typically have had limited support networks and would mainly have been in lower socio-economic groups. Needs for home-help in the Southern Health Board region are assessed by public health nurses, based on the following information:

- Personal and demographic information;
- Modified Barthel ADL Index;
- 10 point mental test score;
- Home and social circumstances.

In conducting needs assessment public, health nurses will usually consult the client's physician.

If the client is deemed to need home-help, a recommendation will be made as to appropriate hours and necessary tasks. A home-help worker will then be identified and assigned to the client and the relevant tasks will be outlined and agreed between the client, the home help organiser/public health nurse and the home help. Tasks could include domestic work, collecting clients' pensions and where necessary personal care. This system is not however uniform across Irish

health boards and Lundstrom and McKeown (1994) commented on the potential conflict between *"the need for flexibility of service provision versus the desirability of having national standards of assessment of client need, eligibility and service provision."*

How it is done elsewhere

Needs assessment in other jurisdictions either mirrors the Irish system or is based on a multi-disciplinary assessment where a team of health care and social work professionals make the client assessment and an appropriate package of care is then devised. The new Scottish health executive proposed yet another model – a single shared assessment where one assessment would create the gateway to all health and social services and would create *"a passport to the full spectrum of community care services, with no subsequent reassessment necessary unless needs change."* This may well be in response to Stevenson's observation (1999) that users and carers within the United Kingdom system have to undergo frequent and often repetitive assessments, often with contradictory outcomes in order to access services. She noted that the systems in use in the United Kingdom varied a great deal, but that all included some element of 'activities related to daily life' (ADLS) and 'instrumental activities of daily life' (IADLs). However, she felt that few systems considered the potential for rehabilitation. Also, she felt that information gathering on cognitive patterns, mood states and social activity was patchy. Stevenson also noted that a potential reason for the disparities in needs assessment and the difficulties in arriving at an agreed common tool were to do with what she termed "professional tribalism" and the variety in objectives and economic and policy pressures on different groups.

Means-testing

A contentious issue within needs assessment is the extent to which the financial means of a client should be considered. This is discussed in the Haslett, Ruddle and Hennessy (op. Cit) research. The majority of service providers interviewed were of the view that financial means should be assessed to avoid inequitable access – the 'wrong people' ending up with home-help. However, the majority of older people interviewed considered means-testing to be an invasion of their personal privacy. In the United Kingdom and Canada there is increased requirement for people to contribute to and in some cases pay in full for home-help service.

For example, financial means are assessed in seven of 11 provinces/territories in Canada and some may require a contribution from the client. Quebec and Manitoba have no formal assessment process and do not charge fees. Quebec has a policy where priority is given to people on low incomes or people with no other options for care. Some areas of Canada have upper limits on cost for home support (personal care and homemaking). These limits are usually based on comparable cost for the individual in long-term care facilities. Some provinces

also have maximum hours of service per week – Quebec (35-40), Yukon (35), PEI (28).

Means-testing is seen by many, including the Irish National Council for Ageing and Older People and the United Kingdom' National Council on Ageing, as being potentially negative since it may limit access to the service to those of very limited means and those who are very well off, while those middle-income elderly are excluded. Interestingly in Finland, which is considered by the OECD to be among the leading providers of services to the elderly, access to home-help services is means tested.

Role of Home-Helper

The Irish home-help service, as described in 1970, was intended to provide assistance with domestic chores and, where appropriate, personal care. This parallels the WHO definition of tasks as instrumental activities of daily life (IADLs) – shopping, housework and meal preparation and activities related to daily life (ADLs) such as bathing, eating, using the toilet and walking across the room. No common set of tasks that home support workers perform exists internationally. In Canada for example, the consensu is that workers assist clients with the activities of daily living (feeding, bathing, dressing, toileting, mobility) and home support tasks (meal preparation, shopping, house cleaning, laundry), but no agreed definition of the role of home helpers (Health Canada 2003). This is similar to the Finnish system.

Social support

WHO also allows for the possibility that the carer might assist the elderly person with social contact, which is currently largely excluded from the brief of the Irish home help. Lundstrom and McKeown (1994) encapsulate the situation thus "In some areas there is the belief that the service should be provided purely on the basis of material needs caused by physical or instrumental disabilities. In other areas there is the belief that there should be a multi-dimensional approach taking into account social and psychological needs." Social support also is excluded in the United Kingdom except in extreme circumstances "Social services will often not provide support to people who are socially isolated – for example because they are physically unable to leave their homes – unless this isolation leads to risk of self harm or mental breakdown."

Splitting the tasks

The role of the Irish home-help worker tends to be spread among more than one person in the United Kingdom where domestic work is performed by different people than those delivering personal care (Curtice, Petch, Hallam and Knapp 2002). In developing the Scottish system after devolution of power, the Scottish Health Executive suggested that older people need access to a range of services

– a continuum of care – if they are to be properly supported at home. A mix including " intensive support and care schemes; more flexible and comprehensive short break services; and a practical, low level shopping/domestic/household maintenance service."

Some Irish health boards have split up elements of home care with the development of a care assistant/care attendant position. Lundstrom and McKeown (1994) contend that this development has not been integrated into the care continuum, making it unclear what the relationship between home help organisers, home helps and care assistants/care attendants. *"The belief in the evolution of personal care between client and Home Help versus the belief that the service should only provide instrumental care and that personal care should be the domain of another group (e.g. personal care attendants*". The practice in the United Kingdom where different aspects of the care package are delivered by different people has led to considerable frustration on the part of clients. *"One man described holiday and sickness periods as 'turmoil' when the people who looked after his wife changed constantly, behaved impersonally and did the minimum"* (Curtice et al 2002).

Downplaying domestic support

The United Kingdom National Council on Ageing point out that this division, between forms of care, and concerns about escalating costs have also led to the de-emphasis of the domestic help element of home-help in the United Kingdom. "Local authorities apply cost ceilings for help at home, and will usually only provide care above a certain level in a residential home setting. Provision for people who need a lower level of service – for example," domestic and practical help – has been eroded.

The emphasis in the United Kingdom on the personal care and on the care of patients with higher needs is perceived by many to have long term negative impacts. Clark, Dyer and Horwood 1998 argue that the policy is "short-sighted because low-level services …can have preventative significance and represent a long-term investment to prevent deterioration in independence, hence the priority given to them by older people themselves."

Need to be enabling
In determining the nature of a home-help's responsibilities, a potential conflict arises as to the extent to which the provision of home-help might increase the dependency of the recipient. Professional caregivers need training and practice in enabling models of care that recognise older people's strengths and empower them to maintain even small measures of independence when they are ill or frail (WHO 2002). This is reflected in statements such as the following from the Southern Health Board training manual for home helps, "To help the client maintain their independence and dignity encourage your client to work with you or to do little tasks themselves if possible…It may take longer but will help to sustain independence."

The National Council on Ageing also highlights a further potential issue with regard to the issue of promoting independence based on the experiences in the United Kingdom

> "Home care services are all too often provided on the basis of low cost rather than support for independence – for example, a person will be given 'meals on wheels' rather than help with cooking and shopping. Recent government policy has encouraged preventative services, but these appear to be aimed at keeping people with higher needs out of hospital rather than helping people with lower needs to maintain their independence."(2002)

Training for Home-Helps

In 1994, Lundstrom and McKeown, reporting on the home help service in Ireland, made the following statement "In some health board regions and community care areas staff training – especially of home helps – is considered superfluous. whereas in other health board regions and community care areas training is seen as an important tool in the provision of a well-run and caring service." This variety of approaches is also to be seen internationally. In Canada, the health authority 'Health Canada' is currently examining whether there should be a mandatory training programme. At present, five Canadian provinces have training requirements that range from a 22-week community college course in British Columbia to two years on-the-job training in Saskatchewan. The remaining five provinces have no mandatory training programme, although Alberta requires workers to complete a competency test. In Canada, payment for attending training sessions also is not uniform across all provinces (Health Canada 2003).

In the United Kingdom no nationally recognised training qualification for home helps exists, although training programmes have been developed by some trusts and social services training departments (Spencer 2000). In Northern Ireland, all home-help organisations provide training for their workers, though not all are trained, and most feel that workers are more committed if they receive training. Many Northern Ireland organisations encourage their home-help workers to achieve an NVQ relating to their work (NISCC 2002),

Process

How the innovation happened

In 2003, following on the publication of many national reviews on the health service, strong national impetus for change in the health service developed. As part of this impetus, the Health Services National Partnership Forum (HSNPF) invited applications from health agencies for projects aimed at examining flexible work practices in the health service. The SHB workplace partnership group identified the home help workers as a group with a pre-existing potential for flexible working. HH were uncontracted workers who were hired on a case-specific basis, and did not have a guarantee of continuity of employment. They further saw an opportunity to increase the degree of team-working and ultimately to improve the service to elderly clients. Based on this they successfully applied to the national partnership body for funding to examine potential innovations in the delivery of the home help service. It was expected that if the SHB study was successful any new systems would be rolled out across the country, through the aegis of the HSNPF.

On receiving the funding, the SHB partnership group conducted baseline research through focus groups with Home Helps (HHs), Public Health Nurses (PHNs) and Home Help Organisers (HHOs) to examine their views on the current communication processes, and current work practices. From this feedback, a new system of communication and service allocation was devised. The system innovation was then introduced and evaluated.

The actual innovation is described diagramatically below:

	Process pre-innovation		Innovative process
Step 1	Client requests service	Step 1	Client requests service
Step 2	PHN conducts assessment using Green Book	Step 2	PHN conducts assessment using New Form
Step 3	Number of hours and duties decided on the basis of the assessed dependency	Step 3	Number of hours decided on the basis of the assessed dependency
Step 4	Number of hours broken down by task (PHN, HHO)	Step 4	Authorised by ADPHN
Step 5	Authorised by ADPHN	Step 5	HH, HHO & PHN meet as a group and determine/agree • Number of hours • Expected duration of service • Duties to be undertaken • Review date agreed in consultation with client
Step 6	HH commences service	Step 6	HH, HHO and client (& carer) meet to cover • Number of hours • Expected duration

			• Duties to be undertaken • Review date
Step 7	Review where Steps 2-5 are repeated	Step 7	HH commences service
		Step 8	Review – where steps 2-6 are repeated

Worker views Pre-innovation

The baseline research showed that there was limited knowledge on the nature of the needs assessment process, and the associated consultations, among the HHs. Some HHs felt that there should be a more structured system of care and contact with increased visits to their clients by PHNs. Many felt that the communication process with other members of the SHB care team for their client was reactive only. This was confirmed by the responses from PHNs and HHOs.

The focus groups also showed that HHs felt a considerable disconnection from other HHs and did not see themselves as having a group identity. They felt disconnected from the SHB, although they recognised it as their employer. HHs also perceived themselves as having little or no power and as not being respected by other members of the care team. A number felt unsure about their position within the care team and relative to clients' family members.

In interviews with PHNs and HHOs, a mixture of views was expressed as to roles and responsibilities in the home help service. Varied communication practices were revealed. Also it was clear from the initial focus groups that a degree of concern existed about the change in pay differentials wrought by a government decision to make a blanket increase in HH pay two years previously. This pay raise (an effective tripling of pay) meant that, in some cases, weekend pay rates for HHs were only marginally less than those for qualified nurses. While PHNs and HHOs recognised that previous pay rates had been too low, it was felt among some that the pay raise ought to have been provisional and related to changes in work practices. This pay change resulted in considerable over-spends on the home help service since there was not a commensurate increase in budget to the health boards.

Developing the new process

In response to the issues identified in the focus groups, the communication process for the pilot project aimed to involve all key stakeholders in meetings where roles, duties and hours would be discussed and clarified. Once hours were allocated, a meeting among the PHN, the HHO and the HH would first be held, followed by a meeting among the HHO, HH and the client. In this way, it was hoped that all those involved would share information. The hope also was that the practice would reduce misunderstandings around appropriate duties, boundaries and roles of the HH for all involved from the PHN to the client and facilitate sharing core information about the client, and any potential changes in client needs.

In addition, a new needs assessment form was developed which would allow for feedback from HHs and continual review. Following the meetings, according to the protocol, the HH, would sign off on her/his understanding of the hours and duties assigned to the individual client on the new form, along with the HHO and the PHN.

Implementation

The new system was piloted in two sub-areas of the SHB region over a twelve - week period. In both areas, the new system was to replace the old, though the PHNs continued to use both old and new assessment forms when assessing patient needs as a comparative exercise.

Feedback on the new communication process

At the end of the twelve-week pilot period, focus groups were conducted again with feedback gathered from both the PHN/HHO/AD and HH groups. The feed back around the new system was largely positive, although there was a considerable increase in bureaucracy due to the completion of both the old and new needs assessment forms. There was also a large increase in time required to organise and co-ordinate team meetings

The PHN/HHO/AD group felt that HHs who had participated in the pilot scheme were "well geared up for what they were going into". So the initial investment of time in the team meetings was felt to "pay dividends" as HHs appeared to be more sure of what they had to do and required less clarification later on.

> *"I found it was very beneficial being able to sit down with the PHN and the client and the HH and we were able to sit there and discuss the actual service that was going in because we all knew what the expectations were"*

The new needs assessment form also was seen to support the new communications process. The PHN/HHO/AD group felt it acted as a tool to clarify needs and tasks with stakeholders and as being a record to underline the accountabilities.The HHS, however, did not always share these views. Some were aware what they were 'signing up to' but others, while they valued the discussion, did not seem to put much importance on signing the form.

One participant felt that the new form involved HHs more, which was seen as positive. It was felt that the new form allowed for better communication with the person actually doing the work (HH) and that the involvement of the HH in signing off on the actual duties fostered a greater degree of openness, particularly in what the HH is expected to do.

The new communications system meant that HHs were more specific when they came back to PHN/HHO/ADs with concerns about clients and work-related issues, it was felt. Those responding also said that HHs were taking a more formal attitude to work with regard to timekeeping, keeping to specific tasks,

engaging in consultation, being accountable and reporting changes in work situations.

The team meeting with the client was seen as very beneficial. Participants felt that, while consultation had previously been possible, it was very disjointed and rarely face-to-face. Most communication prior to the new system happened over the telephone. The team meetings were seen to be beneficial to all parties, in clarifying expectations and requirements, and also in offering HHs protection from unreasonable client expectations. However, concerns were raised about the impact on a new client (or even some existing clients) of up to four people coming into their home at once to do the assessment.

HHs felt that the new communication system was very useful in clarifying their role for the client. However, they went on to say that there were times where they felt they had to work outside the boundaries of their duties for clients – either because they deemed a task to be necessary to the client or because they found it difficult to refuse a request. HHs said the new structure made them feel better about contacting their HHO with concerns, where they had previously been unsure about the appropriate course of action. In particular, they felt that the team meetings gave them opportunities to ask questions and seek clarifications. One comment was that it was "good to be included".

Some negative perspectives

Some of the feedback was more negative. One respondent, for example, said *"€ 75,000 being spent on a paperwork project [sic] was unpopular when HHs were getting hours cut".* At the time the innovation was being introduced, there was considerable local and national debate about the nature of the home help service, and the fact that home help hours were being cut back for a number of clients.

Some HHs felt that there was a gap in understanding with regard to their clients' real needs and that some of the restrictions on the service that had been outlined to them were unrealistic and revealed an absence of understanding. One HH said that there were *"Rules - as if every situation is the same – it's not".* The HHs gave examples such as the need to take clients to hospital (*"[you couldn't] leave them (the clients) organise a taxi?"),* collect prescriptions, or inadequately defined times to task. They feel for example that there is a conflict between the expectation that they would collect client prescriptions during their allocated hours, and the fact that they had been told they were responsible for their client's wellbeing during their allocated work hours. Comments expressing their difficulties included

"Very hard to say no to someone old"
"Teaching us to say no, but you can't say no"

Follow-up

Following on the final feedback on the pilot, a report was made to the SHB partnership working group, who in turn reported back to the Health Services National Partnership Forum. However, in the interim period a number of significant changes had taken place. Most notably a decision had been made to scrap the health board system and develop a new national health service management body – the Health Service Executive. Also, budgetary pressures, that had been so exacting during the period of the pilot, seemed to have relented and there was less pressure for home help expenditure to be reduced. For these reasons, the new system was not introduced on a wider basis and the SHB home help system reverted to prior practices.

It should be noted that, while there was re-branding of the structures, many of the same individuals remained in the same positions with the same responsibilities and briefs. If they had wished to introduce the new system on a more permanent basis, and on a wider scale, the restructuring of the health service would not have been an impediment. In fact, it may have assisted the innovation through the presence of a structure with national responsibility. In considering why the various players chose not to continue the new system, one key reason seems to present itself – a degree of innovation-fatigue. There had been many changes in the public health service over the previous ten years, and many similar test-innovations. The permanent staff was disinclined to fully buy in to the new system on the basis they had little faith it would be supported in the future.

Discussion

Interpreting the results of the study by relating them to the PUBLIN statements (see appendix).

Initiation

Public Sector innovation at the service level is problem driven.

In this case study the driver for innovation was the availability of funding, combined with a perceived gap in service delivery. The availability of funding allowed the SHB to introduce a new more integrative form of delivery in the home help service.

Supporting rationales included changes in international best practice and the National Partnership initiative which sought to improve working practice in a general sense.

The innovation could be defined as reactive since it responded to a funding opportunity.

Recognition of the need originated at service level and was supported by funding opportunity, but identification of need for increased integration and new system of working was at service-level

Performance targets are a driver for public sector innovation

In this case, the key drivers for innovation were budgetary pressure, change in best practice in domicilary support of the elderly and work-based partnership model.

Performance targets are a facilitator of public sector innovation

There was no evidence of this in this case study. Incentivising innovation would seem to be laden with private sector values which may ultimately prove detrimental to the nature of a service such as care for the elderly – this has already been borne out in the UK model referenced earlier in the context-setting for the case study.

To what extent is this a 'top-down' (i.e. policy-led) or 'bottom up' (i.e. demand/practice led) innovation?

This was a bottom-up innovation. It is unclear whether the locus of the innovation had any impact on potential diffusion since the organisational environment changed so radically that previous conditions no longer held by the end of the innovation process. It would seem likely from case study respondents' views that, in order for the innovation to be more widely diffused across the organisation, it would have to be embraced and formalised at policy level.

Design and development

This service innovation is developed through the imitation of private sector practice.

This innovation does not and could not mirror private sector practice since there is no private sector equivalent to this service.

The choices and features of this service level innovation are influenced by underlying organisational politics, dominant values and belief systems.

The features are driven by the assessments and perspectives of the professional groups, who are the full-time workforce. The baseline work done to underpin the innovation was an attempt to include the perspectives of HHs, but given the professional and organisational standing of the PHN/HHO/AD staff there was, perhaps inevitably, a bias towards their perspectives in the design of the new system.

Was the end user involved in the innovation process? If yes, were they involved in order to improve the design features, to increase acceptance of the innovation and/or for other reasons?

The end-users of the service were not involved in the design process, because many of the changes were in processes to integrate decision-making from the

delivery side, rather than in changing the ultimate nature of the service as received by the client. The feedback from the HHs in the evaluation element of the project would suggest that there might be merit in garnering a consumer-perspective. They highlighted the fact that many services that older clients needed in their home,s such as the changing of light bulbs, or minor maintenance (which were outside their formal remit) were still necessary, and that new models of service delivery were still unconsciously underpinned by an expectation of willing family/neighbourly support which many clients did not have.

Selection, Diffusion and Utilisation

The diffusion of this innovation required effective
Networking
Competence building
And alternative thinking

This innovation was not diffused, due to significant organisational change, and a lack of buy-in by local professionals.

The diffusion of this innovation required co-ordination between different government institutions and/or departments.

Not relevant to this case

Direct political intervention, or stimulus by a crisis situation was needed.

Not relevant to this case

Evaluation and Learning

What was critical role of evaluations in the innovation process?

The university was involved in the evaluation of the process, and a concerted effort was made to get feedback from all stakeholders (except clients who were never directly involved).

No rethink occured within the organisation – this may have been due to external changes.

The innovation was broadly welcomed by all stakeholders consulted.

The only bottleneck produced by the process was increased paperwork due to the parallel use of both assessment forms – this would have been a short-term bottleneck since one form would have been phased out on adoption of the process.

The innovation did not induce any other innovations.

There was no direct policy learning captured from the innovation, though there may have been insights into related HR issues.

The entrepreneurs

There was no single entrepreneur in this innovation – the new system was designed by a committee, based on consultation with stakeholders and with best practice. Co-ordination was conducted by someone from the wider organisation, who had no direct involvement in the service in question.

Interaction policy-level and service-level (feedbacks)

Not relevant

The evaluation criteria were defined in part by the external (university) evaluators who were tasked to deliver a dispassionate assessment.

Policy recommendations

The innovation may have had a better chance of survival if it had been tied to a broader national policy that was clear in its intent. Two counter-vailing values were at work which could not be resolved without this clarity at the national level. The change in demographics and lifestyle, that make it difficult for families and community members to care for the elderly, is not necessarily resolved by a more efficient delivery of services. A social policy that implies a desire for increasing 'social capital' in circumstances, such as those presented by an ageing population, should express that value in a way that makes sense of demographic changes and which does not penalise women in the workforce. Programmes that bypass this transitional stage in the Irish culture without giving it due thought, will accomplish neither greater efficiency nor the improvement of social conditions. Further, they will miss the opportunities that are presented by the elderly to rebuild strong, caring social relationships.

Clearly expressing the value – as it accommodates social changes – provides dialogical space for exploring alternatives to service delivery and the training of providers that create synergies among the value of efficient use of public resources, the need for strenghthening the basic relational fabric of Irish society, and changing times.

Secondly, the programme may have failed to endure – beyond the lack of budgetary incentive – because it attempted to resolve issues programmatically and bureaucratically that could have been more easily resolved by attention to agency culture. In reviewing the comments of those who supported the innovation, for example, it appears that the key strength was seen to be that the innovation brought disparate members of the same system in contact with each

other. The primary advantage of the new assessment form was that is promoted a dialogue among administrators and the service providers. In highly effective organisations, this dialogue is a given part of the organisational culture and tends to generate a pattern of relationship and service that works and is sustainable in a given environment. If there is policy in this regard, it would be budgetary support for the development of health service organisational cultures that have the capacity to both be efficient and optimise social capital – including development of the capacity of clients to assist themselves and others. Again, without a clear expression of the intent to preserve and enhance social capital, workers are often discouraged from involving clients who, because they are not bureaucrats, appear to be overly time consuming and therefore impediments to a more bureacratised process.

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On the PUBLIN case studies

The following general presentation is based on the PUBLIN guideline report for case study researchers. See also the introduction to the case study summary report.

The overall aim of this PUBLIN study has been to gain insights into the processes of innovation and the associated policy learning in the public sector. These should contribute to the development of a theory (or theories) of innovation in the public sector, and contribute usefully to policy analysis. Within this study framework, the aims of Work Packages 4 and 5 (the case studies) have been *to understand the interplay between policy learning and innovation at the policy level, and innovation at the service level within the public sectors under study.*

More specifically, the objectives of each Work Package are:

1. To understand the innovation processes present within national public health systems/social service systems.

2. To understand the learning processes underlying policy development in publicly regulated health/social service sectors.

Innovation

Green, Howells and Miles (2001), in their investigation of service innovation in the European Union, provide a suitable definition of the term innovation which denotes a process where organisations are

> *"doing something new i.e. introducing a new practice or process, creating a new product (good or service), or adopting a new pattern of intra – or inter-organisational relationships (including the delivery of goods and services)".*

What is clear from Green, Howells and Miles' definition of innovation is that the emphasis is on novelty. As they go on to say,

> *"innovation is not merely synonymous with change. Ongoing change is a feature of most... organisations. For example the recruitment of new workers constitutes change but is an innovative step only where such workers are introduced in order to import new knowledge or carry out novel tasks".*

Change then, is endemic: organisations grow or decline in size, the communities served, the incumbents of specific positions, and so on. Innovation is also a common phenomenon, and is even more prominent as we enter the "knowledge-based economy".

An innovation can contain a combination of some or all of the following elements:

- New characteristics or design of service products and production processes *(Technological element)*

- New or altered ways of delivering services or interacting with clients or solving tasks *(Delivery element)*

- New or altered ways in organising or administrating activities within supplier organisations *(Organisational element)*

- New or improved ways of interacting with other organisations and knowledge bases *(System interaction element)*

- New world views, rationalities and missions and strategies. (Conceptual element)

Case study statements

In an effort to define a common methodological framework within which to study innovation in the public sector, several research orientation statements were put forward and related policy questions suggested.

These give a *'problem driven view'* of the issue under study. It should be strongly emphasised that this list was only intended to be indicative of what propositions might be tested and it was revised during the course of the PUBLIN study.

For instance, the following statements were added to the ones listed in the table below:

Entrepreneurs played a central role in the innovation process
- Was there a single identifiable entrepreneur or champion?

- Was the entrepreneurs assigned to the task?

- Had the entrepreneurs control of the project?

- What was the key quality of the entrepreneurs? (management, an establish figure, position, technical competence, access to policy makers, media etc)

- Incentives

There was no interaction between policy and service level (feedback)
- To what extent was the policy learning a result of local innovation?

- Are local variations accepted, promoted or suppressed?

- To what extent does the innovation reflect power struggles at the local and central level?

- Was there dissemination of the lessons learned, and was this facilitated by specific policy instruments?

- Where there evaluation criteria? (When?)

- Who where the stakeholders that defined the selection criteria? Did problems arise due to the composition of this group of stakeholders?

- How did the interaction and/or the interests of the stakeholders influence the selection of the indicators used?

Policy recommendations
Based on your experience from case studies, give concrete policy recommendations.
1. Preset also policy recommendations given by the respondents

2. Are the any examples of "good practice"?

The case study reports all try to comment upon these statements.

Moreover, all participants were also asked to use a comparable design for the case study itself and for the case study report.

Service Innovation		Policy Learning	
Statements	**Questions**	**Statements**	**Questions**
Initiation		**Initiation**	
Public sector innovation at the service level is problem driven	What was the primary rationale for the innovation under study? Were there supporting rationales? Was the innovation developed proactively or reactively? Where did (recognition of) the need for the innovation originate?	Public policy learning innovation is problem driven.	How can specific problem-orientated policy innovations be transformed into more general forms of policy learning? Is policy learning largely a reactive or proactive process?
Performance targets are a driver for innovation. Performance targets are a facilitator for innovation.	What are the most appropriate incentives and drivers for innovation in the public sector system under study? Be aware that it may be a driver and not a facilitator	Policies directed at performance measurement are a driver for policy innovation Policies directed at performance measurement are a facilitator of policy innovation	What are the most appropriate incentives and drivers for innovation in the public sector system under study? Be aware that it may be a driver and not a facilitator
This innovation is "top-down" (i.e. policy-led) as opposed to "bottom-up" (i.e. practice-led).	Does the location of the pressure for the introduction of an innovation impact its diffusion and development? Each country case should describe to what extent it is a top-down or a bottom-up innovation	This innovation is "top-down" (i.e. policy-led) as opposed to "bottom-up" (i.e. practice-led).	Does the location of the pressure for the introduction of an innovation impact its diffusion and development? Each country case should describe to what extent it is a top-down or a bottom-up innovation
Design and Development		**Design and Development**	
This innovation is developed through imitation of private sector practice.	Where did the innovation arise? Does it have models outside or inside the public sector?	This innovation is developed through imitation of private sector practice.	Where did the innovation arise? Does it have models outside or inside the public sector?
The choices and features of this innovation is influenced by underlying organisational politics, dominant values and belief systems	To what extent have the choices and features been driven by conflicts (specify: power, funding, belief systems … etc) between different stakeholders? How did the introduction of the innovation overcome the resistance to change at the service level?	The choices and features of this innovation is ° influenced by underlying politics, dominant values and belief systems	To what extent have the choices and features been driven by conflicts (specify: power, funding, belief systems … etc) between different stakeholders? How did the introduction of innovations overcome the resistance to change at the policy level?
The end user was involved in the innovation process	What was the role of the end user? Were they involved in order to improve the design features or to increase	The end user organization was involved in the innovation process	What was the role of the end user organisation? Were they involved in order to improve

	acceptance of the innovation and/or for other reasons? If they were not involved, explain why.		the design features or to increase acceptance of the innovation and/or for other reasons? If they were not involved, explain why.
Selection, Diffusion and Utilisation		**Selection and Deployment**	
The diffusion of the innovation required effective 1. networking, 2. competence building and 3. alternative thinking		The selection and deployment of the innovation required an environment that encouraged effective 1. networking, 2. competence building and 3. alternative thinking	
The diffusion of this innovation required co-ordination between different governmental institutions and/or departments	How can inter-governmental roadblocks be by-passed? To what extent does intra-governmental co-ordination depend on direct political interaction? To what extent does intra-governmental co-ordination depend on stimulus from a crisis situation? Does fragmentation of government create a barrier?	The most challenging public policy innovation takes place at the intra-governmental (inter-functional) level.	How can inter-governmental roadblocks be by-passed? To what extent does intra-governmental co-ordination depend on direct political interaction? To what extent does intra-governmental co-ordination depend on stimulus from a crisis situation? Does fragmentation of government create a barrier?
Evaluation and Learning		**Evaluation and Learning**	
Evaluation played a critical role in the innovation process Research institutions played a critical role in the innovation process Interaction with other institutions/firms played a critical role in the innovation process	Did the innovation meet the expectation of the stakeholders at various stages of the innovation process? Did the innovation have unintended consequences (e.g shifting bottlenecks)? Did the innovation induce other innovations? Is there evidence of policy learning and any associated structure? Had lessons been drawn from earlier innovation processes?	Evaluation played a critical role in the innovation process Research institutions played a critical role in the innovation process Interaction with other institutions/firms played a critical role in the innovation process	Did the innovation meet the expectation of the stakeholders at various stages of the innovation process? Did the innovation have unintended consequences (e.g shifting bottlenecks)? Did the innovation induce other innovations? Is there evidence of policy learning and any associated structure? Had lessons been drawn from earlier innovation processes?