Taking Stock of the New Managerialism in English Social Services

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In Britain, and elsewhere, attempts to install a new regime of management in social services have been continued and relentless. Existing modes of professional organising were criticised for being inefficient, self-serving and failing to respond to the needs of clients. Indeed, for many, the personal social services were '…a metaphor for all that was considered to be wrong with the welfare state' (Harris and McDonald, 2000: 57). To deal with this, attention focused initially on cost reduction and then, later on more radical changes in management. Social care organisations, it was argued, needed to adopt both the practices and the priorities of commercial firms. First under the Conservatives and then, after 1997, under a New Labour government (and a slightly different banner of 'modernisation'), the pressures for such change has continued unabated.

In much of the literature the assumption is that these new public management [NPM] reforms have already substantially transformed professional work. This view is especially prominent in practitioner-based accounts, but can also be found in the more critical literature. Here too the tendency is to treat 'the claims of NPM advocates as though they describe new realities…' (Clarke *et al.* (2000: 7). While the contested nature of restructuring is often acknowledged, few question the idea that the long-term trajectory is towards more corporate and managerial modes of operation. Management values and priorities have or soon will colonise professional work, leading to new incentives, perceptions of significance and mentalities.

The aim of this paper is to question this account of change and suggest and present an alternative to it. In doing so I do not wish to argue that management restructuring has had no impact whatsoever. On the contrary, the evidence points to marked shifts in the way social services operate and in the priorities that now govern much professional work. That said, it is important to question the idea that professional modes of organising have been completely displaced. One must draw attention to the uneven, contested and problematic nature of the reforms. Indeed, in my view the organisations of social care should not be viewed as passive instruments of policy. It cannot be assumed that whatever new policies were deemed necessary were simply translated into new, intended, patterns of action. Because social services have been, and to a considerable extent continue to be, provided by professionals within specific forms of organisation in which they hold key positions, the effects of change have been not always what was expected. The capacity of these groups to negotiate or 'capture' change in ways that minimise disturbance to their day-to-day activities should not be under-estimated.

To address these concerns my focus will be on analysing the nature and effects of management restructuring in English social services departments (SSDs) over a twenty- year period. Given that the evidence on such change is fragmentary - there exist no longitudinal sources - my approach is to draw on the abundant range of secondary data sources from the

academic and practitioner communities. Inevitably this means relying on ad hoc studies with different baselines and research questions. But, while it is hard formally to test the impact of management reforms using such data one can draw general and reliable conclusions about the nature of the changes that have occurred.

The remainder of this paper contains four main sections. First I provide background information on the formation of SSDs and the nature of professional organization within them. Following this, attention turns to the broad policy context and to government attempts, over the past two decades, to restructure management. Section three then focuses on an assessment of change, drawing on a range of secondary sources. Finally, in the concluding section, some of the more general consequences of this restructuring are discussed.

Background

The main focus of this paper is on local authority Social services departments (SSDs) [1]. These were first established in England and Wales after 1971 following the recommendations of the Seebohm report (Webb and Wistow, 1987). The function of these departments was and remains, to assess social care needs and provide (or, increasingly, commission) services for different client groups (adults, children, and families) within a given geographical area. In 2002 there were 149 local authority SSDs in England, employing 277200 staff. Although only a minority of this workforce, approximately 44,000, were professionally qualified, social workers were able to monopolise senior management positions (LASW, 2005).

In organizational terms, SSDs were (and remain) highly bureaucratic, with well-defined hierarchies and detailed rules prescribing services and entitlements. Many social workers resented this attempt to regulate their practice and saw it as a 'perverse imposition' (Howe, 1986: 1). But while professional discretion was limited (especially where resources were concerned) one should not exaggerate this. In most departments a pattern of custodial administration emerged, one that allowed social workers considerable de facto autonomy to shape both the nature and goals of service provision (Ackroyd et al., 1989). Management (even if recognized as such) tended to be weak, unobtrusive and ineffectual as a mechanism for directing services. This, in turn, helped to foster a strong sense of professional identity and a commitment, at local levels, to existing client groups and ways of delivering services. As such, it might be argued that the 'bureau-professional hierarchies' of UK SSDs 'were as much a basis for the power exercised *by* social workers as the basis for the exercise of power *over* social workers' (Harris, 1998: 844).

The Changing Policy Context in UK Personal Social Services

With the advent of a Conservative government in 1979, pressures on expenditure in SSDs (which had begun earlier) were intensified. From the early 1980s, political demands for change mounted in a climate of growing concern over spiralling budgets (for example, for residential care) and a succession of highly publicized inquiries questioning social work judgment (Stevenson, 1994). In this period the New Right also played an important role in highlighting the so-called failings of social work (Cochrane, 1993).

These developments led to moves by the Conservative government in the late 1980s to seek radical reform. A key vehicle for change was the NHS and Community Care Act (1990). This legislation aimed at achieving a transformation from institutional to community based services (or from residential to domiciliary care) and encouraged 'needs' rather than supply led approaches to service organization. SSDs, it was argued, should focus on identifying need and the strategic commissioning of services rather than on their provision. Considerable

emphasis was also placed on developing a mixed economy of care, with local authorities acting as purchasers of services from the independent sector.

A further piece of legislation, the Children Act 1989, also heralded important new directions in policy. The main aim of this Act was to create a unified and coherent framework for public and private child welfare law, altering the grounds upon which the state (represented by the social work profession) could intervene to protect children (Parton, 1991). One consequence of this has been a shift towards more tightly regulated and, in some cases, risk-averse approaches towards decision-making.

During the 1990s, all these demands for change were introduced in a 'climate of financial retrenchment' (Lewis and Glennerster, 1996: 70). Most SSDs were forced to make cuts in the overall levels of services they provided (or purchased) - especially in areas such as residential care (Evandrou and Falkingham, 1998: 254). Financial constraint led to the introduction of policies of charging for services not previously charged for and the use of explicit rationing and means testing (Challis et al., 2001). Finally, budgetary pressures were associated with a rise in the caseloads of many front line professionals and growing demands on them to speed up the pace of work (Jones, 2001: 553).

In many key respects these broad trends in policy and funding continued after 1997 (Orme, 2001). New Labour did not reverse earlier policy goals (relating to mixed economy) and continued to highlight the so-called 'failures' of the social services (Langan, 2000). Indeed, under the banner of 'modernization' central government is now even more prone to intervene to regulate professional training and practice.

Towards 'Managed' Services

Interest in reforming the management arrangements of SSDs began soon after their formation in the early 1970s. However, it was only after 1990, following major new legislation (see above) that this pressure really intensified. Policy makers argued that radical change was needed to achieve the shifts in policy heralded by the NHS and Community Care Act and Children Act 1989. The expectation was that SSDs would be transformed into 'managed services', focused on meeting needs, targeting resources and effectively regulating the practice of front line professionals. To this end considerable emphasis was placed on investing in systems for strategic planning, financial control and the management of contracts (Harris, 1998; Wistow et al., 1996). There were also calls for a major rethink of the way professional work itself was organized. SSDs were urged to implement purchaser-provider splits (Lewis et al., 1996) and systems of 'care management'. The aim was to formally separate professional tasks associated with assessing needs and the purchase of care packages from those of providing services (Lewis et al., 1997).

In some respects the pressure to implement management change was less intense in SSDs than in the National Health Service (for more information on the latter see Kirkpatrick et al., 2004). No attempt was made to re-organize the sector as a whole or create new management boards that were independent of local political control. But demands on senior professionals to respond to new policy were considerable nevertheless. Most SSDs did undergo formal restructuring during the 1990s with a majority introducing new regimes of financial control and some kind of internal purchaser-provider split (Challis et al., 2001).

The advent of a New Labour administration did not see a major reversal of this policy of enhancing management. If anything, the drive for such change has become even more

pronounced. Under Labour there has been a stronger emphasis on using performance targets and frequent inspections of services to influence practice (Langan, 2000).

Assessing the impact of the new managerialism

This section now focuses on the impact of these management reforms on English SSDs, drawing on a range of secondary sources. Three main dimensions of change will be considered. First is the development of general management roles, functions and capabilities. Second is whether management control over the nature of service delivery has been extended. Finally I look at changes in culture and values.

Strengthening the Management Function

The first and perhaps not surprising observation to make is that senior and middle ranking professionals in SSDs are now clearly more involved in management than before. In most departments, 'budget management and control' has taken on far greater importance (Jones, 2001: 552). According to one report there has been 'an impressive investment in staff time and technology' in this area (SSI, 1999: 21). Beyond this is evidence to suggest that senior professionals are spending more time on activities such as contract management, strategic planning and human resource management.

This shift towards management work can also be seen in the delegation of responsibility for budgets and other administrative functions. One recent survey found that 82% of SSDs in England had devolved some budgetary authority to purchase community based care packages to 'first tier management or below' (Challis et al., 2001: 679). Added to this, professional staff at all levels are now receiving more management training than before (LAWSG, 2005). Such changes, while variable, indicate that management skills are becoming increasingly important. The once sharp divide between professional and managerial domains of work has slowly been eroded.

Notwithstanding the above, one would also wish to question how far management capabilities in SSDs have really been enhanced. Despite rising investment, in most cases, management systems and capabilities remain weak and underdeveloped (Whipp et al., 2004; AC/SSI,1999a; AC/SSI, 1999b; SSI, 2002). Even in the area of financial management it has been noted: 'most councils do not fully understand costs and struggle to forecast future activity and expenditure' (SSI, 1998). Many SSDs have been unable to devolve budgets completely or establish internal trading systems (between purchasers and provider functions) (Wistow et al., 1996: 75; SSI, 1999). Few it seems have adopted the kind of systematic approach to financial accounting envisaged in policy and guidance.

Management weaknesses in SSDs are even more profound when one turns to the activity of planning and the development of services. In most cases, the approach to these issues remains 'ad hoc or opportunistic' (SSI, 1999: 77), with Community Care Plans often representing little more than 'public relations exercises'. Indeed, the general conclusion of a number of investigations is that social services have yet to achieve the kind of 'whole systems' approach to strategic planning envisaged by the NHS and Community Care Act (Audit Commission/SSI, 1999a: 32). The vast majority of SSDs, it would appear, remain operational-led rather than needs driven in focus.

A number of explanations may be given for this rather limited success in implementing policy. First is the weak tradition of managing in social services and, until recently, a lack of core skills - or 'mental furniture' (SSI, 1999) - to perform the complex work of strategic

planning. The operational focus of SSDs is also reinforced by the relative scarcity of non-operational managers compared to other areas of the UK public sector (Ackroyd et al., 2006). In the 1990s, as many local authorities engaged in downsizing and re-organisation it appears that the number of senior managers in England actually fell by 9.7% ((LGMB/CCETSW, 1997). More recently the number of 'central/strategic and HQ' has increased, but only slowly, from 17,000 in 1998 to 18,000 in 2002 (Department of Health/National Statistics 2003).

Controlling the front line

As suggested earlier a key feature of policy is the attempt to achieve greater control over social work practice. Such change was deemed necessary to make providers more accountable and to ensure consistency of access to services. Not surprisingly the past decade witnessed a marked increase in the volume of rules, procedures and tick box pro forma used to standardise decisions about care planning and needs assessment (Lymbery 2001). Procedures have also been introduced for the 'scrupulous gate-keeping and strict rationing of scarce resources' (Harris 1998). One survey of English local authorities found that 52% had established policies aimed at 'targeting' budgets according to need or risk (Challis et al., 2001).

These developments led to changes in the nature of professional work. Decision-making is now more constrained by 'ever increasing procedural instructions' (Postle, 2002: 343). There is also evidence of work intensification. Drawing on a survey of 60 care managers in seven community based social services teams, Weinberg et al (2003: 914) note how a growing amount of 'direct time' (currently, over 50%) with clients is now taken up with administrative tasks such as completion of assessment forms. This in turn is attributed to an 'increasing focus on assessment turnover' within SSDs. Carey (2003) also found that care managers were devoting a greater proportion of their time on routine paperwork, with up to 25 hours (out of a total of 35 each week) spent confined to the local authority department office. .

Finally, there are signs in many SSDs that greater emphasis is now being given to the monitoring and evaluation of the 'performance' of front line staff. Whipp et al. (2004) found that a majority of SSDs (from a sample of 12) had adopted policies aimed at regulating both the frequency and content of supervision – the latter focused on making supervision more 'judgmental' or inquisitorial.

The changes described above clearly are significant. As Harris (1998: 858) suggests the 'emergent trend' is now quite unambiguously towards 'proceduralisation and commodification of the social work labour process'. But, while the trend may well be in this direction one must also recognise that change has been more variable and less effective than many assume.

This conclusion emerges from a number of studies and reports. One report by the SSI, for example, concluded that eligibility criteria for allocating resources are 'easily fudged' as staff 'applied their own judgments' (SSI, 1999: 46). Decision making about resources tended to be either 'idiosyncratic or based on logics other than those stated in the eligibility criteria' (ibid). Management information systems are also often inadequate. According to a joint study of the Audit Commission and SSI (AC/SSI, 1999: 28) managers were 'not using the information that is available to assist them in monitoring activity or performance'. Other research confirms this picture and suggests that in many SSDs professionals now receive less formal supervision than before (Jones, 2001). A national study of residential care management in 12 SSDs, found that increasing work pressures on line managers had resulted in 'marked variations' in the 'regularity of supervision' (Whipp et al. 2004). Postle (2002: 344) also observed how: 'Few

opportunities existed for care managers to reflect on their complex work in supervision because an increasing amount of managers' time was taken up with meetings'. Hence, the available evidence suggests a mixed picture of change. While there has been work intensification and some extension of formal management controls these have yet to fully displace older patterns of service organisation based on tacit skills and judgement of front line practitioners. The impression gained is that senior professionals in SSDs are either unwilling or (more likely) too busy to engage in more systematic attempts to impose control.

Changes in values and professional commitments

This final section now turns to the question of how far restructuring led to changes in values and orientations. A goal of government policy has been (and continues to be) the achievement of an enduring 'cultural revolution' within social services (Audit Commission, 1992). The focus is 'changing the whole nature of the work of SSDs in order to introduce market principles', to ensure professionals 'learn new ways of thinking and behaving' (Lewis and Glennerster, 1996: 72). The more recent drive for 'modernization' also requires 'confident staff supported by confident organizations and a change in social work culture…' (SSI, 2001: 7).

It is undoubtedly true that management training and more general moves towards a mixed economy of care have led to changes in values and priorities in SSDs. Numerous studies highlight changes in the language of social work teams – especially those involved in care management - and the growing emphasis on budgets, consumers and formal targets (Carey, 2003). Discourses associated with the commercialisation of care and means testing have, to some extent, colonised professional decision-making.

Such change, as one might expect, is most pronounced at senior levels. According to Harris (1998: 856-8) there is now a must stronger 'business orientation' amongst top managers in English SSDs. Lewis et al. (1997: 23) describe how many professionals now 'relish the changed environment in which they may exercise their entrepreneurial skills'. Indeed, it would seem that there has been a general 'readiness… to endorse a comprehensively critical judgment of previous standards of social care' (Langan, 2000: 158). This in turn is thought by many to herald a more general process of fracturing within social work, between rank and file staffs and a 'separate and freestanding class of managers' (Hugman, 1998: 187).

However, once again it is prudent not to over-state such change. Most studies reveal a marked difference in response between senior professionals and rank and file staffs. As for the latter, commitment to management ideas and goals is either very weak or non-existent (Jones, 2001; Postle, 2002). Typical are the findings from a study conducted by Syrett et al. (1997) based on interviews with 80 staff in one SSD. This found 'little evidence of any existing or developing congruence between the "new" managerial culture and the "old" culture of social work'. More likely was 'overt antagonism' to use of new management labels and titles and a 'deep rooted hostility to the central tenants of managerialism' (160). Research by Jones (2001: 559), based on interviews with 40 social workers in England, also points to rising cynicism and 'divisions between front line practitioners and their managers'. According to Carey (2003: 133):'New idioms such as those of efficiency and economy, which have now possessed social care…appear insensitive, inappropriate and vulgar – especially when they nearly always imply an encouraged drive for cost cutting and a quest for "cheap" and often poor, services'.

Even where senior professionals are concerned one might question how far engagement with new management ideas and practices is anything other than pragmatic. A recurrent theme in

many studies – including some reported above – is the complex and uneven response of managers to the reforms (Thomas *et al*., 2000: 23; Whipp et al., 2004). Senior professionals have often sought to interpret top down policy demands – such as those associated with care management – to minimise disruption or accommodate professional concerns (see Kirkpatrick et al., 1999). There is also evidence of rising stress levels amongst managers in SSDs (Balloch et al., 1999). This has been attributed to job insecurity (in a context of de-layering) and to a growing sense of confusion arising from the need to respond to conflicting policy demands (Jones, 2001; Craig and Manthorpe, 1998). All this has meant that support for change, even amongst those most likely to benefit from it (managers themselves), has been muted or at best, pragmatic.

Conclusion

The evidence presented in this paper is testimony to the dramatic changes that took place in the world of English social services. There has been a marked retreat from the ideal of universal provision based on citizenship rights, towards services that are increasingly targeted and means tested. The focus of attention is now on the most deprived and least privileged groups within society. While SSDs were not abolished (although this now seems possible) they were no longer to be substantial providers of care in their own right. The focus has been on extending the market for social care and transforming the management arrangements of SSDs to bring them closer to the practice of private firms.

As one might expect the impact of all this on professional social work has been mixed. During the 1990s the number of social workers employed in UK local government grew, and the more recent introduction of state registration will further consolidate this process. However this 'success' has been achieved at the expense of the (already limited) institutional autonomy of this profession. Central government and employers are now more able to prescribe he process and content of social work education and training (Orme, 2001). Tightly drawn legislation and guidance was also introduced, notably in the area of children's services. As a result over the past decade social work became a more case-accountable and procedurally regulated activity.

There have also been some important shifts in management practice within SSDs. Substantially more time is now devoted to core tasks associated with financial management, purchasing and strategy. In line with policy guidance and the demands of regulatory bodies most SSDs established systems for cost control and performance management. These systems had some impact on the work of front line practitioners, reducing their room for maneuver in how services were allocated and, arguably, making decisions more transparent. Finally there has been a substantial increase in management training in this sector and some evidence of shifting identifications and support for change amongst a cadre of senior professionals.

However, on the basis of the evidence, my conclusion is that management practice in SSDs has not been transformed. As we saw there remains a significant gap between the theory and practice of strategic planning in SSDs. Services often continue to be allocated along customary lines as opposed to strategic assessments of local needs. It was also noted that while front line practice is probably more tightly regulated than before this process has been neither as universal nor as effective as many assume. Finally and perhaps most importantly is the very limited evidence of change in orientations and values within this sector. For most professionals engagement with management ideas and priorities is at best pragmatic.

In some respects these outcomes are not surprising. The history of SSDs is one replete with stories of conflict between professionals and administrators. Recent developments, one might argue, have only exaggerated this trend. Professionals in this sector traditionally eschewed managerial concerns and priorities especially those linked to monitoring practice and controlling resources. Added to this is the fact that many staff, even at senior levels, lacked the necessary skills or training necessary to implement complex policy requirements. Unlike the new health trusts and housing associations SSDs remained within the orbit of local government and under the supervision of local politicians (Ackroyd et al., 2006). This fact, one might argue, further problematised change. Shifting political priorities at the local level represented an added source of uncertainty for managers (especially where resources were concerned) making it hard, if not impossible, to engage in serious long term planning.

Under these conditions the task of reforming management practice in SSDs was never going to be easy. But, making it even less straight forward has been the approach towards introducing new policy. As we saw there had been little consultation with key professions prior to restructuring. At local levels the top down nature of change created a strong sense that the new management was something being 'done to staff rather than with them'. Also problematic was the sheer pace and quantity of new policy initiatives, a problem that even the government's own regulatory agencies have come to recognize. Most recently a joint review by the Audit Commission and SSI (2001: 2) noted: 'councils can be excused for feeling bombarded by policy initiatives' and admits 'some councils get submerged and overwhelmed'.

Finally one might point to the way in which competing demands and expectations held back change. This has been most apparent where resources are concerned. Cuts in middle management and problems of staff retention reduced the time available for senior professionals to plan services or engage in effective supervision. It has also been hard to generate enthusiasm for change as services are steadily being cut back (and agencies forced to concentrate on an ever narrower spectrum of need). Such conditions, one might argue, are not exactly favourable to root and branch reform.

To be sure it has not all been doom and gloom. Some might argue that a greater focus on the costs of different types of provision was long overdue in SSDs. For certain users the shift to care management was also positive, ensuring a greater fit between their assessed needs and preferences and the kind of services received. New systems of monitoring helped to increase the transparency of front line decision making, arguably reducing the risk of malpractice (Whipp et al., 2004). But these gains came at a very high price. There is now mounting evidence of rising levels of stress and demoralisation in the social care workforce and to record levels of sickness and absenteeism. There is also a trend towards work intensification and deteriorating relationships between junior and senior professionals. In the long term this state of affairs may have a damaging impact on the nature and quality of services provided by SSDs. Historically these services were dependent on a sense of professional vocation and a willingness to work 'beyond contract' The risk today is that management reforms are undermining this ethos and will 'weaken still further the local and moral economy that still prevails and, arguably, still sustains the best social work practice' (Langan 2000: 167). Only time will tell whether more recent policy initiatives that aim to 'modernise' provision in dialogue with the professions will significantly reverse this tendency.

Footnote

1 - In Scotland similar functions are carried out by nine social services authorities.

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