Policy and Practice: shaping and structuring the technologies of care

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Abstract

Developments in social work have been paralleled by advances in the development of information technologies. It is from the interactions between care practitioners, their clients, the care providers, and the tools that they use that the technologies of care emerge. This piece of research started from a desire to understand how to better align those developments in Technology with the needs of social care practice and asks the question: 'How do practitioners use information in practice, and how is that use shaped and directed?"

The thesis weaves together three strands:

- A research study, exploring the micro, meso and macro structures of operational practice in social care.

- An analysis of the role that information and information systems play in the enablement of practice and the appropriation of policy.

- An exploration of the use of Structuration theory as an analytical framework to support the management and implementation of change.

The research considers process and practice within one English Local Authority, although it was undertaken with a growing awareness of and involvement in national Social Care Informatics developments.

Assessment is core to social work practice. Social work research has previously concentrated on the nature of the relationships between practitioner and the individual being assessed, generating models focused on the modalities of practice within that relationship. This work utilises Structuration Theory to review social care models of assessment practice, providing a constructive way to position the procedural and informatics issues of day to day activity. It explores how both local and national policy shapes and influences those activities, and identifies the need to understand the information requirements of practice. It concludes that policy needs to address the information requirements of its delivery, in order to enable the effective emergence of technologies of care which support both process and practice.

Dedication

This work is respectfully dedicated to all those struggling to develop and implement innovative technologies in the public sector.

It is also presented in the memory of my beloved husband, Robin, who generously supported me through every step of the work, but tragically passed away before the final edit was completed.

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Further thanks to family and friends – to Judith, my partner in crime (or rather in Youth Justice) who got her Doctorate ahead of me; to my brother, who's had his for a while; to Hilary and Marilyn, who both made encouraging noises at the right time; to Margaret and David, Maggie and Dorothy, all of whom, I hope would be proud of me for this; my much missed father, who I know would be; my mother, who taught me that the ambition was to have a secretary, not be one – and most of all, my thanks to Robin, my other half for more than half my life, who held the fort, fed the cats, and generally put up with me throughout this process.

Declarations

I declare that this thesis is the candidates own work and has correctly acknowledged the work of others in accordance with the University guidance on good academic conduct. No part of this material has been previously submitted for a degree or other qualification at this or any other University.

P H M Hill (February 2014).

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Introduction

In 1917, Mary Richmond wrote:

> " Social diagnosis is the attempt to arrive at as exact a definition as possible of the social situation and personality of a given client. The gathering of evidence, or investigation, begins the process, the critical examination and comparison of evidence follows, and last come its interpretation and the definition of the social difficulty. Where one word must describe the whole process, *diagnosis* is a better word than *investigation*, though in strict use the former belongs to the end of the process (Richmond, 1917)."

Social work has progressed considerably since Mary's time, but, almost a century after they were written, her words still encapsulate a basic truth; that when working with those in need, and providing support to those who are vulnerable and at risk, it is necessary to both gather and analyse relevant information in order to identify what interventions may be required.

Developments in social work have been paralleled by advances in information technologies, enabling information to be more effectively captured, recorded, analysed and presented. It is from the interactions between care practitioners, their clients, the care providers, and the tools that they use that the technologies of care emerge.

This piece of research sprang from a desire to understand how to better align those developments in technology with the needs of social care practice. As a senior manager responsible for the delivery and maintenance of information services to a Local Authority's social services department I was aware that 'information' was continually being raised as a major component in inquiries into failures in care (Lord Laming, 2003; Bichard, 2004), and yet I was overseeing the implementation of systems which focused on the collection and collation of performance data rather than the support of practice. This apparent lack of cohesion between the expectations of care policy and the commissioning of systems was concerning, and I wanted to explore whether the opportunities presented by emerging technology could be applied to support social care practitioners more effectively.

My initial question was 'how can I design systems that enable practitioners to engage with and use technology more effectively?' But it quickly became clear that, to answer it, I needed a better understanding of what social care practice was, and the contexts in which it happened. This raised the further question of: 'How do practitioners use information in practice, and how is that use shaped and directed?"

In order to address this wider perspective the focus of the research moved from a simple investigation of information technology into the more complex deliberations of *informatics* – 'the study of the structure, the behaviour, and the interactions of natural and engineered computational systems (University of Edinburgh, 2011).'

Recently, the public sector, and social care in particular, has been experiencing rapid and radical change: the outcome of high profile inquiries has inspired policies advocating integrated and multi-agency working; responsibilities for Adult and children's services have been spilt at government as well as local level; a drive towards greater citizen focused service provision has brought forward the concepts of personalised and self-directed care; greater emphasis is being placed on preventative rather than remedial service delivery; demands for service is rising, while funding and resources have been greatly reduced; and technology itself has continued to develop - delivering greater opportunity along with increasing expectations and the assumption that it can and will meet the requirements emerging from both policy and practice.

This thesis describes a journey through some of those changes and considers the role and function of information within the complex interactions of policy, practice, organisational culture, community and client need, and the commissioning of services, that the research has explored. The work has been conducted on shifting sand and at a headlong pace, struggling to keep abreast of change while trying to identify what was, what is, and what's expected to be. In some ways, this has made formulating models and theories difficult, and collecting evidential data almost impossible, while - on the other hand - enabling observation of the impact of policy change and offering the opportunity to investigate the role of information services in the delivery of innovation and organisational change.

At the start of the project, the expectation was that the situation being studied could be captured and defined by drawing on prior research and understanding – yet it quickly became clear that the area under investigation was one that lacked extensive research. Although the HUSITA (Human Services Information Technology Applications) Association had begun promoting the ethical and effective use of IT to better serve humanity, and was encouraging research into IT in Human Services (of which Social Care is a part) the associated body of work was still fairly small: the initial review of the literature identified that, while there had been a range of studies considering the value and effectiveness of assessing for care needs, very little was known about the information model that underpins the process, or the effectiveness of IT systems

developed to support it. Equally, knowledge management research in the public sector was still in its early stages, and while research in practice was shared on an academic basis, few operational mechanisms existed to systematically capture and present knowledge and learning so that practitioners could benefit from each others experiences in the field.

Where research into assessment had been undertaken, it had mostly been directed from the perspectives of professional practice (ie work looking at the effectiveness of undertaking social care assessment through the measurement of its impact on the care client base.) The HUSITA work evidences the early forays into the use of IT within the sector, and illustrates the potential scope for further work and future investigations, but while there is a growing body of work exploring the use of technology within the health sector, only a few have extended their perspectives into the community or care domains. *Health Informatics* is considered to be a relatively new field, but in comparison, the study of *Social Care Informatics* is very much in its infancy.

The challenge underpinning the research questions became, therefore, not one of building on prior work or expanding on issues raised through consideration of earlier research, but of attempting to explore a relatively undiscovered country, utilising complimentary research, and drawing on the lessons from related, rather than specific investigations.

In the years since the start of this project, more directly relevant research has begun to appear. Work has been undertaken, for instance, to look at the effectiveness and use of assessment tools within both adult and child services (Crisp et al. 2006; Eccles, 2008; Mitchell and Sloper, 2008; White et al. 2010). Others have been looking at issues around the use of assessments and technology in a multi-agency environment (Sutcliffe et al. 2008; Baines, Wilson and Walsh, 2010). Some of this has been driven by a need to understand and respond to high profile public issues, rather than a more general concern to understand the impact and use of information in the delivery of care, but has, nevertheless, added to the overall body of knowledge in this area. A picture of how professionals engage (or disengage) with assessment tools, and how the implementation of some systems have helped or hindered the progression of practice is now starting to emerge.

Background and Context

There is no simple definition of Social Care. Even a peremptory search of the Internet produces three disparate, yet interrelated definitions ranging from the specifics of the Social Work professions:

> Social work is a profession and a social science committed to the pursuit of social justice, to quality of life, and to the development of the full potential of each individual, group and community in a society. Social workers draw on the social sciences to solve social problems (Wikipedia, 2010).

Through a consideration of the public sector's provision of services:

> Care services which are provided by local authorities to their residents, or which are commissioned by local authorities (for example, from community & voluntary organisations and from independent providers) (Shrewsbury and Telford Hospital Trust, 2010).

To a much wider, more generic definition:

> organized effort to help individuals and families to adjust themselves to the community, as well as to adapt the community to the needs of such persons and families (The Free Dictionary, 2010).

As an added complication, some of the research relevant to work in this area utilises the more generic term *Human Services*, underpinned by a definition of a Human Services professional as:

> a professional who acts as an agent to assist and or empower individuals, groups, families and communities to prevent, alleviate or better cope with crisis, change and stress to enable them to function more effectively in all areas of life and living (Lincoln University of the Commonwealth of Pennsylvania, 2011).

Like its commonly paired companion, *Health,* 'Social Care' should really be considered as a portmanteau term, encompassing professional, organisational and community activities directed towards the care of the community in general and individuals in particular. In the UK, and in England in particular, the Social Care sector spans personal, private, public and voluntary provision of care, set within a intricacy of financial, governance and regulatory arrangements, all of which interact and interrelate to create a highly complex care economy (Hill et al. 2008).

A large percentage of the social care support delivered within England is provided on a voluntary and individual basis – by partners, children, wider family groups, and even concerned neighbours (Hudson and Henwood, 2009). Voluntary and charity groups also play a role in enabling frail, vulnerable, and disabled individuals to maintain their independence and quality of life. The most prominent facet of social care in England, however, lies with the public sector, charged with a statutory duty of care and expected

to step in when community and social capital arrangements fail. At one extreme, this duty can be discharged through the simple provision of advice – signposting towards charitable services, sources of equipment or publicly available guidance. At the other, it can extend to direct and extensive intervention in people's lives, from the provision of intimate and extensive care services, to the actions taken to safeguard children and vulnerable adults.

English Local Authorities are required by law to assess the needs of anyone requesting help and support, and from that assessment determine the interventions they may make and the level of care they will provide (HM Govt, 1990). The authorities employ practitioners to gather information for the analysis of need, and ask them to capture that analysis as evidence of their recommendations and decisions. As many of those who receive public sector funded care continue to do for an extensive time, there is also a need to refresh and update the information concerning them, so that the services they receive remain relevant and appropriate. Information has been recognised as being an essential resource in the support of this work, whether it is being used to help identify care needs, informing the effectiveness of interventions, or assisting in the co-ordination of services (Social Care Information Policy Unit, 2001).

Recent legislation, white papers, and associated guidance, such as the NHS national Service Frameworks (Department of Health, 2001a), and Putting People First (Department of Health, 2007), have begun to change the emphasis concerning assessment and care delivery from that of a statutory duty on Local Authorities to a community focus supported by co-operation between agencies and greater integrated working. Implicit in this developing policy agenda, which advocates personalised, person-centred care and encourages cross agency, seamless service provision, is the expectation that information technology will provide the means of supporting these new approaches and enable effective integration across the range of organisations and varied professions involved in their delivery. This expectation - that Information systems and services will exist to enable both practitioners and service users to utilise and exploit information as a resource - has been a key feature in a number of policy initiatives over recent years (Social Care Information Policy Unit, 2001; Department of Health, 2003c; Department of Health. 2010; Department of Health, 2011).

Historically, information systems implemented within care agencies were designed as simple record systems. Basic client indexes gradually evolved into systems to manage and support performance monitoring, provide financial information or enable

automation of paper forms. There have been very few tools developed specifically to support practice; the understanding of that practice is patchy, and the impact that these kinds of tools may have has not been fully explored.

These two factors - the push, through policy, to implement common frameworks for structuring information, and the nebulous understanding of the role that information plays in supporting professional practice - create an uncertain footing for the implementation of innovative information systems and the use of technology within the social care sector. There is an understanding that increasing the level of agency available to the service user for defining the shape and content of their care will change the role practitioners play as they support and help define the need for that care. At the same time, there is a risk that the use of standard, rigidly structured tools, combined with expectations of increased efficiency and throughput may deprofessionalise those practitioners and reduce their ability to explore innovative solutions on behalf of their clients (Clark, 2005).

Research Aims and Questions

By engaging practitioners in research that sought to clarify the nature of their work, and explore how information systems might better support their practice, it was hoped that their requirements could be better defined, enabling the development of tools to both mitigate that risk and allow new practices to emerge from the synthesis of professional skills, developments in policy and the implementation of new technologies.

The key questions that underpinned this work were:

1. What is 'assessment?' What does the activity involve and how is information accessed, collected and used within it?

2. What are the contexts in which this activity sits, and what factors influence and shape its delivery? What part do information tools and services play?

3. How do these factors impact on and interact with the implementation of organisational and system change?

4. How is policy translated into operational activity, and what role does the development and implementation of Information services play in enabling (or disabling) this process?

5. What can be learnt from the study of these interactions that might enable more effective innovation, inform future systems development and assist in the management of change?

Through the exploration of the information issues underpinning social care assessment and its associated activities within the public sector, an understanding began to emerge concerning the contextual setting and the associated factors that shape those activities. This understanding was enriched with learning from the implementation of a new policy initiative impacting on the nature of those activities. The research, initially focused on gathering data to support the development of more effective information tools, moved to the wider consideration of the role of information, information systems, and tools in the implementation of change.

Of the theories considered, Structuration Theory appeared to offer the most relevant framework for understanding how practitioners use, and interact with current policies, with the requirements of practice and with the systems developed to support them. Opportunities clearly existed to contribute to the exploration of the theory, particularly in considering the potential it offered in framing how Information systems and organisational behaviours interface and interact.

The application of structuration theory as a framework for analysis enabled concepts to be articulated and the complexity of the environment to be explored. The theory further supported a more longitudinal analysis of the journey from established practice to intended change, along with the issues that shaped and directed that journey, and led to the development of conceptual models reflecting the complex interactions between nationally determined policy, the responses of local organisations and the implementation of policy in practice.

This thesis weaves together three strands:

- An observational study, exploring the micro, meso and macro structures of operational practice in social care.

- An analysis of the role that information and information systems play in the enablement of practice and the appropriation of policy.

- An exploration of the use of Structuration theory as an analytical framework to support the management and implementation of change.

The focus of this particular piece of research has been on process and practice within one English Local Authority (*Countyshire,*) although it has been undertaken with a

growing awareness of and involvement in national (primarily English) Social Care Informatics developments. During the period of the study, the Local Authority concerned moved from being an organisation with a combined Adult and Children's Social Services Department to one where all Children's issues (universal and specialist services) were provided by a Directorate for Children, Schools and Families, and Adult Care became part of a wider Health and Community services Directorate. The Authority also began to implement a challenging shift in the way that adult care was expected to be assessed and service delivery supported. The formulation and focus of the research therefore shifted and developed in response to these changes. The data collected has been viewed and analysed through the 'practice lens' of structuration theory, seeking to understand the role that information and information systems have played in the way that care needs have been 'traditionally' assessed, while exploring the implications of that role in helping to shape the expectations of policy and the delivery of change.

By framing the work within a Structuration analysis the research has also been able to explore how use of Structuration Theory can potentially provide tools to support the design and review of business change within the Public Sector.

Significance of the Study

Despite the increasing expectation that IT tools and services will be exploited –both as a means to support integration between health and care and to support and enable the citizen to commission and manage their own care - the role of information services within the Social Care sector has yet to be fully explored. Although a body of work is beginning to accumulate concerning the use of technology and its success, or failure, as tools to underpin practice, the wider landscape remains relatively unmapped. There is still a great reliance on work with a health rather than a care focus. Suppositions concerning transferability of understanding and the applicability of medical models are generally untested, but are often assumed by Health Informatics professionals when considering approaches to integration. The complexity of the Care economy, the richness of interpersonal interactions, the depth of narrative and the breadth of information requirements it encompasses, offers opportunities for exploration and understanding in a number of informatics areas, such as the study of the ethical and social science aspects of complex information systems, or the support of human-information interaction research. (Marchionini, 2008).

As yet innovative developments emerging from within social care are relatively unexamined and unevaluated; learning and insight is not well shared, and a potentially rich seam of knowledge remains largely untapped.

I believe this work to be significant in a number of ways:

- In its observations of social care activity and associated processes from an informatics perspective

- In its consideration of the factors affecting the implementation of national policy, its interpretation within a public sector organisation and its translation into systems and activities at the operational front line.

- In its exploration of Structuration theory as a framework for the analysis of policy implications and a tool to support their implementation through innovative change.

- As a contribution to the emerging body of work in the field of Social Care informatics

In addition, the work also explores the applicability of theoretical constructs, such as Orlikowski's practice lens, as tools for analysis and as conceptual frameworks to support insight and understanding of both micro and macro phenomena.

Its findings have already contributed to discussions within the Keele Group (Rigby et al. 2011), providing input to an ESF funded workshop considering the need for further research into Social Care informatics, and to the development of national good practice guidance in England, informing the models and concepts underpinning the Adult Care Support Record Framework (Hill and Allman, 2011) - materials commissioned by the Department of Health to update and replace the earlier work on Information for Social Care and the associated models for the Electronic Social Care Record (Social Care Information Policy Unit, 2001).

Section One: Theory and Research Review

This section examines the background to the work, presenting the findings of the literature review along with those of an associated review of theory, in which potential theoretical frameworks were considered for their relevance and applicability

The research was primarily focused on exploring the synthesis between policy, business process and operational practice, the role of the information underpinning those relationships and the use of technology to support that role. The process being considered – assessment of need in a social care context – was known to be complex and information rich. At the start of the project, an examination of the literature suggested that the use of IT to deliver assessment tools was wide spread, but had not yet been widely studied.

Structuration theory was chosen to be the primary theoretical framework, supporting both a longitudinal approach to the work and enabling the complexity of the subject matter to be addressed. The literature review included materials on the application of the theory to information systems studies, and these were utilised to help construct analytical tools as the work progressed.

Chapter One: Shared beliefs and interpretive schemas

> The National Health Service and Community Care Act 1990
> provides at s.47(1) that: Subject to subsections (5) and (6) below,
> where it appears to a local authority that any person for whom they
> may provide or arrange for the provision of community care services
> may be in need of such services, the authority – shall carry out an
> assessment of his needs for those services; and having regard to the
> results of that assessment, shall decide whether his needs call for the
> provision by them of any such services"(HM Govt, 1990)

This chapter explores the literature concerning social care assessment, drawing on a range of guidance, research and practice texts. It positions this exploration through the presentation of a timeline illustrating the succession of policies underpinning the delivery of social care in England, alongside the history of the use of information technologies within the sector. It then examines the assessment models described by social care researchers, looks at a variety of frameworks and tools which have been published and promoted as national good practice, and considers the lessons learned in the implementation and use of systems aimed at supporting some of these frameworks.

1.1 Defining 'social care' and 'assessment'

Daly and Lewis (2000) position social care at the intersection of public and private (in the sense of both state/family and state/market provision); formal and informal; paid and unpaid; and provision in the form of cash and services. They go on to define it as 'the activities and relations involved in meeting the physical and emotional requirements of dependent adults and children, and the normative, economic and social frameworks within which these are assigned and carried out.'

This definition provides a succinct summary of what is a complex social care economy, often hidden behind the 'norms of society.'   Applying this definition, the majority of personal care is actually self-funded, supported by unpaid carers such as life partners, family members, and even concerned neighbours.

This research, however, focuses on a slightly narrower definition of social care, using one which refers to the 'wide range of services designed to support people to maintain their independence, enable them to play a fuller part in society, protect them in vulnerable situations and manage complex relationships (Department of Health, 2006).' These services are those that can be provided by statutory bodies or independent

organisations and can be commissioned by a local authority's social services department in a variety of settings.

1.2 Considering context –legislation, policy and the evolution of social care information systems.

The translation of practice models into day to day practice within the public sector cannot be examined without an understanding of the contexts in which it takes place. Social care services have developed and evolved over the years, responding to the changing demands of an equally evolving tapestry of national policy, reshaping to fit the permissions and restrictions defined by formal legislation as it has been made and remade. The tools and systems that support these services have developed in a reflection of these demands, drawing on innovations in technology as they have become available. Policy on the use of that technology has been sparse until recently, but core policies have begun to be published which incorporate assumptions that technology will be available to support them. Expectations are that the technologies of care will not only become integral to the sector's activities, but will support greater integration across the boundaries between health and social care.

The timeline presented here gives a summary of legislation, policy, event and information related activities that are thought to be significant to this study. Its focus is on Social Care and Adult Care in particular and it therefore omits a number of associated, but potentially influential policies concerning Clinical Health, Mental Health, Housing, and Community Safety; the intention is not to present a comprehensive timeline for the whole of Health and Public sector policy, but to offer the relevant contexts for this research. *A more detailed examination of this view of history is available as Appendix A.*

Poor Laws (17th/18th Cent)
Lunacy Acts (Late19th Cent)

Death of Denis O'Neill — 1945

Care of Children Committee

1948 — National Assistance Act

Children's Act

Death of Maria Colwell — 1970

Policy development of 'Care in the Community'   Early Client Databases

1980

Murder of Isabel Schwarz — 1988

Griffith's Report

1990 — Community Care Act

Looked After Children (LAC) system

Labour Government elected — 1998

Modernising Social Services

Performance Assessment Framework

Information forHealth

Death of Victoria Climbie — 2000

Care Standards Act

No Secrets   Framework for the Assessment of Children

Death of Caleb Ness (Scotland)

2001

National Service FrameworkFor Older People
Single Assessment Process (SAP) to be in place by 2004

Information for Social Care

Death of Margaret Panting

Health and Social Care Act

Valuing People

2002

Fairer Access to Care Services

Death of Jessica and Holly Wells

National Programme for Information Technology in the NHS commences

2003 — Community Care Act (Delayed Discharges)

Lamming Inquiry Report

Every Child Matters

'In Control' Established

Bichard Inquiry Report

2004

Children's Act

Electronic Social Care Record (ESCR) Guidance
Social Care Information Policy Unit disbanded

IfSC Demonstrators
FAME Project

Responsibility for Adult and Children's Social Care separated   Contact Point work begun

2005

Independence, Well Being and Choice

Data collection for research begun

NHS Information Center for Health and Social Care established

2006

Our Care, Our Health, Our Say:
A new direction for Community Services

'Social Care Institute for Excellence (SCIE)' Established

2007

Putting People First:
'A shared commitment to the Transformation of Adult Social Care'

Adult Common Assessment Framework Consultation (aCAF)

Murder of Stephen Hoskin

Death of Baby Peter

2008

Safeguarding Adults

Carers Strategy

LAs bidding to become aCAF Demonstrators

2009

Valuing People Now

First wave of aCAF Demonstrators

Common assessment Framework for children (CAF)
Integrated Children's system Implementatiom

ESCR Implemetation Board

ACT project closed

Second wave of aCAF Demonstrators

2010

Coalition Government comes into power

Capable Communities and Active Citzens

Contact Point cancelled

'The Information Revolution Consultation

2011

'Think Local, Act Personal'

Adult Care Support Record (ACSR) replaces ESCR Guidance

Strategic Improving Information Programme

2012

Health and Social Care Act

'The Power of Information'
A new Information Strategy for Health and Social Care

Fig: 1.1 Timeline of policy, legislation and events relevant to this study

Direct data for the study was collected between 2005 and mid-2009. Analysis includes references to policies and legislation published up to 2012

The timeline clearly illustrates the way that social care policy has grown in complexity over the years, with an increasing number of directives and demands for change. The intentions behind the introduction of new policies and the updating of legislation have not always been clear; a proportion of initiatives have been inspired by the manifestos of the party in government at the time, some have emerged from public concerns, and others have inevitably followed the review of high profile failures in the system - the death of a child, incidents involving mental health clients, or the fallout from gaps and loopholes in existing law. It could be argued that, far from enabling change, the influx of centrally dictated requirements has often constrained Local Authorities, reducing their ability to innovate as they are driven to respond to the initiative of the day. This bombardment of policy initiatives, often with tight timescales for implementation, has created a climate of uncertainty in which the long lead in times that can restrict the development and implementation of new technologies, and the increasing requirement to improve efficiency with ever reducing resources, have added to the complexities of an already complex environment. Change has become a constant in the delivery of care, but the sector's reliance on cumbersome and inflexible technologies, and the failure of policy to address information issues as integral to its delivery meant that, at the time this research was being undertaken, information systems were often seen as disablers rather than enablers of that change.

The latest tranche of information policies and central strategies represent attempts to address these systemic issues, but the success of these strategies will depend on the resources available, the investments made to support their delivery, and the sector's ability to develop a greater understanding of the information needs of citizens, practitioners, and the organisations which support them.

1.3 Theories of Assessment

The word 'assessment' is ubiquitous throughout social care, and is commonly used to describe what is considered a fundamental keystone of practice in both Adult and Children's Services Coulshed and Orme (2006) observe that the process of assessment is core to social work practice, identifying that, while the process of assessment is not unique to social work, what is vital is that social work contribution is recognised and seen as an essential part of any assessment.

But precise definitions to underpin the concept remain elusive and vague: the term is used as descriptive on one hand for short, time limited processes with immediate

outcomes, and on the other for long term, on- going work, with outputs and outcomes emerging at irregularly defined intervals.

Policy appears to view 'assessment' as a managed, time limited event, requiring the 'completion of a community Care Assessment'(HM Govt, 1990) prior to the allocation of resources for adults, and even setting specific performance targets for the completion of assessments concerning Children in need or at Risk (Department of Health, 2000).

Yet social work text books claim that assessment is not a single event, rather an on-going process in which the client or service user participates, the purpose of which is to assist the social worker to understand people in relation to their environment (Parton and O'Byrne, 2000).

In addition to this confusion the term is also used to describe a range of activities that encompass evaluating an individual's need for services or support (Houston and Cowley, 2002), evaluating risk (Baker et al. 2002) evaluating ability (Budd, 2001), and sometimes both needs and ability (Woodcock, 2003).

It is not clear from the general literature if there is considered to be a genuinely different process underlying each form of evaluation, or if they are assumed to be subsets of the same model, the difference potentially lying in who and what is being assessed/evaluated, rather than the *how*. Social work texts, however, proclaim a level of uniqueness in social care assessment, noting that although assessments are undertaken in areas such as counselling and therapy, social workers are involved in assessments that are public. Social work assessments involve making judgements so that decision-making can be better informed (Parton and O'Byrne, 2000).

Health professionals also claim to undertake assessments. The definition of a health assessment appears to be relatively clear cut:

> […] an evaluation of the health status of an individual by performing a physical examination after obtaining a health history. Various laboratory tests may also be ordered to confirm a clinical impression or to screen for dysfunction. The depth of investigation and the frequency of the assessment vary with the condition and age of the client and the facility in which the assessment is performed. The person's response to any dysfunction present is observed and noted. The techniques of the health assessment include inspection, palpation, percussion, and auscultation (Mosby, 2009).

The specificity of this definition excludes a range of assessments undertaken by mental health professionals, community nursing, or occupational therapy professionals, all of whom are likely to be concerned with the individual's quality of life as well as their physical well-being. The general focus of these wider health assessments, however,

tends to remain anchored in the clinical model, with expectations of diagnosis and subsequent treatment. Social workers describe a more congruent, needs-led approach towards assessment (Worth, 2001).

So, while the concept of 'social care assessment' is commonly accepted, the lack of clarity in its definition means that the detail of the activity in practice, the shape of the processes underpinning it, and the information that both require, remain uncertain. Technology and tools designed to support assessment are often seen as limiting and restrictive, their use imposed rather than being regarded as integral to practice (Shaw et al. 2009).

In some ways, policies intended to encourage single shared processes, and to create common frameworks have simply muddied the waters further. The lack of consensus on structure and function (Bisman, 1999) continues to be an issue and the differing emphasis on risk, needs and resources make it difficult for social workers to develop an overarching framework for all their assessments (Milner & O'Byrne, 2002).

A literature review commissioned to look at the implementation of the Single Assessment Process for Older people (SAP) clearly illustrates the tensions created by the range of potential interpretations and the various practices that have developed as a result. The absence of standardisation, it notes, could 'result in a degree of variation to assessments over and above that expected from the variations in the circumstances of older people in a particular locality' (Abendstern et al. 2008, p7).

The review cites a study looking at the approach to assessment used by both social workers and community nurses, in which assessment is defined as 'the means by which practitioners ascertain the needs of individuals in order to determine the most appropriate location for care and match services to needs' (Worth, 2001, p257). While this definition helps identify the *reasons* for undertaking assessment, it provides very little insight into the activity itself. The same study also identified that 'Both district nurse and social work assessment practice can be seen to vary substantially within practitioner groups.' and adds 'One difficulty in exploring the values and theoretical frameworks underpinning assessment is that individual practitioners have difficulty articulating these rather nebulous phenomena … they do, however, have a profound influence on assessment; they affect what questions are asked, what is observed, the style of approach, how the needs identified are understood, the solutions identified and the interventions offered' (Worth, 2001, p258).

It is clearly difficult to design and implement even simple information systems to support 'nebulous phenomena,' and without an established theoretical framework to underpin them, developing meaningful IT tools to support practitioners becomes an equally difficult task.

The absence of a clear framework also limits the potential validity of computerized assessments, raising concerns over their capacity to integrate the complex, multidimensional information social workers collect into a coherent clinical picture (Ames, 1999).

It has been argued that although assessment is a core process in social work it has been inadequately theorised (Coulshed and Orme, 2006). Often the tools used to support the process become confused with the process itself. Garrett accused the Framework for Assessing Children and Families of 'becoming merely a composite set of assessment tasks' (Garrett, 2003, p446) and Glasby, when surveying the readiness of Local authorities to implement the single Assessment process, identified that 'Many (LA's) […] seemed to lack the technical expertise to make informed decisions about the merits of individual tools, failing to identify some of the acknowledged weaknesses of existing approaches' (Glasby, 2004, p135).

There is also evidence which suggests that approaches to practice developed from and dictated by the need to manage limited resources have influenced the shape of assessments currently undertaken by social care professionals. The pressure to 'pre-judge' eligibility for services adds the possibility of distortion in the process outcomes and a potential failure to match genuine need with effective services. Reporting on his findings in the Victoria Climbie investigation Lamming remarked on the 'ill-founded application' of eligibility criteria, identifying that the use of eligibility criteria to restrict access to services was not found in either legislation or in guidance. 'Only after a child and his or her home circumstances have been assessed can such criteria be justified in determining the suitability of a referral, the degree of risk, and the urgency of the response' (Lord Laming 2003, p13).

Interestingly, while the use of such criteria in Children's services was being publically criticised, the guidance for 'Fairer Access to Care,' which formalised the eligibility criteria Local Authorities were to use when determining the allocation of resources for Adults, was being developed, and was published in the same year as the Lamming inquiry was being conducted.

These issues – the confusion of underpinning theory, the imposition of criteria, the use of technically inadequate tools and the requirement to manage access to services - would appear to be key factors in the structuration of social workers activities and how they undertake assessment. In order to influence that process, however – through the improvement of tools, or by increasing the availability of knowledge resources for instance – it would be helpful to gain a better understanding of what assessment *is*.

1.3.1 Modelling Practice

Mary Richmond's definition of social diagnosis (Richmond, 1917), provides both a model for practice, and a starting point to consider the information requirements that underpin it. Abbott (1988) describes diagnosis as taking information into the professional system, while treatment brings instructions back out of it. He suggests that diagnosis has a dual nature – not only seeking the right professional category for a client, but also removing the client's extraneous qualities – and therefore contains two steps: colligation (the assembly of a 'picture' of the client) and classification (referring the colligated picture to the dictionary of professionally legitimate problems) (Abbott, 1988).

Arguably, there is a difference in focus between this generalised definition of diagnosis (narrowing of perspectives to focus on a specified issue and resultant treatment) and the concept of social care assessment (which requires a widening of analysis to account for context) but if so, it is Richmond's label that is misleading, not her description. As the research will show, her basic model remains at the core of practice, albeit overlain with the impact of policy decisions and developments in the understanding of the relationship between need and service (Bisman, 1999). Although there is recognisable value in the concept of 'colligation' there are two notable variances between Abbott's professional archetype and the work undertaken in social care. The first is the value that the client's 'extraneous qualities' may have in informing the appropriateness of interventions, and the second is the lack of a clear and shared specificity for classification. While clients can be categorised (grouped) by general issue of need, which may lead to commonly prescribed interventions, social workers' analysis tends to be cumulative and holistic, rather than seeking to assign pre-defined labels (Iversen, 2005).

Social work research has tended to concentrate on the nature of the relationships between practitioner and the individual being assessed, generating models focused on the modalities of practice within that relationship. As a result of this focus, the models

that have emerged tend to exclude the organisational environment that supports - or constrains - the activity, and present only part of the picture.

Nicholas, Qureshi and Bamford (2003) for instance, considered an 'exchange' model in which 'assessment is regarded as an exchange of information in which the user and carer are seen as experts in their own situation and the practitioner brings their training and knowledge of services to bear in negotiating solutions to problems.' This is contrasted with a more questioning or procedural model where the professional is expert in identifying needs and responses according to certain criteria.

Milner and O'Byrne (2002) similarly identified three different models of assessment, noting that they appear to be closely linked to the salience given by social workers to risk, resources, or needs factors:

1. *The questioning model.* Here the social worker holds the expertise and follows a format of questions, listening to and processing answers.

2. *The procedural model.* In this, the social worker fulfils agency function by gathering information to see whether the subject fits the criteria for services. Little judgement is required, and it is likely that checklists will be used.

3, *The exchange model.* All people are viewed as experts on their own problems, with an emphasis on exchanging information. The social worker follow or track what other people are saying rather than interpreting what they think is meant, seek to identify internal resources and potential, and consider how best to help service users mobilise their internal and external resources in order to reach goals defined by them on their terms.

The main difference between the first and the third models appears to lie in the influence and contribution that the assessed individual might bring. It is also interesting to note that the 'exchange' model bears close resemblance to the cyclical research process utilised in participatory action research (Wadsworth, 1998).

Having separated out these models as being specific and differing approaches to practice, Milner and O'Byrne (2002) go on to acknowledge that all three approaches can be observed during day to day activity, and often appear in combination

This would suggest that, far from being self-contained and mutually exclusive models, these approaches may simply be describing aspects of practice - components of assessment activity – which can be observed and isolated from the activity as a whole.

Coulshed and Orme (2006) presented a critique of these practice models in the 4th Edition of their textbook on Social Work practice, adding a fourth category – that of narrative assessment – which takes the exchange model even further, requiring critical reflection to jointly construct a narrative between the worker and the service user.

They suggest that the questioning model is 'the most fundamental approach to assessment,' as it echoes Milner and O'Byrne's (2002) 'reductionist approach' – one that reflects the social worker's agenda and corresponds to the assessment style noted by Shelden (1995) in which the data are 'shaped' to fit the social workers' theories about the nature of people.

There are clear echoes of 'Social Diagnosis' within this model, notably the need for systematic working, the comparison of information from a range of sources, and the aim of 'building up a picture' (Coulshed and Orme, 2006).

Despite identifying the value of systematic working, the writers of 'Social Work Practice' are highly critical of the procedural model, arguing that 'Workers become obsessed with gathering data rather than focussing on the person who requires a service, and who may be distressed or angered by having to reveal too much about himself or her' (Coulshed and Orme 2006).

1.3.1a Forms, tools and data collection

Coulshed and Orme's definition describes the procedural model as one in which 'workers undertake assessment according to a set of systems developed to ensure consistency and comprehensive data collection.' Further study of their text suggest that they could be confusing the activities of practice with tools intended for the collection of the information and analysis associated with it. They observe that such systems are often rigid and typified by large number of forms to be completed (Coulshed and Orme, 2006). It is particularly interesting to note how their analysis dismisses the use of technology by practitioners as being limited and largely irrelevant to the subject being discussed. Yet the deadline to implement fully electronic social care records, as defined in 'Information for Social Care' had initially been 2004 – two years before this revised text was written.

They do acknowledge the value in collecting information, recognising that 'for social workers working in community care the accumulation of information can be paramount, and that information can be gleaned from a number of sources.' However, while noting that 'to collect data systematically and to record it as a basis for decision-making with

individuals and families is essential, and has been associated with the 'evidence-based approach' to social work'(Coulshed and Orme, 2006. p32), they identify a number of risks associated with the use (or potential misuse) of formal tools.

Research undertaken by Richards and published in 2000 evidences some of this potential counter productivity. While some assessors working with older people valued the clarity of using an assessment form and the ease with which it could be completed, it was discovered that workers tended to focus on collecting the information for the form rather than conducting 'a wide ranging enquiry, which might uncover unanticipated problems and enable the older person to think through the situation more productively or accept help more easily' (Richards, 2000, P42).

Taking the definition given in Milner and O'Byrne (2002) into account, the criticism of this 'procedural model' would appear to arise from the risk of using forms and systems that dominate and constrain practice, restricting activity to checklists and tick-boxes and thereby reducing, rather than enhancing, the value of the information collected.

1.3.1b. Narrative and Participation

The texts generally present the exchange model in a more positive light, and provide a good illustration of the way these models are focused on the practitioner/client interface. The model involves more than merely sharing assessments with users. While emphasising that the worker has expertise in the *process* of problem solving, the model recognises that the people in need and those involved with them will always know more about their problems. The aim is to involve all the major parties in arriving at a compromise for meeting care needs (Coulshed and Orme, 2006).

Participation is key in the exchange model. It requires that the people involved are given the opportunity to undertake their own analysis of their situation, and to identify what might be relevant. While individuals may not be experts in their specific conditions, they are considered to have some expertise in their own care, and that steps should be taken to enable them to participate, despite any sensory or other impairments they might have (Coulshed and Orme, 2006).

The exchange model supports the idea of assessment being an on-going activity; it echoes action research methodologies, and suggest that, rather than being an activity which *leads* to intervention, the assessment is already an intervention in itself. (Richards, 2000, Coulshed and Orme, 2006).

The narrative assessment model builds on this approach, arguing that the exchange model denies the professional responsibilities of the practitioners involved. It proposes a critical reflection that involves constructing a narrative jointly between the worker and the service user (Fook, 2002). Workers are acknowledged to have some expertise – in thinking about solution development and building solutions with people (Parton and O'Byrne, 2000) – but they are not the only experts in the situation. Service users do have 'agency', that is, they are not just passive recipients of the assessment, but have responsibility for making decisions and for being involved in the sense-making activities of assessment. This does not mean there will be agreement: 'the emphasis is on mutual exchange, not necessarily mutual agreement' (Fook, 2002, p 121).

Creative a shared narrative, however, does not appear to mean abandoning systematic methods or informed analysis (Parton and O'Byrne, 2000, Coulshed and Orme, 2006).

In this model the service user appears to be encouraged and supported in undertaking their own 'social diagnosis' – because, while the role and contribution of the practitioner may have shifted from authoritative examiner to supportive facilitator, the underlying principles of colligation – that of gathering intelligence, considering what the evidence demonstrates, and analysing the result - remain firmly in place.

The practitioner may have a further role to play in this model – that of interpreter (Coulshed and Orme, 2006).

The analysis of these assessment/practice models as they are presented and compared in the texts is interesting; there is recognition of the value of systematic methods (in questioning and exchange) but criticism of the tools and approaches that might support them. While the critique of restrictive forms and rigid processes are undoubtedly valid, it is difficult to see how procedural elements could be completely eliminated from either the questioning or the exchange/narrative models – they are the inevitable constraints imposed by organisational management and which define both the level of agency available to the practitioner and the environment in which assessment takes place. Equally, the differentiation between 'questioning,' 'exchange' and 'narrative' imply conflicting approaches to practice, when, as has already been noted, the reality appears to be a spectrum of practice that utilises a range of approaches as necessary.

The relationship between these models and the structures of practice observed and discussed in the data collection phases of this research will be considered in later chapters – but it may be more beneficial to consider them as complimentary, rather than as exclusive alternatives. The different approaches may provide interpretive schemas

that support the components of practice, contributing to an overall framework of assessment behaviour - recognising, for instance, the use of questioning to elicit information, utilising exchange to provide the intelligence and context in which it sits, and employing co-productive narrative to generate outputs and agree outcomes. Considered from this perspective, it is likely to be the balance of and emphasis on particular activities which enables desired (i.e. good practice) or undesired structures to emerge, with procedural tools and instruments acting as resources that afford or constrain the enactment of those structures.

1.4 Tools in practice

1.4.1 Artefacts in use – the role of assessment tools and their associated frameworks

Hughes (1995) suggests that the assessment process includes a combination of objective 'factual' detail and subjective opinions of need. Knowledge and theory, skills, professional judgement and the attitudes and values of the assessor are further variables (Worth, 2001). This contribution from the practitioner has not always been recognised in the growing number of assessment 'frameworks' developed in recent years, despite their aim to distil the understandings of research and operational processes into consistent and coherent approaches for undertaking evidence based practice.

Assessment frameworks first emerged in the late 1980s and were often associated with assessment of risk, particularly in child care. Guidance produced for such assessment, (commonly known as the Orange Book (Department of Health, 1988b),) gave background rationale, including policy and legislation, for particular actions, providing detail on who to see and the kind of questions to ask in order to glean the information necessary to establish whether a child is at risk. The list of topics to be covered and guidance on questions provided a wealth of information for beginning social workers (Coulshed and Orme, 2006).

When such frameworks are implemented, focus and emphasis can move away from the research and theory that underpin them and towards the systems and the tools intended to support them. Many of these frameworks - initially developed in response to the requirements of policy - have subsequently become resources influencing policy development, with expectations being shaped by the promises the frameworks claim to deliver. Although it has been argued that the introduction of frameworks can provide systematized inclusion and analysis of information deemed to be relevant (Crisp et al. 2006) many of the tools they've utilised have lacked reference to common information

standards and definitions, and have tended to present a research, rather than an operational, informatics bias.

It is clear that the designers of these frameworks do not intend them to be seen as purely a set of assessment tools (or data collection instruments.) Most framework developers place emphasis on the guidance and the research evidence underpinning their approach. Nevertheless, tools can, and have been, developed to facilitate assessment within a particular framework (Nicholas, 2003), and frameworks may identify a range of possible assessment tools from which assessors may select those most appropriate in a particular situation (e.g. in work with service users with substance misuse problems). While such tools may 'provide a helpful adjunct' (Skinner, Steinhauer and Sitarenios, 2000, p. 196,) the misuse or misunderstanding of the status of assessment frameworks can potentially lead to uncritical application (Crisp et al. 2006). 'Tickbox' tools, with their emphasis on factual recording, struggle to capture the more subjective issues that assessment entails, and their unconsidered implementation can lead to the kind of restricted practice (the 'procedural model') that Coulshed and Orme criticised. Without understanding the purpose of the questions, there is a danger that information will be collected without interpretation of its relevance or importance (Dickinson, 2006). Howe et al (2000) support this concern, stating that 'although social workers have become increasingly good at collecting information [...] there is less confidence in knowing how to make sense of that information for the purposes of assessment and decision making (p 143).' As the space for professional judgements is increasingly squeezed through rigid work- flows, key social work activities, such as assessment, can become meaningless and mechanistic.(White et al. 2010)

Assessment tools and assessment frameworks are not synonymous, although the boundaries between them are often fuzzy and hard to define. Frameworks are probably best considered as collections of materials – including guidance, theory, models, and principles– intended to systemise practice and create a coherent approach to assessing a given client group, or for supporting a particular policy initiative. Tools, on the other hand, are more specific mechanisms designed to collect, collate and present information for a range of purposes. They include exemplars for information capture (such as those within the Integrated Children's system), forms and schemas that incorporate scoring rules to support decision making (such as the ASSET risk assessment tool used in Youth Justice, or some of the Adult assessment tools implemented to support the Single Assessment Process), and detailed measuring instruments that utilise pre-defined scales

or generate standardised profiles (such as scales of hearing loss, or occupational therapists measures of function and mobility.)

1.4.2 Looking After children: good parenting, good outcomes

1995 saw the publication of 'Looking After children: good parenting, good outcomes' (Department of Health, 1995) – a system intended to support practice in relation to Looked After children. The system (LAC), used a series of forms to collect information relating to Looked After Children from the point at which they had been taken into care. Some forms – the Essential Information Record, the Placement plan, and the Review of Arrangements – were designed to capture basic administrative information in a structured way   But at the core of the LAC system were the 'Action and Assessment' records – long, complex forms intended to assist in the on-going assessment of progress and development of each child. These 'assessment' forms were designed to be tools to both monitor the child and to enable practitioners to work interactively with them. The expectation was that an AAR (there were several, aimed at specific age groups) would be completed over several weeks, during which the child would be actively engaged in the process.

The system received mixed reviews, with some practitioners labelling the AARs as 'cumbersome' and 'clumsy,' but by March 1998, over 90 percent of English local authorities were reported to be using the LAC materials (Garrett, 1999) – mostly in a paper based implementation, although some of companies providing social care systems at the time did make attempts to incorporate LAC forms into their products. The depth of this use – and how it continued over time – does not appear to have been widely researched; the LAC work was superseded by later developments, with some of its materials being incorporated into the Integrated Children System (ICS). The developers felt that the general uptake indicated that the response to the system was positive, but acknowledged that analysing the outcomes might be a difficult task (Ward, 1998).

The full set of LAC forms were extensive and comprehensive, collecting data in a highly structured format. Most attempts to create computerised versions focused on the basic information forms, leaving the AARs, some of which were booklets of up to 40 pages, in paper form. As an additional barrier to their conversion, the forms themselves were copy righted, and so suppliers and authorities needed to obtain a license to use and reproduce them.

Among the criticisms raised about the LAC system were questions of practice bias, the usability of the forms in practice, the perceived push towards 'tickbox' data collection

(and the associated performance managed culture that was being generally encouraged at the time) and concerns that the forms had originated as research, rather than being practice led (Garrett, 1999).

1.4.3 The Framework for assessment of need of Children and their Families

In 2001, the Orange Book was replaced in England by 'The Framework for assessment of need of Children and their Families' (Department of Health, 2000). The Framework was accompanied by the Family Pack of Questionnaires and Scales(Cox and Bentovim, 2000) which included seven questionnaires or scales to complete and score. This constituted attempts to screen children and families (by using scoring techniques) but critics warned that this might lead to inappropriate labelling (Garrett, 2003). The critics also raised questions about how the various 'instruments' and 'tools' included in the Framework might be used and deployed, speculating that, in future, managers would want to know about particular 'scores'. There was also a suggestion that scores or assessments derived from the questionnaires would be required by child protection case conferences, and that judges and magistrates will 'seek from social workers "certainties" which "hard" data provides (Garrett, 2003).

A series of assessment records were developed to assist practitioners to collate, analyse and record the information gathered during an assessment. The records comprised a referral and initial information record, initial assessment record and five age-related core assessment records.
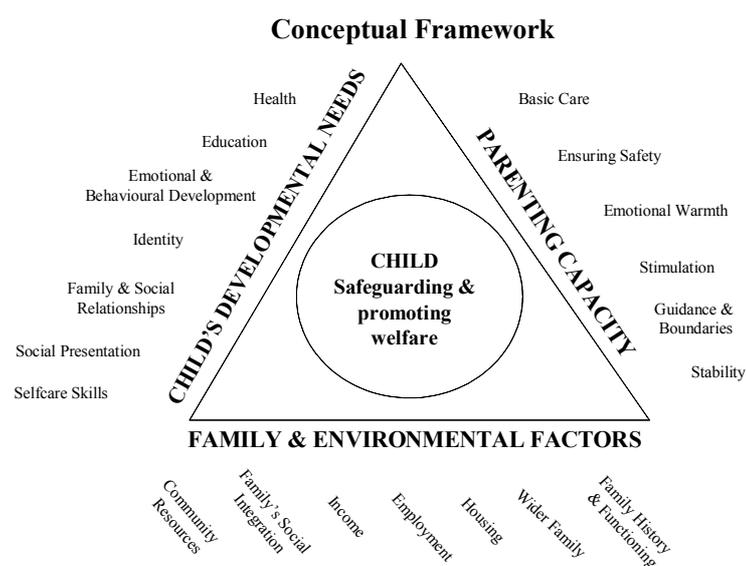
Figure 1.2: Conceptual domains in the Children in Need Assessment Framework

This framework extended some of the work undertaken for the LAC system and was based on a set of conceptual 'domains' (Fig 1.2) which together enabled a holistic view of a child. These domains were presented as a set of interacting dimensions, with the assessment collecting sufficient information to describe the contextual environment surrounding the child.

This approach was a response to perceptions that too much attention was being paid to risk and child protection issues and too little emphasis placed on environmental and familial networks, and failure to incorporate a child, or families', 'strengths' as well as 'difficulties' into assessments (Garrett, 2003).

1.4.4 The Single Assessment Process (SAP) for Older People

This domain based model was reflected in the approach identified to support the Single Assessment Process (SAP) for Older People. The National Services Framework for Older People was published in the same year as the Children's Assessment framework, requiring that (among other things) 'a new single assessment process should be put in place'(Department of Health, 2001a) . This was promoted as 'the first ever comprehensive strategy of its kind' and the initial document was quickly followed by further guidance.

In contrast to strategies being developed to support Children's services, the Department of Health chose not to specify the tools that Adult services were expected to use in the support of SAP. In fact, guidance issued at the time suggested that it was not possible to identify any existing assessment tool which adequately covered all the domains and sub-domains in the NSF for Older People (Department of Health, 2002a)

Instead of publishing specifications, the DOH established an accreditation process for off-the-shelf assessment tools (developed, mostly, by independent bodies,) intending them for national use. The process was led by an independent Accreditation Panel, which evaluated a number of tools against a set of published criteria (Department of Health, 2004b). The Accreditation Panel made recommendations to Ministers, and the subsequent decisions were published on the SAP website.

SAP implementation, however, was not dependant on the use of an accredited tool. Authorities wishing to use other approaches were given the agency to do so (Department of Health, 2004b).

Research conducted just prior to the formal publication of the SAP requirements - looking at the use of dependency measures within Local Authorities - raised a number of concerns about the readiness and ability of authorities to implement the framework, including the risks inherent in developing local assessment tools (Glasby, 2004).

Flexibility had been encouraged in the belief that it would support innovation and create locally focused solutions. This may well have been case for some innovative councils with the commitment, funding and resources to support local development. However, it is likely that, as Glasby predicted, this lack of core direction contributed to the lack of consistency in SAP implementation, and the failure of some Authorities to implement it at all. Another possible contributor to this was the disparate levels of signification concerning SAP within the contributing agencies. While it was considered a high priority in a great many Local Authorities, it generally had a much lower profile in Health, who were focusing on a number of other informatics initiatives at the time. Successful implementation was dependant on on-going commitment across all the partners involved, and this was not always forthcoming.

The level of flexibility allowed also created the agency at both organisational and operational level for previous structures to reassert themselves, with practitioners – lacking clear guidance – abandoning the new tools and reverting to established ways of working (Dickinson, 2006).

1.4.5 The Integrated Children's System

Despite varied concerns emerging from early implementation of LAC, the Assessment Framework for children, and SAP, government policy continued to push for the further development of comprehensive assessment frameworks in social care, building on existing momentum rather than wait for evaluation of the systems being put in place. SAP work began to evolve from a process designed around older people into the core of a Common Assessment framework intended to support all Adult clients, while in Children's services, the progression of LAC and the Assessment Framework was seen to be logical steps towards a completely Integrated Children's System (ICS) for all children in receipt of care.

The work to implement an ICS had been in progress for some time and was well underway in 2002, when the initial consultation document was circulated. When responsibility for Children's services moved to the newly created Department of Children, Schools and Families, the ICS went with it, becoming one of the core

programmes for the new Department. It was intended to be a tool to support the improvement outcomes for children defined as being in need (under the Children Act 1989,) providing a conceptual framework, a method of practice and a business process to support practitioners and managers in undertaking the key tasks of assessment, planning, intervention and review (Department of Health, 2003b; Department for Education and Skills, 2005).

The developers of the system recognised that work with children in need requires skilled use of detailed and complex information, and – somewhat uniquely – ICS was expected to be specifically supported by an electronic case record system. A key aim of the initiative was to provide frontline staff and their managers with the necessary help, through information communication technology (ICT), to record, collate, analyse and output the information required (Department of Health, 2003b).

The Integrated Children's System comprised of:

- a conceptual framework for assessment, planning, intervention and review which builds on the Assessment Framework and the Looking After Children system. This framework is underpinned by the domains and dimensions set out in the Assessment Framework.

- a set of data requirements for children's social care, derived from individual children's records which could also provide the basis for identifying how common information could be held about children across different agencies. This data forms part of the overall information required to plan and deliver children's services; and:

- records or exemplars which demonstrate how information gathered by children's social care practitioners from first contact to closure can be organised and used to generate particular records or reports which are required in the course of their work. These records form the basis of an e-social care record for children.

The system contained over 23 of these 'standard' exemplars, including complex comprehensive assessment tools, placement plans and forms for review. They were presented as a set of forms, rather than as constructed data sets, with the ability to transfer data between them being implicitly assumed, rather than explicitly defined. Subsequent implementation projects would struggle to align information from one exemplar to the next, despite this being promoted as one of the primary benefits of the system.

Initially, the implementation of the system was left to each individual authority. A Local Government circular sent out in 2005 (Department for Education and Skills, 2005) laid out a series of conditions that each instance of the system was expected to meet. Given this level of agency, many authorities proceeded to amend the existing exemplars, or develop their own: subsequent guidance from the new Department for Children, Schools and Families became much stricter, and culminated in a centrally defined compliance document, against which each system supplier had to accredit their instantiation of ICS.

While the approach was innovative, it was also ambitious. Despite initial enthusiasm and general commitment to delivery, concerns were raised, and confidence began to wane (Bell, 2008).

In reality many implementations found practitioners struggling with the requirements of the ICS, and difficulty in reconciling its approach with their practice. The emphasis on IT based systems – intended to enable consistent information sharing and expected to reduce repetitive input – was seen as imposing additional burden on the practitioners, forcing them to spend time in front of a computer rather than with their client. A particular concern was the design and structure of the forms based 'exemplars'(Shaw et al. 2009).

The pace of implementation, the focus on forms rather than processes, the need to adapt existing systems – or purchase new ones – and the requirements to train practitioners while maintaining services under pressure, were all huge challenges to authorities still wrestling to realign themselves with the new policy arrangements. The rigidity of compliance requirements added to their difficulties – and the whole system was brought into question with the death of baby Peter in 2007. The inquiry into his case triggered, among other things, the creation of a Task force to review of the effectiveness of ICS implementation. In late 2009 letters were sent to all Directors of Childrens' services in England, setting out the Government response to that Taskforce's recommendations.

Those letters reinforced the Task Force's key recommendation: the long term vision should be that ICT systems which support children's social care services should be locally owned and locally implemented, within a simplified national framework. The letters also set out the practical steps that Government would take to support local authorities in improving their systems, including by:

• making clear that local authorities will not be required to comply with the published specifications for ICS in order to receive capital funding (in 2009-10) for ICT systems in children's social care;

• explaining how local discretion can introduce greater flexibility for users of the system; and

• setting out the Government's continued commitment to supporting local authorities in the implementation and improvement of their local systems, including by helping local authorities to assess the 'usability' or their systems and to work with suppliers to make improvement (Department for Children Schools and Families, 2009).

The rigid, centralised requirements for compliance had been relaxed: agency returned to the authorities, enabling them to return to implementing and maintaining systems tailored to local use.

1.5 Lessons learned from implementing systems

There has not yet been time to determine if this change in approach for ICS will create the expected benefits that the centrally defined system had failed to deliver. Nor is it certain if, in creating much greater flexibility, this revision of guidance will undermine some of the strengths that an integrated, standards based system were expected to provide. But there are certainly lessons to be learned from this attempt to implement a nationally defined tool within the complex care environment.

The common themes these lessons share – the understanding of the resources needed to support change, the role of systems developers and suppliers, ensuring adequate and appropriate training, the inclusion of client and carer's views and perspectives, and the need for systems that are flexible enough to address a wide range of user circumstances (Bell and Shaw, 2008) – have equal applicability for Adult services, and highlight the need for greater understand of the factors involved in the management and delivery of this kind of organisational and practice change. In addition, recent work identifies the value of, not just involving practitioners and others in the design of these systems, but in working with them to develop a better understanding of the practices and processes that the systems are intended to support (Broadhurst et al. 2009; White et al. 2010).

The declared aim is to convert the ICS into a tool better aligned with the professional task - but if it is to be seen as of real value to workers then its reform must have front line workers at the centre of any redesign (Pithouse et al. 2011).

The Department of Health's approach to the development of the Adult Common Assessment Framework was very different from the top down, centrally proscribed implementation of ICS. It focused on delivering a conceptual guidance document and then funding a set of 'demonstrator projects' to explore the practical implications of the proposed models. This exploratory strategy enabled the work of the Framework team to draw on lessons learned in SAP, and subsequently adapt to the emerging demands of new policy, both in relation to integration with Health, and in responding to the implications of supporting personalised services - even if those implications are not yet fully understood (Department of Health, 2009). The formal evaluation of the work has yet to appear, but practical learning from the projects is currently being disseminated through a web-based learning network[1] .

1.6 Current and Emerging Policy

The demanding pace of change remains an issue. Health and social care policy has begun to move the focus of measurement away from operational performance towards the capturing of needs led analysis and its resultant outcomes. The concept of needs led analysis has been in existence for some time: assessments should 'focus positively on what the individual can and cannot do, and could be expected to achieve, taking account of his or her personal and social relationships (Department of Health, 1989, para. 3.2.3).' But, as (Parry-Jones and Soulsby, 2001) observe, although an overall objective for needs assessment is given, the lack of a clear conceptual framework with precise definitions may make needs assessment difficult to operationalise.

The Personalisation agenda goes further, requiring the underpinning emphasis of both assessment and care planning to be on the identification of community and individual outcomes, with an intention to measure the quality and effectiveness of services against the achievement of those outcomes over time. The widening of scope implied by this approach makes it difficult to identify a distinctive social care 'outcomes' focus (Glendinning et al. 2006).

Hudson (1997) identified that there often is enormous confusion in discussions of outcomes, suggesting that there are basically two kinds of outcomes. 'One represents an

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[1] http://www.networks.nhs.uk/nhs-networks/common-assessment-framework-for-adults-learning

outcome with respect to the *problem* for which the client seeks help. The other represents an outcome with respect to our professional *behaviour*; what we actually *do* to change the nature of the problem (Hudson, 1997, p5).

The record of a service users circumstances at the time of their assessment potentially provides a base- line against which outcomes can be identified at later review. In some circumstances, however, the aim of social care may be to maintain a desired state or process rather than to bring about changes or improvement. This means that a model of outcome measurement in which interventions are expected to bring about changes or improvements 'may not be adequate for assessing social care effectiveness' (Qureshi, 1999, p 258).

Quereshi goes on to ask: 'Is the recording of assessment sufficiently well undertaken to provide a base-line against which the results of any subsequent review can be checked?'

The lessons learned from the implementation of both SAP and ICS suggests that current tools can make it difficult to do so – and that replacing them will require a much better understanding of the role of information within assessment, along with the other factors that influence how that information is obtained, captured and used.

1.7 Explorations in the landscape: recent research

At the time of the initial literature review, there had been very little research undertaken into the relationship between the implementation/use of ICT and its impact on social care assessment. In the years since the start of the project, more directly relevant work has begun to appear. Some of this work has been driven by a need to understand and respond to high profile public issues, rather than a more general concern to understand the impact and use of information in the delivery of care, but has, nevertheless, added to the overall body of knowledge in this area (Johnson & Petrie 2004; Platt 2005). Others have looked at the wider potential for ICT to support care through the development of 'digital welfare' approaches (Loader et al. 2009) and the consideration of issues relating to multi-agency working and the development of integrated care services (Wilson et al. 2007; Baines, Wilson and Walsh, 2010). Particular attention has been given to the success, or otherwise, of ICT dependant initiatives, such as ICS (Mitchell and Sloper 2008; Shaw et al. 2009) and the Single Assessment Process (Eccles, 2008; Sutcliffe et al. 2008), alongside the effectiveness and use of assessment tools within both adult and child services (Crisp et al. 2006; Gillingham & Humphreys 2009),

Crisp et al. (2006), undertook a critical review of assessment frameworks, identifying how the potential of assessment frameworks to contribute to the development of effective practice is dependent upon how they are implemented, while highlighting the danger of them becoming mechanistic checklists. Eccles (2008), explored the implementation of the Shared Assessment Process in Scotland, noting significant variation in the amount and utility of the information being passed on between health and social care staff, along with the different understanding of the purpose of the assessment narrative within different professional disciplines. The inadequacy of the IT tools being used resulted in an inconsistent use of the shared tool and an increase in duplication of paperwork. Mitchell and Sloper (2008), looked at the applicability of the 'holistic' exemplars in ICS to disabled children, considering how social workers frequently employed different approaches when working with disabled children, and the way that the ICS exemplars did not always accommodate these practices. Sutcliffe et al. (2008) evaluated how the implementation of SAP had impacted on practice relating to multidisciplinary assessment through a review of case files. Shaw et al. (2009) studied the implementation of ICS in four pilot authorities, while both Broadhurst et al.(2009) and White et al. (2010), have explored the ways that formalisation of assessment – through the setting of performance targets and the establishment of required timescales – impact on practice. Saario et al. (2012) have shown how practitioners continue to utilise traditional approaches alongside the introduction of new systems: their work, considering projects in both the UK and Finland, has demonstrated that this persistence of traditional, non-electronic recording and communication is not dependant on national contexts.

Many of these studies have been undertaken from a social work, rather than an Informatics perspective and tend to look at the impact of initiatives on the outcomes for services users rather than on day to day practice; while many express dissatisfaction with the design and/or implementation of ICT (and paper) tools and advocate the involvement of practitioners in systems design, there has still been very little examination of what the information needs of those practitioners (and the organisations that employ them) may be. The main conclusion that can be drawn from research about the use of IS in child protection systems is that, despite considerable investment, current forms of IS that aim to enhance practice have not had the desired effect; indeed, the opposite appears to be the case (Gillingham 2012).

Concerns about this continuing failure of systems to engage practitioners or to deliver their expected benefits have led some researchers to challenge the assumptive view that fully integrated, standardised and 'single view' systems should be the goal of ICT developments across health and care. Wilson & Baines (2009) have questioned the extent to which 'deep' integration can be achieved in multi-agency environments with equally multi-informational needs; White et al. (2008) have raised the risks of diminishing professional perspectives and reducing narrative richness through the construction of rigidly defined common languages and ontologies; while Cornford et al. (2013) have begun to explore the dilemmas inherent in trying to record consistent data about individuals when they also form part of more amorphous entities, such as a family group.

Understanding the role of ICT in supporting practitioners, enabling care delivery and empowering services users continues to be a complex and problematical challenge. Nevertheless, a picture of how professionals engage (or disengage) with assessment tools, and how the implementation of some systems have helped or hindered the progression of practice is now starting to emerge. This work aims to contribute to that picture, considering the issues from an Informatics perspective and looking at the contexts in which they sit.

Chapter Two*: Developing the analytical lens*

This chapter looks at findings from both Information Technology and Systems (IT/IS) and Organisational Studies (OS) research concerning the construction, implementation and use of information tools in support of policy and practice. A number of methodological and analytical tools available to support IT/IS projects, together with a range of OS theoretical frameworks were examined and assessed. The need to draw on both perspectives was recognised, requiring the adoption of analytical and theoretical framework that could bridge the two and support the work; structuration theory was identified as being the most relevant, and this is discussed in greater detail. Aspects of this chosen framework are further explored to provide a contextual frame for the research.

2.1 Defining approaches
Examining Methodologies and theoretical frameworks

The initial research proposal had been focused on the potentiality of developing systems that would enable practitioners to engage with and use technology more effectively. The literature review therefore included an examination of tools, techniques and theories commonly used within IS research and systems design, alongside relevant organisational theories that might assist in positioning the understanding of policy and practice within an information systems context. This review process further shaped the development of the underpinning research question, identifying the need for the work to encompass aspects of both IT/IS and OS approaches.

A range of relevant literature was identified, concerning tools and techniques used in the construction and implementation of information tools and systems, methodologies developed to support systems design, and theories relating to the development, implementation and use of technology. More generic Social and Organisational theories were also examined for potential insights into the human interactions of practice and the implementation of policy.

The undertaking of this review provided a critical overview of potential tools for use in the research design, enabling the selection of a theoretical framework to assist in the shaping of the work and the analysis of the findings, and assisting in the clarification of the overarching research question.

2.1.1 IS research and design: Tools, techniques and theories

> The IS researcher entering an organization today is […] faced with complex and intertwined conceptual structures which it is difficult to grasp and render intelligible (Walsham, 1995).

The literature review explored some of the approaches previously taken in IS/IT design and research, and identified the opportunities and issues that might arise from adopting an action research methodology, which is discussed in the next chapter. This exploration included identifying potential tools and approaches that could be used, and critically assessing their application to the work.

2.1.1a Approaches to IS research

Orlikowski and Baroudi (1991) noted that: 'researchers should ensure that they adopt a perspective that is compatible with their own research interests and predispositions, while remaining open to the possibility of other assumptions and interests.' Chua (1986) classified research epistomolgies into three categories - positivist, interpretive, and critical – distinguished by their epistemological and ontological stances, although it is acknowledged that the distinctions are often contentious, and some research papers may be more difficult to classify than others (Klein and Myers, 1999).

Positivist studies serve primarily to test theory, in an attempt to increase predictive understanding of phenomena (Orlikowski and Baroudi, 1991). IS research can be classified as positivist if there is evidence of formal propositions, quantifiable measures of variables, hypothesis testing, and the drawing of inferences about a phenomenon from a representative sample to a stated population (Klein and Myers, 1999).

It can be classified as critical if the main task is seen as being one of social critique, whereby the restrictive and alienating conditions of the status quo are brought to light, and interpretive if it is assumed that our knowledge of reality is gained only through social constructions such a language, consciousness, shared meanings, documents, tools, and other artifacts (Klein and Myers, 1999). It is desirable in interpretive studies to preserve a considerable degree of openness to the field data, and a willingness to modify initial assumptions and theories. This results in an iterative process of data collection and analysis, with initial theories being expanded, revised, or abandoned altogether (Walsham, 1995.)

Interpretivism is the epistemology that encourages researchers to be more interpretive and inductive, thus providing a valuable platform for studying IS in organizations (Johari, 2006). Its aim is to understand how members of a social group, through their

participation in social processes, enact their particular realities and endow them with meaning, and to show how these meanings, beliefs and intentions of the members help to constitute their social action (Orlikowski and Baroudi, 1991). This was the primary approach adopted for this research.

2.1.1. b Approaches to Design.

Early IS design approaches adopted methods used in manufacturing and construction to design and construct machinery or production lines. Royce (1970) described a model in which design proceeds sequentially through a series of phases. This model is often termed the 'Waterfall' method and while it encourages disciplined and structured development, applying it can be proscriptive and inflexible. Formal methodologies based on the model - such as Systems Analysis and Design Method (SSADM) – have seen difficulties arising from the management of ever shifting requirements, poor relationships with users and the emergence of serious problems late in a project - suggesting that the waterfall method may not be the best way to develop the majority of public sector IS projects (Middleton, 1999).

A more flexible approach is that of Soft Systems Methodology (SSM), developed by Peter Checkland and his colleagues at the University of Lancaster in the late 1980's. This takes an action research approach to problems and focuses on creating change rather than simply describing the problem. This is achieved by 'developing models of relevance to the 'real world', or practice situation' (Clarke & Wilcockson 2002, p 399).

SSM would seem to be best applied in stable environments where a required change can be clearly identified and articulated. Its process focused approach may have less to offer where projects are driven by innovative change, particularly those with developments needing to respond to emergent or convergent technologies, or where the objectives for change develop and evolve over time.

Reviewing the literature around SSM led to the identification of cognitive mapping techniques which, along with grounded theory techniques, were subsequently employed to support the research analysis. Causal and concept mapping proved to be a useful way of generating ideas and analysing the collected material, particularly in regard to teasing out the complex structures which were being observed. Concept maps produced using the data collected from the workshops and interviews were used to inform the development of the research questionnaire, and also contributed to the overall analysis of the work.

In the IS/IT world, practically all approaches to system design involve users in the design process. The difference between the various approaches lies in the degree to which users are able to influence the system design (Damodaran, 1996). Methods for involving users range from highly structured and directive approaches, such as Joint Application Design, through interactive methodologies such as Participatory Design (PD) to socio-technical design approaches such as 'rich picture' engagement, 'design-in-use' and co-production or co-realisation.

Joint Application Design (JAD) is a generic term which describes a variety of proprietary and custom developed methods for conducting workshops in which users and technical developers work together on information system (IS) project planning, requirements definition, user interface design, or other activities. (Davidson, 1999) It is promoted as a people process - allowing IS to work more effectively with users in a shorter time frame, although the approach it utilises can restrict user input and limit the associated engagement. JAD workshops tend to have highly structured agendas with clear objectives including a mechanism for resolving open issues that often bog down the design process. The deliverables are clearly defined during the pre-workshop activities so that there can be a smooth and successful transition to the next phase in the life cycle - application design or acquisition.(Jennerich, 1990)

Participatory Design, on the other hand, is an approach that actively involves the individuals affected by change in the design of that change. The methodology originated in Scandinavia in the 1970s and developed from the practices of industrial democracy which emerged at that time. It has become a widely used method in a broad range of contexts including both commercial and academic led information system software development projects (Wilson et al. 2004).

Participation, as with other forms of qualitative inquiry, 'recognizes the obtrusiveness of research into the world of the research subjects, a condition that is often denied in orthodox traditions' (Breu and Peppard, 2003, p 185). The participation of the intended users in technology design is seen as one of the preconditions for good design. Making room for the skills, experiences, and interests of workers in system design is thought to increase the likelihood that the systems will be useful and well integrated into the work practices of the organization. Of central importance is the development of meaningful and productive relations between those charged with technology design and those who must live with its consequences. PD researchers hold that design professionals need

knowledge of the actual use context and workers need knowledge of possible technological options (Kensing and Blomberg, 1998).

The involvement of users and practitioners holds the potential to create a 'mutual learning process' (Beguin, 2003) as well as improving the likelihood that 'the systems will be useful and well integrated into the work practices of the organization' (Kensing and Blomberg, 1998).

A common criticism against PD is its imprecise definition of the concept of *participation* (Olsson, 2004). These kinds of arguments tend to focus on conditions that may prevent participation from working; the arguments in favour generally refer to conditions that may improve its effectiveness. Many of the arguments against participation can be considered pitfalls, which have to be taken into account in the design of the process (Van de Kerkhof and Linnerooth-Bayer, 2001). Group dynamics and processes naturally pose significant potential for miscommunication and conflict for any collaborative team (Breu and Peppard 2003). These issues clearly need to be taken into account when utilising participatory design methods in any research study.

The initial workshops were designed to utilise the participatory approach, recognising that insider 'local knowledge' is as necessary for valid scientific sense making as the outsider researcher's technical expertise (Elden and Chisholm 1993). The fluid nature of the ACT project prevented further formal application of these techniques, but with the extensive involvement of both practitioners and service users in the development of the new tools, there were opportunities to evaluate both the approaches used and the outcome of the work using the learning from other participatory projects. This evaluation was to provide further evidence of the structuration processes being explored.

A limitation with the participatory design approach is that often the focus within participatory design projects seldom moves beyond the design phase, with IT professionals 'taking away' the learning gained in order to build the new system. As IT systems and artefacts penetrate more and more into working lives, the 'design problem' is not so much concerned with the creation of new technical artefacts as it is with their effective configuration and integration with work practices. The key issue for a re-specified IT design and development practice is therefore not only 'design', but also 'use' (Hartswood, Procter and Slack, 2002).

Socio-technical systems design (STSD) is concerned with advocacy of the direct participation of end-users in the information system design process, involving, not just the network of users, developers, information technology at hand, but also the environments in which the system will be used and supported. The approach stands in opposition to traditional system or software engineering design methods that focus attention exclusively or primarily to activities of system engineers who design the computational functions and features of a new system, and who use computer-aided design tools and notations to capture and formalize the results of such a design process (Scacchi 2004). The socio-technical design philosophies of the late 1950's/early 1960's were developed in the 1970's into system design methodologies such as ETHICS (Effective Technical & Human Implementation of Computer-based Systems). The starting point for this approach was work design, rather than system design, and the methodology placed emphasis on the interaction of technologies and people (Ghaffarian 2011). Interest in these initiatives gradually faded away through the 1980's/90's when the adoption of lean production techniques and business process re-engineering dominated, and STSD was largely sidelined (Mumford 2006; Baxter & Sommerville 2011). However, the 21st century has seen a revival of interest in socio-technical approaches, particularly from the public sector where systems can be under-utilised because they introduce ways of working that conflict with other aspects of the user's job, or they require changes to procedures that affect other people's responsibilities. One of the keys to developing systems that are acceptable to the users is a detailed understanding of the underlying work structures (Baxter & Sommerville 2011). Not only are the new technologies becoming more prevalent and powerful; they also offer opportunities to work in more interconnected ways, providing the scope and catalyst for new working arrangements (Clegg 2000). STSD can be challenging, and difficult to undertake, but the approach, and the principles that underlie it (Clegg 2000), offers opportunities to move from consultative participatory design into co-production and co-realisation activities and to develop responsive, holistic systems that more effectively support the way that people work, and empower them to do so.

Co-production is considered the critical mix of activities that service agents and citizens contribute to the provision of public services. The concept originated in the United States during the early 1970s in work whose objective was to improve relationships between communities and local police forces by creating an engagement framework for improving service design (Brudney and England, 1983).

Although the engagement of users is unarguably a pre-requisite to create more user-friendly and usable artefacts and devices, the adoption of a co- production approach recognises that this is not sufficient in and of itself. That is, whilst much attention has been paid to finding ways of better engaging 'users' in the process of designing and developing new systems, for example, through the many variants of 'participative design' methods, this also has to take place in the context of 'user' engagement in the visioning and re-thinking of the context into which such systems and devices are to be procured and deployed (Wilson et al. 2012).

Co-realisation is a methodology that reflects the extent and depth of user engagement inherent in co-production approaches, while echoing the interpretivist approach to research and learning. It calls for a re-specification of IT design as a principled synthesis of ethnomethodology and participatory design. Co- realisation's goal methodologically is to move from intermittent and over-formalised participation to a situation where informal interaction between users and IT professionals becomes a part of everyday experience and the basis for the constitution of a shared practice. A system which embodies workplace specific knowledge and which has IT professionals' practical exigencies of living with the system is likely to produce a more elegant solution to the problems of living with IT. Put most simply, co-realisation advocates taking engagement with users seriously, asking IT professionals to capitalise on the mundane and to 'stick around' and see what happens (Hartswood et al. 2002).

2.1.2 Theoretical Frameworks
Exploring explanatory frameworks for systems, human behaviours and the oversight of change.

In looking to understand the complexities of practice and the potential for information systems to support it, the work needed to be positioned within a theoretical and methodological framework that could encompass both the human and technical aspects of the study.

The literature review therefore also examined a number of theoretical perspectives that held potential for framing and analysing the work.

A range of theoretical theories were considered as potential frameworks for this research, including those of human-computer interaction, actor-network theories, and complexity theory. These and their relevance to the research, are considered briefly below, together with a more detailed review of the framework selected - that of structuration theory.

Brief consideration was given to the relevance of taking a Business-Ecosystems approach (Moore, 1993), but while it was recognised that this might be suited to a wider study of the relationships between social care agencies and their partners, it was felt that taking this approach might exclude some of the more detailed interactions involved in individual assessments .

2.1.2.a Human-computer Interaction

Human-computer Interaction offered a number of concepts and considerations that related to particular areas of the work, but at the time of the review did not include insights that might support a holistic perspective or enable the components to be brought together into a meaningful way. Nor did these approaches offer ways of thinking about change and the longitudinal aspects of the study. This limitation of perspective equally limited the contribution these theories might make to the analysis of the wider context and the role of the technology within it.

Given that the practice being studied exists in a very complex environment, in which the information systems play a supporting, rather than central role, and with the nature of that environment still being fairly nebulous and undefined, it was felt these approaches would be of limited benefit to the study.

2.1.2.b Actor network Theories

Actor network theory provides a narrative approach to describing structures and interactions within in networks and social systems. It tends to focus on the 'how' rather than the 'why' and, at the time of the initial literature review, appeared to be less concerned with analysing the underlying mechanisms and constraints that create or hinder change. While it held promise as a potential tool for describing the contexts within which practice operates, it was not clear from the review how it might be used to support the exploration of the influence those context have on practice or how developments in practice might influence them. As the theory appeared to primarily focus on describing stability, it was felt – based on the materials discovered through the review - that the inherent instability of the environment being studied, along with the longitudinal nature of the research, and the need to address the effects and delivery of change, might create additional complexities when undertaking an ANT analysis, and an alternative approach was sought.

(Brooks and Atkinson (2004) have, more recently, proposed an amalgamation of ANT and Structuration theories to address enquiries into the nature of information systems

(IS) and their development that go beyond the stereotypical concept of them as being constituted of an information technology (IT) and its (human) 'user.' This combined approach is relatively new and was not discovered at the time of the original literature review; it therefore did not contribute to the initial formulation of theory used in this research.

2.1.2c Complexity Theory

The complex nature of public sector organisations, and the equally complex environments in which they operate - the influx of policy initiatives, the political demands of the local community, the influence of partner agencies, the expectations of professional bodies, and the realities of front line practice - might suggest that complexity theory (CT) could provide valuable insight concerning the way that they function within and adapt to those environments.

However, although CT proposes an understanding of how new structures can arise through the interactions of agents within a system and how new, unexpected behaviours might emerge through interactions with those new structures - its analysis tends to focus on the macro - outcomes for the whole system - rather than on the micro interactions *within* the system. This might have had some application within the proposed study when looking at the complexity of interactions between practitioner, user and organisational agencies - but, at the time, it was decided that the real potential it offered - that of positioning that complexity within social care as a whole - probably lay beyond the scope of the envisioned research.

2.1.2.d Structuration Theory

Structuration theory was first propounded as a general theory of social science by Anthony Giddens. In '*The Constitution of Society'* he states that 'structuration theory is based on the premise that […] dualism (the division between objectivism and subjectivism) has to be reconceptualised as a duality -- the duality of structure' (Giddens, 1984).

Earlier observations in the field had recognised that social systems have structure, but that it is 'a structure of events rather than physical parts, a structure therefore inseparable from the functioning of the system' (Katz and Kahn 1966). Giddens takes this consideration further, postulating that structure in social systems is not independent of agency - structural properties are created through social interaction, while social interaction is, in turn, influenced by the structural properties within which it

operates. Giddens expands on this by suggesting that these structural properties exist only in so far as forms of social conduct are reproduced chronically across time and space. He identified this cyclic, interactive process of production and reproduction of structural properties within systems as *structuration:* the structuring of social relations across time and space, in virtue of the duality of structure (Giddens, 1984).
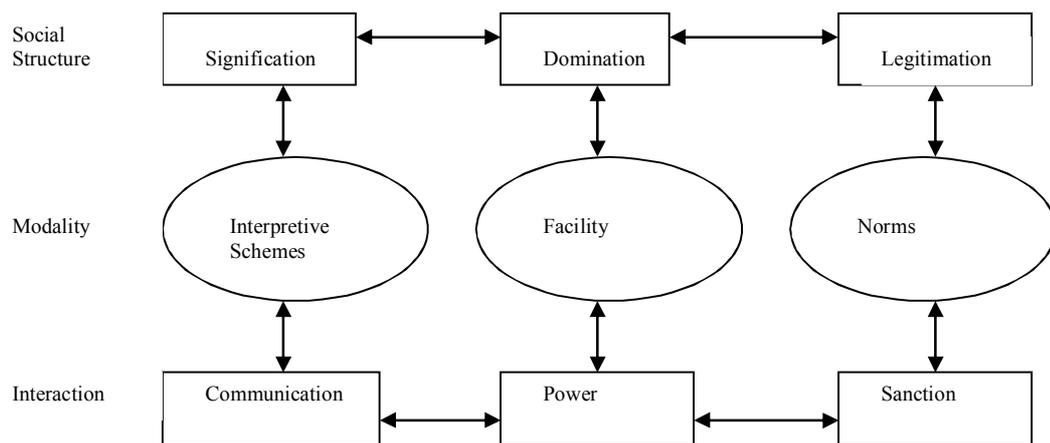
Figure 2.1: The Duality of Structure (After (Giddens, 1984))

In structuration theory 'structure' is regarded as rules and resources recursively implicated in social reproduction; institutionalized features of social systems have structural properties in the sense that relationships are stabilized across time and space. 'Structure' can be conceptualized abstractly as two aspects of rules -- normative elements and codes of signification. Resources are also of two kinds: authoritative resources, which derive from the co-ordination of the activity of human agents, and allocative resources, which stem from control of material products or of aspects of the material world.

Structures do not just exist in and of themselves—they cannot exist without enacted conduct and they are both the medium and outcome of action. While people usually think of structures as large-scale entities or practices that affect us, Giddens forces us to consider how structures are reproduced: it is enacted human conduct in the form of structured practices that maintains and reproduces these structures (Yang, 2010).

And while structural properties in social systems may not reproduce those systems, they shape, channel, and facilitate system reproduction whenever it occurs by providing agents with the practical awareness of the practices, relations, and spatial-temporal settings they require in order to participate in the reproductive process" (Cohen, 1989, p201).

Human agency, in Giddens' formulation, is the 'capacity to make a difference' (also known as 'transformative capacity') (Giddens, 1984, p 14) and within structuration theory, agency is intimately connected with power. This is one of its defining characteristics, since the loss of the capacity to make a difference is also powerlessness. In practice, human agents almost always retain some transformational capacity – no matter how small. Power involves the exploitation of resources (Rose, 1998). An important feature of the theory is its recognition of the time-space dimension and its role in the reinforcement and/or the evolution of structure properties. Structure refers, in social analysis to 'the structuring properties allowing the 'binding' of time space in social systems, the properties which make it possible for discernibly similar social practices to exist across varying spans of time and space and which lend them a 'systemic' form' (Rose, 1998, p 3).

Dimensions or modalities of structuration—the theoretical elaboration of how power is used— include *patterns of communication* (signification), *use of power* (the capacity to dominate), *and norms of behaviour and conduct* (means of legitimation and morality) (Stillman, 2006). Modalities can thus be seen to act as the locus of interaction between the knowledgeable capacities of actors and the structural features of social systems. It should also be stressed that the splitting of the duality of structure into these three dimensions is simply an analytical device; in practice, they are inextricably interlinked. For example the operation of norms depends upon power relationships for their effectiveness and are deployed through symbolic and linguistic devices (Jones and Karsten, 2003).When human actors communicate in interaction they draw upon different interpretive schemes that are defined by Giddens as "stocks of knowledge" about what actors are doing and why. They represent modes of categorization. Based on these categorizations aspects of every-day life are codified and interpreted. Actors employ these interpretive schemes in order to make sense of the interactions, to understand them. In employing the schemes they (re)produce structures of significations (or meanings) (Chisalita, 2006).

The use of power creates structures of domination. Callinicos (1985) shows there are at least two steps in how Giddens conceptualizes power:

- power in relation to action

  Power is the human capacity to achieve outcomes "the capability of the actor to intervene in a series of events so as to alter their course: as such

it is the "can" which mediates between intentions and want and the actual realization of the outcomes sought after"

- power in relation to interaction or power as domination

    Power is the transformative capacity used for domination, expressed through control over others. There are two main ways of dominations: allocation (economic domination, control over material goods) and authorization (politico- ideological domination, control over people).

Power is the *regular and routine* mechanism for achieving sets of transformations. Power is generative: it provides the capacity 'to do otherwise'. Power is conducted through communication, the use of resources, and the norms/sanctions for particular beliefs and practices (Stillman, 2006).

An interaction is always constrained as well as enabled by the norms employed within it. The norms define what is expected from the other people, what it means to behave appropriately in a situation of other. Actors use norms to sanction their own behaviour or the behaviour of others and reproduce structures of legitimation. Structures of significations are always associated with structures of domination and legitimation (Chisalita, 2006).

An important facet of ST is its recognition that the duality of structure evolves over time, being re-produced continuously within the process called structuration. Agents continuously produce, re-produce and develop social structures that, at the same time, constrain as well as enable them (Fig 2.2).
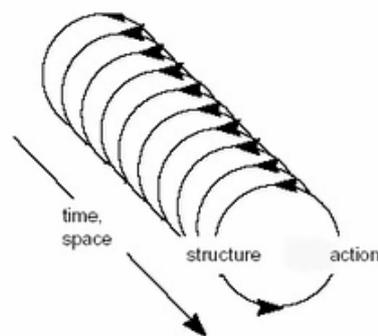
Figure 2.2: Structuration over time and space from (Rose and Scheepers, 2001)

Social practice which endures over time is, effectively, routine - people repeating recognizably similar encounters. However, structuration literature suggests that structure is more dynamic than conventionally assumed. The structures that guide

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peoples' actions … emerge out of their daily experience within that context (Sandfort, 2003a).

Social practice spreading over distance, involving both geographical space and larger numbers of people, incorporates Giddens concept of system integration. Social practice which spreads through time and space (democracy, market capitalism, watching television) becomes stable, institutionalized. Technology, information systems, may become part of that practice (Rose and Scheepers, 2001). Social change is explained by the alterations that human action brings into the structures (Chisalita, 2006).

Structuration theory has been criticised by other social theorists both for conflating agency and structure, and for using rarefied conceptualizations (Rose and Scheepers, 2001). It has also been accused of subjectivism, 'offering victory to the knowledgeable human actor' (Clegg, 1989).

Giddens view of structuration offers a conceptual mechanism for explaining the reproduction of social structure; however, Archer (1996) suggests that this is not the crucial question which needs addressing. The question of substance is: 'why do some forms of social reproduction succeed and become institutionalized, and others do not?'

As Giddens' original formulation was intended to address theoretical rather than empirical issues, it is probably fair to say that ST was not originally intended as a mechanism to answer that question - although it is possible that combining a structuration model with the socio-ecosystem approaches propounded in complexity theory might create the potential to do so. Fuchs (2003) for instance, has suggested integrating Structuration approaches into the science of complexity 'in order to establish a dialectical theory of social self-organization' (Fuchs, 2003, p133).

2.1.3 Bridging the divide
Addressing IS/IT issues within the sociological concerns of organisation and practice

IT research commonly focuses on the provision of explanation, development of invention and the delivery of solutions to practical problems. The primary focus of organisational study however, is on human behaviour, looking to discover regularities, generate general principles, and identify causal relationships (Orlikowski and Barley, 2001). While it is perfectly possible to research and design new technology without reference to the human environment in which it might be employed, and equally possible to study organisational and human behaviour independent of the technology and systems they use, it is hard to see how research into the use and implementation of

technology within organisations can be effectively studied without reference to both epistemologies.

There is, therefore, a need to engage with both perspectives when undertaking this kind of hybrid research, exploring the way that 'technological systems interact with political actions and human choices over time to produce complex, emergent phenomena' (Orlikowski and Barley 2001, p159).

After extensive consideration, the 'practice lens' of Structuration theory (Orlikowski, 2000) was identified as the framework with the most potential to support the work, enabling not just reflections on the complexity of the environment, but also an analysis of issues from a variety of perspectives - from the micro-view (the activities of individuals within an individual case) through to the meso/macro-perspectives of organisation, community and public-sector culture.

2.1.3.a Structuration and Information Systems Research

Giddens original theory is a general theory of social sciences and takes little account of technology. Apart from some comments on the knowledge society and digital economy in more recent work, Giddens makes almost no reference to information systems in his writings (or, indeed, to the specifics of social and organisational changes in which IS might be implicated) (Jones and Karsten, 2003). But ST has been subsequently taken up and applied to IS and IT research in a variety of ways.

Its application is not without difficulties, and presents two main challenges. Firstly, that structuration theory is complex and involves concepts and general propositions that operate at a high level of abstraction. Secondly, the theory is not easily coupled to any specific research method or methodological approach, and is therefore difficult to apply empirically (Pozzebon and Pinsonneault, 2005).

Orlikowski proposed a Structurational Model of technology, challenging the accepted dualistic view of technology and offering a duality of technology instead – 'technology being a product of human action, while assuming structural properties' (Orlikowski, 1992, p406). Given the challenging nature of this perspective, it is not surprising to find it followed almost immediately by an acknowledgement of the tendency for technology to become reified, 'thereby losing its connections with the human agents that constructed it or gave it meaning.' (p406)

The components of the Structurational model are comprised of human agents (users), technology (as material artifacts), and institutional properties of organisation. The model also distinguishes between *design mode* and *use* mode, recognising the different stages in the lifecycle of an IT system (Orlikowski 1992, p410).

DeSanctis and Poole (1994) formulated 'Adaptive Structuration Theory' - a framework for 'studying variations in organization change that occur as advanced technology is used' (DeSanctis and Poole 1994, p122). They identified a need to create a synthesis between the perspectives of decision theorists and institutional analysis, which they termed the '*social technology* perspective.' (p124) AST utilises Giddens' initial formulation, but adds a number of additional concepts: *spirit* (the general intent with regard to values and goals underlying a given set of structural features (p126)), *structural potential (*the combination of spirit and the structural feature sets of advanced IT (p127)), and *appropriations* (the immediate, visible actions that evidence deeper structuration processes (p128)).

DeSanctis and Poole's framework has been criticised as being too embedded within the traditional casual and deterministic approaches that Giddens was challenging. Jones argued that the application of AST in experimental studies to test causal models bears very little resemblance to Giddens's ideas (Jones, 1997). Subsequent to De Sanctis and Poole's formulation of ADT, Orlikowski (2000) proposed an extension to the structurational perspective through a practice-orientated understanding of the recursive interaction between people, technologies and social interaction. She suggested that previous structuration models of technology departed from Gidden's formulation of structures (that of only having a virtual existence) by situating structures within the technology, and counters the concept of structures 'embodied' within technological artifacts by arguing that 'properties of technology only become structures when they are mobilized in use ' (Orlikowski, 2000), p406).

Seen through Orlikowski's practice lens, technology structures are emergent, not embodied. What users do with technology, she says, 'can be framed as *enactment*, rather than appropriation' (Orlikowski 2000, p406-7).

These two approaches form the two mains schools of thought concerning the application of ST in IS research - the adaptive structuration perspective of DeSanctis and Poole, and the view through the practice lens put forward by Orlikowski and her colleagues. Pozzebon and Pinsonneault (2005) studied literature produced by both groups in order to assess how IT researchers have empirically applied structuration

theory. They were particularly interested in identifying the methodological strategies involved, and therefore focused on *process* studies that described their methodology in some detail.

Two strategies have emerged as central in the use of structuration theory: narrative and temporal bracketing in its two modalities, fine-grained and broad-ranging. These two modalities represent two different ways of analysing the structuring of processes: to be closer to the ongoing events, collecting empirical material with high density that supports the structurationist analysis of a shorter period (fine-grained bracketing); or to be further from the ongoing events but with a longer period of analysis, often allowing a historical account (broad-ranging bracketing). 'The choice depends primarily on researchers' purposes and the degree of density in the data they are able to collect' (Pozzebon and Pinsonneault 2005, p1368).

This bracketing is purely a methodological one, based on the intentions of the given study, and should not be confused with the more traditional split between the micro and macro spheres of sociological analysis. While Giddens identified a distinction between "social integration" (systemness on the level of face-to-face interaction) and "system integration" (systemness on the level of relations between social systems or collectivities) (Giddens, 1979), he subsequently reinforced the interdependence of these two levels of integration within the overall process of structuration. In particular, he emphasised that 'No study of the structural properties of social systems can be successfully carried on, or its results interpreted, without reference to the knowledgeability of the relevant agents' (Giddens, 1979).

Stillman (2006) reiterates this interdependency, suggesting that any split between macro and micro level analysis is a strictly artificial one. He draws on a description of reality as 'constituted by sets of intersecting 'strips' or 'frames' (Goffman, 1997), which contribute to the duality of structuration in the dialectic between personal agency (frequently co-present, micro-level interaction) and the group (macro, and even meso-level), instantiation of structural principles to constitute institutional realities, and views Giddens' outline of the modalities of structuration as a contribution towards an analysis of simultaneous micro and macro-level interaction in the construction of reality (Stillman, 2006).

Pozzebon and Pinsonneault's analysis adds weight to the call for further collaboration between IS and organisational studies. '[...]much of the potential of ST in helping to increase the understanding of organizational life and change remains to be developed. In

their turn, IT researchers have spent considerable time over the last 13 years applying ST in empirical work and trying to find ways to address the difficulties of applying a structurationist framework' (Pozzebon and Pinsonneault, 2005, p1369).

This viewpoint is further supported by Rose: 'The application of structuration theory to date has been very largely in the theorizing and analyzing modes; the theory itself (the double hermeneutic) implies that this will eventually feed back into practice. [...]translation into the style of the IS discipline and employment of its modes of thought and expression may provide tools which are of more direct value to the practitioner' (Rose 1998).

There is, therefore, opportunity to further develop the use of Structuration Theory in both IS and organisational studies, particularly exploring the potential it offers to help frame how information systems and organisational behaviours interface and interact. And while there are some theoretical controversies surrounding its use, its application creates opportunities to construct and analyse models encompassing the micro, macro and meso perspectives on the production and reproduction of social and organisational structures.

2.1.4 Framing realities
Positioning the interactions between policy, organisation and practitioner

Although the initial impetus of this research lay with ambitions to deliver more effective information services to front line practitioners, the need to understand the factors which impacted on and shaped that practice widened the investigation to include consideration of both the institutional and social contexts in which it occurs. Jones and Karsten (2008) have suggested that using ST to consider the linkage of individual micro-level action and macro-level institutional processes, can widen the scope of IS research from its traditional focus on phenomena associated with computer-based information systems at the individual, group, and organizational levels, and enable it to address the broader institutional and social developments in which IS are increasingly implicated. The constant shift in policy, organisational environment and public perspectives concerning social care services provides a good illustration of both the complexity of the sector, and the value of utilising a structurational approach when considering its analysis.

Micro structures observed in front line practice at any given point in time emerge through the behaviours of individual actors and their interactions with a range of shared rules and resources; some – but not all – of these will have been appropriated from the

meso structures created and reproduced at organisational level – the actions of managers, enacting organisational rules and utilising organisational resources. These rules and resources are themselves appropriated from the macro structures within which these organisations (and the individuals working within them) are situated (Sandfort, 2003a).

As Giddens himself states, institutional (macro) analysis and (micro) analysis of strategic conduct are not mutually exclusive: each "has to be rounded out by a concentration on the duality of structure" (Giddens 1984, p. 288).

Sandfort further observes that, while structuration theory allows us to examine institutional forces that shape the rules and resources of social systems, it also enables us to direct our attention to the ongoing social process of people within organizations that draws on and modifies these structures through daily work. This translation between micro- and macro processes […] is what is so valuable about the utilization of structuration theory to understand field conditions (Sandfort, 2003a, p611.).'

The complexity of the public sector environment, with its layers of central and local government exisiting alongside a number of other institutional and cultural influences, challenges the simple macro/micro analysis commonly used in structuration analysis. A number of intermediary – or *meso* level – insititutions and organisations can be identified as sitting between the high level structures of government and policy setting and the localised structures of front line practice, influencing and adding interpretation to the translation between the two (See Figure 2.3, below.)
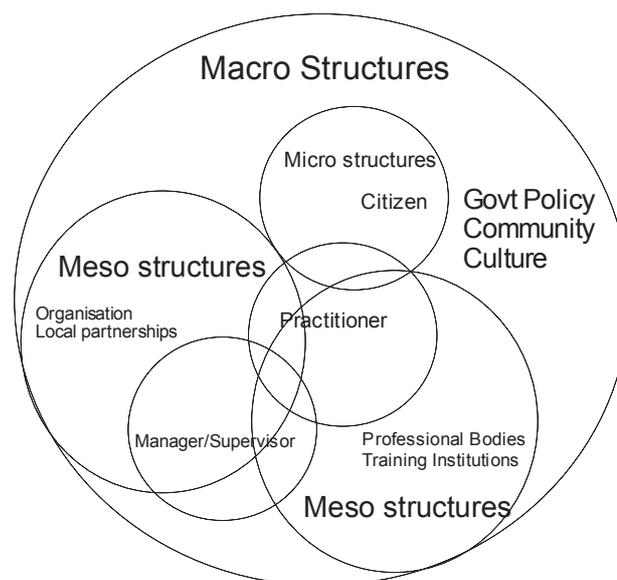
Figure 2.3: Complexity of structures within the Public Sector

The use of the terms micro, meso, and macro to differentiate between levels of scale and complexity has been in existence for some time (meso being common terminology in evolutionary sciences for instance, where it is a taxonomic tool for marking periods of transition or intermediacy) but are now beginning to be used in both economics and sociology with an ontological, rather than a merely classificational perspective. The meso is perceived as something that is made of complex other things (micro) and is itself an element in higher order things (macro) (Dopfer, Foster and Potts, 2004).

For the purposes of this text, and in line with work published on health policy and priorities (Kapiriri, Norheim and Martin,. 2007), the micro-level is defined as encompassing the individual in the organization, their interactions with clients and those who support them, and the team environments within which they work. Meso is the level of the organization, its structure and culture. Macro is the level of professional institutions, the market, government, community, cultural traditions and the like.

The distinction between these micro-meso-macro levels does not lie at a fixed point: structures interact both within and between each level, forming the complex meta systems of culture and society which emerge from those interactions. Equally, the expression of agency which shapes the production of structures at one level can subsequently influence and shape the reproduction of structures above, below and congruent with them. The isolation of 'structure' within this kind of complexity, therefore, cannot be seen as an attempt to describe reality, but rather as a tool of analysis that allow rules, resources, agency, interaction and influence to be identified and their relationships modelled.

It is also important to remember in this kind of analysis that structures may not always emerge from appropriative behaviours, but can also arise through coercive or subversive actions. At the micro level, agency can be expressed, not just through the enactment of shared rules, but through reaction to those imposed at meso or macro levels. Organisations may also choose to exercise meso-agency, reacting to macro structure rules – or by responding to emergent micro-structures - in the same way. Interpretation and translation can be important factors in the transmission and appropriation of both rules and resources, and their origin and provenance may support or may discourage their adoption and enactment; tensions may arise between formal 'imposed' rules, and tacit, shared cultural values. Analysis of context, culture, and the balances of power therefore need to be accounted for when constructing structuration models, and will potentially limit their applicability to other sectors and other cultures. The analytical

frameworks that underpin such an analysis should, however, be more generally applicable and therefore support the creation of similar, but contextually relevant models in other environments.

2.1.5 Formulating an analytical frame
Applying the practice lens

Giddens's structuration theory offers a distinctive perspective on issues that may be relevant to IS researchers, but also has a number of features that may be potentially problematic in terms of common assumptions in the field (Jones and Karsten, 2003). In IS work, it is subsets of social practice (often characterized as business systems within organizations) that become the focus of attention, often with an emphasis on the development and use of the supporting technology, rather than on the practices they support. These are somewhat arbitrarily determined, usually on the basis of their task orientation. Some of the more formal mediating roles of discourse (characterized as information) for business systems can be supported by computerized information systems (Rose and Scheepers, 2001).

Giddens theorises that social structure only exists at the instant of action – that it is a 'virtual order of transformative relationships' that exists, as a space time presence only in its instantiations in practices and as memory traces orientating the conduct of knowledgeable human agents (Giddens, 1984). A number of IS researchers who have sought to utilise ST in their understanding of the use of technology have struggled with this concept, and have sought to explain the apparent persistence of structure as reified within the information artefact (DeSanctis and Poole, 1994;.Poole & DeSanctis 2004; Jones & Karsten 2008)

However, if structure, as defined by Giddens, only exists in action and interaction, then it cannot be inscribed or embedded in technology, since to do so would be to give it an existence separate from the practices of social actors and independent of action, thereby turning the duality, which is such a central feature of Giddens's position, into a dualism (Jones and Karsten, 2008).

Orlikowski (2000) addresses this apparent dilemma by identifying that 'while a technology can be seen to embody symbol and material properties it does not embody structures because those are only instantiated in practice'. From this viewpoint, the information artefact does not represent or embody 'structure' but becomes a repository for rules and for associated resources (usually data) from which structures emerge in use.

Information Technology artefacts represent important linking elements for the structuring of organizations. This relevance appears to be extremely clear if we observe the mediation role that this kind of artefacts plays along several organizational dimensions. They represent powerful devices to store and transmit the knowledge and the experiences that are a fundamental portion of the idiosyncratic resources of the firm. At the same time we can think of artefacts as means to generate and transmit rules of action and rules of decision (Masino, 2003).
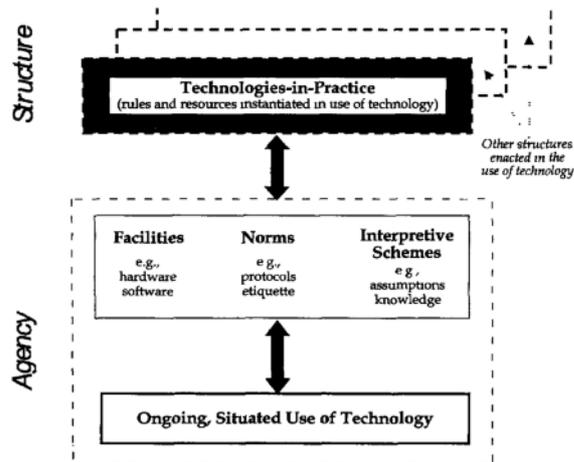
Figure 2.4: Technologies-in-practice. (Orlikowski, 2000)

The 'practice lens' focuses on emergent technology structures enacted in practice, rather than embodied structures fixed in technologies (Orlikowski, 2000). Viewed through this lens a *technology-in-practice* references the specific structure routinely enacted as the specific technology (computer, software, device, or even paper based tool) is used in everyday activities (see Fig 2.4). Information systems act as allocative resources in the structuration process, enabling the emergence of structure through use, and supporting its reproduction over both time and space.

When considering the use of technology as mechanisms which support generic interactions – communication though e-mail or groupware, preparation of documents in word processing, or retrieving data and information using search engines or knowledge tools for instance – the lens can remain relatively unfocused on the specifics of practice and concentrate on the interactions between the technology and the individuals (or groups of individuals) using it. For more situated and specific practices, however, the analysis of that practice – the factors that impact on it and the role that technology plays within it – has to be extended to include the other rules and resources which influence and shape it. From this perspective, the use of ST provides a potential bridge between

the factors that shape technology – in hardware and system design, and in software development – and the social systems, the contexts, in which its users sit.

An information system may be theorized (in structurational terms) as a social system (information practice), supported by a material resources (information technologies), which are designed and managed by a further social system. IS, in turn, supports the interactions of a wider business system (Rose and Scheepers, 2001).

In order to understand the issues associated with the use of technology and information systems within the social care sector, it is therefore necessary to gain some understanding of the social practices that the technology is intended to support. The positioning of that technology also needs to be proportional to the overall subject: a focus that places technology at the centre of the analysis will inevitably lead to reification over the effect of the technological artifact, rather than a consideration of the recursive relationship between technological artifact and people (Stillman, 2006).

Webb (2003) defines *technologies of care* as 'specific ways of intervening, shaping, regulating and directing the lives of people, through particular types of practical rationality (professional skills, expertise, knowledge, values), and by relying on specific instruments, technologies and techniques of intervention to shape behaviour. This shaping or standard setting can take place either at a distance, as with health care telematics, or in close proximity, as in monitoring parenting skills through computer simulation exercises in family centres.' Stillman (2006) interprets this definition as encompassing systems that support the administration of services as well as those that have a direct impact on care.

2.1.6 Refining the Research Question

The question identified in the initial research proposal had been 'how can I design systems that enable practitioners to engage with and use technology more effectively?' The perspectives gained through the literature review, which had identified both a paucity of research into the informational aspects of social care practice and the potential opportunity to contribute towards a greater synthesis between the learning from IS/IT and OS studies, indicated that the work would benefit from a reformulation and refocusing of this question. The lack of knowledge concerning the role of information in operational practice, set beside the growing imperatives of policy to implement and use new technology suggested the need for a better understanding of what social care practice was, and the contexts in which it happened. The overall research question therefore needed to be reformulated so as to support an exploration of

the wider contexts within which the implementation of new technology was placed, while developing a greater understanding of the factors which shaped and directed the practice it was expected to underpin.

The question was therefore revisited to become: 'How do practitioners use information in practice, and how is that use shaped and directed?" This, in turn supported the further development of the research design, enabling it to encompass, not just the implementation of systems, but the organisational and social contexts within which that implementation takes place, recursively directing, shaping, and responding to new technologies of care.

Section Two: Research and Findings

Research that takes place over a period of time is, inevitably, subject to points of review and revision, the nature of the work changing as data is acquired, concepts are formulated and hypotheses are tested. The longitudinal nature of the study demands a process of adaptive change within the research design, responding to shifts in environment, engagement, and overall enterprise. This project was no exception, needing to be responsive to both changes in policy and in the organisation being studied.

At the start of the study, the intention had been to undertake an action research approach. However, the focus and content of the approach changed over time, the work being shaped by a number of external factors, not least of which was the organisational response to a new policy directive, which impacted on the context and direction of the study. As opportunities for evidential and measurable action grew increasingly limited, the approach become primarily that of ethnographic/participation observation; the methodologies employed during the pursuit of the research developed progressively, emerging from the experience of constructing the initial proposal, undertaking the investigative literature review, and conducting a pilot exercise in the field.

While much of the work concentrated on the observation of practitioners and the nature of their practice, this observation was undertaken in the context of implementing a major policy initiative and the development of new information tools intended to support the associated change in both business processes and practice. In this way, the research, while hopefully creating a better understanding of social care practice (in particular the way that practitioners gather and use information and associated intelligences) was primarily aimed at enabling reflection and critical review of the Informatics policies, practices and systems that support public sector services. Using Structuration theory as an active analytical tool supported an iterative exploration of both the observed praxis and of the theory itself, grounding the associated epistemologies within the realities of practice while – at the same time – enabling new perspectives on both theory and practice to emerge.

Chapter Three: Observing the instantiations of structure
Research design and Methodology

> Participant observation is the process enabling researchers to learn about the activities of the people under study in the natural setting through observing and participating in those activities. (Kawulich 2005)

This chapter describes the design and development of the research project along with the methodologies used for research and analysis. It starts with a consideration of the factors influencing the project design, including the role of the researcher, the ontologies and epistemologies underpinning the work, the challenges in the primary research methodology and the role of the theoretical framework. It then goes on to examine the research design in more detail, describing the three strands of the work and how they interlinked, and presenting the methods used for the data collection and analysis, including a profile of the responders to the questionnaire. The chapter concludes with a consideration of how the ethical issues of the research were addressed.

3.1 Overview of the research design.

3.1.1 Initial considerations

A number of initial considerations impacted on the decision to undertake this research. Both the benefits of and potential limitations to the work had to be taken into account when deciding the scope and focus of the project. The benefits:

- Identifying an opportunity to develop my skills and widen my knowledge, supporting both professional and personal development.

- Creating the potential to develop a greater understanding of the sector in which I was working, and my role within it.

- Enabling my work to be better informed and for me (and my team) to deliver more effective implementation

- Better informing the development process that underpinned the products I and my team supported

were balanced against a number of practicalities and their associative restraints:

- The need to focus on issues pertinent to my professional role

- The level of access needed in order to obtain meaningful data

- The relationship between the investment needed for the project (time and personal resources) and the benefits that might bring to both myself and my (then) employer

- The potential complexity of the research and the sustainability of the overall project.

My interest was in considering current and emergent phenomena, and in looking at ways to inform and enable innovation, as well as gaining a greater understanding of my own practice. Practicalities suggested I was best placed to undertake an interpretive study within my employing authority. This, together with the factors identified above, led me to consider the value of an action research approach - which would enable the work to be investigative - rather than undertaking an experimental study or historical review.

Walsham (1995) identified that the role of participant observer or action researcher requires the researcher to be a member of the field group or organization, or at least to become a temporary member for some period of time. This enables the participant observer to get an inside view, and can avoid them being barred from confidential or sensitive issues.

As the senior manager leading an Information Strategy Team within the Authority's Care Services, I felt I was in a position to not only engage in interaction with groups of local practitioners - to observe and analyse the contexts within which they worked, to identify the tools they were using, and to investigate the role that those tools played in their day to day practice - but also to respond to those observations through further development and refinement of those tools.

Initial enquiries with my Director and several of the relevant senior practice managers identified that they would be interested in and supportive of the work, so the basic concepts were expanded into my initial research proposal, which then became the foundation of my project.

At the time when that proposal was being formulated, the social care sector was in the process of responding to a number of policy changes. The implications of both the Lamming inquiry(Lord Laming, 2003) and the Bichard report (Bichard, 2004) were still being assessed, and Adult services were struggling to understand and implement the Single Assessment Process. The issues being considered concerned both aspects of policy and the potential for developing innovative approaches to practice. IT and

Information systems were seen as likely enablers in the process of change, with recognition that, if those systems were inadequately designed and implemented, they also held the potential to restrict and inhibit genuine innovation and change.

The need to position the research in this shifting environment, while attempting to understand and model what is, in many ways, a moving target, suggested that the methodology for the study had to be able to encompass as well as respond to change. The flexibility and responsiveness of an action research approach was initially chosen to meet this requirement.

As the research progressed, the complexity and pace of change within the sector increased, with a growing number of initiatives targeted at Children and Young people, and the emergence of national demands for transformative developments within Adult services. The demands of my role as facilitator in the delivery of this wide scale change agenda limited my ability to instigate and assess research relevant action in specific tools, and this resulted in the primary methodology for the research shifting from the initially envisaged action-orientated participatory research (Park 1999) to the observer as participant/participant-as-observer approaches of participant observation (Atkinson & Hammersley 1994; Kawulich 2005; Guest et al. 2013),   As my understanding of the complexity of the research topic increased, there was also recognition that a range of tools and methods would needed to be in order to gather the relevant data, and to support greater understanding of the components of the work.

The research activities collected data through both interactions with practitioners and participation in the ICT component of a major policy implementation. The overall work retained an action research focus, while the research study was an iterative one; stages of interaction and data gathering were interspersed with sessions of analysis, theory building, modelling and reflective review - the outcomes of which were then fed back into further work and analysis. The initial pilot exercise assisted in the shaping of the main strands of the final work, and the early work with the Adult practitioners similarly contributed to the work of the implementation project. (See Fig 3.1)
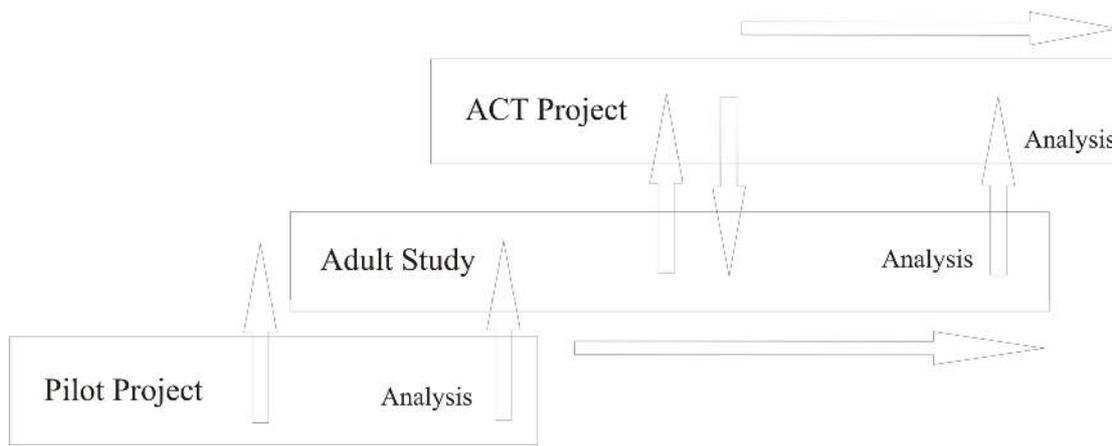
Figure 3.1: Simplified structure of the research, illustrating contemporaneous activities and associated interactions between the strands of work.

3.1.2 Assumptions underpinning the research design.

The significance of action research approaches lies in their capacity to generate and test theory to improve learning in order to improve practice (McNiff and Whitehead, 2006). In order to achieve this goal and by doing so generate genuine reflective learning and associated improvements in practice, it is important to identify the fundamental assumptions which underpin both the approach to the research and the analysis of its findings. These assumptions encompass both the base ontology of the work (the underlying concepts that position and influence the approach to the research) and the associated epistemologies which frame the learning emerging from it. In this piece of research, those assumptions needed to recognise both the complexity of the environment being studied, and the positioning of the research as a bridge between the understanding of social care practice and the informatics practice intended to support it (Orlikowski & Barley 2001).

3.1.2a Ontological assumptions:

- the environment is complex, and the actions and reactions of actors within it are influenced by a range of perspectives, rather than through a single interpretation of context.

- As a designer and producer of information systems I am both part of the problem and the source of the solution – I play a role in translating the needs of practice for the professionals I support into the requirements of my own practice,

and am responsible for ensuring that this translation is effective enough to respond to those needs.

- Information only has value *as* information when it is accessed and used by human agents – knowledge is applied, and intelligence derived through the use of information, not the storing of data.

- Values are an integral part of the work, underpinning both the need for and direction of the research – the aim is to create understanding in order to support greater utility, effectiveness and appropriateness when developing tools. The different perspectives of the contributing agents have significance; my understanding of those perspectives is, inevitably, influenced by my own.

3.1.2b Epistemological assumptions:

- Knowledge of a complex environment cannot be solely derived through isolated study of its individual components; it must address the synthesis of the whole.

- Understanding of behaviour emerges from a consideration of context, meaning, and associated values alongside the observation of activities. What individuals believe they are doing influences what they do.

- Models and frameworks are tools to support the emergence of knowledge. They provide ways to represent and analyse aspects of structure and behaviour, but should not be viewed as absolute descriptors of either.

- Knowledge is not an absolute, but emerges through negotiating a shared understanding across a range of individual and professional points of view. What is 'known' will always be coloured by the contexts in which that understanding is created.

3.1.3 Primary methodology: Participant Observation.

An action research approach was initially chosen for the work, with an aim to work towards practical outcomes, as well as creating new forms of understanding (Reason & Bradbury 2001). Action Research utilises methods of inquiry founded on the assumption that theory and practice can be closely integrated by learning from the results of interventions that are planned after a thorough diagnosis of the problem context (Davison, Martinsons and Kock, 2004). As a process, it requires both action - usually to bring about change in an organisation, a community or a specified programme - and research, generally intended to increase the understanding of either the

researcher, or the client/community, or both (Dick, 1993). As the focus of the ACT development shifted the opportunity to generate measurable change within the period of the research became limited. However, one way of conducting Action Research is to engage in participant observation, which can be seen as a systematic attempt to discover the knowledge a group of people have learned and are using to organise their behaviour (Spradley 1079). This approach emerged as the primary methodology for the project.

Participant observation is an approach that enables researchers to learn about the activities of the people under study in the natural setting through observing and participating in those activities. It is considered a staple in anthropological studies, especially in ethnographic studies, and has been used as a data collection method for over a century (Kawulich 2005).

A participant observer uses observation to research a culture or situation from within (Law et al. 1998). The researcher usually becomes involved in a variety of activities over an extended period of time, enabling him/her to observe the members of the (observed) group in their daily lives, and participating in those activities to facilitate a better understanding of the group's behaviours (Kawulich 2005). Through this observation, the researcher becomes the instrument through which and by which the phenomena of the investigation are selected and filtered as well as interpreted and evaluated. The way in which they operate is therefore crucial in transposing "reality" into data and in producing a close correspondence the actual and the recorded event. (Schwartz & Schwartz 1955)

It is particularly useful when the focus of interest is how activities and interactions within a setting give meaning to beliefs or behaviours, but can be time-consuming and costly, as it can take a long time to uncover the hidden meanings of the situation/context (Law et al. 1998)

There are four theoretically possible roles for sociologists conducting field work, ranging from the complete participant at one extreme to the complete observer at the other. Between these, but nearer the former, is the participant-as-observer; nearer the latter is the observer-as-participant (Gold 1958).

Non-participant observation allows a researcher to remain as an accepted outsider, watching and recording the interactions as a "fly on the wall." It can be particularly useful when the researcher is concerned to describe and conceptualise the "taken for granted" practices of everyday life: the routines and strategies that those they are

studying develop in carrying out their work which may be so common and familiar as to be outside their conscious awareness. (Fitzpatrick & Boulton 1994)

Participant observers, on the other hand, participate in the daily life of the organisation over an extended period of time, watching what happens, listening to what is said, and asking questions. The researcher may encounter difficulties in being accepted by the group initially and then in sustaining the role long enough to observe the full range of events, but the justification for such efforts is in the way participant observation enables the researcher to see and experience the institutional culture from the point of view of an "insider." (Fitzpatrick & Boulton 1994)

Guest, Namey, & Mitchell (2013) mapped a number of common participant observation activities onto a two-axis grid to create a set of Participant Observation Continuums (Fig 3.2) In this diagram the x-axis identifies the degree of participation relative to the degree of observation, while the y-axis describes the degree of revelation or concealment of the researcher role. It shows the range of approaches that can be taken, from adopting a highly observational/low participatory stance where the research role is obvious and prominent (observer-as-participant), to undertaking a highly participatory approach in which the role of observer becomes obscured by the contribution the observer is making (participant-as-observer).
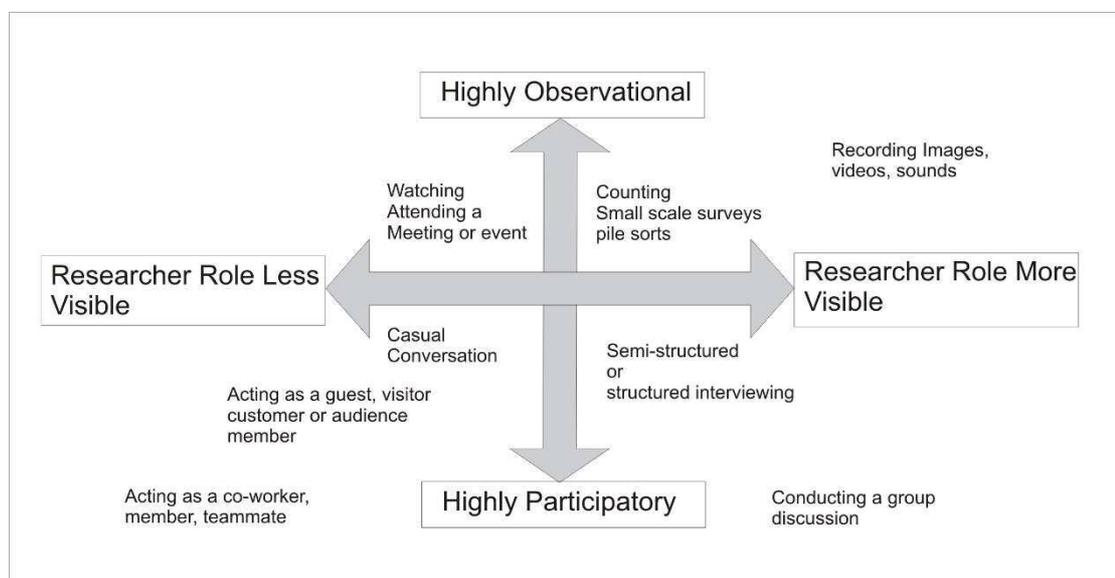
Figure 3.2 Participant Observation Continuums (Guest, Namey, & Mitchell, 2013)

The research for this study employed a number of activities within these continuums, ranging from highly observational (undertaking the questionnaire) through participatory

66

but visible research (workshops and interviews) to the high participation/low research visibility engagement in the ACT project and its associated development work

Participant observation is inherently a qualitative and interactive experience and relatively unstructured. It is generally associated with exploratory and explanatory research objectives—why questions, causal explanations, uncovering the cognitive elements, rules, and norms that underlie the observable behaviours. The data generated are often free flowing and the analysis much more interpretive than in direct observation. And it is this aspect of participant observation that is the method's greatest strength as well as the source of critiques that sometimes surround participant observation studies (Guest et al. 2013).

3.1.4 Focus of the research.

The study that forms the core of this research was focused on one, county based, Local Authority in England (initially looking across both Children and Adult services, but moving to an Adult focus in the latter half of the study.) It was initially hoped that some of the data collection tools used in the research could be used to collect comparable data from a neighbouring Authority, as this would have added additional robustness to the work. Unfortunately, the contact within the other Authority, and through whom the data would have been collected, was unable to conduct the exercise as planned, and subsequently left the relevant Authority to take up work elsewhere. This loss of contact (and the associated loss of access to data) highlights the risks of this kind of research, which is highly dependent on the researcher being effectively engaged with the agency (or group) which forms the focus of the study.

Despite the lack of a comparable data set from a similar Authority, adopting the action research/participant observation approach meant that the data which was collected retained validity within the context of the work and the perspectives of its contributing participants (Ottosson 2003, Iacono et al. 2009).

This approach also supported the longitudinal aspects of the study, which took place over roughly three years, against a backdrop of policy and organisation change. The picture assembled was both rich and detailed, and reflects the transitional contexts in which it was acquired – the moving of both operational practice and culture from 'traditional' care delivery towards initial steps into personalisation of services, and with the business processes and supporting systems still developing as the requirements and implications of relevant policy emerged.

In considering the fundamental question underpinning this research – how do practitioners use information in practice, and how is that use shaped and directed – it was clear that the responses required were likely to be descriptive and exploratory, rather than statistically precise. Framing the work within the dynamics of structuration theory gave further weight to the need for textual richness in the analysis, demanding data sources that helped identify sources of signification and legitimisation, clarified the roles of rules and resources, and assisted in evaluating, not just levels of agency but the modalities through which that agency is expressed. As the goal of qualitative research is the development of concepts which help us to understand social phenomena in natural (rather than experimental) settings, and requires giving due emphasis to the meanings, experiences, and views of all the participants (Pope, Zeibland and Mays, 2000), it was decided that the research should pursue a primarily qualitative approach to both data collection and its subsequent analysis.

The complex nature of the study dictated the use of a similarly complex set of tools and methodologies, with data being gathered through the use of participatory workshops, one-to-one semi-structured interviews, a questionnaire, and a review of relevant documents, as well as an active involvement within the associated development project. Taking the role of lead supplier for IT systems in both the initial ACT project and the subsequent transformation work enabled participatory observation of the approach to and delivery of the project, including the interpretation of policy requirements, the involvement of practitioners, the commissioning of tools and IT services, and the implementation and subsequent evaluation of the new tools and practices. Data collected included field notes, minutes of meetings, project and progress reports, specification documents, emails, supervisory sessions with ICT staff, evaluation reports and one-to-one interviews with management and operational staff. Transcriptions of both the workshops and interviews were analysed and used for the construction of the questionnaire, with relevant findings being fed back into the transformation/development project at relevant stages of the work. Documents collated for analysis included local policies, procedures and guidance, locally developed business models, national policy and guidance, professional guidance and training materials, and enquiry reports, along with a range of related legislation.

This rich collation of data enabled a detailed reflection on Informatics policies, practices and systems, and the way they impacted on the identified practice. Theory building was

primarily supported by qualitative analysis techniques, including concept mapping, exploratory modelling and the use of Structuration theory as an analytical framework.

3.1.4a Adopting a qualitative approach to the collection and analysis of data.

Qualitative research methods involve the systematic collection, organisation, and interpretation of textual material derived from talk or observation (Malterud 2001). These materials […] describe routine and problematic moments and meanings in individuals' lives. Accordingly, qualitative researches deploy a wide range of interconnected interpretive practices, hoping always to get a better understanding of the subject matter in hand (Denzin and Lincoln, 2000).

Grounded theory (Glaser and Strauss, 1967), for instance, provides a rigorous and structured approach to qualitative data analysis (QDA), supporting the discovery of shared concepts, and enabling observations to be interlinked and examined.   Three characteristics of grounded theory—inductive, contextual, and processual— fit with the interpretive rather than positivist orientation. The focus here is on developing a context-based, process-oriented description and explanation of the phenomenon, rather than an objective, static description (Orlikowski, 1993). Adopting a grounded theory approach as a mechanism used to 'discover patterns and processes and understand how a group of people define, via their social interactions, their reality' (Stern, Allen and Moxley, 1984) proved to be a useful tool for the exploration of the gathered research data, particularly with regard to the pilot study.

The descriptive and narrative nature of the data employed in qualitative research presents opportunities to gain a richer view of sociological phenomena than approaches using purely quantitative analysis. It also supports the exploration and analysis of complex structures and environments, and the reflective, iterative and adaptive nature of action research (Malterud, 2001).

Whereas quantitative methods aim for reliability (that is, consistency on retesting) through the use of tools such as standardised questionnaires, qualitative methods score more highly on validity, by getting at how people really behave and what people actually mean when they describe their experiences, attitudes, and behaviours. In addition, the reasoning implicit in qualitative work is held to be inductive (moving from observation to hypothesis) rather than hypothesis testing or deductive (Pope, Zeibland and Mays, 2000).

Combining the methods may be appropriate at times, for example when noting frequency counts and estimates for specific types of feedback from groups, or when validating and informing the qualitative research. Pope, Zeibland and Mays (2000) characterised the relation between qualitative and quantitative methods as complementary rather than exclusive, and the application of basic quantitative rigour provided useful discipline in the creation and subsequent analysis of the questionnaire used within the project. The primary focus of that analysis was, however, qualitative in nature, exploring perceptions and patterns of behaviour rather than attempting to demonstrate statistical significance.

3.1.4b Utilising the Structuration framework for analysis

As Rose and Lewis identified, structuration theory is too complex and diverse to be adapted wholesale. Relevant concepts must be selected and adapted into theoretical frameworks (Rose and Lewis, 2001). This work concentrates its attentions on the duality of structure; it does not attempt an exploration of Giddens' stratification model for agency, nor does it address issues of time-space distanciation in any detail. Rose and Lewis converted their tools into language familiar to the IS community, noting that 'Practitioners using such tools may be entirely unaware of the theory base behind their analysis' (Rose and Lewis, 2001), but as the framework analysis tool used in this research evolved and emerged from a developing understanding of the application of the theory to the issues under investigation, it was decided to retain some of the more 'theoretical' language in order to reduce potential dilution and divergence from the principles of the theory.
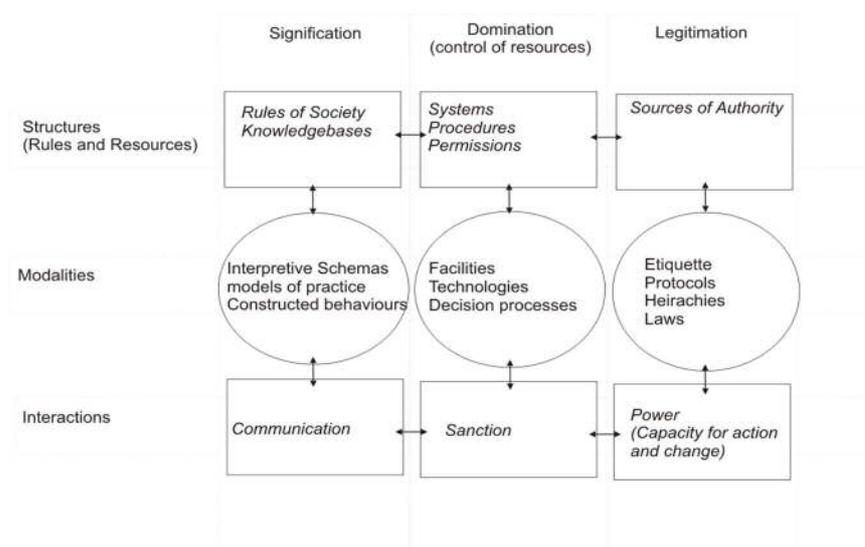
Figure 3.3: Structurational framework analysis tool developed for the research (based on Giddens, Orlikowski and Stillman).

The tools developed for this work (see Figure 3.3 and 3.4. below) drew on the concepts and models presented in earlier papers, and was utilised initially as an analytical map, to relate the observations of the research to the theoretical concepts, and subsequently as a framework for bringing the different levels of bracketing together into a more holistic view. The framework tool was also used in the evaluation of the impact of structural change, in particular the introduction of tools and activities in support of the new national policy initiative.
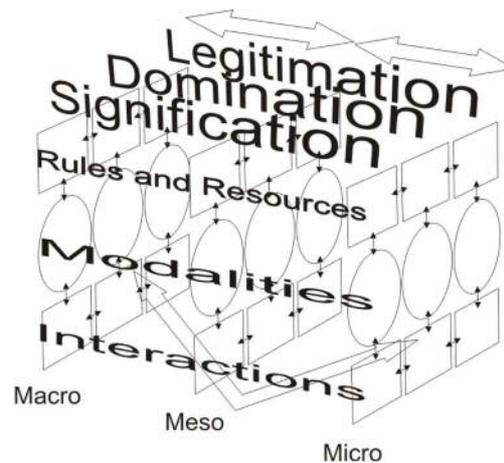
Figure 3.4: Structurational framework combined to form a Macro-Meso-Micro model

The framework analysis tool (Fig 3.3) was used to create pictures of understanding for each of the detailed areas of the work. Figure 3.4 illustrates the theoretical interweaving between the micro, meso and macro-level levels, leading to the creation of structure across the whole.

3.2 Research Design

3.2.1 Key stages of the Research.

In keeping with the cyclic and responsive nature of action research, the project was to move through a number of key stages between its inception and the compilation of this thesis. The work began with the undertaking of a literature review to assist in scoping and justifying the research and a pilot study, to test the proposed methodologies and construct preliminary models. This was followed by the submission of a formal research proposal, based on the outcome of the review and the pilot study.

A review of direction, scope and the practicability of the project was built into the preparations for each stage, along with the need for associated risk and contingency

plans. This enabled the structure and content of the work to be tailored to address both internal issues (such as changes in practitioner access and availability) and the necessary response to a number of unpredictable external factors (such as the introduction of new policy initiatives, or changes in timescales or requirements within existing ones.) Inevitably, given the complex and shifting environment within which the research was being conducted, this was to mean that some planned strands of work were reduced or dropped, while additional data was gathered through other routes or from new sources.

The preliminary literature review was undertaken as planned, supporting the construction of an initial research proposal alongside the shaping of the pilot study, which was to test both the validity of the fieldwork methodology and the use of interpretive approaches in the subsequent analysis of the collected data.

Consideration was given to the most appropriate methodology for data collection, and in keeping with the action research approach, and the intention to include a strand exploring the development and use of new information tools, it was decided to adopt and adapt participatory design techniques as a means of eliciting micro-level data, alongside more traditional ethnographic approaches.

The initial proposal for the research was submitted in 2006, with the intention of the research supporting and, at the same time, learning from the development work being undertaken at the time. The proposal, along with declaring the intention to work with and observe local developments, outlined a set of comparable workshops and interviews to be conducted with three groups of practitioners – one working in Children's services, one in Adults, and one based in the Youth Offending team. It was intended that the analysis of data obtained from each group would then be brought together and used to create a generic questionnaire, enabling comparative data to be collected from a wider sample of practitioners, and for the analysis of these data to inform and shape ICT developments.

The pilot study, based on a participatory workshop with representative practitioners from a multi-agency Children's service, took place in March 2007. Follow-up one to one interviews were also conducted with a number of the workshop's participants, although the data from those interviews was not analysed in any great detail at the initial stage.

The analysis of the pilot study was presented at a workshop in June 2007, along with a revised research plan, which considered the overall shape of the project in greater detail. The basic approach – the use of workshops, interviews, and a questionnaire to support

input into ICT developments – was still key to the work. However, it had already become clear that the initial scope, encompassing three distinct sets of practitioners, had been both ambitious and impracticable. The intended work with the Youth Offending Team was abandoned at this point, and – in recognition both of the theoretical framework which had been chosen to underpin the research, and of the impact of policy changes which were already being felt within the Authority – the project had evolved to include a more longitudinal analysis, intending to examine the impact of technological and policy change on the way that assessment services were structured and delivered.

Although valuable data had been obtained from the pilot work with Children's practitioners, the opportunities to input learning into tool developments for Children's services were severely limited by the requirement to implement ICS – the Integrated Children's system – which, at the time, was expected to be compliant with nationally defined specifications. The focus of the research therefore moved from a wide overview of social care practice and assessment to a more delineated investigation into practice within Adult services, the development of tools to support it, and the role that information and information systems play in the implementation of new practice and new policy initiatives.

The new research plan broke the project down into four stages:

- One: Gathering data concerning practice and the structures within which it took place. This was to include the workshops, the initial interviews and the sampling data from the questionnaire

- Two: Observing the design and creation of information tools to support front line activity. (The ACT project)

- Three: A review and follow up stage, seeking to investigate how the implementation of new technology and tools had impacted on practice and to identify what may have changed, what may have been reinforced, and to what level the practitioners had engaged with the new tools.

- Four: Final analysis, write up and presentation of the work.

Figure 3.5 illustrates the progression of and interactions between the three phases of the work
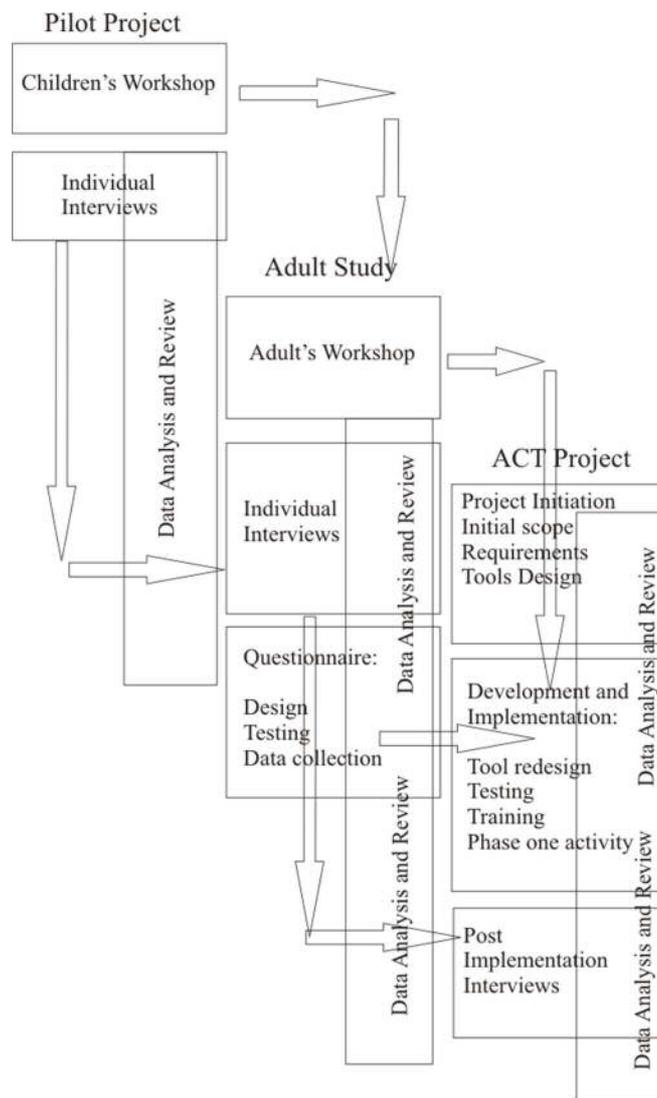
Figure 3.5: Detailed overview of the research activity

The progression of each stage was not seen as dependant on the completion of the previous one; in fact, there was considerable overlap between stages one and two, and then two and three, the design and development work taking place – and being informed – in parallel with the interaction with the practitioners. Analysis was on-going and iterative, with models being developed, tested, and then revised as the research progressed.

The project gathered data through:

- The pilot workshop with seven Children's practitioners.
- One-to-one interviews with the five Children's practitioners directly involved in assessment work.

- The main workshop with four Adult practitioners

- One-to-one interviews with all four

- Observation of the ACT (Assessment and Care Planning Tools Project) from inception though to pilot evaluation. Data collected included field notes, minutes of meetings, project and progress reports, specification documents, emails, supervisory sessions with ICT staff, evaluation reports and one-to-one interviews with management and operational staff.

- Distribution and subsequent analysis of a questionnaire to Adult practitioners (One hundred and forty one responses returned)

- Interview with the Senior Manager acting as executive for ACT

- Post pilot interviews with the Manager of the pilot team, plus a nominated practitioner.

- Local policy documents, including procedural guidance, and training materials

- National policy documents, including legalisation, white and green papers, reports from inquiries, and best practice guidance.

3.2.2 Workshops, Interviews and Observations

Action research focuses on problems of both practical and theoretical importance, and requires those who experience or 'own' the real world problem to be actively involved with the research at least in selecting the problem and sanctioning the search for solutions. This dependence on subjects requires feedback to and active interaction with the people involved at least in the beginning and in the action phases of the research process (Elden and Chisholm, 1993).

As IT systems and artefacts penetrate more and more into working lives, the 'design problem' is not so much concerned with the creation of new technical artefacts as it is with their effective configuration and integration with work practices. The key issue for a re-specified IT design and development practice is therefore not only 'design', but also 'use' (Hartswood, Procter and Slack, 2002). In PD, workshops are usually held to help diverse parties ("interested parties" or "stakeholders") communicate and commit to shared goals, strategies, and outcomes (e.g., analyses, designs, and evaluations, as well as workplace-change objectives) (Muller, 2002).

This is of particular importance when there are expectations that the proposed system will be developed for use by a range of professionals who come to the problem with different perspectives and understanding; the use of exploratory workshops enables

language and concepts to be examined, different interpretations and meaning to be identified, and assists mutual understanding to develop.

The issue of language as it applies in practice and service delivery is also important. For both staff and service users, successful working relationships across organisations require that the language used to describe what is going on be clear and meaningful in terms of what actually happens in service delivery (Bell, Kinder and Huby, 2008).

3.2.2a The Pilot Study

The pilot study was undertaken on behalf of the authority's Integrated Disability Service (IDS). At the time that the workshop took place this was a newly established service, developed in response to expectations outlined in the Children Act (2004) that required co-operation between Local Authorities and their partners in order to improve well-being for children. While working together across the services was not new, there were clear challenges in developing integrated services that could work in co-ordinated and consistent ways.

The IDS brought together a wide range of practitioners from a number of agencies, forming a single, multi-agency service intended to support Children and Young People with Disabilities in ways both appropriate and proportional to their needs. The service was aiming to establish a single shared business process to deliver a consistent service to all their clients. Key areas in this development were an understanding of how social care assessment and case management practice fit in relation to more specialised services, and the development of a shared information system to support the new business process, delivering a more holistic view of a supported child.

The senior lead for social work within the IDS described her role as 'looking at integrating information, assessment across teaching, across social care, across key working and health and looking at what are the common denominators of assessment, what the common areas we can store information.' The workshop was intended to assist in informing that discussion for the IDS, and to support a similar aim as part of the overall research.

Seven practitioners from the IDS took part, the majority being qualified social workers or specialist teachers (involved in services that covered speech and language issues, visual impairment, behavioural support and children's disability social work.) It was not possible to include specialist health workers in this particular study, and it was recognised that their absence might limit the validity of the findings when considering

specifics in specialist practice. The social workers present also had some experience in child protection work.

Five of these participants also took part in independent interviews; the sample included a family key worker, a social worker and specialists in visual impairment, speech and language and pre-school support.

3.2.2b The Adult Services Workshop

The second phase of the research focused on practice and activity in adult services care management and reviewing teams. Where the IDS was developing as a cross-professional, multi-disciplinary service, targeted at a relatively small population of children and young people with specific disability needs, the adult services teams were specialised in social work. At the time of the research, they were providing support to the County's population of adult and elderly service users, with needs ranging from simple support through to complex home or residential care. Four practitioners contributed to the workshop, all of whom were qualified social workers with a range of practice experience, including duty work, initial assessment, care planning and review. All four contributed individual interviews as well as participating in the workshop, and were subsequently involved in the ACT project work.

At the time of the adults workshop, early discussions had begun to understand the potential changes arising from the 'Putting People First' policies and the introduction of personal budgets, but these discussions had not yet impacted on organisational arrangements or front-line practice.

3.2.2c The ACT project and review

The third phase of the research focused on the development of new assessment tools – initially as part of the Assessment and Care Planning Tools Project (ACT) and later absorbed into the wider Transformation Project, aimed at implementing the requirements of new policy through business transformation.

The ACT project was initially established in Sept 2007, with a project team that included both fieldwork and support services practitioners and managers. The aim of the project was to create new tools to support the reshaping of assessment practice within the existing process.

2007 had also seen the publication of a number of documents, including Putting People First (Department of Health 2007), promoting the need for change and a shift towards more personalised services. In contrast to the Authorities low key response to the Single Assessment Inititative, the senior managers in Countyshire considered these newer, transformational policies as having greater signification; their focus on encouraging the creation of operational structures which were outcome focused, personalised, and respectful of choice, reflected and reinforced many of the cultural and practice based beliefs with which social work practitioners and managers were familiar. They also came backed with additional resources to assist their implementation: the Department of Health had recognised that the proposed changes could not happen without some support from the centre, so funding was identified and allocated, its availability linked to the expectation of change. Countyshire chose to utilise their allocated funding by establishing a programme of change aimed at a challenging and radical transformation of both process and practice. This meant that, as this funding became available, the focus and the approach of the ACT project also had to change, adapting the work in order to respond to the demands of the new, developing policy agenda.

The project was undertaken using a PRINCE styled approach in which I – as Manager of the Information Strategy Team – was allocated the role of 'Senior Supplier.' The Project executive, a senior fieldwork manager, was encouraging and supportive concerning the inclusion of the research strands into the project, and welcomed the opportunity for the tool development to draw on the understanding emerging from the workshops and interviews. The data collected included an interview held with this Senior Manger in which the analysis of the questionnaire was discussed, and his views on both the evidenced practice and the change in practice implied in the new policy were explored.

In addition to field and meeting notes, records of correspondence and discussion held during the development and implementation of the new tools, two further interviews were held – one with the Manager of the team piloting the new approach, and one with a practitioner, discussing their experience of that implementation. Data was also drawn from the formal analysis of the first phase of the project, which was undertaken by the Authority.

3.2.3 Data collection – workshops and interviews

The discussions within the workshops and all of the interviews were captured as digital sound files, enabling verbatim transcription of much of the material. Two of the initial

ACT meetings were also recorded, but as doing so provided only minimal data over and above the minutes and meeting notes, this practice was abandoned for later meetings. The pilot workshop provided just over four hours of recorded material. The second was shorter, at just under two and a half hours. This was partly due to lessons learned in conducting the first workshop, but was primarily because of the knowledge and experience among the participants: the multidisciplinary nature of the pilot workshop generated more discussion than was required in the second workshop, where the participants shared a greater commonality of understanding. Each interview took between one and two hours.

Both workshops were held as open, discursive events, with participants encouraged to contribute and, in places, challenge presented viewpoints. A preliminary set of questions was shared with attendees prior to the event, and was used during each workshop as a checklist to ensure that all the identified areas had been covered. Attendance at the workshop was on a voluntary basis, with agreement from the HR department that - as the content was to involve a reflection on practice and operational activities - participants could list their participation as part of their personal development portfolio. A member of the Information strategy team attended each workshop, primarily to take notes, but also to ensure that the discussion remained balanced. They were asked to intervene if they felt that, as facilitator, I was inappropriately 'leading' the discussion or dismissing relevant topics without adequate exploration. Neither event required this kind of intervention, but the presence of a semi-independent observer was both a reassurance and a control; notes taken by the observer in each instance were included in the analysed materials.

As both groups were small, the workshops were managed as single, shared discussions, with no sub-division of the participants. Topics were raised and discussed, using the preliminary question set, with group responses being agreed and recorded on flipchart sheets. As a topic was completed, the sheet was posted to the wall, enabling the group to check earlier responses in later topics, and ensuring that issues were fully captured. A 'parking zone' and post-it notes were also provided, so that questions could be captured and returned to later in the day. Both workshops were lively events and the participants were fully engaged in the discussions, sharing perspectives, exchanging experiences and illustrating their points with observational examples.

All the interviews were conducted as one-to-one, face-to-face, semi-structured, narrative interviews in which the responses received from the practitioner triggered further

questions and discussions. The semi-structured interview reveals explicit and tacit knowledge through the social process of discussion. Explicit knowledge may be readily available in texts and guides but the ability to reveal tacit knowledge is of particular value to the designer/researcher, as it is knowledge that would otherwise not be available (Luck, 2003). A narrative interview takes the form of a conversation and participants relate their experiences, bringing in whatever they consider to be relevant. The researcher probes where necessary to guide the interviewee through the research topic(s) (Bates, 2004).

The interviews generally took place in a private space and proceeded without interruption, although in two cases the interviewee was still 'on-call' and the interview had to be suspended while the interviewee dealt with an urgent telephone call. This was not unexpected, given the nature of social work, and in neither case was the interruption very long. The participant interviews were conducted after practitioners had attended the relevant workshop, and this gave both a starting point and a common ground for the one-to-one discussions. The same format was used for each person interviewed, creating consistency without imposing a structure as to how an individual should respond (Luck, 2003). Interviewees were asked to consider recent work they had undertaken and to 'walk through' their understanding of the work and what it had involved. The interviews were also used to check understanding of the concepts presented during the workshops, and to validate and/or clarify some of the analysis arising from the workshop materials. Interviewing people individually not only had the advantage that their ideas were personal and not affected by group pressures and influences, but also added richness to the data through illustrative and personal narrative. As the interviews took place after the workshops, each of the practitioners had had an opportunity to reflect on the group discussions and provided further insights into the topics discussed.

This narrative, reflective approach was also employed in the discussions with the ACT project lead, and the later review interviews, where both the manager and the practitioner were asked to reflect on, and illustrate, the way that practice had changed with the introduction of the new process and tools.

3.2.4 Data analysis

The recordings of the workshops and summaries of the interviews were transcribed into Word files and, along with the observers' notes and the session output material, were coded and categorised using qualitative analysis software (NVivo). Local policy and

procedural materials were included in the analysis and coded using the same categorisations.

Analysis of the workshop and interview data was undertaken utilising a grounded theory approach. The three basic elements of grounded theory are concepts, categories and propositions. Concepts are the basic units of analysis since it is from conceptualisation of data, not the actual data per se, that theory is developed (Pandit, 1996).

Material acquired during the course of the pilot study was coded according to four main categories - *Assessment* (issues relating directly to the processes underpinning assessment such as triggers, content, outputs and outcomes), *Practice* (activities undertaken by practitioners, such as information gathering, analysis, decision making, communication etc), *Review* (issues and activities linked to cases where an assessment has already taken place), and *Restraints* (matters relating to constraints and controls within both the process and the practice.) These categories emerged as common themes from the discussions held within the initial workshop and were subsequently supported by the more detailed analysis of the second workshop and the interview transcriptions. More detailed and specific concepts were identified in the body of the source materials and were allocated to these categories as the coding progressed.

Models and concept maps were then developed to describe the structures and activities identified through this iterative analysis. A concept map is a graphical representation where nodes represent concepts, and links represent the relationships between concepts. The links, with labels to represent the type of relationship between concepts, can be one-way, two-way, or non-directional. The concepts and the links may be categorized, and the concept map may show temporal or causal relationships between concepts.(Siau and Tan, 2005) These models and maps, together with the results of the questionnaires and the observational experience of the developmental project were used as to inform a structurational analysis of the practices and processes described and mapped throughout the research.

Particular attention was paid in this process to the issues of agency for both practitioner and service users, along with the evidence for technologies-in-practice - the role and impact of information and information tools in shaping structure and in enabling (or disabling) the exercise of that agency.

Data obtained in the workshops and interviews was cross referenced with local procedural and policy documents, providing additional organisational context to the analysis.

National policy documents were revisited to provide input into the Framework analysis tool at each level of analysis, but were primarily drawn on for insights into policy change and structuration at Macro and Meso levels. Observational notes were made at, or just after ACT and associated meetings, and stored with formal meeting minutes, relevant emails to and from members of the transformational project team, specifications for tools, evaluation reports and other project documents. This material was reviewed in context with the relevant policy documents and also provided input into the Framework Analysis, enabling identification of the factors shaping – and being shaped by – the policy change.

3.2.5 Questionnaire design and analysis

Questionnaires are used to enable the collection of information in a standardized manner which, when gathered from a representative sample of a defined population, allows the inference of results to the wider population (Rattray and Jones, 2007). The primary research questionnaire was therefore designed to investigate whether the operational structures described within the workshops and identified through the interviews would be reflected and supported by other practitioners within the organisation.

The role of the questionnaire is to provide a standardized interview across all subjects. This is so that all respondents are asked the questions that are appropriate to them, and when those questions are asked, they are always asked in exactly the same way (Brace, 2004). Researchers use questionnaires to measure knowledge, attitudes, emotion, cognition, intention or behaviour (Rattray and Jones, 2007). This approach captures the self-reported observations of the individual, and the data collected must be accepted at face value, given that it is impossible to explore the real, individual meaning of each response, and because questionnaires reveal little of the context in which such responses were formulated (Murray, 1999).

Clearly, the data collected should be as accurate as possible. However, it is important to acknowledge that complete accuracy is almost impossible to obtain in surveys where respondents are asked to report their behaviour or their attitudes. Inaccuracy can also arise because of problems within the questionnaire itself. These can include: ambiguity in the question; order effects between questions; order effects within a question; inadequate response codes; or wrong questions asked because of poor routeing (Brace,

2004). These risks can be minimised by ensuring that the questionnaire is subject to a level of independent evaluation and – if possible – tested or piloted prior to its use in the field.

There are a range of scales and response styles that may be used when developing a questionnaire. These produce different types or levels of data and this will influence the analysis options. Therefore, when developing a new measure, it is important to be clear which scale and response format to use. Frequency scales may be used when it is important to establish how often a target behaviour or event has occurred, while a Likert-type scale assumes that the strength/intensity of experience is linear, i.e. on a continuum, and makes the assumption that attitudes can be measured. There is no assumption made that equal intervals exist between the points on the scale; however, they can indicate the relative ordering of an individual's response to an item (Rattray and Jones, 2007).

Free text response or open questions may be included to allow respondents to expand upon answers and provide more in-depth responses.

The primary questionnaire was split into three sections: the first collected basic information relating to the respondents, such as age and gender, along with other profiling information - whether or not they held a social work qualification, how long they had been qualified, how long they had been working for the Authority and so on. This section included questions about their familiarity with and use of technology both at work and at home.

The remaining two sections, split between issues of *Practice* and *Process*, presented a number of statements, with respondents being asked to score against a Likert-type Scale the commonality (or otherwise) of these statements in their experiences when undertaking social care assessments. For some statements, space was given for respondents to expand on, or detail their responses, and a final section was included to capture additional observations on the undertaking of assessments along with comments on the use of tools and technologies and how they might be improved.

The statements within each section were developed by drawing on the data gathered in the workshops and the interviews, and the design and content of the questionnaire were tested by sharing the pre-release draft with the members of the ACT project team - a representative group containing both managers and practitioners. Their feedback was used to refine the design, changing the order of questions in the first section and amending what were seen to be ambiguous statements in the second and third part of the

document. Every effort was made to ensure that the statements were as clear as possible, both to avoid confusion and to improve consistency of response. This review process was extremely valuable, both in improving the quality of the survey and the responses it elicited, but also in enabling the managers concerned to promote the value of completing the questionnaire when it was distributed to their staff.

Permission to distribute the survey was obtained from the Head of Adult Services, who provided a letter to accompany its distribution, recognising the value of the information it was looking to obtain and asking staff to allocate time to its completion. This endorsement undoubtedly contributed to the subsequent high return rate, which was approx 70% of possible respondents. This percentage was probably closer to 75% of those staff actively in work, as the department, in common with many at the time, had a number of staff absent due to long term sickness issues.

The questionnaire was electronically distributed via local team managers, with a percentage returned the same way. The remainder were collected in batches within each team and returned in paper form. A small Access database was created to collect the results and each response was entered into it anonymously, the original return being marked with the entry number so that queries could be retraced to the original if required.

3.2.5a Profile of participants

One hundred and forty-one responses were received. Nine of these came from Administrators and team managers, who were eliminated from the detailed analysis because they self-identified as not undertaking (and not previously having undertaken) assessments. Respondents fell into a wide range of age groups with no particular group dominating the sample. Not unexpectedly, only one sixth of the respondents were male, reflecting the general predominance of women within social work.

Table 1: Population profile of responders to the Questionnaire -Age by gender of respondents:

Age Group	Gender			
	F	M	(blank)	Total
a) Under 25	2			2
b) 25 to 29	8	2		10
c) 30 to 34	11	1		12
d) 35 to 39	15	1		16
e) 40 to 44	21	3		24
f) 45 to 49	9	5		14
g) 50 to 54	21	2		23
h) 55 to 59	6	4		10
i) 60 and over	9	3		12
j) Not stated	14	2	2	18
Total	116	23	2	141

Approximately two thirds of the group regarded themselves as 'qualified', although approx. one third of these did not hold a formal Social work qualification. Occupational Therapists made up a half of this subset, while the rest declared a range of diplomas, NVQs and other qualifications, including one registered nurse.

Length Employed	Qualification held											Total
	Not qualified	Qualifying	Less than 1 year	1-5 years	6-10 years	11-15 years	16-20 years	21-24 years	21-25 years	Over 25 years	Not given	
Less than 1 year	9		5	5	6	3	1		1			30
1 to 5 years	17	2	1	19	9	3			2	1	7	61
6 to 10 years	10		2		7	2	1			2		24
11 to 15 years	2	1			1	2		1		2		9
16 to 20 years	1			1			2			4		8
21 to 25 years									2			2
Over 25 years	1									1		2
Not given	1		1	1	2							5
Grand Total	41	3	9	26	25	10	4	1	5	10	7	141

Table 2: Population profile of responders to the Questionnaire - Time in post by Length of time qualified:

A high percentage had only been employed in their current post for less than five years, with very few claiming more than ten years of consistent employment. In retrospect, this question might have been better framed as 'length of time engaged in social work,' as the figures mostly likely reflect the high turnover of social care staff, both through

promotion and via transfers between authorities, rather than being indicative of the length of work experience and level of expertise represented in the responding group.

Given this range of ages and the characteristic balance of gender representation the analysis focused on overall responses, and made no attempt to distinguish differences due to age or gender factors. To support the anonymity of the material, and to enable meaningful comparisons, responses from individual, geographically based, teams were aggregated into larger groups, primarily based on the type of work being supported. A large number of the respondents identified themselves as working across a range of client groups, but the high level categorisation enabled a comparison of behaviours between team *types* (Older People, Learning Disabled, Mental Health, Hospital and the Reviewing Team), and which – in turn – helped to demonstrate the consistency of practice behaviours and the differentiation between process driven ones.

The responses to a second questionnaire, used to evaluate the perspectives of practitioners taking part in the first phase of the personalisation project, were also utilised as a data source for this research. This questionnaire was developed by members of the project team and – while it drew on some of the materials within the first survey – was not designed specifically for the research. As the project had taken place within a single Adult services team, the numbers of individuals surveyed and those who submitted responses were small. For both of these reasons, this data was not subjected to any quantitative analysis, and has only been used as indicative or illustrative evidence, mostly drawing on the textual comments made in individual submissions.

3.3 Ethics and Engagement

> … researchers must strive to protect subjects from undue harm arising as a consequence of their participation in research. This requires that subjects' participation should be voluntary and as fully informed as possible and no group should be disadvantaged by routinely being excluded from consideration.(Social Research Association, 2003)

The Economic and Social Research Council identifies six key principles of ethical research:

> 1. Research should be designed, reviewed and undertaken to ensure integrity, quality and transparency.

2. Research staff and participants must normally be informed fully about the purpose, methods and intended possible uses of the research, what their participation in the research entails and what risks, if any, are involved..

3. The confidentiality of information supplied by research participants and the anonymity of respondents must be respected.

4. Research participants must take part voluntarily, free from any coercion.

5. Harm to research participants must be avoided in all instances.

6. The independence of research must be clear, and any conflicts of interest or partiality must be explicit (Economic and Social Research Council, 2010).

Every effort was made to ensure that these key principles were met at every stage of the project.

The design and conduct of this research was subject to review and scrutiny from both academic and organisational perspectives. Approval for the project was sought from the relevant management groups within the authority, with the research proposal being shared and discussed with a number of senior managers and practitioners throughout the initial and pilot stages of the work. At the beginning of the work both the Children's and the Adult's management team were supportive of the project and the approach that was proposed, and this support continued through the later stages, with Adult managers being involved in the design and testing of the questionnaire. The project managers of both the children's ICS project and the Adult ACT project were made aware of the research, and members of the ACT group were provided with a summary of results from the questionnaire, along with some of the initial models and analysis arising from the workshops and interviews.

A regular overview of the project was shared with my supervising manager throughout the period of the research, as well as with my academic supervisor, ensuring that I retained support from within my Authority as the research progressed. There were, inevitably, some changes in management personnel during the project's lifetime which - along with the changing structures and priorities within the Authority - limited later engagement, but the research retained general support and the practitioners involved were both open and generous throughout.

Issues of consent and confidentiality were also addressed at all stages. Attendees at the workshops were informed that the event would be recorded, but that no identifiable attribution would be made for any quote or reference subsequently drawn from the data. This assurance was reiterated at every interview and has been respected throughout this text. In addition, practitioners were asked to be careful when offering illustrations of

their work with anecdotes concerning clients, or when describing specific assessments they had undertaken. At no point was it thought necessary for the research materials to include identifiable client data, and the practitioners were specifically asked to avoid using identifiable names or references in the workshop discussions, and to pre-anonymise any examples of completed tools or case records that they wished to share when interviewed. This requirement was observed by all the participants, and no client identifiable data was collected or held at any time.

Practitioners completing both the initial and subsequent evaluation questionnaires were also promised anonymity; no individually identifying data was included in the data set, and completed questionnaires were entered into the analytical database using an arbitrary record number. Team data was aggregated into categorised groups to avoid potential identification through small numbers. As there was a potential for individuals to be identified though some of the textual comments they had provided, these were specifically excluded from the summary feedback given to the in-house groups. A small number of these comments have been excluded from the analysis and from this document for the same reason.

Although I was employed by the Authority which was the subject of the study, and was supported through allocation of time and the co-operation of managers and staff, the research was independently funded, and at no time was there pressure to present a specific perspective or attempts to influence the findings.

These findings are described in the following three chapters, which focus on the Micro, Meso and Macro perspectives of the work.

Chapter Four: Structuration at the Micro level
Modelling social Care Assessment

It has been suggested that, in the absence of clear policy and practice guidance on assessment practice, practitioners have to rely on implicit knowledge, based on professional values, the culture of the office, and their own assumptive worlds (Worth, 2001).

4.1 Observing and identifying operational structures

The primary focus of this research was targeted at gaining a better understanding of how practitioners engaged with information and information systems in the day to day undertaking of their work. The workshops and interviews enabled the exploration of that activity, examining the factors that influence and shape it, and investigating the part that both information and information technology play within it. This chapter considers some of the findings of those explorations, looking at and modelling the micro structures of activity and practice that were being created and recreated on a daily basis at the time of the research. It also examines how evidence from the questionnaire both supported and challenged the understanding that emerged from the initial analysis and presents a structuration analysis of assessment practice using the framework tool developed over the course of the research. (Fig 4.1)
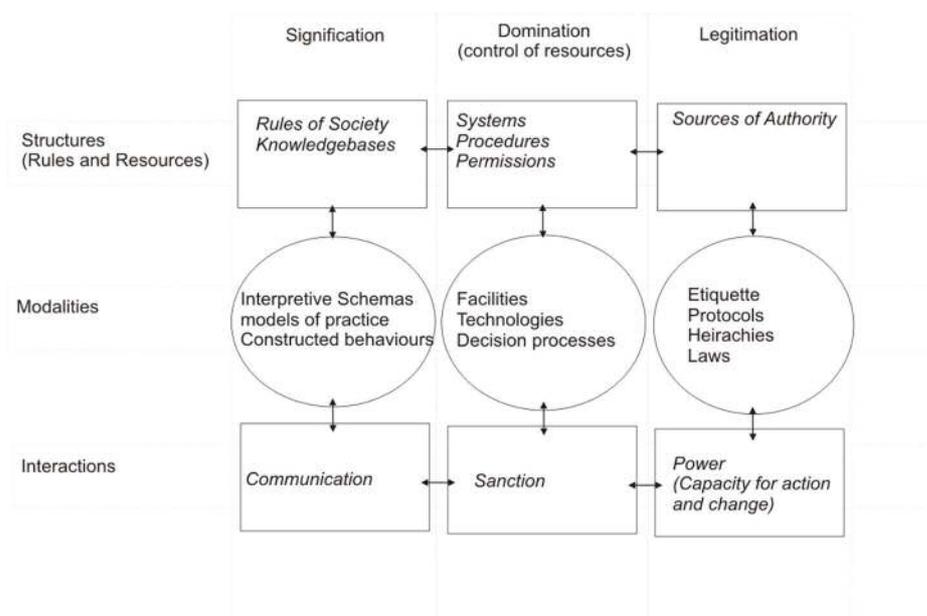
Fig 4.1: Framework tool for Structuration analysis:

Chapter Five presents a similar analysis at meso level, considering the creation of organisational structures, while Chapter Six examines how a policy change made at the macro level is translated through, and impacts on, both meso and micro structures.

As a precursor to the discussions that follow, it should be noted that the analysis throughout this work has been shaped though the practice lens of structuration theory, which posits that the structures which can be observed when considering day to day activities – the modalities and interactions of social care at the operational level – only exist as they are enacted through social activities, being constantly created and recreated through a complex structuration process. These structures are considered to be transient and dynamic—they emerge from enacted conduct and they are both the medium and outcome of action. The modelling and analysis of the research findings therefore focuses on the identification and exploration of the component factors which contribute to and shape this process, and which are, in turn, shaped by the structures that emerge from their interactivity. Emphasis is placed on the role of information, tools and technology resources as primary components in the creation of the technologies of care. The models presented in these findings should not be thought of as representing separate, complementary (or conflicting) structures to be isolated and observed without reference to the other factors in play, but should be considered as sub-structures, not existing in isolation but emerging and remerging as consistently recognisable phenomena within the overall structures being observed.

This work does not attempt to identify or address potential hierarchies inherent in the factors it examines, nor does it postulate how weighting, precedence, or perceptions of signification might influence their interaction. These are areas that offer opportunities for future research, and could be used to further refine the models presented here.

4.1.1 Definitions used in the analysis of the research

Both the Children's and Adult workshop offered an opportunity to explore the interpretive schemas of practice - the concepts and values that the participating practitioners shared - and to find common ground for communication. Among the children's workers, the lack of specificity in the use of the term 'assessment' was less of a barrier than might be initially suspected, although the content of the interviews suggest that common understanding begins to diverge once the level of detail impacts on specific professional practice. This is unsurprising, and reflects expectations of difference between 'holistic' and 'specialised' assessments. The differences appear to lie, however, not in the overall approach to practice, but in the breadth of focus and the

depth of detail the practice addresses. To analyse the findings, a way was needed to frame the terminology so as to create clearer and more consistent meaning - clarifying the difference between assessment as a practice, what is labelled as 'assessment' for the requirements of the business process and the various assessment tools used to support practice across a range of client groups, issues and at varying levels of information detail.

Drawing on the concepts emerging from the data, the following terminology was developed, and will be used from this point forward to differentiate the components being described:

- Assessment *practice* describes behaviours and tasks employed by practitioners in their role as care professionals while delivering requirements of the business process.

- Assessment *process* describes the factors and mechanisms that trigger, shape and direct practice, and the outputs that feed structured business processes.

- Assessment *tools* describes standardised tests, forms and other information artefacts used by practitioners to support both assessment practice and assessment process.

- *Formal* assessment describes the application of both assessment practice and assessment process that takes place within a structured business model and which is subject to statutory performance monitoring.

- *Semi-formal* assessment describes assessment practice and assessment process utilised during the delivery of care and care support.

- *Informal* assessment describes assessment practice and/or assessment process initiated through non-structured contact with client, carer, other family members, or in discussion with a fellow practitioner.

The data collected from the workshops and the subsequent interviews indicated that assessment *process* and assessment *practice* can be modelled as two intertwining strands, each supporting the delivery of the other.

The components of the assessment process are sequential in nature, and shaped by the context within which the assessment process takes place. Assessment *practice* is both iterative, and interactive, with the depth and breadth of the investigation being shaped

by the issues under investigation and the primary focus of the practitioner(s) undertaking the work.

Although these definitions were initially derived from the analysis of the pilot workshop, their applicability was supported by subsequent discussions with the Adult practitioners. The questionnaire was designed to help explore this perception of process and practice being separate but complementary components of the overall structures, and the subsequent analysis of the responses demonstrated the levels of agency in practice and some of the constraints that following process applies. The models of practice within process that emerged as part of these considerations will be discussed in the next chapter.

4.2 Assessment Practice: transforming rules and resources into the structures of professional activity.

> There's also a big part about getting a picture of the situation – because, you know, we use the term assessment in social care, but, basically any particular situation, whether it's – if you want a new bathroom […] and somebody comes in, and they come in and they have a look – in doing that, they're doing an assessment. They're gathering information about what you've got, what needs to be done, and what you want to be done. It's as simple as that. (*Adult Social Worker*)

Embedded within the range of business processes and rules (see Fig 4.1a) that construct the model of case management and care delivery - whether that be formal recording, semi-formal monitoring and measuring through the provision of service, or informal interactive discussion and observation - lies a conceptualisation of 'assessment practice,' which underpins the behaviours and activities of practitioners and enables them to make professional judgement decisions based on knowledge and experience.
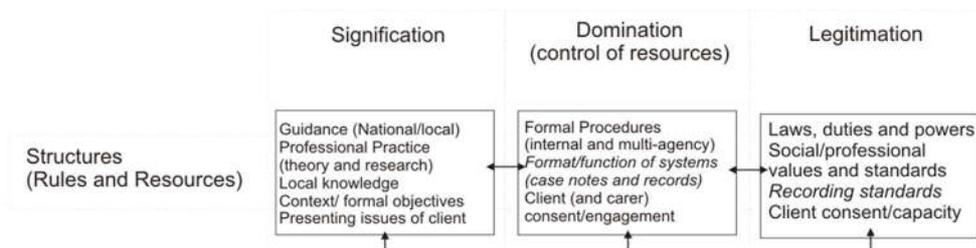
Figure 4.1a: Micro Structures/Rules and Resources (populated)

In order for these behaviours to occur, the structures that enable care delivery must also afford the exercise of professional agency, creating 'practice space' within the business model; contexts within which care practitioners can gather information and apply analysis to determine need, capability or risk. This 'space' is primarily constructed through interactions between the practitioner and their clients, and in a practitioner's interactions with other practitioners – but it can also be observed in their interactions with information resources, enabling both input to and construction of the outputs of an episode of practice: an iterative enactment of structure which emerges from the expression of practitioner's agency within the dynamics of the structuration process. (Fig 4.1b)

| Interactions | Client, Carer
Other professionals
Supervisors
Practice Peers
Information/knowledgebases | Service user and carer views
Service user consent
and agreement
Recording/note taking
Access to information
Information sharing | Engagement with client
(and carer)
Client and carer
aims/objectives
Use of formal tools |
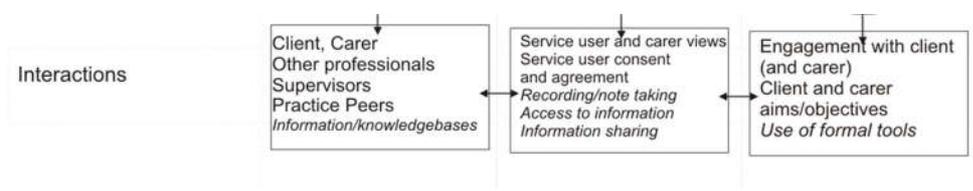
Figure 4.1b: Micro Interactions (populated)

Practice space gains legitimation through the allocation of the work and the authority given by job roles, but is dependant on signification from professional viewpoints and client needs, with domination of resources determined by the tools being used and the information available. The requirements for and the professional perspectives exercised within any given practice space may structure both the contents of and the outputs from that space very differently from the next. The range of 'types' of assessment – from overview to comprehensive, diagnostic to contextual, generalist to specialist – suggests that purpose, focus and context, in dictating both the rules and the resources available for practitioners to draw on, also dictate the approaches they take, the information they choose to collect and use and the details of the analysis they generate. From the discussions that took place within the workshops, and in the interviews that followed, however, it became apparent that the *practice* of assessment has a great many common and consistent features, reflecting the definitions legitimised through formal guidance. As Gursansky's work on case management states, it is primarily 'an information-gathering phase, during which the worker ensures there is a sufficient information base from which to make decisions about how to work with and help a service user. It is a two-pronged process involving both establishment of the facts and the application of a disciplined analysis (Gursansky, Harvey and Kennedy, 2003).'

Differences appear to arise from the granularity of focus, the positioning of the event within the business *process model* (and therefore the output expected from it), and the level of formality within which the practice space is situated. Thus the assessment of specific issues and needs might require the inclusion of detailed and exacting scales of measurement, while an assessment undertaken to determine overall context of need and circumstances may focus on textual recording of perspectives and more qualitative information. The tacit knowledge and professional focus of the practitioner involved also inevitably adds signification to the focus within and content of the resulting analysis.

The complexity of this iteration – the way in which practitioners gather, reflect and analyse, gather further data and finally reach what they feel to be an informed conclusion is illustrated by the responses to the questionnaire. Two questions had been formulated, with the expectation that they were mutually exclusive – the first asking the frequency with which the practitioner gathers all the information and asks all the questions before making any analysis or decisions, and the second asking how often the practitioner assessed need and circumstance as they went along, adjusting conclusions as more information became available.

The expectation was that practitioners would score one question high and the other low. In actuality, 88% of the practitioners identified 'frequently' or 'occasionally' in response to the first question, and 81% in response to the second. This pattern of response was consistent when analysed on a team grouping basis, and therefore unlikely to be the result of different practices at initial assessment and during review. Rather, the respondents were perceiving *both* of these statements to be applicable to their practice:

> I think what they're actually saying […] is that we reserve judgement about recommendation until they've got all the evidence, but they will actually be considering the evidence as they go. […] I think what they're saying here is – I wouldn't make a recommendation until I've done a final analysis, so I would do that at the end, but I would be looking at an on-going assessment as I go through the process. (*Senior Adult's Manager, discussing the results of the questionnaire.*)

This interpretation was further supported by comments made during the Adult interviews:

> I think both happens. It's a process through the moment that you arrive in the area – possibly assessing from the gate to the door […] there's a whole process going through of sort of taking in the information, and then, as soon as you collate enough information then you're starting to make decisions, work things up – looking against FACS, looking at risk assessment […] there's a whole number of process that actually mentally go on from that point. So decisions,

possibilities, are being addressed from a very early stage. *(Adult social worker)*

This understanding of practice - which, like interpretive research constructs a picture over time, and adjusts that picture as information is added and further intelligence taken into account - challenges the traditional information artefacts that present 'end of process' forms for completion, and suggests the need to develop a portfolio of tools which can be used to collect and record the developing picture in a more interactive way.

Historically, these kinds of practice spaces have been isolated from each other, constructed within the domain of individual professions and delivered by specific practitioners. They have developed their own taxonomies and tools, which have, in turn, helped define the boundaries within which professional practice takes place. A single collaborative approach, involving multiple agencies but coordinated by the social services care manager, was the original intention behind the community care reforms (Department of Health, 1989; McNally, Cornes and Clough, 2003). The evidence suggests, however, that such a pivotal approach was not fully established and that, instead, separate assessments, often with little sharing of information, have taken place (Abendstern et al. 2008).

The advent of policy requiring increased co-operative and multi-agency working can be seen as a threat to the autonomy of the professional within these defined spaces. Yet, by recognising the modalities that shape and structure the undertaking of practice (Fig 4.1c) along with the need for a whole series of practice spaces throughout a multi-agency business model, the common threads of assessment practice may provide consistent mechanisms to help link these spaces together and enhance the work the practitioner undertakes within them.
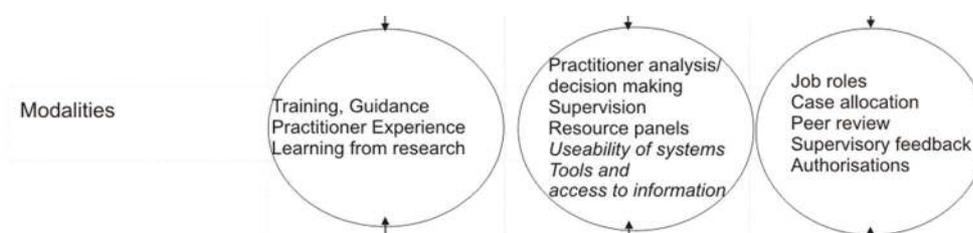
Figure 4.1c: Micro Modalities (populated)

Policy is currently driving the sector towards structures that create shared and increasingly common practice spaces, centred around and focused on the individual; in this personalised model, the person themselves may undertake much of the assessment

practice, supported by the practitioner – but the need to gather information, understand the context, and apply constructive analysis remains the same.

Information tools and services have potential to support this kind of approach in two ways - through the development of tools that enable assessment practice alongside the assessment process, and through the provision of filters, translators and interpreters that enable the output of these tools to be accessed within the next practice space in relevant formats and at the appropriate levels of detail.

The process requires that the practice happens, and that certain outputs are generated as a result, but given the range of capabilities and conditions that individuals present to an assessing practitioner, there is a necessary degree of agency in the way that practice is undertaken. This is particularly true concerning the order in which information is obtained and the way that it is captured and recorded. Responses to the questionnaire showed that some practitioners work directly with the provided assessment tools and forms, some utilise them as operational checklists, and some prefer to complete the tool after they have visited their client. Where mobile technology had been introduced with the capability to complete electronic tools (removing the need to subsequently transcribe the information) there was both positive and negative reactions to the idea of using them directly with clients. Each practitioner tends to have a personal preference for the way they work. Their personal experiences and expectations inevitably shape their response to the use of such interactive tools, but the experiences and expectations of the clients they are working with also seem to play a part; many justify their approach by positioning it as part of the way they relate to their clients. In among the additional comments received in response to the questionnaire were two very different statements which demonstrate the need to understand these perspectives when considering the design and use of tools and technologies to underpin the structuration of both practice and process.

The first practitioner rejects technology as a distraction and a barrier:

> I would not wish to use any IT equipment whilst undertaking face to face assessments with clients since I am adamant that any such equipment would hinder rapport building and any sense of confidentiality/confidence with the client. (*Questionnaire response*)

The second embraces it as a tool to create engagement:

> I have found that using pictures, via power point, for people with a learning disability has aided their sense of being involved in a review. I would like to develop this further, re-interactive, sound , photographs that are familiar to service users, pictures to enhance choices and options. (*Questionnaire response*)

The expectations of policy are that the majority of practitioners will engage with and appropriate new technologies as they are introduced. Some of the current lack of engagement may arise from a general reluctance to use technology, along with limited familiarity with the tools, both of which might be addressed through training. However, the potential that technology offers may not be fully realised unless these new tool and technologies can afford the agency practitioners need in order to engage with clients, allowing them to enact effective, interactive practice.

4.2.1 Relating concepts to observable activity: the issue of language

> 'It depends what sort of assessment it is, doesn't it. We have six sorts of assessment – we have formal and informal assessment, standardised and non-standardised assessment and informative and summative assessment.' (*Speech and Language support worker*)

It was clear, throughout the data gathering phases, that while practitioners shared a general and common concept of what 'assessment' might be, they also reflected the nebulous understanding and uncertain interpretations of that concept (explored in Chapter One.) In both the workshops and the subsequent interviews, the word was often used as shorthand for a number of more specific kinds of process and practice, with subtle (and sometimes not so subtle) differences between the practitioner groups. In addition to the list quoted above, social workers also undertake 'initial' and 'core,' 'overview,' 'comprehensive' and even 'specialist' assessments, using the terms to reference the practice ('doing' an initial assessment), the tools or forms utilised to record the information collected as part of the process, and the output document produced at the end of the activity. Risk and capacity assessments were also mentioned, suggesting that term is used generically as well as specifically, and that both the purpose and the focus of the activity can vary from case to case. The consistency of terminology, and the associated understanding of meaning, supports the articulation and reproduction of the rules of society, enabling signification in the creation of structure and consistency in its recreation over time - so this ubiquitous use of the term risks divergence in interpretation as well as creating confusion and misunderstanding. Profession-specific world-views enable individuals to work within their own profession, rather than facilitating communication across inter-professional boundaries (Hall, 2005) and a lack of precision in terminology can lead to a failure in communication between practitioners in a multi-agency setting; they share what appears to be a common language, yet assign meaning drawn from their own sphere of professional reference.

The local organisational guidance written for practitioners demonstrates this lack of clarity. The Adult Services guidance relating to the receiving of referrals defined an assessment both as:

> … the gathering of information about a person's situation, needs, strengths, abilities and difficulties, and the impact of these on the individual's safety and/or independence. We use the information gathered to decide if the person needs help and support from social services (Countyshire, 2006b).

And in appendix of definitions supporting that guidance as:

> Assessment: Finding out and gathering information about a person and their circumstances, then analysing that information to identify the person's eligible needs and where they need help to enable them to live as independently as possible.

> Assessment ends when sufficient information is gathered to be able to apply the eligibility criteria. At this point the person will either be signposted out or move on to the care planning stage (Countyshire, 2006a).
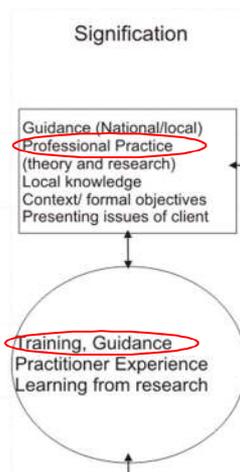
Figure 4.1d: Micro Signification

The definitions document then expanded on this by describing a number of types of assessment, from contact through to comprehensive. These are not incompatible definitions, but do place a different emphasis on what is expected of the activity: where the first definition focuses on information gathering, the second specifies analysis as a required component. Presenting definitions in this kind of guidance provides sanction for commonly shared interpretive schemas (Fig 4.1d), thereby creating legitimisation as well as signification – any lack of clarity, or inconsistency weakens that legitimisation and enables greater agency (interpretation) in the application of those rules.

Despite the nebulous nature of its definition, the concept of 'assessment' is considered to be a core component of social care practice. It is also seen as a key step in accessing public funded services, and as such, has been made a requirement in English Law.

The Children Act (1989) placed a duty on Local Authorities in England to safeguard and promote the welfare of children who are in need:

> … by providing a range and level of services appropriate to those children's needs. (Part III, section 17) Where it appears to a local authority that a child within their area is in need, the authority may assess his needs for the purposes of this Act at the same time as any assessment of his needs is made (Ibid, schedule II)

This requirement for public sector services to undertake assessment was further defined in the Community Care act (1990) which states:

> … where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may be in need of any such services, the authority (a) shall carry out an assessment of his needs for those services; and (b) having regard to the results of that assessment, shall then decide whether his needs call for the provision by them of any such services. (Section 47)

These two Acts form the foundations on which the current Local Authority provision of social care have been built, sanctioning its existence as part of public services and creating the legitimisation for its delivery (Fig 4.1e) - although the provision of such services and the practice that supports them have developed over a much longer period; in a clear example of how structures are shaped through the influence of the structural properties from which they emerge, the adoption of the current legislation was partially driven by the experience of how those services were being delivered at the time.
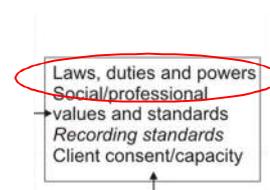
Figure 4.1e: Micro Legitimation

4.2.2 Definitions in National Policy and Guidance

While the practice texts promote assessment as an on-going, iterative process, social care policy and guidance documents tend to present it as a discrete activity, often focusing on the role it plays as the 'opening salvo' in a Social Worker's engagement with their client. The 'Framework for the Assessment of Children in Need and their Families' states:

> Assessment is the first stage in helping a vulnerable child and his or her family, its purpose to contribute to the understanding necessary for appropriate planning and action (Department of Health, 2000)

This view of assessment as a stage in a definable process has been further promulgated by texts that explore case management approaches in social care and related sectors.

> Case management is a set of logical steps […] Assessment is the information-gathering phase, during which the worker ensures there is a sufficient information base from which to make decisions about how to work with and help a service user. Many agencies employ a condensed assessment process prescribed by targeting, resource and priority parameters (Gursansky, Harvey and Kennedy, 2003).

Guransky et al also describe it as: 'a two-pronged process involving both establishment of the facts and the application of a disciplined analysis - a clear echo of the Social Diagnosis definition (Richmond, 1917).

Focusing on assessment as a 'starting point' can lead to the activity being given signification as primarily a gatekeeping exercise, informing decisions concerning resource allocation, rather than the identification of care needs. It has even been identified as a potential point for division of labour, suggesting that the care manager might make the assessment for a social worker, who then refers the case […] for decisions about resource allocations (Walton, 2005).

This perspective is possibly stronger in Adult services, where assessment has inevitably been linked to the determination of access to care criteria, and is now seen as the source of data for resource allocation systems used to identify eligibility for funding.

However, the guidance produced to support the implementation of the Single Assessment Process acknowledges that assessment plays a far more complex role in the planning and management of care. It defines the activity in more general terms:

> Assessment is a process whereby the actual or potential needs of an individual and related matters are identified, and their impact on independence, daily functioning and quality of life is evaluated, so that appropriate action can be planned (Department of Health, 2002c).

It reiterates the 'two pronged' approach:

> (It) is about collecting information on a person's needs and circumstances, **and** making sense of that information in order to identify eligible needs and decide what support or treatment to provide (Department of Health, 2002c).

And goes on to categorise four potential 'levels' of assessment.

- Contact assessment (including the collection of basic personal information);
- Overview assessment;
- Specialist assessments; and
- Comprehensive assessment.

Of these, it is the contact assessment that is expected to take place at the 'first stage,' refering to a contact between an older person and health and social services **where significant needs are first described or suspected** (Department of Health, 2002d). Other levels of assessments are expected to be undertaken only if and when needed, with professionals carrying out an overview or comprehensive assessment if, in their

judgement, the individual's needs are such that a more rounded assessment should be undertaken. This expectation – legitimised in guidance, but given significance through the interpretive schemas of practice (Fig 4.1f) - has become central to the modalities of Adult Social Care. A common phrase which surfaced in the discussions with Adult practitioners and which influences their exercise of agency in their interactions with clients, is that 'assessment should always be proportional to need.'
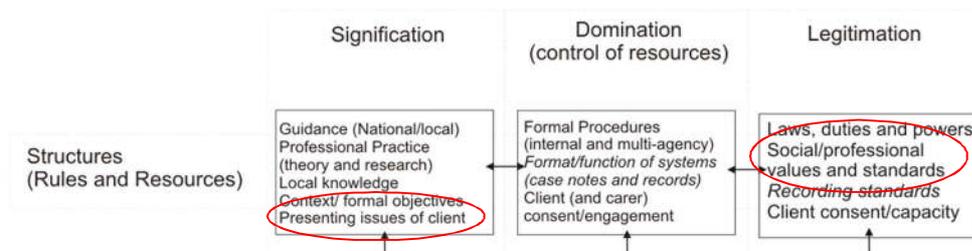
Figure 4.1f: Need as a structural feature in both signification and legitimation,

 The Adult approach applies proportionality according to the breadth and depth of functional need. In children's services the decisions are more concerned with vulnerability and the overall level of risk to a child – and here the expectations are that any child involved with social services will undergo a full assessment as defined in the Framework for the Assessment of Children in Need and their Families. This expectation is reflected in the functional split between the Children's Common Assessment Framework tool (CAF), designed for use in universal and second tier services, and the Integrated children's system (ICS) assessment exemplars, which included the full set of the framework's domains.

4.2.3 Functionality, risk, context and core information: the key elements of assessment practice.

4.2.3a Reasons to Assess: Legitimation and sanctions for action

During the course of both workshops, the participants were asked to collate a list of intentions underlying their assessment practice - reasons 'why' they assessed. Some of these reasons were highly pragmatic and procedurally driven: practitioners assess because people ask them to.

> 'The families have asked? Children, families […] requested it.'
> 'The other thing [...] is legislation. Got to.'
> (*Participants at the Children's workshop*)
>
> (Participant) I think this, for me, in our role as social workers we have a duty of care. To provide services to people who have needs.

(Facilitator)) So – we're assessing, because we've got a legal duty?

(Participant) That's part of it. That's an aspect of it

(*Discussion in the Adult's Workshop*)

Legitimation for the assessment process lies in there being a formal basis for the activity to be undertaken – through the requirements of law, and the dictates of local policy and procedures - but the furtherance of that process into practice also requires a professional basis for the work, where the modalities of legitimation (sanctions and norms) emerge from the agency given to a practitioner to exercise their social and professional values. (Fig 4.1g)

Figure 4.1g: Professional Legitimation

Most of the reasons for those requests, and for invoking assessment activity, are concerned with investigation of circumstances and from that determining the signification of need; deciding if the person concerned is at risk, understanding whether intervention is needed, what form that intervention needs to take, and determining if the person is eligible for formal support.

> ' ...one of the biggest reasons that I assess is to unpick exactly what's going on […] what is happening ' (*Children's social worker*)
>
> ' …the assessment gives a picture of the person's needs. Once we've got an understanding of what their needs are and what they want from the service – because assessment as well is about the customer telling us what they want' (*Adult social worker*)

Another reason given for undertaking assessment was its use to inform others – not just the individual concerned, but also carers, parents, and other practitioners working with them.

The comparison between the Children and Adult practitioners identified a number of commonalities in the reasons they identified:

Integrated Disability Service (children)	Adult Practitioners
Eligibility	Duty of care
Requested	Legal requirement
Identify need implications (risk included)	Picture of need
Monitoring progress/outcomes	*Understand Service Users needs and
Identify next steps	wishes. Desired outcomes
Strategies	Measurement against criteria
Prioritising (risk)	Risk (measurement)
Identify requirements/sign posting	*Understand circumstance
Evidence of change	Explore issues and opportunities
Situation	Trying to achieve change
Circumstance	Allocation/ of resources management
Context	
Flexibility	
To develop skills	
Issues with an environment	
Promote inclusion	
Improving outcome for child	
Understand what is going on to help others to understand legislation	*these were identified as being particularly important

Table 3: Reasons to assess identified within the workshops

Most of the reasons that practitioners present for undertaking an assessment also define the aims and objectives of that assessment; these objectives are a primary part of the rule set which, in combination with the resources the practitioners bring – their knowledge, experience, and skills – and the information resources collected and collated as they work, structure and create the overall modalities of assessment practice.   These modalities are expressed in the interactions between the practitioners, the service users and their carers, in the use of assessment tools and the updating of information resources, and in the interrelations between practitioners as peers, when consulting with other professionals, and in supervisory or support roles. (See Fig 4.1c, above)

A key factor affecting the legitimation of these interactions is the issue of consent (Fig 4.1h.) This was raised continually within the children's workshop and was consistently repeated in the individual interviews. Without consent, an assessment cannot take place - unless it is clear that a child is at risk of harm, in which case the safety of the child takes precedence

Laws, duties and powers
Social/professional
values and standards
Recording standards
Client consent/capacity

Figure 4.1h: Legitimation through consent

over the wishes of the parent, and child protection procedures will be set in motion. In Adult services, it was identified as a fundamental requirement that has to be addressed before any detailed assessment can be undertaken – although determining whether consent has been given is not always easy:

Can we go out and assess them? I don't think we can. But you do wonder, sometimes, if things are coming from a third party, you end up assessing over the phone – information gathering – before you come to the point where you realise that the service users isn't actually aware (*Adult social worker*).

… with people who are in the more advanced stages of dementia who haven't got the ability to give that consent, then we still do reassess or assess (*Adult social Worker*).
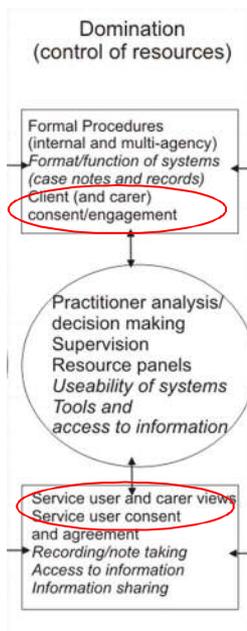
**Fig 4.1i:
Domination and
consent**

Consent - more specifically *informed consent* - is a powerful tool in practice. It not only provides legitimation to engage in interaction, but also impacts on the modalities of domination (Fig 4.1i) The term is used to identify where an individual has agreed to sanction cooperative behaviour, both between the user and the practitioners, and between the practitioners themselves. It engages the service user and their carers with the work that is being undertaken, enables negotiation and discussion and helps define how practitioners from several agencies are expected to work together. It can also severely limit and constrain the agency that practitioners have, since without consent to share, information may not be requested from others or disseminated beyond the practitioner leading on the case. In extreme cases the service cannot be delivered, or a necessary intervention made, without clear legitimation to transfer the modalities of domination from those of individual choice to those sanctioned by the social expectations expressed in law.

4.2.3b Knowledgability and signification: collating holistic views across information domains

'We are specifically looking at the child, aren't we – to begin with. The child's at the centre of the assessment, would you say?' (*Children's Social Worker*)

And basically, my […] way of assessing, […] has always been to say to people, well, tell me what it's like for you. Tell me about from when you get up? And talk me through the process about how you manage things, you know, what difficulties may be there, or how you overcome them – and really just listen to the person and actually just hear how it is […] you can actually get sort of a real picture of what their day is. (*Adult social worker*)

One of the primary resources for the structuration of both assessment practice and the assessment process within which it sits, is the information that practice collects, collates, and uses in the analysis of an individual's circumstances and needs. Assessment practice is both structured by and gives structure to, this information, with practitioners drawing on other information resources - the explicit and tacit knowledge

bases of professional knowledge and personal experience – to assist them in their analysis and understanding, and to direct and shape any further investigation. The outputs of this analysis provide further resources for both the legitimation of subsequent actions and signification for the objectives those actions are intended to achieve.

The Framework for the Assessment of Children and Families (Department of Health 2000) identified a number of phases during assessment - phases which 'overlap and lead into planning, action and review:' These are:

- Clarification of source of referral and reason;

- Acquisition of information

- Exploring facts and feelings

- Giving meaning to the situation which distinguishes the child and family's understanding and feelings from those of the professionals

- Reaching an understanding of what is happening, problems, strengths and difficulties, and the impact on the child (with the family wherever possible);

- Drawing up an analysis of the needs of the child and parenting capacity within their family and community context as a basis for formulating a plan.

(Department of Health 2000)

These concepts were clearly being reflected in the study's discussions with practitioners, where the steps they undertook in their assessment practice included information and intelligence gathering, alongside their analysis and decision making (Fig 4.1j.) These actions were supported by a set of behaviours, in which communication, focus and prioritisation appeared to be key. The location and focus of the work also appeared to be influential in determining their behaviours.

These strands of practice are interwoven and not prerequisites of each other. Information and Intelligence gathering can happen simultaneously - 'Intelligence' being the term used here to describe the context and perspectives that place and shape the understanding of the information/data collected. Assessment practice does not appear be linearly 'phased' with clear divisions between each step, but parallels the interactive and iterative nature of action research. Behaviours and actions are repeated and revisited until such time as there is sufficient knowledge and understanding for judgement to be made.

Figure 4.1j: Domination – information resources

One of the most commonly referenced subject for assessment was **need**. The children's workshop discussion considered the identification of what needs a child may have, what

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the level of that need was, and what impact might arise if there was no intervention to ameliorate the need. But the discussions made it clear that 'need' was not an absolute, linked to a given condition or arising from medical diagnosis. It is a fluid, context dependant concern; 'need' can be defined as the gap between the cause of concern, diagnosis, or presenting issue, and the current level of amelioration for/of that concern. Some 'needs' may relate to replacing current coping systems or mechanisms (such as supporting parents to avoid long term stress and consequent failure to cope)

> ...it isn't a general 'need', it's about the difference between the difficulty and whether of not that difficulty is being adequately supported (*Children's worker*)

The Children's practitioners focus on determining whether the child and their family are equipped and capable of managing those issues which are 'different from or additional too' the generally accepted expectations within a family. They ask the question - does the context within which the presenting issues lie adequately support and address those issues? If the answer is no, then the practitioner will consider both rules of signification (do I need to act?) and of legitimation (do I have sanction to do so?) in their subsequent decision making.

Adult workers also raised issues around need, linking it to concerns around an individual's eligibility for services, and identifying the complexities of separating the individual's perspectives of what they want from the underlying need or issue that has triggered their contact with care services.

> My first thought was 'what does she want?' What does she need, how is she coping?' (*Adult Social Worker*)

Another commonly referenced item was risk. Understanding and dealing with both need and risk is core to care delivery, and their predominance was to be expected.

> You're looking at how that's impacting on that person's – life, quality of life basically. The way that they're doing things – what are the risks around that? (*Adult Social Worker*)

When it comes to looking at the impact of not addressing need, the two may be linked together:

> … we prioritise the child's needs we've talked about, but also we do assessment to prioritise organisationally how risky that situation is - ie urgency on response (*Childrens' social worker*)

Context was identified as an important part of assessment practice, being instrumental in helping, not just to determine the breadth of focus and the nature of the information and intelligence to be collated, but to inform and direct the resultant analysis (ie. provide signification for action). Education support workers tend to assess children in

school or service delivery settings. Pre-school services and Child Social workers – like their Adult counterparts - generally assess in the home.

> Sometimes you might see a child at school and they might be behaving very differently […] from the kind of person they are at home, so you get a different slant (*Child speech and language therapist).*

> I think the added dimension to going to visit someone at home is that then you start with the observations. What you see, you know? How long it takes them to get to the door – if they can get to the door even. […] it's all of that extra information […] And the dynamics of - if there's a carer there, neighbours or whatever, the dynamics within that – just that whole observation – atmospheres and stuff like that (*Adult social worker).*

Assessment undertaken in other settings – such as schools, hospitals, or care homes - may lack some of that contextual information. Equally, the context in which an assessment takes place may restrict or skew the information available when trying to analyse a need.   Some issues can be addressed by comparing observations of the individual in more than one context. This would seem to be a more common tactic among children's worker, who have a greater opportunity to observe a child in a range of environments.

> ... you can't assess a selectively mute child by going into the home because obviously they'll shut up when you go in, but you can do it by instructing parents how to collect samples, that sort of thing, so you can do some sort of assessment in the home and make a comparative assessment in different contexts (*Child speech and language therapist).*

The observable structures of practice lie situated within a given instance of practice space, and are created through the interactions between practitioners, clients, and other, relevant individuals (Fig 4.1k.) For all the practitioners interviewed, the key to achieving effective assessment was seen as communication - with other professionals and with the service users, their carers and their families.
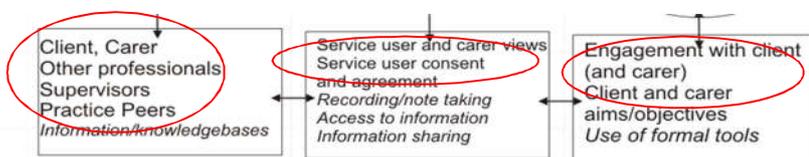
Figure 4.1k: Interactions: Communication

This included a need to translate information into terms that were understandable and directed at a given audience and an awareness of the potential for technical and specialist terminology to confuse or confound those unfamiliar with its usage.

> ...we have a very specific understanding of our area and then you have to put it in terms and contexts that other people can understand (*Children's speech and language therapist).*

… unless they're also a specialist in – whatever your specialism is – they're not going to know those words anyway *(Comment made during the Children's workshop)*.

Communication of meaning is vital in translating rules of signification into action. In social care, achieving an effective communication with the service user is a fundamental component of assessment practice, as well as a key factor in its structuration. Without it, the level of understanding a practitioner would be able to develop for a client's needs and perspectives would be severely limited - and the client (and/or their carers) would be equally unable to comprehend the reason certain services were being recommended or what an intervention might be intended to achieve.

> I don't like to go in with a whole tick list of things […] about I need to ask for this and this and this – no, I like to see what comes out in the discussion, hopefully put people more at ease, and then, generally I find by the end of it, when I do ask the questions that need to […] be asked, they're very open about it, and quite happy just to say […]

> I think it makes it more difficult for myself. I'm still trying to work out, even after five years […] I don't like to be sitting, writing, as though I'm not really listening […] 'just wait a sec while I jot all that down.' I'm still, even now, trying to work out the best way of doing it *(Adult Social Worker)*.

It also enables the practitioner to further develop their analysis, adding to the level of general intelligence concerning the context of a case, and ensuring that individual views, expectations and perspectives are appropriately accounted for when analysing need. It is in these interactions that agency – of practitioner *and* client – is primarily exercised, situated within the modalities of domination determined by the relationship between practitioner and client (Fig 4.1l). It begins with negotiation over the stages of the assessment process, is supported by informing and engaging co- operative consent, and continues with the updates and contacts that retain the service user's involvement.

Practitioner analysis/decision making
Supervision
Resource panels
Useability of systems
Tools and
access to information

Service user and carer views
Service user consent and agreement
Recording/note taking
Access to information
Information sharing
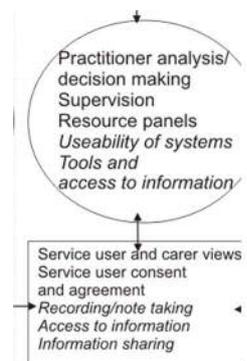
Figure 4.1l: Domination – modalities and interactions

> I think what they're trying to do – because in looking to use the form as a checklist and then making quick notes, which again is the huge majority […] this is about trying to be respectful to people – it's having the conversation, recording enough so you can make an accurate assessment […] it's just like in an interview, isn't it – I mean, it's just so embarrassing, isn't it, if you're just writing the whole time, and there's no eye contact *(Adult Service Manager, discussing the results of the questionnaire)*.

The level of this communication, like the depth and breadth of the assessment process, is determined by rules of signification which require it to be proportional to the identified need. This may, on occasions, mean communicating through a third party -

someone used to communicating with the subject of the assessment and therefore able to express their views and perspectives:

> … social workers who don't know the child, often that becomes second hand from […] somebody who's very close to the child, who's used to communicating independently away from the parent (*Children's Key Worker).*

In children's services, this independence from the parents view can be important, since the focus of the assessment process is required to be on the needs of the child, even if the specific issue identified lies mainly with a parent.

Children's social workers regularly utilise information supplied by, and about, parents within their analysis of a child's needs. Similarly, Adult workers draw on family information and input; in some cases, it may be necessary for them to conduct separate conversations with clients and with carers in order to understand the context of a case. While only 20% of the practitioners surveyed identified that that they frequently needed to speak to the client without the carer present to get a true picture of need, another 59% identified that they occasionally needed to do so. In the reverse question – the need to talk to the carer without the client present – there was a similar level of response, with 24% identifying a frequent need and 56% an occasional one.

Two more important concepts are the **focus** of the assessment and the **purpose** for which it is being undertaken; the primary specialism of the practitioner - the professional rules and knowledge resources they enact – provides both signification and legitimation, structuring the modalities of their practice and playing a role in determining the breadth of the assessment practice and the level of detail required to inform it. The social worker takes a holistic view, creating assessment records that cover a number of domains, evidenced by summaries and relatively low specific detail. The education support worker or the occupational therapist focuses on their specialist domain and supports their assessment through detailed, specific evidence, such as test scores and other measures of ability. Focus and purpose also impacts on the nature and extent of intelligence gathering that assessment practice may require. Concerns over behaviours or performance in the classroom may require a children's practitioner to assess the suitability of the teaching environment, or even to recommend that the child be placed into a different, more appropriate school. Whereas understanding the family context - the relationships with parents or siblings, may be more relevant for a child that is failing to thrive. Risks and needs therefore need to be considered as existing within an environment, rather than as isolated factors, and a specific risk, or need, may be ameliorated by the context in which they sit. An elderly adult may be physically fragile,

for instance, but the condition is not identified as a risk, because they live with family members who provide appropriate support.

> …daughter lives with them, and […] there's a carer goes in every day […] Whereas you might say 'actually, this person is stubborn, doesn't want any help …' and that actually is a much greater risk even though – if you like – the symptom is the same symptom that you're looking at (*Adult Social Worker*).

Understanding the nature of the presenting issues, and therefore the requirements for including or excluding settings and/or environmental circumstances in the breadth of the assessment practice, was presented as an important contributory factor in achieving successful, sustainable outcomes for both children and adults.

> ...you're trying to understand the context, you're trying to understand whether it's a one off, you're trying to understand whether this is […] a series of incidents […] the context in which the child was injured completely, so you're trying to deal with the complexity of the context really (*Childrens Social Worker*).

The measurements that take place - the matching against eligibility criteria, the considerations of ability and capacity, and the identification of opportunities for change - are directed at clarifying and categorising this contextual need, creating a multi-dimensional analysis which applies whether the requirements be wide ranging and holistic, or focused and specific to a specialist area, such as speech and language, or visual impairment.

Inherent in this approach are on-going tensions between the restraints of time and resource that require prioritisation of the areas to be investigated, and the desire to obtain a complete and holistic picture of the individual concerned. While prioritisation is often seen as a way of restricting and managing resources, it can also be important to identify where there is a particularly pressing need, or there are concerns which need to be addressed first. As someone in the children's workshop observed:

> ...you're thinking - before we need to sort this out with a speech language therapist we need to get them chewing before they're speaking (*Education support worker*).

This tension is further developed in Adult services, where policy promotes a concept of proportionality, dictating that the level of assessment should always be proportional to the individual's needs. While this may be a sensible approach in most cases - limiting the level of potentially invasive and unnecessary questioning - there is always a chance that an underlying (and potentially more serious) issue may be missed.

This tension is managed through the level of agency the practitioners have in determining the depth and direction of their investigation when undertaking an

assessment. While their approach is generally focused around the needs and issues of the individual, they are empowered to ask more general and contextual questions, which enables them to draw up a more holistic view, and to include those wider consideration in their analysis. This can be seen in the responses to a set of questions posed in the questionnaire:
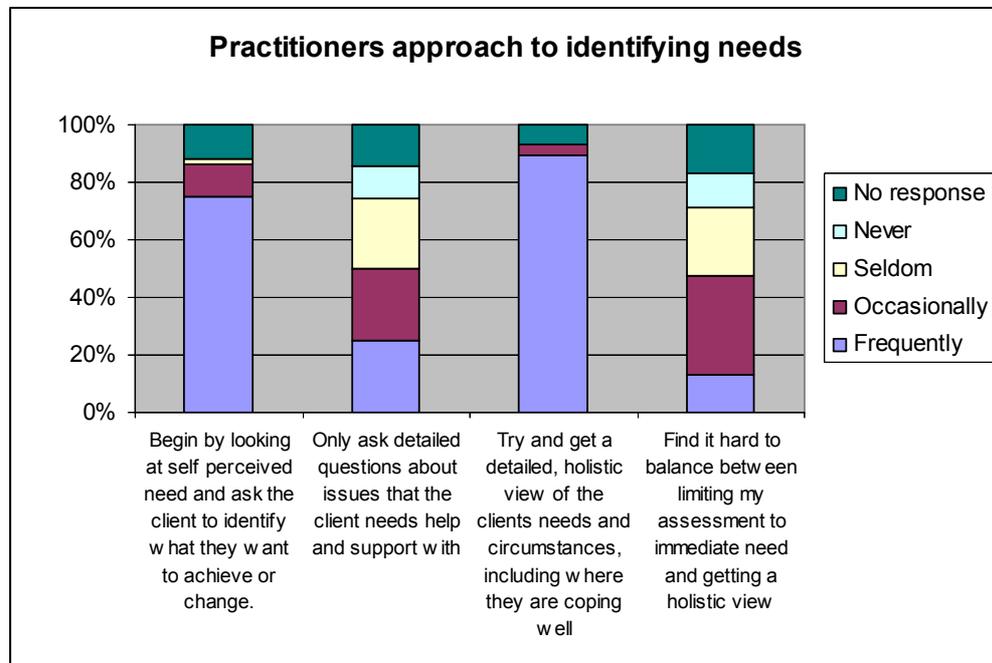
Figure 4.2: Analysis of Questionnaire - Strategies for identifying needs

A high percentage of the respondents identified that they begin their assessment by considering the views of the client, but only a quarter of them claimed that they frequently restricted their questioning to those presenting issues. The majority habitually aimed for the more holistic view, and while a small percentage identified that it was frequently hard to balance the proportionality of the assessment, most felt that it was an occasional or infrequent concern, with some claiming to never have difficulties at all.

While impossible to determine from this kind of self identified evidence whether or not this was genuinely the case, the responses demonstrate a pattern of practice, centred on the individual and their current issues, but considering the context of those issues, and taking the wider picture into account where it is relevant to do so.

The scope of the picture being painted and the depth of detail it contains is partially structured by the assessment tools the practitioners are required to use. These tools act

to both afford and constrain, directing and determining the information the practitioner is expected to collect, while acting as a knowledge resource that prompts and supports the holistic expectations of practice. These tools and systems - which support access to and interaction with information resources – are important mechanisms in the structuration of practice, with their utilisation and usability impacting on the modalities of domination, affording – or constraining - access to core resources (Fig 4.1m.)
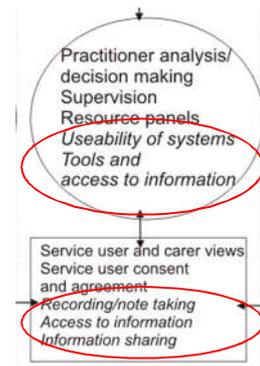
**Figure 4.1m:
Domination –
Information tools**

Both the children's and the Adult services in *Countyshire* utilised assessment tools built around 'best practice' conceptual frameworks, which defined the 'wider picture' and identified the areas that the assessment practice was expected to consider in its investigations. The children's tools were based on the National Children in Need Assessment Framework, which has been discussed in Chapter One. Adult services used a locally published model, drawn up from recognised good practice and reflecting the domains identified within the Single Assessment Process.

Both of these models identify a set of information domains: areas of interest and investigation that enable contextual analysis and contribute to the understanding and determination of need. When brought together the information within these domains present the required holistic picture of the individual, their environment and their needs. The division of this picture into pre-defined domains presents consistent frameworks shaped by input from practitioners' knowledge and experiences and which, in turn shape the undertaking of assessment practice. These frameworks are given signification by reference to research and their inclusion as part of practitioner training, have legitimation through inclusion in policy and local procedure, and form a primary resource within assessment practice. They are aimed at enabling practitioners to work consistently, both within iterations of assessment for an individual, and between the individuals they assess; and they support proportional investigation, allowing the focus of an assessment to fall on specific areas of concern/need, while ensuring that the overall view is still addressed and included in any considerations.

As well as generic tools designed to capture and record narrative and analysis across the defined domains, practitioners may also utilise a range of more specific, standardised tools – detailed scales and tests which are used to measure a range of issues, usually

related to ability or capability. These standardised tests can add rigor to information and intelligence gathering, contributing to an understanding of both the ability and the potential for progress in a child, helping to situate a young person in relation to their peers, evidencing an Adult's cognitive capacity, or measuring levels of physical impairment. They may add meaning to observed behaviour or help clarify the reasons underpinning specific development issues. They also contribute to intervention planning, and comparisons of previous scores can provide a means of measuring progress at a point of review. They are not as commonly used by social workers as they are by specialist services, although there are tools available to use should specific issues need to be evidenced for court proceedings or to support particular lines of investigation.

4.2.3c Building transformative capacity: the value of intelligence, and the analysis of need

> But the information gathering is part of the assessment, isn't it? That's where it starts' (*Education Support worker*)

> Understanding what is happening to a vulnerable child within the context of his or her family and the local community cannot be achieved as a single event. It must necessarily be a process of gathering information from a variety of sources and making sense of it with the family and, very often, with several professionals concerned with the child's welfare. (*Framework for the Assessment of children and Families, DOH, 2000*)

> … it's very much that you've got information that's already been recorded, that's come from the customer service centre. And often you would look to see what else is on the system, whether they're a new client, or whether there's been […] involvement in the past, whether they're already receiving services […] and obviously with that, you've got that information. (*Adult social Worker*)

Assessment practice is founded on what is known, builds on what can be found out and is driven by a need to know. It brings together facts and figures, considers past history, examines current circumstance and predicts future possibilities. It does so in order to determine if intervention is needed, and if so what those interventions need to be. It
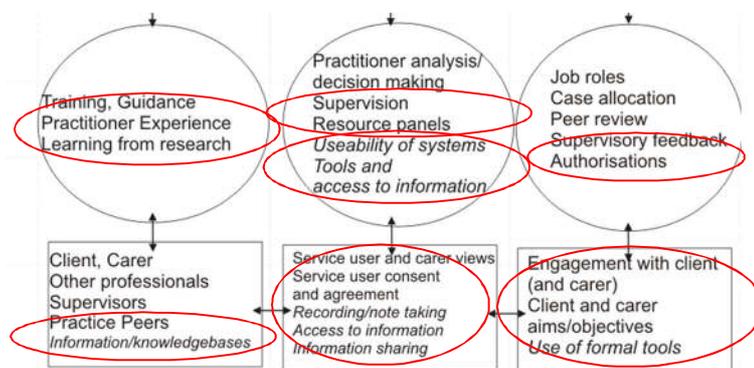
Figure 4.1n: Modalities and interactions of assessment – enactment of structures in practice

looks to encourage certain kinds of outcomes and to discourage, or even prevent others. And it collects, collates and generates the evidence on which decisions about those interventions are made.

Information gathering is a primary strand in this process; pulling together what is known about the individual being assessed, attempting to fill in gaps and negotiating with the client, their carers and other practitioners in order to obtain and share - not just information, but the knowledge it represents. This core information set – what is known and what is not yet known – acts a resource that supports both the human capacity to achieve outcomes and the transformative capacity used for domination and control. It also establishes the foundations from which the holistic view of the client will be developed and refined, enabling decisions to be made and actions taken.

The information available at the start of an assessment process can vary from simple, basic demographics, through the minimum requirements prescribed by a referral form through to an intensely information rich case file. The practitioner needs to sort through what is available, negotiate access to what others might hold, and identify what gaps remain.

If there has been previous work undertaken, then being able to access earlier records can help inform this stage, as does being aware of which other services and practitioners are currently involved. The value of linking record systems - of having information structured in such a way as to make what is needed available - was recognised during the discussions, along with an acknowledgement that this is something that could be managed more effectively.

> I think that's where the information system really clicks in, because you've got […] probably got well rehearsed, well used information systems within our own organisations and within our own cultures, but what we don't do is cross reference with each other *(Children's Worker)*

The scale of information resources available for a practitioner to draw on prior to an assessment visit will depend on the length of time the individual may have been involved with care services, but, where such material is available, it is commonly used to inform the visit.
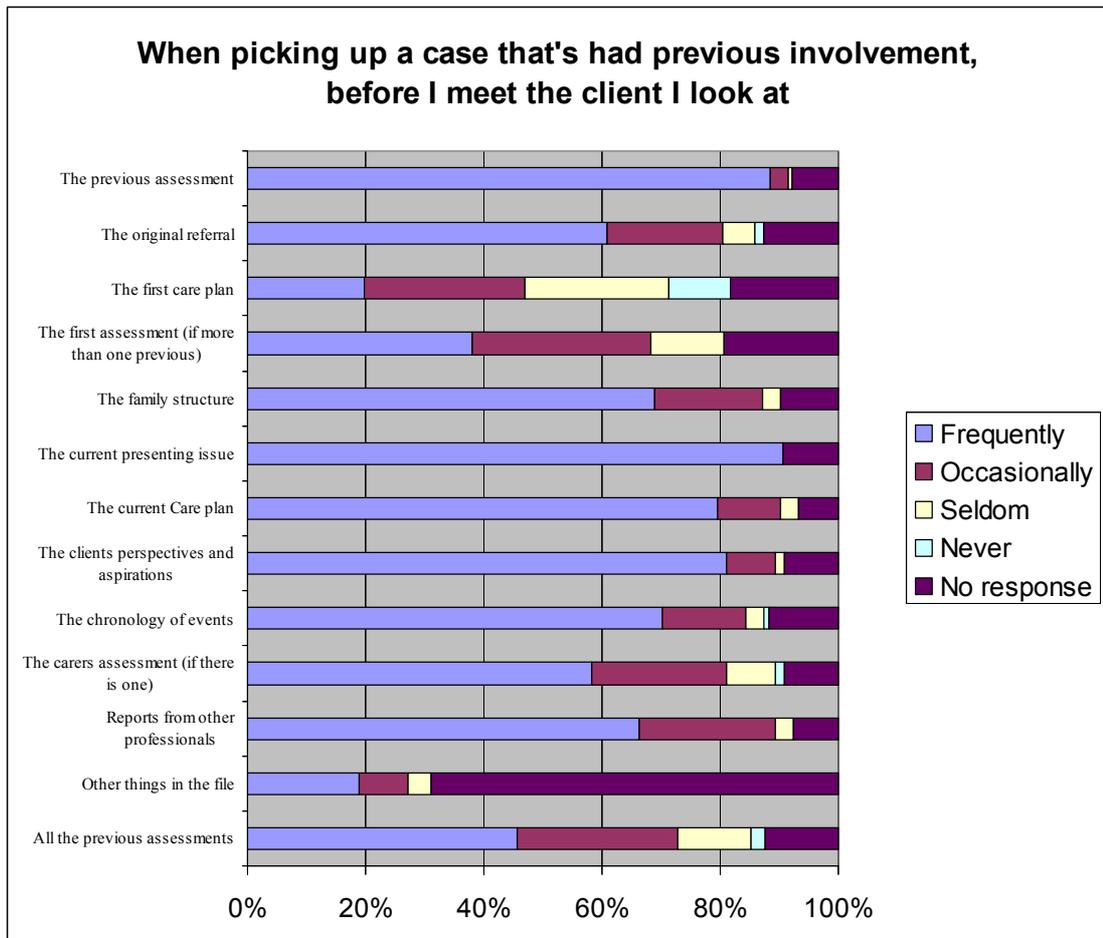
Figure 4.3: Analysis of Questionnaire - Information sources consulted prior to an assessment visit

Here again, the tensions of the holistic view and the proportional investigation come into play. In some cases, particularly in children's services, a vast amount of information may have been gathered over time; although this is seen as a valuable resource, it is often not captured or presented in ways that enable a practitioner to find what they need without spending a large amount of time reading and interpreting previous assessments and case notes in detail. The focus therefore tends to be on 'skim' reading and considering the more recent detail in order to glean what is considered to be relevant and important material.   The way that case records were held in *Countyshire* at the time of the research– partly on the client database, partly on paper – did not make identifying the most relevant material easy, but the interviewed practitioners were clear about the benefits of doing so:

> I think – just looking at one, previous assessment is not as valuable as seeing a whole picture. You can get a complete – and also it depends on who's done the assessment, because it might be a different discipline – looking at different issues … to be able to look quite far back is really, really useful, because sometimes you'll get to people's houses, and they'll say – they'll talk to you about […] for example, say they've seen a psychiatrist – and I think I saw

somebody about my memory, or something – and if you can prompt them, so 'do you mean Dr such and such?' […] because a lot of people have a lot of history – it can make things a lot easier than – just trying to guess who they're talking about, when they're talking (*Adult Social worker*).

The mechanisms of case recording in social care have primarily developed around narrative, reflective approaches, utilising note taking, written observations and the creation of reports to populate formal case records. These case records form the core of a case 'file', supporting further content, include correspondence and contribution from other professionals, such as health or housing reports. The content and quality of these records vary from practitioner to practitioner, with care teams creating their own 'in-house' styles and standards, which may dictate the level of detail recorded for any given case. Information systems within the sector, although more consistent in content, have been generally designed to capture activity and monitor performance, and tend to provide only limited functionality for the support of practice and evidence of decision making. Often, therefore, the information that might be needed may not have been recorded at all:

> I think perhaps social workers haven't been good at evidencing why they do what they're doing […] why they're doing it, all the reasons for it […] it's often been the case that a worker will go out on duty, come back and have an informal discussion with the line manager and say 'well, this person needs it for this reason' – they will give their views, whatever, and then a service is put in place, but there's – anybody wanting to follow that through, there's no – in many cases – no written evidence as to what happened, why it happened (*Adult Reviewing officer*).

Lack of information and/or evidence of previous involvements does not prevent a practitioner from undertaking an assessment, but it may mean duplication and repetition for the client, and creates a risk that some issues may be missed.

Assessment practice does much more than simply gather information. It aligns it within and across defined domains and positions it in context - questioning relevance, making connections, and interpreting value, thereby adding meaning and signification.

> … there was often a great deal of detective work about it. Who's funding this, what's the history of that, why did that person go to that residential home, and all that kind of stuff (*Adult reviewing officer*).

This aspect of the practice might best be described as generating 'intelligence,' drawing on concepts utilised by other investigatory agencies, such as the police.

> Intelligence in general can be thought of as the complex process of
> understanding meaning in available information. A typical goal of intelligence is

to establish facts and to develop precise, reliable and valid inferences ... for use in strategic decision making or operational planning (Clark. 2004, p 13).

Practitioners are sometimes able to draw on alternative modalities of domination, undertaking assessment practice independent of specific cases, and using intelligence gathering to address issues of context relating to service setting without needing to be specifically related to a particular individual. This flexibility of knowledge generation enables practitioners to conduct investigation and generally improve outcomes, even if consent has not been given to address issues for a particular individual.

> ' ...we can investigate an environment the child is within – without investigating the child. Because we can go in and, you know, they're saying 'we're having difficulties with this child,' Say 'have you got parental consent?' No – but you can say what is happening in your classroom generally […] you know, you can go in and say 'you're going to have problems with more than one child in this classroom if you don't deal with X,Y and Z (*Educational welfare officer)*.

It would appear that this application of assessment practice is more common within Children's services, where there is a greater ability to influence outcomes for a number of children by addressing issues in shared environments, such as classrooms. While it is likely that similar skills are employed by Adult workers when investigating safeguarding issues in care homes, day centres, or other settings, these kind of investigations are not common, and are usually undertaken by specialist staff; this aspect of practice was not directly evidenced in either the Adult workshop or the subsequent interviews.

Intelligence gathering encompasses a wide range of knowledge sources, both specific to services users, carers and their families - such as references to patterns of behaviour, sibling experiences, family relationships and environmental/community settings - and non-specific knowledge, such as information drawn from research, statistics, past experience with similar cases, or general consultation with other colleagues. This tacit knowledge, both general and specific, provides significance and acts as a valuable resource in assessment practice, yet is not well supported beyond peer networking and informal communities of practice. There were no consistent mechanisms in *Countyshire* for informing practitioners about ethnic customs, for instance, yet they were required to consider issues of culture and religious practice when undertaking their assessments. Equally, there was an expectation that assessors understand and take into account issues arising from medical conditions. Practitioners respond to these requirements by drawing on their personal knowledge-bases and often, where the subject is less well known, enhancing them through specific enquiry and

research.   In response to the statement 'When I assess I research any medical conditions the client may have in order to inform my assessment,' 57% identified this as a frequent occurrence, and 28% as an occasional one.

Another valuable source of information and intelligence are the practitioners from other professional and voluntary services who are, or may have been, working with the individual concerned. Referrals may be initiated by a GP, on discharge from hospital, through a health visitor, or – in Children's cases – raised by a teacher. As many of the cases referenced during the Children's workshop were those for school or nursery age children, the initiator of the referral was often a provider of universal service for the child, and as such, viewed as a prime source of information about the child. Communication with these sources is, like communication with the service user or their parents, an important part of assessment practice.

The referrer is not the only professional who is likely to have access to this kind of information, and working to identify who may be relevant to consult and involve at an early stage helps to avoid duplication of work, confusions over responsibilities and keeps the focus of the assessment process clear. The establishment of multi-agency teams is seen as a positive move that will help support this process; not every case requires consultation with other professionals, but where relevant – and with the appropriate individual's consent - practitioners will engage with one or more others in order to clarify concerns, identify risks, obtain a new perspective, or simply gather further information to assist in their analysis. The appropriate individual is usually the person being assessed, although for young children it is more likely to be their parent; as with other areas where consent is generally required, there are exceptions for matters of serious risk or concern, and formal processes to be followed where the person lacks capacity to consent on their own behalf.

In Adult services, the most common of these consultation are with the individual's GP, or the community/district nurses providing health treatment or support, but the responses in the questionnaire demonstrated the wide range of professional groups who potentially contribute to the wider 'care team' supporting any given individual.

GP	Housing officer	Care Suppliers
Health visitor	Specialist medical Practioner	Behavioural therapist
Occupational Therapist	Mental health/Larning disability officer	Day Services and Residential Providers
Advocate	Physiotherapist.	District Nurse
Other Allocated worker/Colleagues	Day Care Providers	McMillen Nurses
Benefits Agency, our finance sections, advocacy services etc.	Home Care Agencies	Intermediate care workers
Employment Agencies	Home Care Supervisors	Hospital Staff
Care Agency	Respite services	District Nurses - Community Psychiatric Nurses
Managers of Care Homes, Managers of Day Care Centr	Learning Disability Nurses	Voluntary Organisations eg age Concern, Alzheimers Society,
Physio/contenance advisor	Speech and Language Therapist	
Psychologist and Physiotherapist	Nursing/Ward Staff	
Referrers eg Accommodation Wardens	Neighbour	
Secure Providers	Police.	

Table 4: Range of other professionals approached for further information during assessment (*collated from questionnaire responses.*)

The holistic picture is therefore built up using information from a potentially wide range of sources, the richness and detail of that picture shaped by the richness and relevance of the resources it draws on.

The third strand of assessment practice is the information analysis: the profiling of need and the identification of how that need might be addressed.

> ... the analysis of a child's need is a complex activity drawing on knowledge from research and practice combined with an understanding of the child's needs within his or her family (Countyshire, 2001).

It is tempting to assume that Information analysis is a logical and sequential result of collecting information and collating intelligence - but this is clearly not the case. Practitioners describe analysis as an integral part of assessment practice, continually reviewing and revising their conclusions as more information becomes available and further intelligence is received. This is similar to the grounded theory approach - the iteration and refinement of analysis as concepts are identified and further data gathered to test the robustness of developed theory.

There are inherent risks in drawing early conclusions, and good practice guidance recognises the value of reflexive working, exploring hypotheses and seeking disconfirming data along with confirming evidence. Initial conclusions, drawn from the presented issues can be deceiving, and while intuition may turn out to be correct, disproof is as important a consideration as proof (Milner and O'Byrne, 2002). Practitioners are not necessarily looking for single root causes, but uncovering deeper seated issues can change the whole direction of proposed actions and may require completely different services.

> It's the unpicking, isn't it. It's why do you assess – to see if you can find what's gone wrong […] what's going wrong, what the problem is. (*Children's worker*)

> You know, you have got to explore things, and you've got to […] you've got to be as inquisitive in many ways, to try and get to issues that may not be particularly obvious (*Adult Reviewing Officer*).

They are also looking for what's going *right* - identifying strengths as well as weaknesses; any proposed plans need to take these into account and not threaten loss as well as gain. Key to this is understanding the perspectives of the individual concerned, and enabling their views and 'voice' to be both captured and used to inform the analysis of their needs.

The analysis that emerges from the activities of practice space shapes the practitioner's recommendations as to how the needs identified may be addressed (through the authorisation and allocation of resources) and the desired outcomes achieved. These recommendations can range from simple advice and guidance for self actions that the assessed individual might take, through requests for further assessment – either to be undertaken at a greater level of detail or as focused practice from a specialist service or practitioner – to the specification of detailed care services and interventions. All three levels of response can be included, as the level and impact of need in any one aspect of a person's life may be different from that in another. The practitioner's analysis may also account for how recommendations that address the most serious needs might impact on other, lesser, needs, identify current and future risks (balancing those associated with taking the recommended action against those of taking no action at all), and seek to clarify the level and sustainability of social capital- family carers, friends, neighbours, advocates and other volunteers - that the individual may have to draw on. The quality (and, to some extents, quantity) of the information resource therefore plays a measurable role in the modalities of domination and the associated exercise of power, helping to shape the consequent interactions between citizens and the services they may receive.

The primary purposes underpinning the practice of assessment in social care can be identified as:

- the determination of the issues that may be impeding the client's ability to enjoy a good quality of life, to cope with daily living, or to function within and contribute to their community, and the needs for services or support that arise from them (legitimation)

- the determination of any risks (physical, psychological, and sociological) arising from those issues (signification)

- the consideration of how those issues may impact on carers, creating further risks and issues that may also need addressing. (both legitimation and signification)

- the identification of potential interventions, services, aids or equipment that would support and aid the individual in addressing their issues and meeting their needs. (domination)

These purposes both shape and are shaped by structures of practice that build information resources by gathering information across a range of domains of interest, identifying signification and legitimation through the contexts within which that information sits, and managing agency and domination by including, as part of the input to the overall analysis, the wishes and objectives of the individual being assessed, the views of their carers, and the professional perspectives of other practitioners who may be working with the individual (or with their carers).

> If you're a practitioner, you're drawing on legislation, theory […] you know, all those different experiences – practice experience to guide you in that decision. (*Adult Social worker*)

As has already been noted, the specifics of any particular case will inevitably vary dependant on the purpose and depth of the investigation required, along with the agency exercised by the practitioner when undertaking it, but the commonalities of assessment practice can be modelled as a form of interactive research and analysis, with the focus of the investigation on the individual at the centre, and considering issues of risk, resources and need.

In some ways, this could be seen as an affirmation of Richmond's definition of *social diagnosis* (Richmond, 1917). Unlike medical diagnostics, however, the intent is not to track symptoms in order to determine root cause and from there prescribe specific treatments; rather it is to define and describe a more holistic and contextual picture, within which the requirements for and impacts of care services can be determined.

4.2.4 Structural reinforcement: tacit knowledge and cultural resources

Practice space is constructed, deconstructed and then reconstructed as the practitioner traverses their working day, moving from case to case, and engaging with clients and their carers – either directly, or through some form of interaction with information that

identifies and describes them. The structures of activity within that space are partially determined by the inherent agency of practice itself - the ability of the practitioner, when interacting with an individual, to determine the effectiveness of their approach in achieving the intended goals. In doing so, the practitioner not only draws on models of activity they may have been taught in training (the 'questioning' and 'exchange' models described in Chapter One for instance,) but also on the knowledge and understanding they may have gained through previous practice and in discussion with their supervisors and their peers. This cyclic reinforcement – in which the more you do, the more you know and understand– enables flexibility of response, but, in doing so, structures the patterns of behaviour through the iteration of tried and 'tested' strategies.

> You talked about learning 'as you go' – we've had skills from previous experiences, and brought them with us – and then through training and supervision, we have made adjustments and changes and learnt. And yes, it's been a huge – call it a learning mountain, not a learning curve at all (*Key Worker in Children's services).*

Every professional discipline derives its knowledge from a particular theoretical base, related research findings and accumulated practice wisdom and experience. Social work practice, however, differs in that it derives its knowledge base from theory and research in many different disciplines. Practice is also based on policies laid down in legislation and government guidance. The Children's Assessment Framework identified that:

> It is essential that practitioners and their managers ensure that practice and its supervision are grounded in the most up to date knowledge and that they make the best use of the resources described in the practice guidance as well as other critical materials including:
>
> - Relevant research findings;
> - National and local statistical data;
> - National policy and practice guidance;
> - Social Services Inspectorate Inspection Standards;
> - Government and local inspection, audit and performance assessment reports;
> - Lessons learnt from national and local inquires and reviews of cases of child maltreatment (Department of Health, 2000, p. 16).

Equally, Adult practitioners are encouraged to continually update their skills and knowledge, collecting and presenting evidence of their on-going professional development to complement their personal experience and 'in-practice' learning. Peer review, supervision from line managers and more informal communities of practice encourage the sharing of and discursions around what is 'good' or 'bad' practice.

> … I then talked to my colleague about the situation, and said 'would this be what you would have done?' So, just reinforcing that I hadn't – missed … that you don't miss anything. Because there are certain risks […] that I've not come across. I just wasn't sure how we could minimise that risk – if there's anything we can do, if […] and I just then got it confirmed, that – that's about all […] that's what I would have done (*Adult Social worker*).

This shared knowledge base and the tacit rules that it supports and creates is an important contributor to the structuration of operational activity – providing signification as well as knowledge resources, defining a number of behavioural constraints, supporting the agency of practice, and shaping its outcomes – but is often downplayed in policy and guidance, at both macro and meso levels.

In fact, the tendency to design systems around what practitioners *do*, rather than what they know, highlights some of the inherent tension between the rhetoric of practice and policy and the requirements imposed in the implementation and management of services. Practitioners often perceive the business process as being mechanistic, particularly where workers are constrained by restrictive standard assessment procedures and packaged formulations of service delivery (Gursansky, Harvey and Kennedy, 2003).

This propensity for systems that constrain and direct is almost undoubtedly the reason that social workers tend to be reluctant to engage with and use technology, seeing it as a restrictor in the exercise of their practice, rather than delivering services that support and inform it. Orlikowski (2000) observed how users draw on their knowledge of and experiences with the institutional contexts in which they live and work, as well as the social and cultural conventions associated with participating in such contexts. People's use of technology becomes structured by these experiences, knowledge, meanings, habits, power relations, norms, and the technological artefacts at hand. Such structuring enacts a specific set of rules and resources in practice that then serves to structure future use as people continue to interact with the technology in their recurrent practices. In this way, over time, people constitute and reconstitute a structure of technology use, that is, they enact a specific 'technology-in-practice.'

In the world of social work, and the activities of the social care practitioner, technology has emerged as something perceived as being positioned 'outside' of practice space – an administrative adjunct that captures performance and activity after the event, rather than an integral tool that records evidence and supports decision making. The current structures in which the technology sits, reinforced by the nature of the applications it delivers have become less 'technology-in-practice' and more 'technology-*after*-

practice.' Some of this has been the inevitable result of the inflexibility of hardware that tied a computer to a desk; the majority of care practice takes place in individual's homes, and not in the practitioner's office. There are expectations that the introduction of newer technology that supports mobile and flexible working in a range of environments – wireless connectivity, tablet PCs, digital pens, voice recognition software, smart-phones and so on – will address this disconnect between systems and practice, but the increased mobility of the hardware alone may not encourage its use, practitioner engagement being dependant on the development of appropriately practice focused tools.

At the time of the research, *Countyshire* was in the process of introducing tablet PCs into their adult teams. The initial implementation was within the reviewing team, where take up had been good, and the response to their use generally positive. However, the return on the questionnaire clearly identified that a large percentage of the recording being undertaken by this team while working with their clients was still paper based, with 20% of the team indicating that they seldom or even never made use of the mobile device for this purpose.
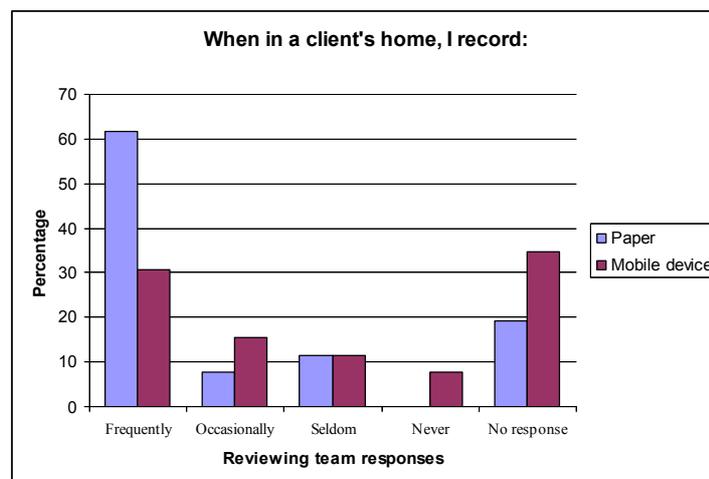
Figure 4.4: Analysis of Questionnaire - Reviewing teams response to method of recording

To date, developments in information technology have tended to be focused on the reification of procedural, meso-level structures, rather than reflecting the micro requirements of practice, but with the introduction of tools that are mobile enough to use within the bounds of practice space, new ways of working and new requirements are beginning to emerge.

4.3 The social work practice lens: structuration at the micro level

> ... how practitioners work is influenced by a number of sources ... In terms of the way we record, and the policies and procedures of individual government – local government. You know, we all work quite differently. There's the use of technology. So many factors which influence how we do things (*Social worker, speaking in the Adult Services workshop*).

Throughout the research the factors captured through the data analysis were mapped, and their role in shaping the observed structures identified, using the structuration framework analysis tool. A summary of the factors identified in this chapter as underpinning assessment practice is given in Figure 4.2 (above.) This breakdown focuses on the primary role of these factors and is intended purely as a mechanism for
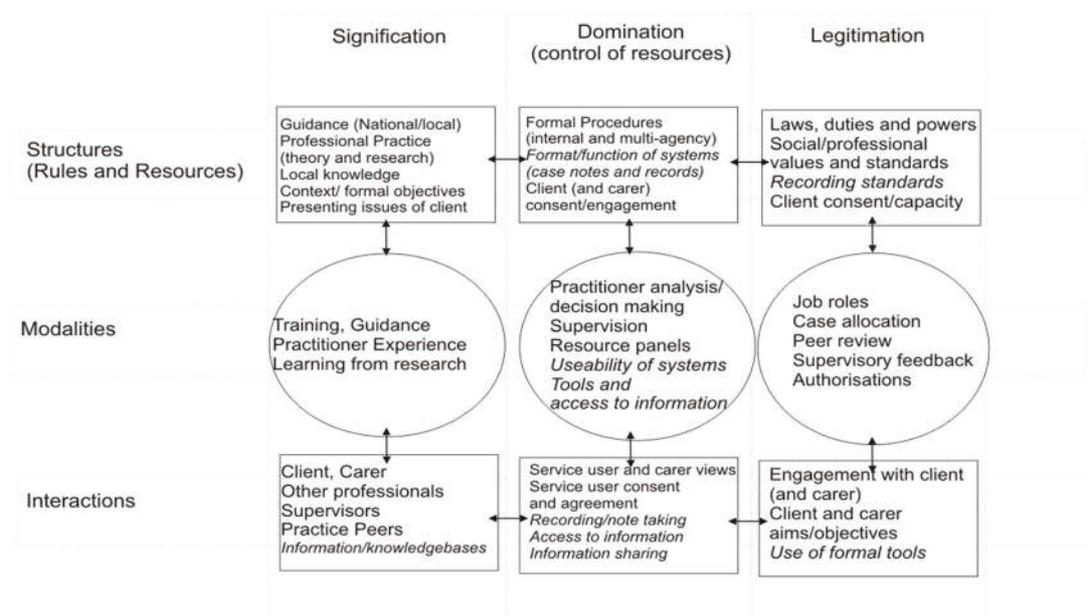
Figure 4.5 The social work practice lens: Populated framework tool, analysing structuration of assessment at the micro level, focusing on assessment practice.

modelling and analysis – in practice, these factors are closely interlinked and it is from the interplay between them that observable structures emerge.

Assessment practice is situated in the enactment of rules in day to day interactions, focused through the modalities/mechanisms that enable or disable practice, and driven by the re-iterative duality of signification and legitimation which both shapes and is shaped through the domination of resources. In this context, information is power – both underpinning the human capacity to achieve outcomes, and underwriting the transformative capacities expressed through allocation and authorisation.

The findings of the research demonstrate that the micro structures of assessment practice can be effectively described as an *intelligence* activity – an iterative, interactive gathering of information that, though on-going analysis and contextual positioning,

presents an informed picture of the assessed individual – enabling practitioners to clarify issues, identify risk, and inform decision making when determining the need for support or intervention. Practice is structured by the enactment of societal and professional rules, utilising a range of knowledge resources which provide both signification and legitimisation, and is realised through the interactions between practitioner, client, carers, and others. Agency sits within the modalities underpinning those interactions – the levels of emphasis on client choice, professional decision making, and the access to and availability of supporting information and knowledge resources. This supporting information, which both informs and is informed by assessment practice, is generally rich in detail, tends to be constructed (and deconstructed) as narrative, is coloured by the individual (and their carers) 'voice', and draws on a number of tacit resources, such as the practitioner's training and experience and their knowledge of the local environment.

> …what guides me when I'm out in practice is not just policies, procedures and the resources, or individuals needs, but there's legislation there […] and there's theory […] and applying that sort of knowledge to maybe somebody who's experiencing grief and how that's managed, and linking them then with the resources that are in the area that can provide that sort of support […] what's important for any practitioner, any worker, is to actually see that person as an individual [...]   Because people can change very, very quickly. And because one worker's been out and assessed, that's been the situation, that doesn't necessarily mean coming in with a different viewpoint is going to have the same agreement as to what that person has […] and it's bringing in an open mind and just taking things as they are, and what that person is saying, and basing my knowledge and my outcomes – basing the outcomes on what the information is there and then. It's drawing on resources, it's drawing on the policies and procedures, it's drawing on my knowledge of theory, it's drawing on my knowledge and experiences of resources in the area, it's a whole combination of things that happen […] quite unconsciously a lot of the time as well – because of your experience. And working from them as being the expert. (*Adult Reviewing Officer*)

The micro structures that exist within and define practice space, and the agency to undertake the activities that create and recreate them, are, in turn, shaped and constrained by the organisational structures within which they take place – the requirements of the assessment *process*, which is explored in the next chapter.

Chapter Five: Exploring Meso-Micro Interactions
The dialectic of process and practice

Standard 14	How We Achieve This
We will complete the assessment, care plan and review within the timescales, and by the deadlines, set out in our guidance	**New Assessments Older People** • All assessments should begin within 48 hours of first contact • All assessments should be completed within 4 weeks of first contact • 70% of these should be completed within 2 weeks **Services in Place Older People** • All services should be in place within 4 weeks of completing the assessment • 70% of these should be in place within 2 weeks • All community equipment (aids & minor adaptations) should be delivered within 7 working days **Hospital Discharge - Reimbursement** • 3 days to complete assessment & care plan from receipt of section 2 notice • 24 hours to have services in place from receipt of section 5 notice **First Reviews** • Begin within 3 months of completion of care plan **Annual Reviews** • Begin one year of completion of first review or unplanned reassessment • Apply assessment & care planning timescales. ***Under development***

(Countyshire, 2005)

5.1 Meso Structuration – Business Processes and Performance Management

The day to day activities of assessment practice take place within contexts defined by the organisations responsible for those activities. These contexts – the formal hierarchies of organisational management and the business processes which shape and direct practice activity – provide the practice lens of process through which structuration at the meso level can be observed. Organisational structures emerge from the inherent dualities of meso structuration – the dynamics between the purposes and objectives of the organisation (legitimation,) the expectations of the communities it serves (signification,) and the resources available for it utilise (domination.) This chapter considers the factors that shape and are shaped by those dynamics as evidenced in the day to day activities explored in the workshops, in the interviews and through the data from the questionnaire. It presents a meso structuration analysis of assessment process using the framework tool, and examines the positioning of assessment practice within the business processes of the organisation being studied. The roles of information and information technology – as resources to support both practice and process, and as repositories of rules – is also explored.   Insights into longer term organisational

activities (such as the review/development of business processes, and the introduction/ management of change) are discussed in chapter six.

The unpopulated framework tool is re-presented in this chapter for clarity (Fig 5.1)
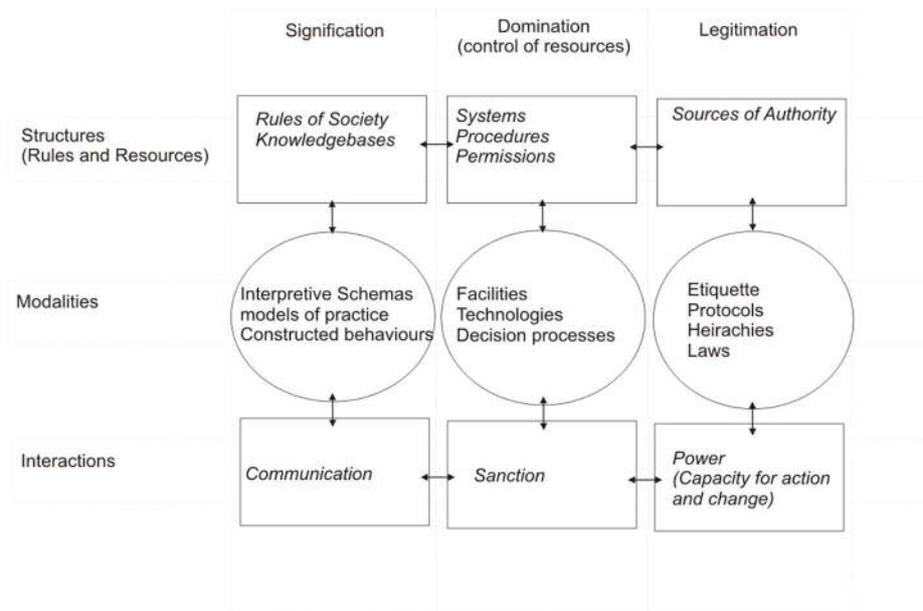
Fig 5.1: Framework tool for Structuration analysis:

5.1.1 Statutory Responsibilities: legitimation for organisational authority.

English law places a statutory responsibility on Local Authorities to undertake an assessment of those who may be in need of support and care, and from that assessment to determine the level of support, through the application of pre-defined rules and criteria. The laws that underpin this responsibility provide the primary legitimation for assessment to take place (Fig 5.1a.)
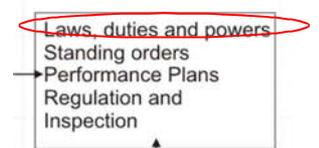
Figure 5.1a: Legitimation through law

This responsibility applies to Adults in the general community:

> … where it appears to a local authority that any person for whom they may provide or arrange for the provision of community care services may be in need of any such services, the authority—
>
> (a) shall carry out an assessment of his needs for those services; and
>
> (b) having regard to the results of that assessment, shall then decide whether his needs call for the provision by them of any such services.

(HM Govt, 1990)

To Adults being discharged from hospital (where there is a concern that it may be unsafe to discharge them without support/care):

> (2) The responsible authority must—

(a) carry out an assessment of the patient's needs with a view to identifying any community care services that need to be made available in order for it to be safe to discharge him…(HM Govt, 2003)

To those engaged in the care of another:

… the carer may request the local authority […] to carry out an assessment of his ability to provide and to continue to provide care for the relevant person; and if he makes such a request, the local authority shall carry out such an assessment and shall take into account the results of that assessment in making that decision (HM Govt, 1995).

And to children who appear to be in need, or where there are safeguarding concerns:

Where it appears to a local authority that a child within their area is in need, the authority may assess his needs for the purposes of this Act (HM Govt, 1989).

It is therefore expected that every English Local Authority will have formalised arrangements in place to enable social care assessments to be undertaken, and for relevant services to be provided where the assessment has identified that the care needs of the individual meet agreed/approved criteria. It is important to note that, while the law imposes this statutory responsibility, it does not dictate how it should be met.

(4) The Secretary of State may give directions as to the manner in which an assessment under this section is to be carried out or the form it is to take but, … it shall be carried out in such manner and take such form as the local authority consider appropriate (HM Govt, 1990).

So, while the dictates of policy and the formulation of national guidance play a substantial role in the signification of assessment practice and the legitimisation of its application, the control of the resources which support that practice lies with the individual Local Authorities, who are empowered to distribute their allotted resources in line with their

Figure 5.1b: Meso Legitimation internal rules and external regulation

own local governance, determining both their internal organisational arrangements, and their approach to local, external partnerships (Fig 5.1b). This organisational agency, while overseen by inspection regimes and regulatory requirements, inevitably leads to a level of flexibility concerning the implementation and interpretation of law and policy, which, in turn, contributes to and shapes the local structures of assessment process.

5.1.2 Formalising Rules into activity: organisational hierarchies and business processes.

In order for Authorities to meet their statutory obligations, they establish hierarchies of management, define arrangements for the delivery of services, and develop local business processes/procedures. These internal rules of action frame assessment practice, formalise case management, and underpin the allocation of services and the delivery of care in the public sector (Fig 5.1c).
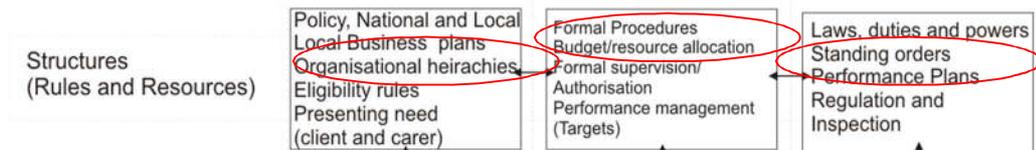
Fig 5.1c: **Meso Rules and Resources – organisational structures and hierarchies**

They also serve to constrain and direct activity, being translated into action through formalised schemas and hierarchical domination of resources. Transformative capacity for the interpretation of these schemas sits at the higher levels of the organisation: changes may be initiated through internal reviews of organisational performance, revision of budgets, external input, such as inspection reports, and requirements to implement changes in local or national policy, or as response to community complaints or concerns (Fig 5.1d.)

These formalised structures, which shape and direct the undertaking of assessment
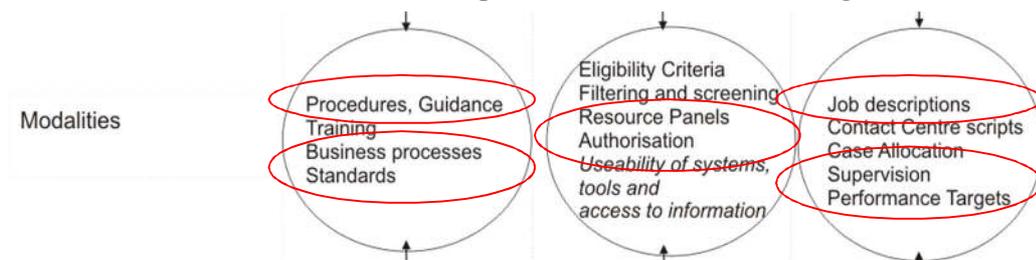
Fig 5.1d: **Meso Modalities – formalisation of activity**

practice, can be observed in the day to day interactions between managers, practitioners and administrative staff (Fig 5.1e,) but also emerge through the regular reproduction of standardised activities in a predefined series of steps – the assessment *process.*
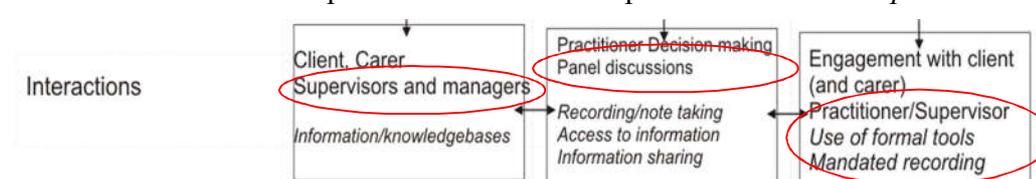
Fig 5.1e: **Meso Interactions – management and monitoring of activity**

5.2 Assessment process: managing the regular and the routine.

> ...generally our assessment would be going in at the initial point of … an initial assessment and looking at all the aspects of a family and how different things might impact on that families ability to cope and what services they may need from us [….] And we might need to do a more in depth assessment depending on what the family's needs are (*Children's Social worker*).

Business processes are generally envisaged as a series of steps, with identified decision points directing activity along predefined routes. The assessment process starts with an initiating contact, then navigates through the assessment of need, the planning and delivery of services, and, where needed, into an iterative and on-going review. The first stage in this process is intended to act as a gateway to services, determining who is entitled to support, for how long and to what extent, and the subsequent assessment stage is generally designed to generate a structured, formal measurement of an individual's personal needs and circumstances. Aggregation of this information is expected to contribute to the monitoring of need across the community, and to assist in the commissioning of services.

Management of these steps commonly includes defined standards and targeted timescales for the delivery and completion of each stage (Fig 5.1f.) Example targets are quoted at the start of this chapter.

Figure 5.1f: Meso rules of domination

In some circumstances, particularly where the individual concerned has simple, clear needs, this high level, simplified model can be easily applied and followed.   But for individuals with more complex needs the overall process can be equally complex, requiring interactive iterations of assessment practice, input from multiple practitioners and the provision of multiple services which may then lead, in turn, to further formal or semi-formal assessment.

Additional complications lie in the way the processes interlink; individuals are not supported by a single worker from start to finish, but move through of a series of stages with their own, discrete instances of practice space. Responsibility and ownership changes from stage to stage, which enables the work to be focused, but also creates the risk of confusion and duplication of work, especially when information is not available or communication breaks down.

> … I've encountered situations where I'm dealing with an issue, somebody has rung back up, the contact centre have referred it to duty, duty have acted on it,

> when I'm already actioning at that time – and we've got two workers working on the same issue, duplicating work. (*Adult social worker*)

The workshops focused primarily on the formal 'assessment' stages (both initial and review) of the overall business process, but the discussions included consideration of other stages, both in terms of the information that was obtained in the earlier steps, and that which was required by later ones . The concept of 'practice space' and the consistency of assessment practice within it emerged from some of these discussions, where it became clear that, while there were differences in the information required by and obtained in these stages, the differences generally arose from proportional relevance and depth of the practice, rather than from distinct differences in the practice itself.

One observation that emerged from these discussions is the different perspectives with which information is viewed dependant on its application within assessment practice as opposed to the assessment process. Intelligence gathered by practitioners informs decision making and provides context to support the selection of interventions and the management of risks. Practitioners view it dynamically, recognising that both context and environment are subject to change, and that decisions made on any given day may need to be altered on the next.

> …that's another thing about assessment – you have to update it and make it current, otherwise […] it's pointless …
>
> It's normally a process, isn't it.
>
> It doesn't just end …
>
> (*Conversation between children's workers at the first workshop.*)
>
> I think it's difficult, because I think assessment – assessment is a rolling process to me – because our assessments are only ever as good as the next day really, because basically the person's situation can change, it's so dynamic. But we can't be involved in someone's life every day. So every time we intervene, it builds on our previous assessment and contributes to the next assessment. So I think you could say that intervention finishes, but I'm not sure whether assessment ever really does finish. (*Adult Social worker*)

In contrast, the information captured for the purposes of the business process is specific, structured and static; outputs from an assessment process stage are fixed at the point when they are compiled. This information serves a number of purposes. It evidences progress through the process along with the undertaking of the practice; it describes the individual, in terms of need, current services, and their

Figure 5.1g: Meso Domination – Interaction with information resources

personal/environmental context along with their preferences and personal objectives; it

captures recommendations and potential risks; and it provides the raw data for performance monitoring and other business intelligence needs (Fig 5.1g.) This information also serves as a resource in informing future practice, assisting a practitioner to familiarise themselves with a particular client's history of care.

The range of information requirements that underpin these different purposes – along with the more dynamic requirements of assessment practice – can make it difficult to design assessment tools which effectively capture everything that is needed. There is also a distinct and difficult tension between the use of 'tickbox' forms and the need for freeform recording to capture narrative and customer 'voice.' The advance of computer based recording and the associated difficulties in aggregating and analysing text based data has meant that the regulatory demands of a managerial, performance focused culture has heavily weighted the development of these tools towards the coded and structured 'tickbox' forms that practitioners struggle with, even though policy continues to emphasise the value of customer views and their contribution to the management of their own care. Practitioners therefore tend to respond to the needs of practice by taking notes during visits and interviews, either using the tools as an adjunct to these notes, or else completing them after the event, drawing on the notes to summarise and categorise the information required. (See Fig 5.2)
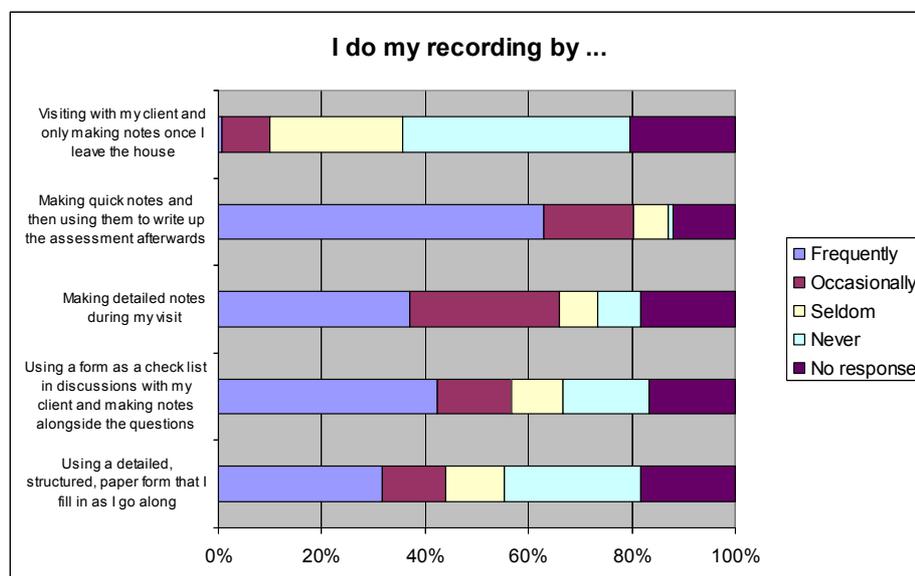
Figure 5.2: Analysis of Questionnaire - Adult practitioners recording practice during assessment, showing high proportion of note taking, with much lower use of formal tools.

The inaccessibility of the deskbound computer system has contributed to this separation of practice and process recording, leading to a common complaint from practitioners

that too much time is spent sitting at a computer and filling in paperwork. Mobile technology is expected to help alleviate these concerns, although the tension between structure and narrative is likely to remain until tools can be developed that effectively address both sets of needs.

5.2.1 Assessment in context: modelling case management and care delivery

The formal business procedures that frame the assessment process are only a small part of the interactivity that takes place between an individual and care services. The 'traditional' view of case management extends beyond the determination of need and the identification of services, and includes, not just the on-going monitoring and measurement of service effectiveness and quality, but also a range of ad-hoc contacts and advice. Assessment, planning and review are time limited events with clear start and end points; the majority of interaction actually takes place during the delivery of care services, where contact may take place weekly or daily, or even be on-going – intensive services, such as night sitting, may be provided for several hours at a time, and in respite and residential care services, support may be available twenty four hours a day.

The individuals who deliver these services – the trained social worker supporting a child, a qualified occupational therapist providing reablement support and advice, or simply a home care worker supporting an older individual in their activities of daily living – inevitably engage in a form of assessment practice when interacting with their clients (Fig 5.1h.)
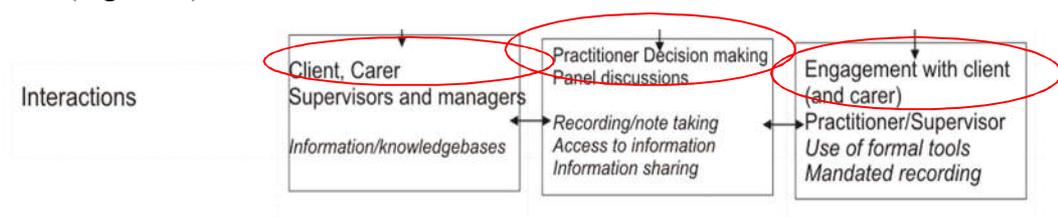
Figure 5.1h: Meso Interactions – intersection with assessment practice (practice space)

By becoming familiar with an individual's environment and personal circumstances and understanding their particular needs and aspirations, carers – both formal and informal – accumulate day to day intelligence; they utilise it through variations in service, adjustments in timing or frequency, or changes in equipment/regime, and may even refer the individual back to more formal processes if the change is sufficient to warrant formal reassessment.

Only a small proportion of this day to day intelligence is formally captured or recorded when the service is being delivered in a client's own home, although formal carers can and will take notes, recording significant observations and notifying other members of care support teams if they consider the information relevant and noteworthy. Some daily recording will also take place in day centres and in care homes, although practice varies immensely, and the data rarely becomes part of the overall client record. Often these notes are made in order to evidence the service, and to protect workers, rather than inform and support the individual. Nevertheless, this on-going, semi-formal assessment process plays an important part in the care of an individual, enabling timely and relevant reactions to change, and providing a range of additional information and intelligence input that adds signification to the formal process.

> I think that's also important, because it actually gives you an idea – at least you've got a bit of a starting point – but what's all this going on in between times, from when the review's going to take place? So that, I think, can be really useful. *(Adult Reviewing Officer)*

In addition to the provision of agreed services, the case management approach includes a level of ad-hoc and informal support, enabling an individual or their carer to contact a named worker or team for help and advice. This type of care–co-ordination role is valued in Children's teams, but tends to be time limited in Adult services: allocated practitioners support individuals and carers in the creation of care and support plans, and undertaking initial reviews, but their involvement drops to a minimum once services have become established. Exceptions exist for clients with minimal capacity and little or no support available from family or friends, but the majority of long term care cases are not felt to warrant named co-ordinators; support is provided by a named team, rather than a specific practitioner, and queries and contacts are dealt with by whoever is manning the team's duty desk at the time. Even this 'informal' support is underpinned by assessment practice – a contact generates an instance of practice space, within which the practitioner gathers and analyses presented intelligence and makes decisions about whether action should be taken and by whom. The structures that have emerged from the creation of contact centres and their interaction with duty desks (see Fig 5.4, below*)* has somewhat blurred the line between the formal and these 'informal' processes – but once with the duty officer it is the outcome of their assessment practice which provides legitmation in determining whether the formal process needs to continue or not.

> I was just thinking that it's people that – if it's new people – that we don't know them, it goes on (*the list for further assessment*) … if it's someone we know, and

they've got, say, a home care service, but they need a slight increase, or they want to reduce, then you can often deal with that on duty, can't you. (*Adult Social Worker*)

The formal assessment process is given legitimation through an initiating interaction, usually through an external contact of some kind - a referral from another agency or service, a contact made by the individual their family or their carer, or a notification of concern from a third party, such as a neighbour or friend. It may also be triggered at a transition stage in the subject's life – such as a change in location or in personal circumstances. This is more common among children's cases, where they may be moving to a new school, or reaching an age where a different agency or service will become responsible for delivering care, but may also be applicable to adults, with the need for a care assessment identified as part of a planned health intervention for instance, or as part of a planned transition when moving from one authority to another.

Further iterations of this process may also be initiated internally, given legitimation by the outcome of a semi-formal or informal assessment - either because new information has come to light, or because there has been a major change in the individual's circumstances.

The most constantly referenced initiator for an assessment in the Children's workshop was the existence of a concern - usually a concern about or for the child, such as their failing to progress academically, or a fear that they may be at risk in some way. Concerns raised by anyone – even those made anonymously – are always considered and a formal decision will be made as to whether there is sufficient evidence to investigate further. *Countyshire's* procedures clearly state:

> A referral is defined as a request for services to be provided by the Social Services Department. The response may include no action, but that is itself a decision and should be made promptly and recorded (Countyshire, 2001).

It is expected however, that concerns raised by other practitioners – doctors, teachers, children's support workers – will be *informed* concerns, with an assumption that one iteration of assessment practice may have already taken place.

> Assessment often starts before referral – because the person referring would already have done some sort of informed assessment in order to decide that they need to do a referral (*Children's social worker*).
>
> ... one of the things we get is referral from schools where they haven't done – they just get a gut reaction – there's something wrong and they refer. We can't do anything with that referral, we go back with the referral and give it to them and say 'look, you need to do something first.
>
> ...you need to have adequate information to say … we feel this child's at risk…

It's about information gathering at the Universal services level

(*Discussion in the Children's workshop*)

This requirement for further investment from the referring practitioner evidences the behaviours inherent in assessment practice - the accumulation of relevant information, along with contextual intelligence, both of which inform the decision making process. Sometimes a referral is made because of other concerns about the family, with an expectation that this will impact on the child referred in some way.

> 'If the concern is about parenting, then it's part of a process, because what you're saying is 'has the child got abilities to ameliorate for the lack of parental support […] they're sat in front of the telly five hours a day […] has there been anything achieved?' (*Children's worker*)

The participants in the Adult workshop reflected on an equal range of sources and legitimation for an initial contact, from the health practitioner making a referral related to health conditions, or the individual asking for help – both specific and non-specific – through to the concerned friend identifying risks or even recognising that the individual is in crisis.

The list of process initiators identified in the Adult workshop included:

- Crisis
- Change in circumstance
- Request for help
- Re-assess as duty
- Request from others, carer, neighbours, GP
- Potential risks, POVA (Protection of Vulnerable Adults – the formal safeguarding procedures for Adults)
- Capacity
- Recognition of problems
- Incident or event e.g. residential

There is less expectation of prior professional assessment with Adults, as a high proportion of initial contacts are self, or family initiated referrals.

5.2.2 Filtering and screening: contact centres and duty desks.

The first stage of the assessment process is intended to act as a gateway to services, determining levels of client need (signification) and constraining the allocation of resources to those with eligible needs (domination.) (Fig 5.1i)

Up until the late 1990's initial contacts were commonly received by a professional social worker assigned to a 'duty' desk. Social workers were assigned to duty on a rotational basis, with responsibility to deal with in coming calls, faxes or visits. They responded to immediacies and emergencies, alerted colleagues to issues concerning active case lists, signposted enquirers to other support if appropriate,

Figure 5.1i: Meso Domination – resource allocation based on levels of signification

and, where relevant, initiated the formal assessment process, recording details of both the potential client and the issues they were asking for assistance with before passing them on to team managers for allocation. This work benefited from the involvement of a qualified worker, who was able to use the practice space created around the duty desk to filter the relevance of enquires, identify existing involvements, prioritise responses, deal with crisis situations and to gain insight into the nature of the issues they were being presented with. It also came to be seen as inefficient and wasteful of resources: members of the public, presented with a range of possible contact numbers, struggled to understand who they should call, and duty officers often spent time dealing with minor issues and even irrelevant calls.

> … in my experience on duty we used to take all kinds of things […] people phoning up and saying ' how long do they [...] defrost their turkey before Christmas' […] they're all those kind of things that, traditionally, when people didn't know where they went to, they go to Social services […] And we'd get asked about all kinds of things, and it's only that, in the last two, three decades, that we've narrowed down so much what we do […] we may, in some circumstances get involved in sort of housing issues, but ultimately we don't, to the degree that we would have done twenty, thirty, years ago. (*Adult Reviewing officer, discussing duty during the workshop*)

By the turn of the century, the role of the duty social work officer could be seen echoed in similar structures throughout Local Authority services. A citizen, needing to contact their local council for help or advice, could find themselves facing a bewildering range of phone numbers, local offices, and job titles, and, even having made contact, might then be transferred several times, speaking to any number of officers before –hopefully – making contact with the relevant person. While developed through entirely good intentions, this maze of administration and bureaucracy was perceived as being both

wasteful of resources and indicative of poor quality services. The first decade of the 21st Century saw the commissioning and publication of a range of government reports considering the efficiencies of public services, and their interactions with the public. The reform programme that followed was intended to raise standards of service, reduce inequalities and increase responsiveness to users and was supported by a range of innovative projects across central and local government. Key to this reform was the recognition that new technology held the potential to become an enabler for services (Cabinet Office, 2005)

Local authorities, keen to show value for money and to demonstrate effective performance, responded by setting up centralised contact centres, investing – to a certain extent - in e-government initiatives and beginning to consider the development of 'one-stop-shops' – premises which a citizen could visit in order to conduct all and any business with their council. The term '**contact centre'** is generally used to describe a facility which enables an organisation to manage all its client contacts through a range of communication channels, such as telephone, fax, letter, and e-mail. They are a distinct 'step-up' from **call centres**, which purely handle telephone calls, providing a wider variety of services and intended to be, not just the first port of call for customers, but an all encompassing solution for the majority of their requirements. A **one stop shop** provides a similar range of services, but on a face to face basis.

Countyshire, like many Local Authorities, reviewed and amended a range of organisational structures and business processes in line with national recommendations, and they set up a contact centre to act as a citizen's primary point of contact for a number of services, including Social Care.

As the focus of this new arrangement was the council's interaction with the public, a number of referrals made by professional practitioners – such as those from schools and other agencies concerning children, or those supporting formal hospital discharge of adults, for instance – would continue to be routed via the relevant social care teams and their duty desks. But individual enquiries and requests for support from members of the public, including those wishing to raise concerns about a child, were to be received by the staff in the contact centre, where – through the use of standardised scripts and formal checklists– call would be screened and then either directly dealt with, passed to relevant services for further work, or redirected to other services and agencies according to predefined criteria.
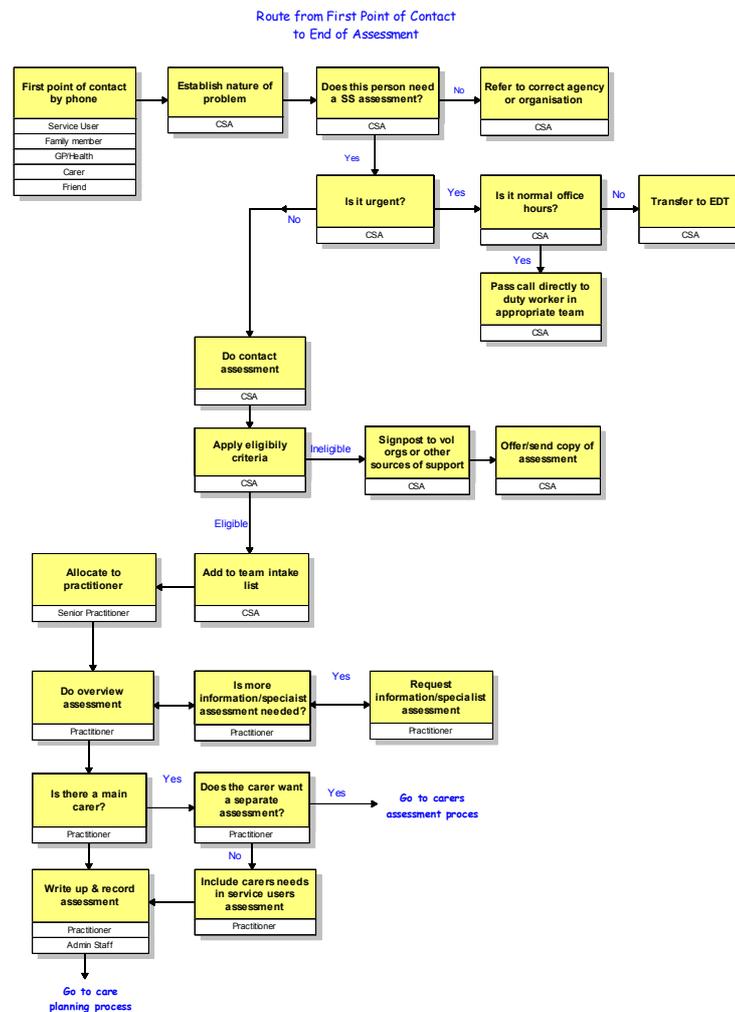
Figure 5.3*: Countyshire* **Adult Assessment Business process map (2006)**

This new process (Fig 5.3) did not fully replace the duty system, which remained in place in order to responded to crisis and emergency calls, but it was expected to filter out irrelevant calls, provide a quick response to simple enquiries, and redirect (or 'signpost') low level concerns that did not meet the authorities initial eligibility criteria.

> Things like, somebody needs […] a call alarm, or things like that, you may refer people on, do that, and then there's no further action – it would have been dealt with, you've given out information and signposted somebody on, because it may be ultimately all they wanted, (*Adult social worker*)

The contact centre's single point of call is intended to make it easier for citizens to get both access to information and response from services across a number of Council departments. But for Social Care – most noticeably in Adult Services - it has also introduced an additional stage into the assessment process, solving some issues, but creating others. A majority of the calls can be and are, dealt with at the point of contact, which means that a smaller number of calls are passed to the duty desk. Filtering calls requesting support through scripts and tools designed to tease out the potential

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eligibility for services also means that a larger proportion of those that do reach duty have genuine care concerns

While it is arguably more cost effective and efficient to screen contacts in this way, the use of standardised scripts - which contact centre staff are trained to follow – can, on occasions, create disproportional responses. *Countyshire's* introduction of a low-level support service, for instance, increased the number of people calling for simple support or advice. The contact centre staff, having been trained to conform to the norms established by their criteria based checklists, continued to engage these new callers in the full screening process, often referring them on to community teams, rather than the service they had been expecting.

> … we've been aware that people are actually ringing in to – because they want a smoke alarm, as an example – low level – but, as part of the screening within the Service centre, they're actually being screened as having substantial needs – so what's been happening is there's been an impact, not just on people coming to Phillis, but there's an impact on community teams as well (*Low level support service manager).*

This kind of centralised, 'pooled service' arrangement – where callers rarely, if ever, speak to the same person twice – relies on having accurate, up-to-date information available in order to offset the lack of specialised tacit knowledge and experience. The contact centre staff are not social workers, and rely on the guidance given to them through their scripts and the information available to them on systems to assist them in ensuring that callers receive the help they need. When they are uncertain, or have concerns, they still have the option to pass a caller on to a duty worker – but for the majority of calls, where they have identified that the caller has a social care concern, their scripts lead them through a simple piece of assessment practice, collecting immediate and relevant information in order to assess needs and eligibility. Tools and systems need to be designed to support appropriate recording, and ensure that the information collected is proportional to the issue within the call. If scripts are inflexible and overly detailed, callers can be subject to detailed and unnecessary interrogation, but, equally, if steps are not properly followed, vital information may be missed and calls subsequently misdirected, causing delay in dealing with individual issues, or even creating duplicate work.

> … if we're the assigned worker and obviously contact centre are sending stuff to duty, then they're involving another worker when possibly we're the ones that should be contacted. So, ideally what the contactor should do is check […] to see if there's a person that's allocated or assigned and pass that information to the relevant person rather than just being 'this has to go to duty' […] there has to

be that consideration as to the appropriate person it needs to go to in a team.
Adult social worker

These issues can be compounded by the compartmentalisation of information resources or the incompatibility of information tools: in *Countyshire* the majority of general calls were collected on and managed through the corporate customer relationship systems, with the social care client data base only being invoked and updated once initial identification and general assessment of the call has taken place. While the use of a two layered system approach may support concerns for a customer's privacy, double entry requirements – where the caller's details are first captured on the CRM, but then have to be re-entered onto the social care system if no record is found for them there – tend to act as a barrier to rather than an enabler of access to services, and there are high risks of creating duplicate records, which can lead to the kind of double working described above. At the time of the initial research, some testing had been done to identify the feasibility of interfacing the two systems to reduce the creation of duplicates and avoid the need for re-keying details, but while this had been shown to be technically achievable, it had not been seen as a priority for further development.

A majority of contacts can be satisfactorily resolved within the contact centre through the provision of standardised responses; calls relating to active cases may simply be passed to a relevant worker, and straightforward queries can often be dealt with at the point of call. Decisions to progress a contact or referral are based on a range of criteria, including eligibility for services, levels of risk and presenting need. While their scripts are relatively proscriptive, contact centre workers retain a level of agency in determining the progression of a contact, allowing them to prioritise concerns, or to raise issues with supervisory staff. Contextual information gathered during the call may contribute to these decisions, along with access to previously recorded data. Contact centre 'filtering' can therefore still be seen as an instance of practice space, albeit a highly restricted one.

Callers presenting in ways that indicate their ineligibility for local authority support are usually signposted to other services or alternative sources of information, such as voluntary agencies and specialist groups. Those that meet the eligibility criteria are logged on an action list and this, along with the details of the call, is passed to the relevant care teams for further action. Calls identified as high risk and/or cause for concern (i.e. with sufficient levels of signification) may result in the normal processes being by-passed and duty workers being contacted directly.

[…] there are certain issues where the contact centre go directly to the duty social worker if they feel it's an emergency. I don't know what their criteria for an emergency is, but there are some times where they sort of miss the computer bit, and go straight to the duty social worker. (*Adult social worker*)

Countyshire also operates an emergency duty system, providing access to care support outside of normal office hours. The contact centre is able to use this service if a call that causes concern is received late in the day, or on a Friday afternoon, when – if passed through the normal route – a priority issue may not be picked up by a duty worker until the next working day. 'Fast tracking' to duty is more common with calls concerning children, but will be applied where concerns about an Adult's safety are raised.

> Sometimes they're known to us […] they might not be receiving services, but known to us. But occasionally you'll get somebody who's never […] but there it's an emergency – a POVA or something – and that comes straight through. But you only get that if you're on duty, on that particular day, or […] once a maximum amount of months, really. (*Adult social worker*)

Once names and presenting issues have been entered onto a team intake list, it is passed to the relevant team:

> … I found most information comes from the contact centre say on Monday, then – unless it was urgent and being directed straight to duty, then that information was then being input onto the system, and they were having duty meetings in the morning – so there was almost another filtering process going through, looking at duty lists. So they've got whatever information is coming through, and whoever is covering duty at that point – so to me there's another stage again where a possible form of assessment is happening as well in some teams. To make decisions as to whether […] something needs to be actioned (*Adult social worker*).

This is another instance of practice space, in which the duty worker is given sufficient agency to override the decisions made by the contact centre – changing the categorisation of eligibility where appropriate, signposting on to other services, or fast tracking activity in order to address risks. These decisions are shaped by the level of need (signification) from an assessment practice perspective, as the eligibility bands specified by the process are both broad and generalised.

> (*Facilitator*) …at this stage, we're saying […] 'we think they're eligible,' we've got as far as duty, and duty, you say, do further screening – so is that another standard set of questions, or is that more driven by the presenting issue?
>
> (*Adult Worker*) It's more driven by what information you've got.
>
> (*Facilitator*) So that depends […] where are you going to, to get that further information?
>
> (*Adult worker*) Sometimes the service user, sometimes the referrer, depends […] generally the referrer.

(*Facilitator*) So, we're back to the referrer at that stage. And presumably what you're simply doing at that point for that point is expanding the issue – or are you asking other questions as well?

(*Adult Worker*) Just getting more information about the issue – but then having to decide on what action to take.

(*Facilitator*) Right. So in there, there is a decision.

(*Adult Manager*) It could be about the urgency of the response.

(*Adult worker*) The urgency. Does it need a duty visit, or can it go on to allocation? (*Discussion in Adult workshop*)

If the issue is considered urgent at this stage, then a duty worker can choose to initiate further work - perhaps undertaking a visit - which may, or may not, result in the commissioning an emergency service. Once the situation is considered stable, the case will then added back to the duty list, joining the rest of the incoming cases awaiting formal allocation.
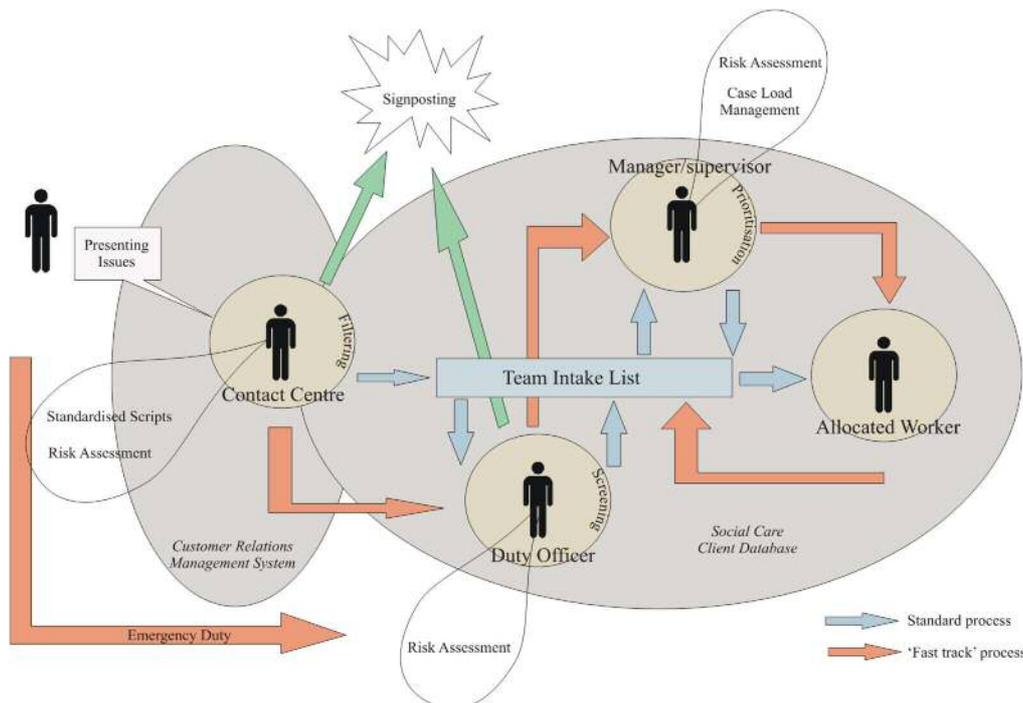
Figure 5.4*:* **Filtering and Screening structures: from contact to allocation**

The iterations of practice space can be seen within the formal structures of the process, with opportunity at each stage to 'fast track' the concern, enabling timely response to crisis and the prioritisation of risk (Fig 5.4.) Information services provide vital support to these processes, enabling existing clients to be identified, and, where relevant, provide additional information to inform and support decision making. Used effectively, with appropriate training, they help prevent unnecessary duplication of

work, with contacts identified as being related to 'active' cases bypassing these screening stages altogether; any new issues they present are passed directly to workers already allocated to their support.

The effectiveness of this iterative screening process in filtering out low level and non-significant need is illustrated by the responses to the questionnaire:
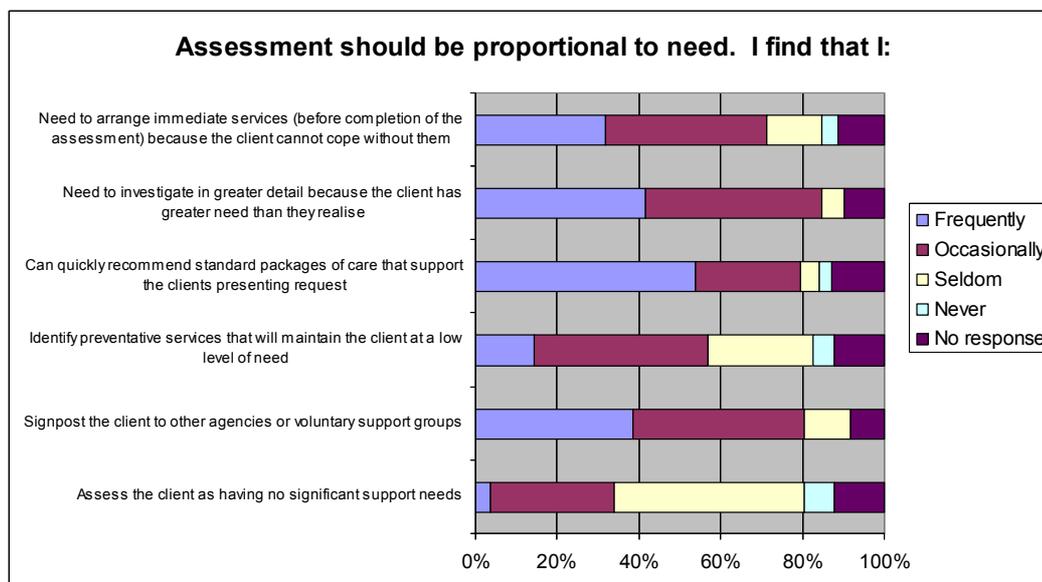
Figure 5.5: Analysis of Questionnaire - Pattern of responses illustrating the small proportion of clients with few or no support needs reaching the full assessment stage

A high percentage of workers (46%) identified that they seldom assessed clients as having no significant needs, which suggests that the majority of those who present with low level need have already been filtered out by the time that cases reach allocation within a team. Additionally, only 14% of workers identified that they were making frequent recommendations for preventative services to maintain low levels of need, which supports a similar conclusion.

5.2.3 Domination of workforce resources: prioritisation and allocation

The formal process requires managers to review intake lists and allocate incoming work to their teams. This stage in the customer's 'journey' takes place in another iteration of practice space, although its focus is as much on the availability and skills of the team members as it is on the needs and issues being presented for consideration. Managers and supervisors allocating work have to account for individual workloads and the complexity of cases currently being dealt with, along with the targets set for timescales, and the possible risks suggested by the presenting issues within individual cases.

Decision making at this stage therefore concerns *priority setting*, allocating available work (authoritative resources) to ensure that targets are met and potential risks are managed. This is distinct from *resource rationing,* which impacts on the distribution of (allocative) resources – in the form of financial support or the commissioning of services - to individuals at the point of service delivery (Hudson and Henwood, 2008).

There is no specifically proscribed method for managing the allocation process, and a number of modalities are utilised, ranging from an individual manager personally selecting and allocating the work, through delegation down to supervisors, to group decision making, with cases discussed in team or duty meetings. No one strategy is employed exclusively; while team managers retain the final decision on any given case, there are benefits in opening the process up to discussion, as previous research has shown (Hardstone et al. 2004).

High levels of workload, coupled with on-going demand, creates a pressure for decisions to be made quickly, and team managers – or their delegated supervisors – need to call on their own assessment skills to assist them in determining the ordering and distribution of allocated cases. Here, again, the availability of information and intelligence concerning the case provides a valuable resource to support their decision making.

> (*Interviewer*) …in doing the allocation, you're almost doing a bit of assessment practice, aren't you?
>
> (*Manager*) Yeah, there's a great deal of that […] it isn't just simply getting names off a list. We have to go into each one […] and it's almost like being a detective really – just to establish what do we need to know, in order for us to make that decision (*Interview with Reviewing Team manager*)

Not every piece of new work comes through the allocation process: the 'fast track' for high risk or emergency cases has already been mentioned, and social workers can be required to pick up additional tasks from a number of sources – from existing clients on their active caseload, through contact with service suppliers (raising issues identified through the on-going semi-informal assessment embedded in service delivery) or even through requests from more specialist services. The majority of the workload is, however, managed this way, as the responses to the questionnaire illustrates (Fig 22):

I undertake assessments when:
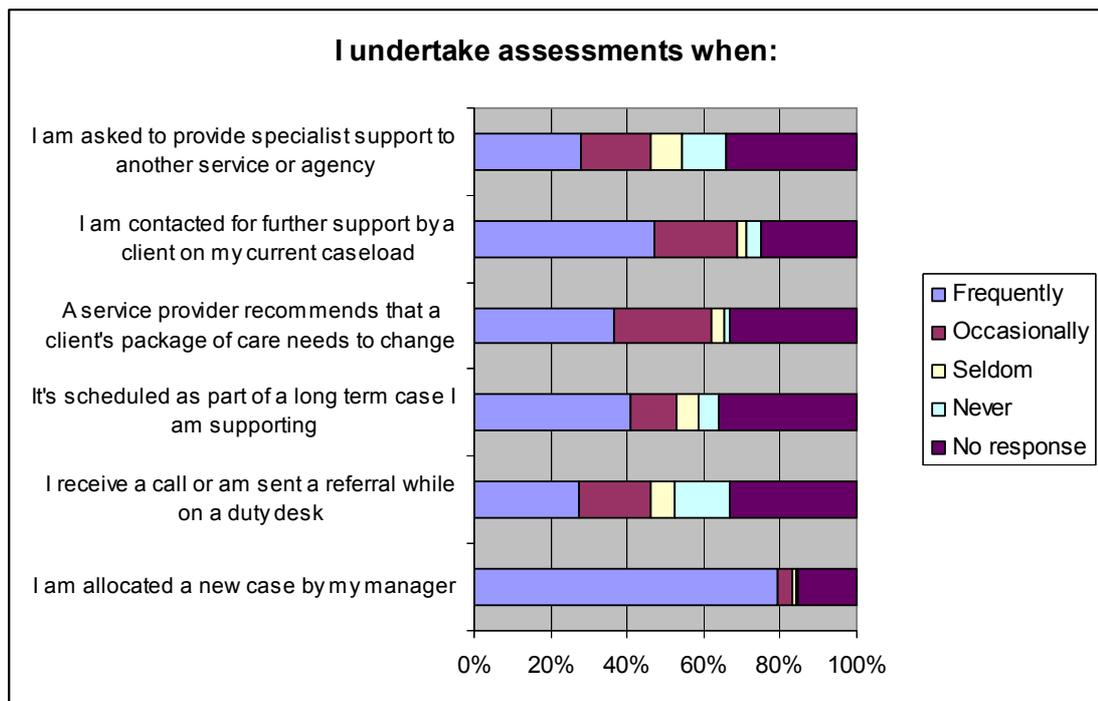
Figure 5.6: Analysis of Questionnaire - Allocations of assessment work reported by Adult workers: note that duty work is only undertaken in specific teams.

By the time a case has been allocated to a worker, a significant amount of information has been collected, and a level of analysis applied. Where the person concerned has had previous contacts with the Authority, then the records of that contact may be available, and the worker is able to familiarise themselves with the individual's history.

> Generally they come to me in two different ways. From duty, or from the allocation desk. We have two different lists. But generally allocated work. So initially it comes from my senior in the form of an activity (*note – electronically*) which will say brief details of what the situation is … and then I'll read back on all the history – working a lot with older people, all the time. Not all the time – but a high percentage of the time - we know they've been through the system before. So we've got information (*Adult social worker*).

This collation of data needs to be considered critically, especially if the source of the contact is not the individual themselves. Understanding the perspectives from which the issues have been presented can be invaluable when approaching the person they concern: while organisational policy requires that Adult clients have given consent for the visit to take place, and are therefore aware that issues have been raised, the signification in the contact may change when they do not have the same level of concern as their relatives or friends.

> (*Social worker*) Generally, by the time you go out as an allocated worker, you've got a good idea about what the person's wanting to discuss – if it's from the person. Of course, if it's from […] well, then you've got a good idea about

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somebody's perspective about what […] and it maybe that's completely different …

(*Interviewer*) Do you sometimes turn up and the person concerned goes 'I don't know what Fred was talking about, I've got (sometimes) this that and the other. I can cope with that, and that's never a problem?'

(*Social worker*) Yeah. I mean, it's part of policy, isn't it – that the person's actually aware that we're coming […] so that at least they'd've have had some discussion with Fred about […] why did you make that referral, I'm going to tell them when they get here that it's all perfectly fine and […] but you've generally got somebody's perspective – quite a good idea if we go out (*Conversation during interview with Adult social worker*).

5.2.3a Domination: eligibility criteria and resources rationing

(*Team Manager*) I think there's another reason why we do assessments – it's to do with the other side of social work – it's about budgets. And it's about resources. And usually the words 'lack of.'

(*Facilitator*) One of the reasons is therefore allocation of resources. That's allocation management, isn't it. You've only got so much money, so who deserves it more …

(*Social Worker*) Allocation against the greatest need.

(*Facilitator*) And the only way you know that, is by assessing in terms of (*the above*) because otherwise we could all do it with self-assessment and individual budgets, isn't it – just fill in all the tick boxes and -

(*Social Worker*) Send out the questionnaires –

(*Facilitator*) You meet the criteria, there you go.

(*Team Manager*) And obviously it's about evidencing why you deem that some person should have it and the other person shouldn't have.

(*Facilitator*) So there's a justification around that allocation of resources that's supportable, rather than merely 'what happens here.' (*Discussion in the Adult workshop)*

One of the primary requirements of any business process is ensuring that resources are used effectively. This inevitably leads to organisational rules determining the distribution and allocation of those resources; when demand is high and resources limited, those rules tend to include criteria which define decision points for eligibility and priority. Controlling spend has always been a dilemma in social care, just as in other public services, and the assessment process has had to evolve to include the application of eligibility thresholds as part of its decision making. The constraints created by the applications of these rules persist throughout the assessment process: the factors which influence initial screening decisions (see Fig 5.1i, above) can be similarly evidenced in subsequent assessment stages. Where the social worker's concerns may be focused on the signification of 'what does this person need and how can we help?' the

organisation – constrained by the meso-domination of allocative resources - must also ask 'what can we afford?'

The vision in the 1989 White Paper, *Caring for people*, was one of user centred, needs-led assessment and care management, but it also recognised that this had to be squared with financial probity:

> The aim of assessment should be to arrive at a decision on whether services should be provided and in what form. Assessments will therefore have to be made against a background of stated objectives and priorities determined by the local authority. Decisions on service provision will have to take account of what is available and affordable. Priority must be given to those whose needs are greatest.(Department of Health 1989)

With the publication of the Community Care Act (HM Govt 1990) Local authorities were given responsibility for the provision of services, and with it, a requirement to do so in cost effective ways, within their available budgets. The Adult assessment process therefore became a primary modality for applying the rules of domination - a way to determine both eligibility for support and the financial resource allocated for its delivery. A report commissioned by the Commission for Social Care Inspection (CSCI), just prior to its merger with the Health Care commission, identified three modes of resource rationing (Hudson & Henwood 2008):

- *Rationing by directive* – the establishment of formal rules and procedures requiring explicit, rules based decisions which are applied in consistent and standardised ways. This is a 'top-down' approach, requiring overarching policy (national or local) which is then subject to operational interpretation and implementation.

- *Rationing by discretion* – requiring the exercise of professional judgement, with informal, individually focused decision making, allowing judgements to vary on a case-by-case basis. This is a 'bottom-up' approach, shaped by practitioners, and which should develop to reflect local issues and needs.

- *Rationing by diversion* – limiting demand on the system, either by diverting that demand to other services, or by returning responsibility to the applicant. Rationing by diversion may encompass characteristics of both of the other modes of rationing – it may be explicit and rule-based, but it may also be heavily contingent upon discretionary judgement.

All three modes can be observed within Local Authority strategies, with the structuration of resource rationing emerging from interactions between the nationally established and locally implemented rules, the organisational agency to set local policy (and therefore to determine the allocation of their resources,) and the specific agency of individual practitioners. There is an understandable tension between the rules-based 'top down' requirements of rationing by directive – established by policy and implemented through business process and management requirements - and the

perspectives of practitioners who struggle to retain sufficient agency to deliver rationing by discretion. Rationing by diversion is primarily evident in local decisions concerning the applicability of the nationally set eligibility criteria and the point at which thresholds are set, but can also be seen in the creation of partnership arrangements, in support for voluntary agency schemes, and in the development of both direct payments approaches, and more recently, the introduction of individual budgets.

For Adult services, the formal policy framework concerning eligibility for care support is that of 'Fairer Access to Care Services' (FACS) (Department of Health 2002b). The first set of FACS criteria was published in 2002, and then updated in 2003 in response to initial implementation issues; an additional update and further guidance was published in 2010, addressing some of the policy developments driving social care transformation and the personalisation of services.

FACs lays out a set of conditions for 'potential eligibility', which describe a range of issues and care needs. These conditions are banded into four levels, from 'Low' (minor needs) to 'Critical' (serious needs or risks.)   The intention was to create a standardised framework for categorising need so that response to requests for support would be consistent across the country; each band represents a threshold of need against which an individual can be assessed, and which can be used to determine whether or not that individual will be eligible for supported services. A local council is expected to set their local eligibility criteria accordingly: each local FACS criteria comprises the bands from the framework that represent the needs that particular council will meet, having taken its resources into account.

The implementation of the FACS framework was never intended to be a purely 'rules-driven' exercise, as the guidance clearly states: 'frameworks, case examples and the like can only ever support the exercise of person-centred, competent judgement (Department of Health 2003a)' However, Local Authorities were quick to see the value of this approach, with a large number choosing to set their thresholds at 'Substantial' or above (Hudson & Henwood 2008).

While the introduction of this approach has apparently improved consistency of response at a local level, the inconsistencies of its implementation across Authorities has perpetuated the perception of social care being subject to a 'postcode lottery' whereby where you live will impact on the level and quality of service you receive. Practitioners clearly feel that their agency for professional judgement, and with it the

ability to ration at local level and through the exercise of discretion, has been seriously curtailed.

> '(*Social Worker*) I don't think that's why we do what we do – a lot of that is about restricting services. And that's a very - sounds like very negative, but that's what we do. You think about that whole process. We're gatekeeping. It's quite interesting how we talk about the FACS criteria, but then we've also got little gates within that as well. You know, someone doesn't meet the bathing – there are two little gates there that, really, probably is totally illegal.
>
> (*Team Manager*) They are, but they're there. There's only one criteria …
>
> (*Reviewing officer*) There's only one criteria – that's FACS criteria …
>
> (*Social Worker*) A medical need's 'pain all the time' and yet, really, we should be looking at the FACS criteria.
>
> (*Team Manager*) …all about risk and dependency …
>
> (*Social Worker*) So I think assessment – a lot of what we do is about restricting …
>
> (*Team Manager*) But obviously there is that – there is the value in the filtering out …
>
> (*Discussion in the Adult workshop*)

> And I guess that's the other thing about the gatekeeping. If, in the culture of the team, there is – you know – well, we need to try and avoid giving service, at whatever cost, then I think – you know – you're already […] you've failed, basically. In my view. (*Adult social worker*)

Employing 'rationing by directive' as a primary strategy has led to equally directive structures, although not necessarily ones that meet the expectation of fair and consistent access to services described by the policy. With business processes and their resultant structures shaped by local (and often political) agency, and with interpretation subject to the operational cultures developed during implementation, there is a growing critique of the ways in which FACS has been put into effect.

A similar risk/needs model is utilised in children's services, although there is no national equivalent of FACS; there is a greater emphasis on meeting statutory duties, such as those laid down in the Children Act, and compliance with these requirements has to be met alongside priorities arising from the general assessment of need. In *Countyshire* the four levels of need and prevention – universal services, vulnerable children, children with complex needs, and those with acute needs – are addressed through specific services and broadly allocated budgets. The cut-off point for specialist social care lies within the border between vulnerability and complexity, and eligibility for support is measured against thresholds of risk as well as need; professional

discretion plays a greater role in the allocation of resources, along with diversionary policies that promote early prevention and work towards independence.

> …obviously the purpose of social work, child protection in terms of risk would be about 'is the threshold around significant harm?'
>
> But we do talk about risk in education, in terms of risk of failure, risk of exclusion, risk of significant social exclusion, those things.
>
> And that again, we prioritise the child's needs we've talked about, but also we do assessment to prioritise organisationally how risky that situation is - ie urgency on response …
>
> If we've got a kid on the verge of exclusion because they're not accessing, they're, you know, frustrated, then that's very high priority. We might fast track (*Discussion in children's workshop).*

It was clear from the workshop discussions that the Children's workers felt they held greater agency to make discretionary judgements than those in the Adult session. Although eligibility criteria were identified as playing an important role in those judgements, they were less prescriptive and more subjective; there was a stronger sense of an assessment being the formal mechanism for determining what happens next, such as assisting in the improvement of outcomes for a child or identifying skills that can be developed (in the child, parent or in the setting which supports the child), rather than being the mechanism for determining eligibility for service.   The use of the assessment process to justify interventions that would support a child and improve their circumstances was felt to be important, even if that improvement was going to be small.

> It's to improve the outcome for the child, isn't it. It's not necessarily about meeting best potential ... because sometimes, you know, the children that we work with, they don't […] there isn't the potential … The steps are small (*Children's worker).*

It is normal practice in children's services to consider the potential impact of *not* providing a service. As with Adults, the issues associated with reducing budgets and increasing pressure for services continue to be challenging.

5.2.4 Outcomes of assessment practice: planning interventions and support:

> We would never walk away from a child that we've assessed without inputting next steps, even if they weren't one of ours, we'd be saying where to go or what to do next (*Children's worker).*

While the gathering of information, the incorporation of intelligence and the construction of analysis can be seen as iterative and interactive, there comes a point when the practitioner is sufficiently informed to feel able to make judgements based on the current stage of analysis and to recommend actions. This point may be reached

when it is felt that further iterations will add little additional value to the analysis, or at an interim stage, when there is felt a need for urgent intervention to address immediate issues, even if the whole picture is not yet clear.

At this point, the assessment process recognises that a stage in 'assessment' has been 'completed'. The outcome may be a recommendation for further, or more specialist assessment, but a clear decision point has been reached and needs to be recorded. The record has to show the evidence against which that decision has been made, and the formal process of writing recommendations, producing care plans and setting targets for outcomes will need to be undertaken.

5.2.4a Evidencing signification: recording, reports and recommendations to resource panels

> We would always write a report, certainly in my team we'd always write a report following the assessment – the plan might be written by the school in light of the report (*Children's Worker).*

The assessment process generates a range of formal outputs which serve to record the process itself, present the results of analysis, identify any services or interventions required and recommends any further actions to be taken.

This is not purely a recording stage in the process, but a modality of working that contributes to the legitimisation of the decision making (Fig 5.1j); it is also forms part of the on-going communication with the subject, the carers and/or the setting involved. In Children's work, the presentation of proposed plans gives parents an opportunity to become involved in the shape of interventions and the outcomes they have been designed to support. Reference was particularly made to the issues of language in relation to these documents - the need for them to be written in a way that enables them to be accessed by their intended audience. Communication issues were discussed in the previous chapter, as they form a common theme running throughout the practitioners' interaction with clients, carers and other practitioners, but they have a very clear role to play in the outputs of the assessment process, and the information artefacts created at this stage.

Figure 5.1j: Meso Domination – information recording and allocative resources

The primary outputs listed by Children's practitioners were reports of findings, usually including any recommendations being made, plans for next steps- including referrals on for further assessment - scores obtained from standard assessment tools, targets or

success criteria which may need to be measured, and - if the client is eligible for service and interventions are to be made - the date when the case will need to be reviewed.

Adult services require similar outputs, with a completed assessment intended to both evidence the analysis of need, and to inform the process as it moves into the care planning stage. The identification of support required, made at the end of the assessment, forms the basis for a draft care plan, against which more specific proposals for services and packages of care will then be identified.
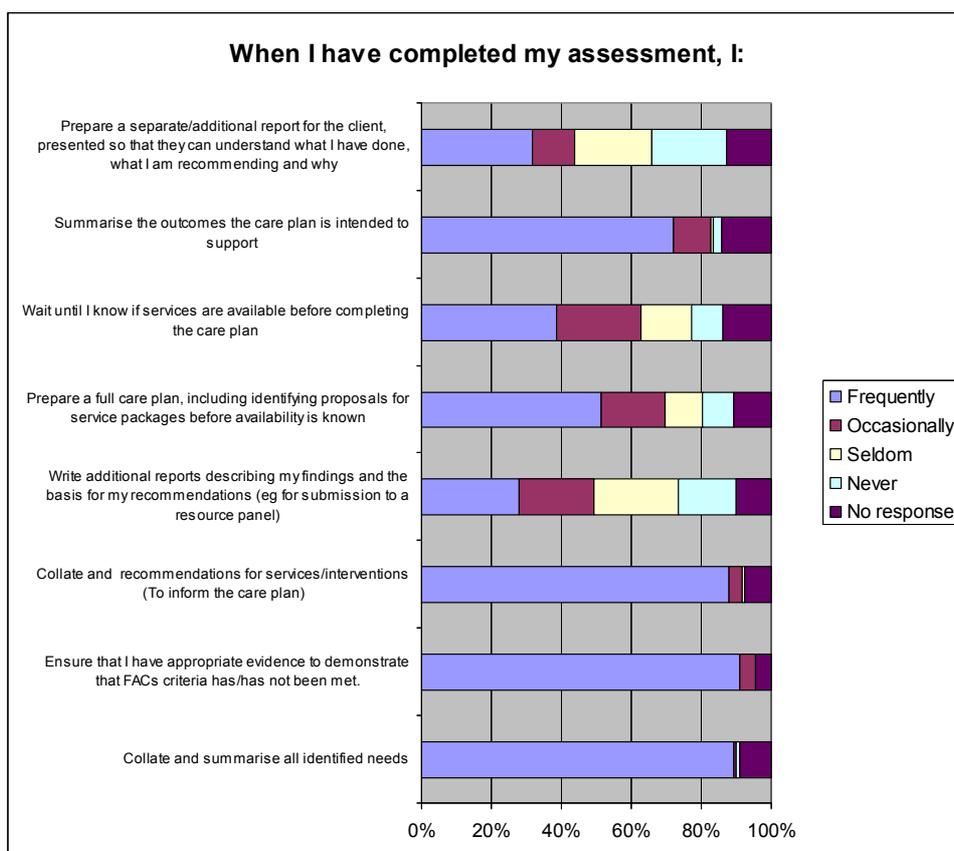
Figure 5.7: Analysis of Questionnaire - Actions following the completion of an Adult assessment. *Note the high regularity of evidencing FACS, completing a summation of need, and in making recommendations for services.*

At this point, the process requires a summary of findings, evidence to support decisions around eligibility criteria, and – where appropriate – recommendations for services, and/or further assessment (Fig 5.7). The information is generally recorded using formalised assessment 'forms', which may be literal papers forms, or – with increasing likelihood – electronic forms where some of the data is captured in a structured form and the remainder held as semi-structured narrative. As has been illustrated earlier, it is common practice to take notes while working with the client, and for the form to be completed later. The emphasis for the practitioner is on communication and

investigation, with recording needing to flow from the interactive conversation, rather than being restricted by a formal, structured, form.

> …for students, or for people going to review, it is just an aid to memory in terms of, you know, prompting really … basically the reality is that it's a free flowing thing, and good practice is that you allow people to talk, and too much structure can stifle that I think. (*Adult Social worker)*

This approach to practice can result in the practitioner undertaking several iterations of recording – taking notes, completing the form, and then transcribing the result into one or more databases – in order to meet the demands of the formal process. One of the intentions behind the introduction of mobile technology had been to enable practitioners to complete their assessment forms while working with the client – saving them from repetitive transcription tasks. Initial limitations in the technology made this difficult to achieve in *Countyshire*, with practitioners enabled to make notes and complete the forms electronically, but still being required to manually update the central database.

> Using the tablet, I add previous information prior to a review and this forms part of my report. I add notes to this during the interview and this speeds up the process of adding the information onto CareFirst. The completed report is usually on the system the same day, unless issues are raised during interview that require follow up. The paper form is used in the same way but because it is all handwritten this takes longer to decipher and type up under the relevant headings, then transfer to CareFirst (*Free text comment from questionnaire)*

While some practitioners, like this one, reported benefits from using the tablet PCs, others were less positive, and it was clear that simply presenting the existing forms in an electronic format did not enable the associated change in practice required. The project to develop new, more interactive tools, and its subsequent transformation into work responding to changes in policy, is discussed in the next chapter.

Alongside the record of the assessment, other formal reports may need to be prepared. Often these are needed so that supported requests can be submitted to resource and service allocation panels before services can be agreed and commissioned:

> For example … if it's an initial assessment and it's looking like say, somebody wants family link […] then we would fill in the assessment, and then we would fill in a form for SONAP – for the south's overnight panel – and then that information would be entered onto … a summary of the situation, and we would take the initial assessment to the meeting and we'd discuss it there. (*Children's Social worker*)

Resource panels are another modality for resource rationing, with agreement to provide high cost services being overseen by service managers. The need to submit requests to these panels creates an additional step in the process between assessment and delivery of services– that of needing to seek approval for the purchase of specific services where

the planned service may require resources over set thresholds. They act as additional organisational controls, supporting rationing by directive, with panel members being required to consider the impact of requests on overall budgets and resources. The requirement for these panels generally emerges as a response to local resource management policies, such as 'one in, one out' approaches when managing spend on residential care, or the setting of upper thresholds for spend on home care. Some practitioners, however, may see 'presenting to panel' as an opportunity to promote rationing by discretion, writing their reports and presenting their case in order to 'play the game' on their client's behalf. This creates a risk of the client's perspectives being lost or downplayed, and their needs exaggerated, in order to achieve a 'positive' result from a panel.

> … it kind of felt like you were actually demonstrating the person definitely needed a service. […] And I think … things are written to ensure that they get the service. (*Manager of low-level services*)

Even if practitioners are not deliberately biasing their reports – and it would be difficult to disentangle structures of established practice from the intent and behaviours which shape those practices - it is clear that the use of panels and the requirement to submit cases for their consideration can add additional signification to the collection and compilation of information during assessment practice.

> (*Social Worker*) … I know it's always about the person, but some assessments are … you're doing them for panel, for example. Now, assessing, I assess them in the same way, but there's also information I know I need to have which is - for the assessment, for panel – so, sometimes those assessments can be slightly different […] but as I like to go with the flow of the conversation, there are certain things which you know have to be in your assessment, which, if you haven't discussed by the end of it, you've just got to get that information – and it might be completely irrelevant to the person that you are talking to, but there are certain things […] sometimes it opens a whole new … discussion…

> (*Interviewer*) … that says to me that the structure about saying 'I know the next stage of the process might be 'this having to go to panel' is obviously influencing what you're then doing in terms of the questions you're asking and the information you're gathering […] would you be collecting that information anyway, or is it genuinely that this isn't relevant, but the process requires you, that you have this information at the end of it?

> (*Social Worker*)Yeah … the process requires it. Even if it wasn't for panel […] there are certain things you have to have documented on the system – and if you haven't documented them, you get questioned – you need to put this in… for example, religion … which is very important … to some people it's not very important.

> (*Interview with Adult Social Worker*)

Outputs produced during the assessment process not only serve to inform future practice, but also establish 'place markers' for longer term case management processes, enabling a managed move to the next stage of work. In addition, they contribute to and support quality assurance within the process - evidencing the basis on which decisions and recommendations have been made.

> ...what you've got is an output that says 'this is why I did it, this is what I've done, this is what I've got (*Children's Worker*).

Even if, at this point in the process, the person concerned has been identified as not being eligible for services, or that no direct action or intervention is needed, the assessment activity will still have had an impact on that individual and potentially their family as well. 'Managing expectations' was identified as a meaningful outcome even where no direct service had been provided.

> Sometimes it's not about the outcome, it's about how it felt. Because it could be, at the end of that whole process, the decision is that no services can be provided. You can make suggestions, but all of that is about how it feels to the person. (*Adult social worker*)

5.2.4b Planning intervention and monitoring outcomes: moving through assessment to the provision of care and on-going review.

> 'Intervention, change, and then progress maybe.' (*Children's social worker*)

Once the need for intervention has been identified, the primary outcome of the assessment process is movement to the next stages of care - the co-ordination and implementation of the care plan, the delivery of service and the monitoring of the longer term outcomes the plan is designed to support.

The emphasis in the established ways of working – in the weighting of the process and the focus of the practice – has traditionally been on the assessment: the identification of need and associated risks. Supporting this emphasis is a clear, although generally unexpressed, expectation that, once the assessment is completed, a care plan can be quickly constructed which both addresses those needs and manages those risks. This expectation probably arises from the contextual intelligence approach within assessment practice, which does not see an 'end' to assessment and considers the requirements for intervention and service as a part of the overall analysis. The output of assessment practice includes recommendations for further action, which provide the foundation for care planning; while the process defines two different stages, the information flows within and across practice space cannot be so easily differentiated.

> …then you can maybe explore […] so you're almost like you've got the picture, but then you're exploring that in a bit more detail. And sometimes it's actually a fact that they then … although they might be coming up with 'well, I need homecare to come in every day' you can actually go a bit further than that, and actually say, well, okay, what would they do if they came in?' And how would that work? And try and come up with some of the suggestions […] So you're already then exploring the kind of 'meeting the needs' from within that […] and I guess that's the way I've kind of worked. (*Adult social Worker*)

Practitioners clearly have to balance their activities between the formalities of the assessment process and the interactions of assessment practice, which engages the child or adult and their families/carers in looking at their needs and working with them to identify what they might wish to achieve, while clarifying what may be possible. The aim of the process is to determine if they are entitled to services and what those services might be. The aim of the practitioner is to ensure that those services and the frameworks that support them ensure the best possible outcome for the individual being assessed.

> I think, for every child I work with one of my major outcomes that I always have in my mind, even if I don't expressly say it in every report is that I want them – I want the child to feel that they're being supported (*Children's worker*).

Until recently the greater focus on active interventional services in child care (specific therapies, placement, adoption, counselling etc) and their linkage to other, universal, services delivered to children, has tended to generate more detailed and specifically tailored plans than those produced for Adults. The limited options available in traditional Adult care services – home care, day care, respite or residential care – has limited the negotiation of care plans to what's available and what's affordable, with packages of care often being compiled by matching the needs identified within the assessment with services which have already been contracted. The introduction of direct payments (enabling individuals to purchase their own choice of services) and the concepts underpinning the personalisation of Adult care have begun to counter this 'pre-packaged' approach. These (rules) changes have, in turn, begun to impact on the structures within which assessment practice and assessment process interact, and will be discussed in the next chapter.

Not every plan will remove, or even meet, every need. For a child with a long term condition or disability for instance, the plans may be more about ensuring the child is supported and in a position to reach what potential they have, rather than eliminating the need for future support and on-going intervention.

> ...with our kids I know that, while I have a child on my case load, they are always going to have that difficulty. It's always going to be there – it's a

lifelong thing to live with. You don't *lose* the language disorder. If you've got it, you've got it (*Children's Worker*).

For Adults a plan may be addressing aims that range from supporting a return to complete independence, through an intent to stabilise and maintain the current quality of life, to a recognition that, at best, the services provided will support (and possibly slow) an on-going deterioration.

> …her situation may - it may be that … and then she deteriorates to the extent where her choices, to some extent, are taken out of her hands … (*Adult Social Worker*).

The combination of assessment and care planning therefore sets the initial baseline against which the effectiveness of intervention and services can be measured; once services have been commissioned and implemented, the business process leads onto to the next formal stage – the review.

5.2.4c Review

> ...you might be checking if the intervention is sustainable. It might have cost loads and you can't keep it going, or might be taking loads of time from someone who's not going to be there, or the person who's done the work in school is on maternity leave next term (*Children's Worker*).

Review is an important stage of the assessment process, both completing and regularly re-initiating the cycle of care.   It is underpinned by the same rules of signification as the assessment stage, and enables the effectiveness of interventions to be checked, progress against objectives to be measured and the stability (or otherwise) of context to be confirmed. The legitimation for and the frequency of its undertaking may be identified by statute, defined by performance targets, or promoted in good practice guidance. Reviews can be undertaken by the same practitioner who carried out the initial assessment, by another practitioner from the same support team, or - as is increasingly happening - by a member of a specialised reviewing team. Activities in review can range from a simple comparison between assessed circumstances, current circumstances and the care plan, to undertaking a full-blown repeat assessment, utilising the same assessment process and potentially requiring the same input of assessment practice.

> The way review works is that people are all kept on lists and for different areas, and they're done annually. You know, we go back out and we see what's already in place, and we look at when that was put in place and what information that we've got on the system – and we're looking to build on that, based on what that individual's needs, circumstances are at the time and day that we visit them (*Adult Reviewing officer*).

Review can be seen as the next iteration of formal assessment practice – like the screening and filtering stages that proceed it, it checks the value and applicability of the information previously gathered, adds newer information to the record, confirms or updates intelligence, and analyses changes in need, the effectiveness of intervention and the overall progress of the case.

> The way the review report's laid out, is we've got different areas, one is contributory, one's background, and to me there are two parts to the review which should be […] partially completed before you go out. The background section, for me, is what's taking you to the point of review – and I need to go through all my records to write a summary of that. So I know when I'm going out, this is what the recommendations were at the last review, and I know historically what has happened, in terms of our involvement. Might not detail all of it in background, but – by preparing that sort of aspect of the review, gives me the foundation on which to do the review and take things forward (*Adult Reviewing Officer*).

Formal review needs to be distinguished from the semi-formal activity undertaken as a response to crises or an unscheduled change in circumstances. Practice triggered by the latter two tends to focus on specific issues, addressing the immediate needs arising from the issue of concern; the formal review is more holistic in approach, even when scheduled as one of the outcomes of a semi-formal intervention.

> Certainly one of the difficult - differences between our team and the local teams is that one call into duty – a recording could be four or five lines as to why they need something put in place – an increase in care package […] we have to write a full report and assessment, and substantiate, for exactly the same thing. And so, you know, local teams are recording very small bits of information. Whereas we're giving – you know – the next practitioner, whether it's our team or any other team, a very clear baseline from where they were at that point (*Adult Reviewing officer*).

Eligibility and overall level of need will also be considered at this point, with options to reduce the level of services or even close the case; this may be a complete closure, or a decision to end services while continuing to monitor the service user concerned.

> I think, if your assessment is good … then it has been as relevant as possible, in which case you can measure […] if they can't implement the things you suggested, then you haven't suggested the right things, have you? (*Children's worker*).

The ultimate measures of success in the delivery of social care is that objectives have been met, the person concerned is appropriately supported, the intended outcomes have been achieved and the person themselves are happy with the arrangements made. Regular review helps ensure that these goals are not only achieved, but also maintained; the impact of longitudinal change can be identified before a crisis arises; the risks arising from deteriorative or debilitating conditions can be managed; and quality of life

can be sustained. Similarly, regular contact and review can help support the attainment of longer term outcomes; for some looked after children true success may not be achieved for several years - an outcome that relates to a child becoming a well adjusted and fully contributing member of society, having realised their full potential, can only be evidenced once that child has grown and is no longer eligible for services.

5.2.5 Supporting process, enabling practice: information resources and tools.

The discussions in the workshops reflected the iterative nature of assessment practice, but equally demonstrated that, far from there being *an* assessment in the formal assessment process, each decision point forms one step in what may become a series of iterative assessment stages, each of which start with a concern and end with a decision - even if that decision is only to refer on for further assessment, or to revisit the issue at a future review. Contacts and referrals are screened and filtered through a number of these stages, with decisions not to proceed arising because the subject may not meet eligibility criteria, because they may have been directed to the wrong service, or simply because there is insufficient information to justify taking the formal process any further.

It may be possible to define a common 'core' of information/intelligence collected as standard in all assessment practice - the basic descriptors of the person being assessed, including structures of environment and family. In current 'separate' assessments (reflecting those described by (Abendstern et al. 2008)) practice enriches this kind of information by either the addition of wider contextual information - the holistic view encouraged by social care needs-lead assessment - or by the addition of more detailed, specific information relating to specialised areas of practice, such as health, mental health, cognitive function, or behavioural analysis. The SAP and CAF policy directives supported the development of an approach in which business processes capture and share both the common core and relevant areas of the enriched record in a way that reduces duplication, improves data quality and enhances the delivery of service. Equally, the need for consistent, meaningful information, common standards in recording, and accessible, strongly governed record systems underpin the expectations of more recent policy; implicit in the delivery of person centered, multi- agency care is the support of equally person-centered, multi-agency information systems. One challenge lies in developing tools that will empower individuals to exercise greater choice and control over their own care, while supporting formal assessment processes. Another is designing these tools so that they do not impose restrictions on assessment practice and reduce the benefits of professional expertise; for those that need

professional input the analytical skills of the practitioners are an important contribution to care. Some of the enrichment that is envisaged may be in danger of being diluted or lost if business frameworks and the information tools which deliver them develop in a way that constricts rather than makes space for assessment practice.

The micro-structures of day to day activity and practice are situated within and partially determined by the formalised structures of organisational process and procedures that legitimise the activities, while controlling many of the resources that underpin them (Fig 5.8.) The more formal factors relating to process impact on the factors identified in Fig 4.5 (Assessment practice,) and will, therefore, also impact on the agency of practitioners in the exercise of that practice. It is from the combination of both of these sets of factors that the day to day structures of assessment emerge.
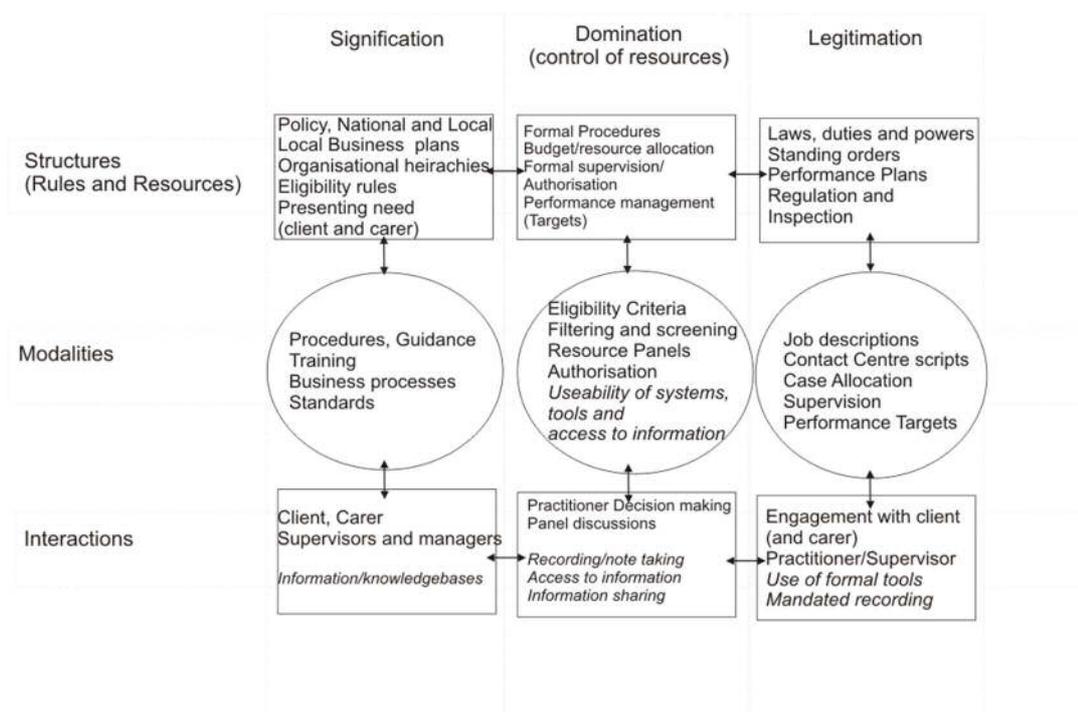
Figure 5.8: Factors identified underpinning assessment process identified in workshops and interviews

5.2.5a Reshaping modalities: the use of ICT tools.

The tensions between the requirements of formal processes and the interactive, investigative approaches favoured by practitioners has contributed to the creation of structures which are perceived as being overly bureaucratic. Social Care researchers writing in Community Care note that while the use of ICTs is central to professional

practice, time spent in front of the computer has become excessive. In their research, social workers, particularly those in duty and assessment teams, reported spending on average 80% of their time at the computer (Hall and Peckover, 2008).

The questionnaire used in this research did not specifically ask about the time practitioners spent using a computer, but did ask that respondents tick to indicate which tasks (from a given list) they used a computer for. The responses indicate that, while the majority did use the PC to complete their client recording, they were also using it as a communications tool (email and the intranet), for research (Internet and specifically practice knowledge bases), and as a general administration tool (Excel and Word)(Fig 5.9.)
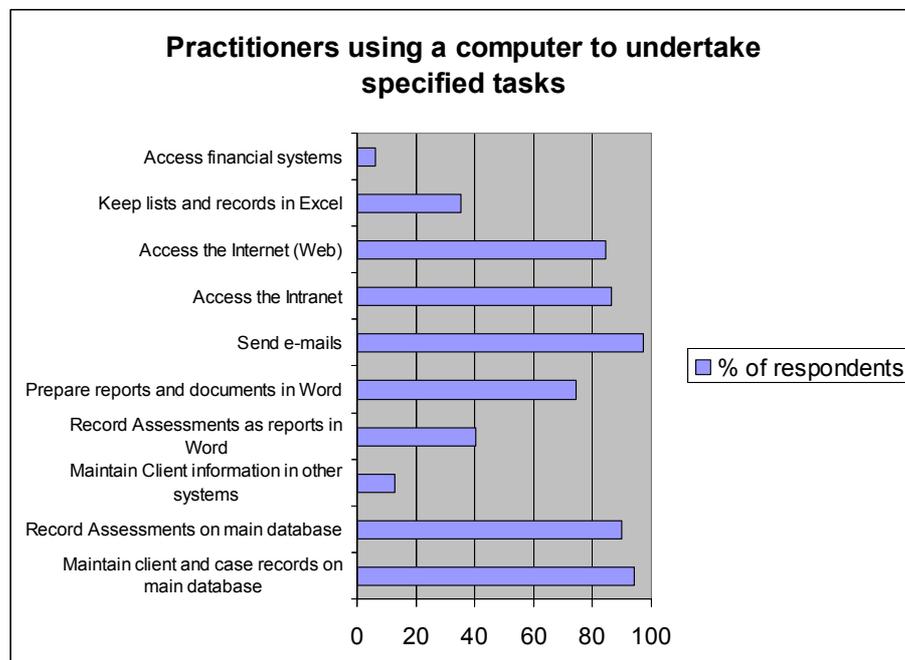
Figure 5.9: Analysis of Questionnaire - Range of tasks undertaken by practitioners using IT

This reflects the way that IT is beginning to become an integral part of everyday life and is no longer perceived as a specialist 'technical' tool. Over 30% of respondents to the questionnaire indicated that, not only did they have access to a PC at home, they used it every day (Fig 5.10.)
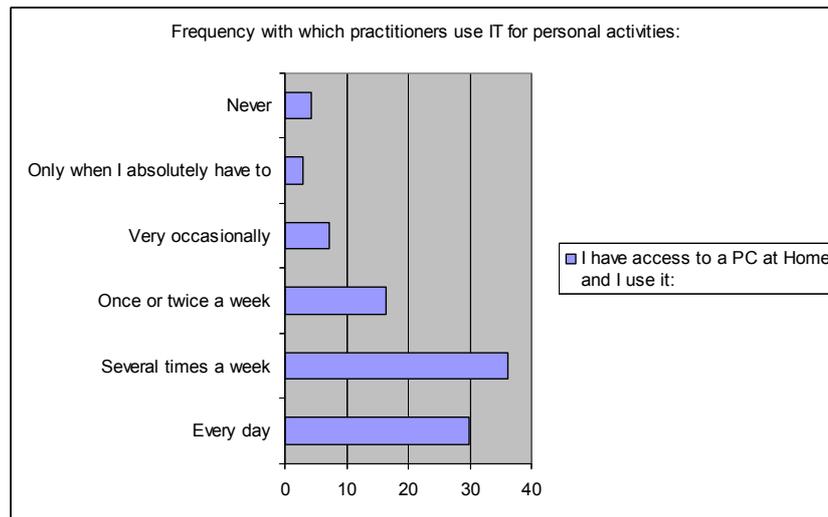
Figure 5.10: Analysis of Questionnaire - Practitioners having access to a home PC and frequency of use

There is no doubt that the emphasis on performance management emerging from managerealist policies and the associated need to deliver against pre-determined targets has increased the signification associated with formal, structured recording and the use of computer technology to capture it. Access to IT resources has unquestionably created changes in the behaviours of practitioners and underpins the expectations expressed by the business processes. But it is difficult to determine whether the introduction of technology has constrained, or afforded practitioner's agency within the structures that have emerged – no evidence seems to exist concerning the amount of time spent writing reports and updating case files prior to the introduction of electronic recording, and it is therefore impossible to identify how the impact of increased recording requirements might be balanced against the efficiencies of using electronic tools and the associated reductions in the duplication of work and the transcription of records and data. Here is good evidence of structuration in action: the development and implementation of technological resources, initially appropriated by innovative organisations and practitioners, has created expectations at both organisational and policy level, which, in turn, have influenced the development of policy and the business processes needed to support it. While updated policy provides the legitimation for change, the organisational agency to interpret its execution creates new modalities for implementation, adding signification through training and the development of new business processes. New structures emerge from the interaction of the workforce with the new rules and the resources they have available to support their application. These structures, along with the interpretative modalities and the overarching intentions of

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policy, influence the development of technology by shaping the direction of further exploration and innovation.

The next chapter presents some of that evidence by considering the findings from the final stage of the research – the undertaking of a project intended to make significant structural change in *Countyshire* in order to address the implementation of new policy.

> …originally I said 'well, why can't we just change the tools' - but you have to have the system changed to go with it to deliver – to have the ability to deliver.
>
> *Manager of the pilot team in post implementation interview*

> 'On the surface it appears that all that is required is a simple shift from professionally-directed support to self-directed support. However, this is proving to be more complex and primarily cultural and technical in nature.
>
> The first year of Social Care Transformation […] has focused on both changing culture and practice and developing tools and processes to support the new approach …
>
> *Post implementation review – phase one of the Transformation project.'*

6.1 Observing Macro structuration through a Meso and Micro lens

Recent work with national policy groups and government departments has provided some insight into the factors which shape the expectations of structure expressed in policy and law, but because this particular research project gathered data from a single local authority it would not be possible, nor appropriate, to use it to directly explore or evidence structuration at the Macro level. Rather the analysis that follows arises from the observation of implementing changes in national policy; examining the way that macro expectations of structure are translated into micro level activity through changes designed and implemented at the meso level. The practice lens for this analysis is, necessarily, my own – that of the informatics specialist, involved in the design and development of systems intended to direct and support the intended change.

Although the initial focus for the development phase of the research had been on a local project intended to reshape assessment tools, the requirement for the authority to respond to emerging developments in national policy – encouraged through the allocation of grant funding for the support of associated initiatives – created both a shift in objectives for the development project and an associated shift in focus for the research. The initial intentions underpinning the development work – that of producing tools and instruments designed to support the structures arising from the interactions of existing practice and process - became subsumed into a much larger programme; one aimed at implementing major changes in both process *and* practice, even though, at the time, the implications of that change (and the resources that would be required to support and sustain it) were far from clear.

The framework analysis tool was used both to identify the factors being addressed in the process of change, and to assist in exploring and understanding the structures that emerged from that change.

6.2. The constraints of Macro structures: Rules, Regulations and national policy

While a Local Authority may have considerable agency to determine the local structures that support and deliver process and practice, that agency is both afforded and constrained by nationally determined laws and duties (legitimation,) the level of allocated resources (domination,) and the requirement to comply with, and deliver, national policies (signification.)

Fig 6.1: Macro level rules: establishing constraints, affording meso-agency

Policy is rarely set out in a single, clear and definitive document. Often it emerges from a series of publications, with early presentation of concepts and overviews being followed by the allocation of resources and/or directive advice and then supported by subsequent and more detailed guidance. Responses to consultations, the evaluation of pilot projects, feedback from early implementers, and the oversight of regulators, all contribute to the content of later documents, and are similarly reflected in updates to government guidance and in advice from professional and national agencies.

The requirement for transformation in social care was initially signalled in the Department of Health's social care Green Paper, *Independence, Well-being and Choice* (2005) and was subsequently reinforced by the White Paper, *Our health, our care, our say: a new direction for community services* in 2006 (Department of Health, 2006). *Putting People First* then gave some direction to the intended change and identified a number of objectives that it should be aiming to achieve (Department of Health 2007).

The (*PPF)* concordat clearly articulated expectations of change in both the modalities of social care and the interactions enabling its delivery (Hudson and Henwood 2008). These expectations redefined the concept of *Personalisation* - the process by which services are tailored to the needs and preferences of citizens (Prime Minister's Strategy

Unit, 2007) - in Social Care terms, aiming to enable choice and put control in the hands of those who need support and services. Person centred care was not a new idea, but *PPF* placed much greater emphasis on the individual being empowered to define and direct their care and supporting their personal goals and objectives. Many practitioners welcomed the idea of this new approach, seeing in it a closer alignment with the signification of their social work training than the heavily process driven structures they were working within at the time. Early discussions within the ACT meetings about the new approach were both enthusiastic and lively; the practitioners within the group focused on the positive aspects of personalisation and the benefits they thought it would bring to clients.

> … it is about being person centred isn't it … what are the important things for you? (*Adult Reviewing officer*)

However, the changes required to effectively deliver the new approach – along with the structures needed to ensure that it became a sustainable change – were going to be challenging. The Senior Manager acting as Exec of the ACT project wisely offered a note of caution:

> I think we're very aware that there's … it's a Herculean task, because the staff are so used to doing things in a very kind of prescriptive, service led way – and now we're asking them to do what they're trained to do - and - it's something a bit more demanding practice-wise. So, it's a huge task … (*ACT Project Executive)*

The nature of the changes the Department of Health expected were set out in a Local Authority Circular early in 2008, along with details of the funding allocated to each Local Authority in order to help them achieve it. It is interesting to note that, unlike some earlier policy initiatives, the changes proposed were not centred in changes of directive rules and regulations (legitimation,) but were instead focused on the way those rules were to be interpreted and applied (the modalities of signification.)

> If personalisation is a cornerstone of the modernisation of public services what does it mean for social care? What it means is that everyone who receives social care support, regardless of their level of need, in any setting, whether from statutory services, the third and community or private sector or by funding it themselves, will have choice and control over how that support is delivered. It will mean that people are able to live their own lives as they wish, confident that services are of high quality, are safe and promote their own individual requirements for independence, well-being and dignity (Department of Health, 2008).

Achieving this transformation would depend on changing the nature of the interactions between individual, practitioner and organisation, and reshaping the domination of

resources, the aim being to give the individual increased agency in determining how allocated finances would be used to fund their care.

> This move is from the model of care, where an individual receives the care determined by a professional, to one that has person centred planning at its heart, with the individual firmly at the centre in identifying what is personally important to deliver his or her outcomes. (Department of Health. 2008).
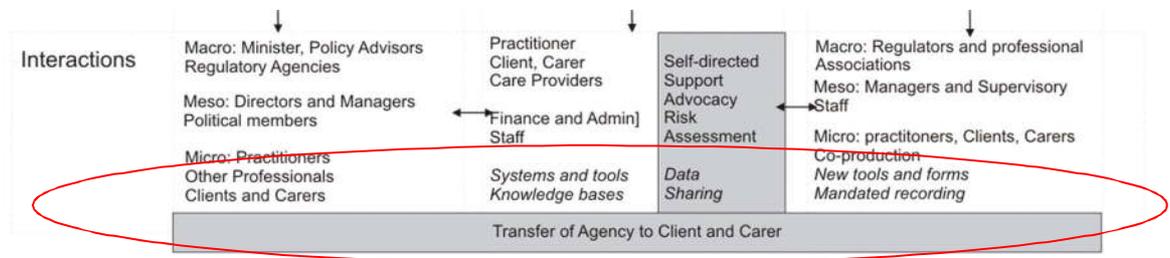
Fig 6.2 Changes in Micro level Interactions arising from Personalisation Policy

This shift from an organisational domination of resource to structures in which the individual is empowered to exercise personal agency in both the choice and control of their care services would need to be supported by a similar shift in the way those resources were allocated and distributed:

> In the future, all individuals eligible for publicly-funded adult social care will have a personal budget […] a clear, upfront allocation of funding to enable them to make informed choices about how best to meet their needs, including their broader health and well-being (Department of Health, 2008.)

The circular also emphasised the expectation that these changes would not be targeted at specific client groups, but were to be fundamental to the delivery of care.

> Importantly, the ability to make choices about how people live their lives should not be restricted to those who live in their own homes. It is about better support, more tailored to individual choices and preferences in all care settings. (Department of Health, 2008)

A major programme was consequentially established to oversee this transformation in *Countyshire*: a new management post was created, and existing projects were reviewed and revised in line with the new trajectory of change. The ACT project was to become part of a portfolio for change in Adult Services:

> It is envisaged that ACT will make a major contribution to the Local Commissioning Vision Outcome Building Block 1 and will be managed as a central project within the portfolio of change initiatives for delivering this outcome:

> "Assessment and care management roles will change shape and people who use services will need support to plan their own package instead of professionals care planning."

ACT Report to Senior Management Team, December 2007

6.3 Moving from old to new policies: positioning the ACT project in a Macro context

6.3.1 From SAP …

Despite having limited success elsewhere in the country, the SAP initiative (see Chapter 1) had struggled to take root in *Countyshire*; although local SAP assessments forms had been drawn up, their use was sporadic, and was dependant on the issue and subsequent retention of paper based, client held folders. No shared information systems had been implemented to support it, and the majority of workers in both social care and health had quickly reverted to more familiar tools and processes.   The ACT project made no effort to build on any of the local SAP work: its initial focus was on three simple objectives: to develop a new assessment tool that had the potential to be used for self-assessment as well as by practitioners; to update the current care plan so that it better reflected the client's intended outcomes; and to create a new reviewing tool that could draw from both the assessment and the care plan to make the process easier and more consistent.

Fig 6.3: Initial objective of ACT - simple changes in micro modalities

The intention was to utilise the new software facilities to develop the operational tools, ensuring that relevant information could be easily passed from one stage to the next, while making sure that all the necessary data for monitoring process, performance and outcome were being captured alongside the requirements of practice

6.3.2 Through CAF …

The conceptual development of a Common Assessment Framework for Adults was initially proposed in the White Paper, 'Our Health, Our Care, Our Say' (Department of Health, 2006), suggesting that it could be developed by drawing on the experience gained to date from the implementation of the Care Programme Approach (CPA) for Mental Health, the Single Assessment Process (SAP) for Older People, and Person

Centred Planning for People with Learning Disabilities. The Adult CAF was expected to shape similar structures to those previously expected from the implementation of SAP, supporting seamless delivery of services across health and social care, and avoiding duplication of information collection and procedures (Centre for Policy on Ageing, 2009).

The subsequent consultation document identified that the rules defined by this framework should set out the principles to inform assessment, care planning and support (based on a personalised and person-centred approach (Section 3)) and establish how best to fit information sharing into developing assessment and care and support planning arrangements and the introduction of self-directed support and personalisation (Section 4 (Department of Health, 2009))

The consultation document also stated that the aCAF was **not** intended to be another assessment tool or document of practice guidance, or a rigid structure to be followed under all circumstances (Department of Health, 2009.) These statements probably contributed to the initially low level of signification that staff in *Countyshire* considered these developments to have.

The decision to recognise but not be bound by national developments gives a clear example of organisational agency in action; as a policy arising from an earlier initiative (SAP) where compliance had not been heavily enforced, aCAF - unlike the rigid definitions of ICS with its emphasis on demonstrable compliance – was generally seen as being more advisory than regulatory, providing direction rather than directive.

However, as an acknowledgement of both SAP and the work that had commenced nationally to develop it into the Adult CAF, a fourth objective was added to the terms of reference identifying that the project would: 'future proof the new assessment and care plan formats so that they are compatible with developments with Single Assessment Process and Common Assessment Framework.'

> It would become the Specialist 'social care' assessment in CAF terminology. It could be used to populate the CAF overview/holistic assessment format. The advantage would be that our social care assessment format would be designed to be outcome focused, personalised and promote choice, openly address rights and risk management issues in partnership and be suitable for self assessment purposes in contrast to the rather 'functional' design of CAF. (*ACT group minutes Oct 2007*)

6.3.3 …to Transformation and Personalisation.

The early ACT work had recognised the need for a review of business processes, but had focused on providing better support for practitioners rather than intending to generate major process change. However, the emerging policy issues, including possible moves towards the use of personal budgets, were beginning to be discussed within the County, and concepts such as 'self-assessment' and 'personalisation' started to appear in the project's conversations and to underpin the thinking in the development of its products. As at national level, it was becoming clear that the continuation of Social Care delivery in its existing form was becoming less and less sustainable; the impact of an aging population, reductions in available resources, and the drive towards more efficient and effective services were all combining to put additional pressure into a faltering system.

Elsewhere in the country, pilot authorities had begun to explore the use of Personal budgets for their clients, which were initially seen as an extension of existing direct payment schemes. Feedback from these pilot sites, however, offered little or no insight into the information issues they had encountered, and provided no advice or guidance concerning the development of supporting information tools.

6.3.4 Redirection and revision of the project objectives

A subset of the ACT project board met with the head of Adult Services in early January, looking to re-scope the project in light of the new vision for Local Commissioning and to fully understand how the ACT project would fit into the broader transformational change. It was decided that the programme of work would include extension of the mobile working project, as well as developing tools to enable self assessment, allocate funding to personal budgets and support self directed care (Fig 6.2.)
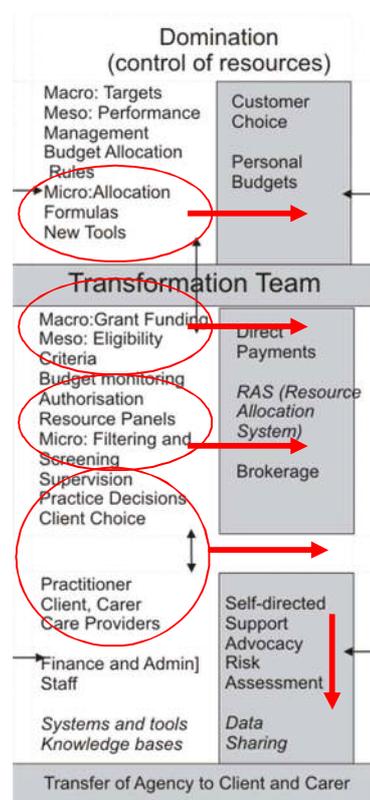
Figure 6.4: Development objectives of the transformation project – changes in meso and micro domination and transfer of agency in client

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While this change in focus was understandable, the move from being a simple development project, building on knowledge and understanding of existing structures, to one requiring the implementation of tools associated with new processes and new approaches to practice, created huge challenges. The timescales outlined for the transformational programme added further complications, limiting both development and testing time. New staff resources, in the form of some additional posts - mostly filled by seconded practitioners - had been provided for the overall transformational programme, but no additional resources were made available to the Information Strategy team to support the ACT developments. The team was supporting a similarly challenging project (ICS) within Children's services, and tensions around how work within the team was prioritised continued to increase.

It had been hoped that the research would be able to demonstrate that the introduction of tools which utilised a better understanding of practice would evidence greater appropriation and engagement from practitioners, with new structures emerging from a more effective use of and access to information resources. In reality, the progress of the ACT project mostly served to illustrate the difficulties inherent in managing innovative change. It particularly highlighted how new structures cannot simply be planned and delivered as envisaged, but emerge from the articulation of new rules, the accessibility and alignment of resources that support them, the modalities employed in their development and delivery, and the interactions that are enabled – or disabled – by the approach to the implementation of the change.

In retrospect, planning to develop and implement new tools on the scale of complexity and change required to support Personalisation in Adults was always going to be a challenging prospect. Doing so in tight and inflexible timescales, while still exploring the implications of the change and the information needs that the change required, was inevitably going to limit the ability to innovate and require restrictive compromise.

The work on a new toolset was expanded to include further development of the planned assessment tool, aimed at supporting simple self-assessment; the addition of a tool to enable support planning; and development of a reviewing tool that would reflect the simplified assessment, while capturing the effectiveness of chosen services and progress made against the aims expressed in the care plan (*ACT Project Group: list of products version 4, Aug 2008*).

Support planning was seen as a more relevant term than the more traditional 'care plan,' as the intention was to enable the individual concerned to plan their support needs (with

assistance from a practitioner, or other help if needed) The proposed support plan format was also intended to record more than just formal packages of care, capturing the person's views of what they wanted to achieve, along with any contributions from family, friends and neighbours.

Partner projects within the program subsequently commissioned additional tools, in particular those designed to process and capture the outcomes of the proposed resource allocation system (RAS.) These were required to first calculate the value of an initial budget based on points identified via the new assessment and then to subsequently track the proposed budget within the support plan and record the final approved budget, identifying whether that was to be paid directly to the client, or continue to be managed by the authority on the client's behalf.

The revisions of the ACT objectives required that the work link to the wider transformation programme, which included the redesign of the existing business process. Countyshire Adult services started this work by undertaking a 'brown paper exercise' that mapped existing processes as extensively as possible: two practitioners were seconded from front-line service to both undertake the exercise and then to lead on the re-design. While this approach undoubtedly enabled practice issues to be identified and ensured that the initial exercise reflected front-line reality, it also restricted some of the innovation in the re-design work. Neither practitioner had any previous experience in either business process design or informatics development; the structures that the re-design proposed did not necessarily reflect the opportunities that available technology could provide, and while efficiencies were identified in the new approach, the tendency was to reiterate modalities that the practitioners found both familiar and comfortable.

One proposed process, for example, required the production of a letter, to be completed and sent before the associated record was captured within the central database. When it was pointed out that the letter could be automatically produced from the database if the record was entered at the start of the process, the response was one of surprise: the practitioners had not been aware that this kind of automation might be possible.

This lack of knowledge and awareness of potential was to prove frustrating for the team developing the tools, but is a good illustration of the role of knowledge resources in the structuration process. An understanding of possibilities supports engagement with innovation: without it, the structures that emerge remain embedded in existing technologies of practice, increasing the potential for new technology to be seen as a constraint rather than an enabler of change.

6.4 Phase one developments

6.4.1 Analysis of the required changes

Timescales were tight: from the initiation of the program in early 2008, the plan was to have the new business process defined, the tools designed and tested and the first team trained and operational by the end of September that year. This was designated *Phase One*, and an evaluation was planned for early 2009 in the expectation that full roll out would be taking place from April 2009. It was recognised that this was going to be challenging, and the phrase 'it doesn't have to be perfect, just good enough' was often used in project meetings when difficulties were raised.

It is doubtful that any of the people engaged in the transformation programme really understood the scale and complexity of the intended change, as the implications of the Personalisation agenda and the shape of the structures that would be needed to deliver it were still being explored on a national, as well as local level. Initial concepts were being refined and revised as pilot projects elsewhere in the country began to report and Authorities began to share their transformational plans. Nationally funded groups, such as the Care Services Efficiency Delivery (CSED) and independent consultancies like iMPOWER were providing support for transformational programmes, on one hand enabling the sharing of ideas, and on the other promoting the particular approaches that they had been involved in developing. Both CSED and iMPOWER contributed to *Countyshire's* thinking (CSED supporting the brown paper exercise, iMPOWER assisting with the development of the RAS) but while some members of the CSED team acknowledged the contribution that information tools and services could potentially make, neither team encouraged engagement with the information team in the early stages of the work.

This may be because the programme was primarily aimed at transforming front-line micro level structures, with an emphasis on changes in practice and the way that practitioner's interacted with individuals. As with the seconded practitioners, the perception of the information systems as administrative monitoring tools and the lack of developments aimed at support for practitioners in the field may have limited awareness concerning the possibilities that effective information services can offer, resulting in the information issues being given lower priority. An equal lack of awareness concerning the structural complexities that can impact on the development of effective information

tools may have contributed to their omission in guidance and planning published by both nationally funded and independent groups, despite the expectations expressed in the relevant policy documents that tools and technologies would underpin the expected changes:

> this transformation is not starting from zero; a number of building blocks are already in place. There has been significant investment in tools and technologies to support change and this will continue over the next three years(Department of Health, 2008.)

The overarching analysis using the Structuration framework tool illustrates the extent of the changes identified from expectations in policy and the objectives of *Countyshire's* transformation project:
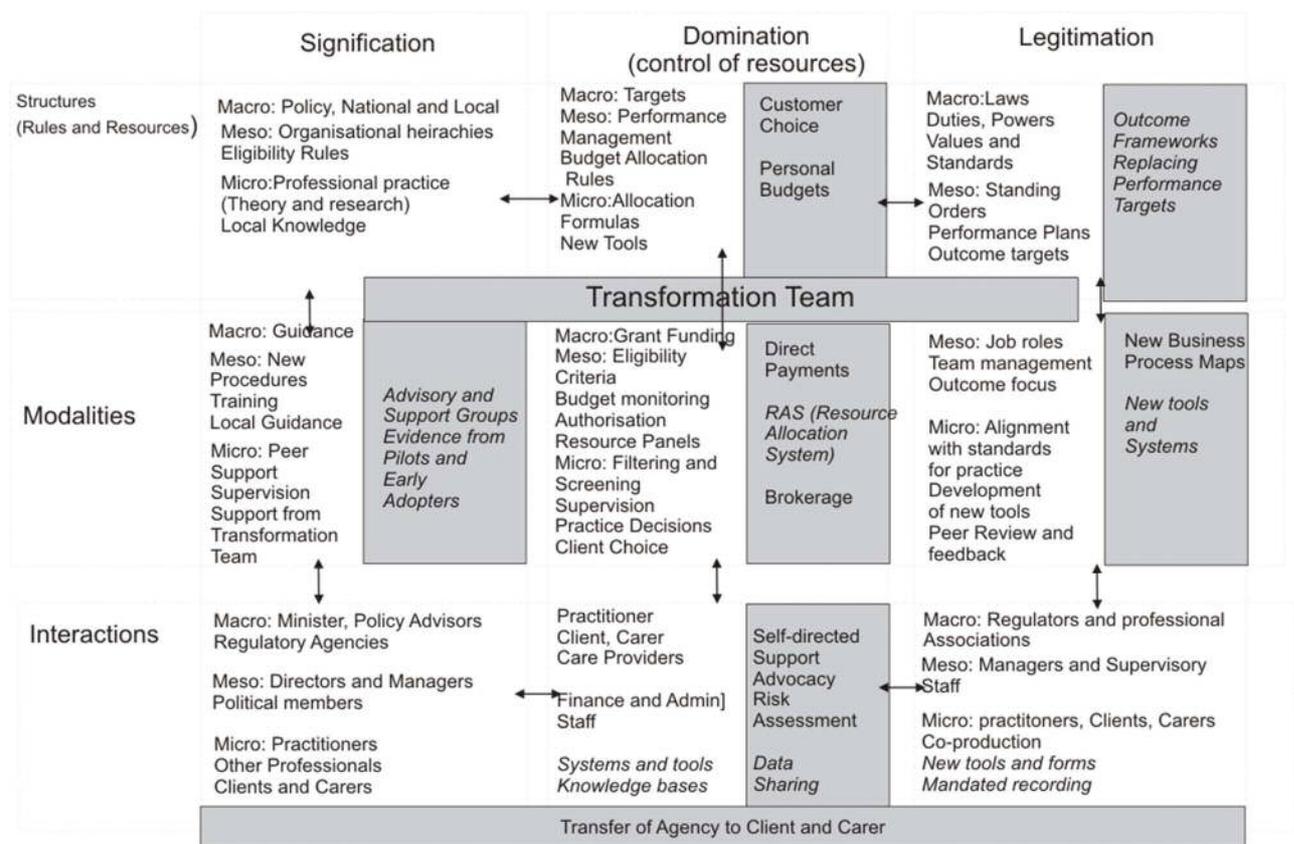
Figure 6.5. Structurational analysis of change emerging within the transformational project

Although the focus of the work was on frontline business process and delivery of practice, shaped as a shifts in domination (increasing client agency) and supported by new approaches to interactions (through co-production and supported planning tools) it was the changes in the underpinning rules – both operationally and in the expectation of culture change – and the implementation of new information tools (resources) that were to be the primary drivers of the change. It was quickly realised that changing culture would be one of the biggest challenges facing the project.

… people still have to develop their style – their assessment style within the new framework   And I think that that – when you're suddenly told 'sorry, you can't do that anymore' – that's hard, because everyone's been delivering community care in slightly different ways, and… everybody had their own style, and actually, this limits the scope for developing a style and how you couch the questions *(Manager of the pilot team).*

6.4.2 The challenge of 'self-assessment'

The policies promoting the provision of personalised services underpin the legitimation of approaches that support self assessment and enable self directed support. The changes required by the new approach aim not just to transfer agency from practitioners to the individuals they support but to increase the overall levels of agency that the structures of delivery allow. The empowerment of the service user lies in a change in domination - the individual allocation of financial resources based on identified need, giving them the freedom to purchase the care they consider appropriate for the achievement of their personal goals.

Conceptually, the idea of 'self' assessment, with a view to the individual concerned identifying their own care needs, fits very well with this philosophy of transferring agency and power to the individual, enabling them to express choice and take control of their care. The idea of full self determination, however, becomes problematic when linked to the allocation of public funds and the determination of eligibility for supported services. The role of the practitioner also becomes uncertain; the value of the tacit skills they bring to assessment practice is challenged by 'self' assessment models, and their function in helping shape both interventions and services is reduced as individuals are empowered to undertake their own support planning.

From a practice perspective, this aspect of the new approach was probably the greatest challenge. While practitioners welcomed the idea of empowering the service user, the shift of focus in the assessment *process* – with some of the decision making that had traditionally followed formal assessment now moving to the support planning stage – created confusion about how and when to apply assessment *practice*, and the level of detail practitioners would need to collect and analyse.

> … the practitioners are so used to assessment being at the core of everything, that, when I've said to them, look actually what we want from the assessment is something very straightforward, very short, that all – and the only purpose of it will really be to […] allocate an amount of resource so we can get onto the interesting stuff – how are we going to use the resource then, to support people in meeting their needs. But it is really difficult with staff, because there's almost

a kind of superstitious feeling that unless you've got … an assessment that's ten pages long - something's not quite right (*ACT Project Executive).*

The term 'self-assessment' is subject to the same issues of language and interpretation that have been raised for 'assessment' elsewhere in this thesis, and may well have exacerbated the confusion between the new process involved and the place of practice within it. Strictly speaking 'self' assessment could cover any reflective analysis undertaken by the subject in relation to their care needs. A systemic review of the subject undertaken in 2005 had presented a very broad definition of the term, identifying the potential for confusion when using it to describe requirements for systemised information tools (Griffiths, Ullman and Harris, 2005). The same review presented a number of issues concerning both practice and policy in relation to the use of self assessment approaches, and highlighted the need for further research and exploration of the concept.

The review also raised concerns over the development and use of associated information tools, noting that 'the design, content and layout of self-assessment material is crucial and active involvement of potential users in the process may be beneficial' (Griffiths, Ullman and Harris, 2005)

Countyshire established processes to consult with service users on the format and content of their new tools, engaging with representative groups as prototype forms were produced. These were mostly pre-emptive exercises, with members of the groups invited to comment on pre-designed materials rather than genuinely participatory design sessions. Nevertheless, service user views were taken into account and a number of adjustments made to the materials in response to the comments received.

Although the initial intent was to develop tools that enabled individuals to assess their own care needs, feedback from similar projects elsewhere in the country had begun to highlight the need to comply with requirements extant in law, and to sound a note of caution concerning the legalities of accepting self assessment as the basis for allocating public resources. These concerns were to be later confirmed in the outcome of a complaints case brought against Cornwell County Council in 2009 (Mitchell, 2009).

Without legitimation to move to full self assessment, *Countyshire's* response to these concerns, like many authorities, was to modify their approach to one of *supported* self assessment, a process in which practitioners would be expected to engage with the individual, to assist them in completing a simple assessment form and to confirm their agreement with its contents. Self-assessment would still be encouraged, with a copy of

the form sent to prospective service users ahead of the practitioner's visit so that the individual could complete it if they wished, but the process would retain a formal sign-off by the relevant practitioner before any scoring or associated resource allocation could be applied.

6.4.3 Issues of Domination: Timescales and other restraints

These shifting requirements within the project added additional challenges to the tight timescales for the translation of the paper based forms into computerised tools. Although the original project had aimed to develop a coherent set of tools designed to transfer and reutilise information throughout the business process, the disjointed nature of the new project workstreams meant that it became impossible to implement any kind of meaningful information flow between the new tools, even if there had been sufficient resources available to develop them concurrently. Learning from the other aspects of the research was disregarded as project managers worked to deliver change within the timescales set by senior managers. Deadlines for the delivery of working systems prevented any coherent analysis of requirements, and the project plan was staged in such a way that the tools required for the early parts of the business processes were expected to be made available for testing before the design work for subsequent stages had been finalised. Nor were the technical developers given room for flexibility or innovation in their design stages: where the initial ACT project plan had talked about interactive prototype development, the new project working groups delivered 'finished' paper products which were required to be instantiated within the computer systems 'as is' and with minimal change.

These expectations were possibly driven by perspectives within the Adult directorate that considered the required tools to be simple extensions of paper systems: a lack of understanding, both of the potential in the new technologies, and the complexities of managing information as a resource, meant that while the importance of having new tools was acknowledged, the need to align and link them was not.

This is not entirely surprising, given that the traditional views of change management tend to compartmentalise and deconstruct the intended change, reducing it to a sum of parts, rather than viewing it as an evolving structural shift in which the interactions of the parts would afford or constrain the overall change. This traditional approach may be successfully employed when the desired structures can be clearly and specifically articulated, but struggles to support the kind of innovative and improvisational change needed when requirements have not yet been fully explored or defined.

It became very clear, as the ACT project progressed, that many of the required changes had *not* been anticipated. Research notes made during the initial period of deployment reflected on the evolutionary aspects of the project, identifying that:

> Practitioners will need to experiment with use of tools, as the needs of practice are still unclear and are likely to emerge through use. Initial expectations as to how they will be applied are recognised as tentative, and that this phase will explore the implications of the new cultural perspectives as part of the implementation.
> The pioneers are being sent into a mostly unmapped wilderness, equipped with the tools we have predicted they need to use – but the true requirements will only be identified as the wilderness is explored and new structures begin to emerge. The shape, impact and acceptability of those structures will need to be reviewed and tools amended to enable an evolution of structuration towards acceptable fit within the envisioned change. (*Researcher's notes*)

6.4.4 Tensions and divergences

The structures that emerge in collaborative working – as well as the outcomes of that work - are shaped, not just by the rules and resources (knowledgebases) that generate structure within each group, but also by the compatibility of rules and resources where those structures intersect. This was clearly evidenced in the way that the mismatch between the traditional, product focused approach to change management that shaped the work of the transformational project team, and the need for a more improvisational, evolutionary model to support technical innovation, generated a growing sense of dissatisfaction within the Information Strategy team (IST) - particularly concerning the usability and general quality of the tools they were being asked to produce. It also created a view within the wider project team and their directing management that the technology was inflexible and could not effectively respond to the needed change. These conflicting perspectives were further exacerbated by the tight timescales within which the project had committed to deliver the change. The ambitious deadlines set to introduce phase one of the new approach allocated only minimal time for testing; as the development resources were equally limited – both in terms of availability and appropriate skills and knowledge – there was little opportunity to discuss the presented requirements, let alone refine and develop them.

The plan was to deploy the new approaches within a single care management team for a minimum of three months, before undertaking an evaluation to inform subsequent roll out across the County. Training was planned for the end of Oct 08, with the post implementation evaluation and review to be undertaken in February. Initially, the intention had been to have everything in place prior to the implementation training, but

the timescales involved meant that the new tools had to be deployed in stages; the assessment tool was required to be delivered and working in the live environment in time for the training even though the support planning and resource allocation tools were still in development and the design work on the reviewing tool was not yet complete (See Fig 6.4).

	Sep-08	*'My review' signed off by project executive*
	Sep-08	*'My review' awarded crystal mark by the Plain English Campaign*
	Sep-08	*'My review' output spec given to IST*
Sep/Oct-08		*Development of staff & customer user guidance*
	Oct-08	*''My review' CareAssess prototype tested with the pilot team*

Figure 6.6: Extract from Project 'Position Statement' for Sept 08, illustrating the timescales allocated for development. *Note the order of events, requiring a paper version of each tool to be finalised (through the application for a Plain English crystal mark) before the tool is developed and tested within the technical environment*

The systems team within the IST logged their growing concerns, and continued to raise them as the project progressed, concerned at the lack of consultation and testing, and aware of the limitations being imposed on the tools by the rigidity of the project approach. Notes submitted by the systems developer in Aug/Sept 08 registered both her dissatisfaction with the work and concerns that: 'we have not been able to make full use of the system functionality and may well have missed opportunities to make this a better way of working for both customers and staff.'

The response from the project team was to reiterate 'it doesn't have to be perfect, just good enough' – reflecting their commitment to the pre-determined timescales and consequent reluctance to recognise the need for a more evolutionary approach. This team, given legitimation by the decisions of senior management, held the domination of power within the project, and – despite the concerns of the development team - the development of the tools therefore had to adhere to the rules of the project management approach.

The initial deployment was undertaken in the Care management team which had also piloted the use of tablet PCs. The assumption was that their familiarity with the mobile tools would give them the technical skills necessary to work with the new tools. This proved to be true in some cases, but not for all, and the limited amount of testing for the tools prior to implementation meant that it was not always easy to distinguish between a genuine technical problem with the forms/tools, and those that arose from low levels of confidence or understanding in the use of the technology. The post project evaluation

would later recommend that staff be encouraged to develop their core IT skills to a minimal standard of competency, demonstrating how the introduction of new technologies can require the acquisition of associated skill and knowledge resources which may not have previously been seen as pre-requisites for 'core' practice. A lack of these skills may mean that the structures the tools are intended to afford do not emerge as expected; practitioners tend to develop coping strategies, using (or potentially *not* using) the tools and enacting structures in ways that makes sense to them.

6.4.5 Implementation

Despite the limitations of their design and the issues associated with their development, the tools were seen as a positive, not just in capturing the new requirements, but in directing practitioners to work in the new way and to engage with the cultural changes.

> The idea behind self assessments and the tool is that it is a customer's tool; this holds many benefits including the added benefit of practitioners not needing to spend a substantial amount of time writing their assessments after the visit has taken place… the 'my assessment' self assessment tool encourages the culture change by forcing practitioners to help the customer identify key areas they feel they need support in and then using the standard set of questions to identify specific needs and customers outcomes. *ACT progress report Nov 2008*

The piecemeal development of the tools, however, meant that they did not support the new processes as seamlessly as originally intended; the imposition of administrative steps (such as needing to copy and paste from forms on mobile devices into the central database) added a layer of cumbersome bureaucracy to the process. There was some evidence, both in the responses to the post evaluation questionnaire, and in the interviews held with members of the pilot team, that a number of practitioners were reluctant to lose some of the narrative they had been used to recording, particularly with regard to risk, and were consequently making (and keeping) notes in addition to completing the new forms. One view was that this was an indication of a resistance to change, with the practitioners being caught in a 'traditional' mindset that favoured established behaviours and therefore tried to revert to and recreate the 'old' structures.

> They're still professionals … but because we've been so rigid and prescriptive for so many years that, actually, staff are institutionalised. The process has institutionalised them and has stifled that creativity (*Manager of the pilot team in post implementation interview*).

Discussion with the practitioners, however, suggested that the reasons for their additional note keeping were more complicated, with dissonance arising between the streamlined approach expected from the new organisational procedures, and the professional rules underpinning social work practice.

…if we talk about personalisation, it's something that practitioners have wanted, and actually welcome […] because what we would say is that we have been so shackled by bureaucratic red tape and process, and always we wanted to be person centred – and actually, we've shouted for that. We've advocated for it, and to the best of our ability we have spoken up on behalf of our – then – service users. […] So we did become advocates, as well as … but we have to equally bear in mind that we have to operate within a statutory organisation, who has got its own systems, process, legislation and framework, you know, within that. So, we have to bear that all in mind.

Social worker in pilot team – post implementation interview

The tools had been designed to support the new process, but had not been extensively tested in a practice environment, and some practitioners struggled to reconcile the limited recording requirements of the new tools with their expectations of evidencing professional concerns and the reasons underpinning their analysis.

> The support plan tool needs to be amended to enable practitioners to not only identify risk but to record their recommendation and advice particularly when risk can be reduced by equipment etc and practitioner needs to recommend course of action in the interim.

> Currently practitioners feel that they have been deskilled because they feel unable to provide their professional opinions/risk management decisions and this could perhaps have been avoided if the support plan had more 'scope' for manoeuvre. *Practitioner's comments in the project evaluation questionnaire*

And at a more fundamental level, there was some evidence that the new tools had not quite achieved their overall design brief.

> People write comments at the side of the boxes because nothing fits.
> *Response to question concerning customer's use of the paper form sent prior to a visit.*

The limits of the tools were an inevitable result of the piecemeal approach to their design and the limited amount of time available to test them prior to their use in the 'live' environment. Although the first stage of implementation had deliberately *not* been identified as a pilot, it was still pioneering a number of new approaches, and the tools were only one aspect of the major cultural and structural change being introduced. While the functional design and the underpinning information flows could have been managed better, there would still have been a need for further development and changes as the structures engendered by the new modalities being introduced continued to emerge, evolving over time and being shaped the experiences of the practitioners and their managers responses to them. Many practitioners – familiar with the previous technologies – saw even the limited tools in a positive light, their concerns being focused on the more fundamental changes they were being asked to make.

The tools are good. And the process is good – and you can see the work that has gone into achieving that, and into creating and developing the customer's journey […] but – it's very difficult to … to operate in one particular way, which we have done for many years, then to go and have – potentially two days training, and then go live. I don't think there was – certainly enough thought into us as professionals. And how we would manage that. And how we were expected to manage the day to day job (*Social worker in pilot team – post implementation interview*).

6.4.6 Evaluation

The closure report for the ACT project acknowledged that time spent on testing the tools and IT solutions with the demonstrator team had proved to be helpful, but, rather than identifying the need for a more exploratory, interactive approach to tool development, the report advocated even greater rigidity in their commissioning:

> Needed a more robust and formal quality and acceptance criteria for IT solutions to evidence requirements clearly and prevent timescale delay

(ACT closure report Nov 2008)

The reluctance of the transformational project to team to engage with the knowledge resources within the IST, and to explore the potential of innovative approaches, limited the functional capabilities of the tools that were deployed, which, in turn, limited their use in practice. The struggle to deliver these tools as designed and requested in a resource and time limited environment created a negative perspective within the transformational team concerning the technology and its capability to deliver, and opportunities to improve the quality of the tools were lost.

In contrast to the intentions of the original project, the change in tools was primarily one of content, rather than technology; while there was improvement in the alignment between what was being captured in the main client records and the information tools used in the field, practitioners continued to work with tools designed as paper forms, with minimal data flow between them.

In the post implementation evaluation, practitioners identified a number of concerns with that content, particularly in relation to the format of the questions and the language they used.

> ' … the assessment tool is not fit for purpose as it is. It is not person centred as it is not written in sensitive or easy to understand language. It has increased the length of assessment as we have to spend so long explaining it in order to get the required information.'

> 'Main problem is language used on SAQ; not clear at all. Questions …
> regarding 'My Behaviour' are inappropriate and extremely difficult to ask
> someone.'

This was despite the forms being designed by a small group of practitioners, shared with service user groups and crystal marked for good English before they had been finalised. It is possible that some of the critique being offered after three months of use evidences the change in culture and the resultant shift in emphasis from professional domination of resources to a greater agency for the individual. As the rules change – not just the written ones concerning the business process, but also the tacit underpinnings of assessment practice and professional culture – then what may once have been seen as acceptable and useful language may no longer be considered appropriate.

Many of the concerns raised by practitioners in the evaluation review were centred around the ability to support individuals with complex care needs, or who lacked capacity to self-assess.

> … the customer's telling us what they wanted, and then we do the narrative of telling the story. And at the end of that we agreed outcomes with them. And I suppose that's the pivotal bit … it's what I just said. 'We agree outcomes with them.' So, in reality, I feel that we still work with out customers to identify – to enable them to identify their outcomes, but it's certainly recorded in a very different way, and where we have got people who lack capacity, have potential behavioural problems, or risk of harm […] have complex needs, the new system, I would suggest, doesn't support those people (*Social worker in pilot team – post implementation interview).*

The change in overall approach, while increasing the agency of most individuals, potentially creates a widening gulf between general service provision (support) and safeguarding (management of risk.) The focus on self-directed support raises the risk of safeguarding falling to the side; if structures are not seen as being 'safe' then it is likely that unanticipated structures will emerge with practitioners creating additional 'work arounds' to address their concerns. As the new structures develop and evolve, consideration may need to be given to further separating the two services, retaining a trigger or indicator in one in order to formally initiate the other. Arguably, the current view of 'assessment' also supports such a separation, with the more traditional assessment supporting safeguarding, while the more universal support services move towards greater self-determination and self assessment.

The development of personalised approaches increases the opportunity for the level of agency available to the service user to increase, building on the concepts within the narrative model of assessment practice (Coulshed and Orme, 2006 – see Chap

1). However, the primary thinking around process in *Countyshire* focused on the points of interaction with supporting agencies, defined and controlled as part of a clear, linear journey. The scope of the service users agency therefore emerged around defining expected outcomes and in decision making around need, risk and intervention - the shared constraints of assessment process limiting the potential to introduce alternative and innovative models of self assessment as a process, rather than simply a practice methodology. There is a risk that, by taking this focus, the services will remain locked in a perspective whereby social care support remains restricted to those with a high level of need, and that preventative intervention may be targeted as too little and too late. The alternative - that of deliberately separating the process for determining financial input and support from the services provided by practitioners (which then become chargeable services alongside care) - begins to challenge a number of fundamental assumptions about the role and purpose of the public sector in commissioning and delivering care. The modalities of domination, expressed as a constraint of financial resource, tends to place those with low level needs and/or the ability to fund their own care outside of the boundaries of public sector care, delivering a structure whereby monitoring and profiling information is limited to a sub-set of the wider population in need of care.

6.5 Further developments and final observations.

The ACT project had been intended as phase one of the transformation work, and had addressed implementation in one team while existing structures continued to be maintained elsewhere within the Authority. The intention had been to evaluate this first phase prior to a controlled roll out across the remaining teams, but – while there were plans to extend the implementation, and some further work undertaken – this process was interrupted and then superseded by yet another centrally driven initiative. Discussions concerning the feasibility of developing the Adult Common Assessment Framework (aCAF) had continued at national level, and Authorities were asked to present development bids for pilot projects, with an associated offer of funding and support from a central team. Countyshire, despite their initial reluctance to engage with aCAF work, saw this as an opportunity to gain additional resources for their local transformation. A project proposal was drawn up with input from an external consultant and an entirely new software supplier, and submitted as a bid for consideration: when this bid was successful, the focus shifted from the further

implementation of the ACT tools to a new partnership development with local Health teams and yet another iteration of new tool development using even newer technologies.

The work of the ACT project is therefore best seen as a *stage* in process of development – one where the tools were designed around the expectations of practice, the intended approach to business process, and within the limits set by time and the understanding of the technologies available.   Structures emergent from this phase (driven by the levels of both organisational, practitioner and client agency, the appropriation or enactment of tools, and emerging performance) would subsequently contribute to the on-going structuration at both meso and micro levels - informing the next stage of tool development and influencing the further revision of process.

The role of the Transformation team lay in translating the new approaches and expectations expressed in policy into local procedures and activities, and in commissioning and allocating resources to enable these new modalities to be shaped and implemented. This activity was itself subject to structuration processes: the use of formal project management techniques (rules,) the knowledge and skills of the members of the team (resources,) the modalities of commissioning, development, implementation, training, and evaluation, and the interactions between the team, the commissioning managers, the resources groups (including my own information strategy team,) and the practitioners engaging in day to day practice.

The observations of the project illustrate the way that the delivery of change and the emergence of new structures in practice can be constrained by the structures that develop within such an implementation team, both by the limitations of available knowledge resources and by adherence to established rules and modalities: there was a clear tension between the need for a prototyping, pioneering approach that would support the emergence of new and innovative structures and the more rigid, controlled aspects of formal project and change management, which focused on product based deliverables. This tension was exacerbated within the Information Strategy team where there was recognition of the complexity of the work and the potential for the information solutions to help address and reduce some of that complexity, while being disengaged from the business developments and being presented with pre-defined tools, 'signed-off' as paper based designs.

Although the opportunities for introducing innovative technology were ultimately limited, the work clearly demonstrated the complexity of factors involved in the structuration of public service delivery. These include the defining rules of policy at the

macro level, the meso level decisions about the revision of business processes and associated modalities for the allocation of resources, and the enactment of those changes through the micro structures of operational practice. Within this complexity, information tools and services serve as repositories of rules, act as allocative resources in the storage and transmission of data, and support communication and discourse over space and time.   The structures that emerge from the use of these services, situated within and shaped by the tacit knowledge – both professional and cultural - of experienced practitioners, form the day to day technologies of care.

The data collection for this research had been completed as the initial work on the aCAF bid began preparation, and it was at this point that my engagement as a participant observer in Countyshire ended. I subsequently left the Authority to work on national strategy development, from which perspective I was able to observe, not just the progress of aCAF work in Countyshire, but other social care informatics developments across the whole of England. The insights gained from the undertaking of the ACT work, along with my observations of practice, would inform my contribution to the new macro strategies, supporting an understanding of how the structures being described at the Macro level would be subject to Meso-level implementation of systems and through them, impact on the structuration of Micro-practice.

These insights suggest that the key to the successful development of technologies of care lies in taking a step away from traditional implementation approaches, where the ICT is seen as a separate and distinct activity, and moving into a more holistic delivery of change with the information services and resources being regarded as a fundamental component of the intended activities.

> I think the best thing about this is… suddenly everything that we knew isn't there anymore, having that joined up practice guidance – so that it's not IT guidance, information governance guidance, and a 'how to do an assessment' from a social work, or social care, perspective – and actually, an ideal opportunity now with the project group is really learn from what we've done in the past three or four months, and then shape that – so that, when we deliver training, from both ends we deliver joint training, and we inevitably bring the cultural change through what we do.
>
> *Manager of the pilot team in post implementation interview*

Section Three: Discussion and Conclusions:

The social care sector is a complex environment, serving citizens and their communities through a web of private, voluntary and public sector services. This research has studied one part of that complexity, considering the activities of public sector social workers and considering how those activities are shaped and influenced by the contexts in which they sit, and the tools and resources available to support them.

The application of Structuration theory has enabled, not just the modelling of the individual aspects of the work, but consideration of the way they interweave and interact to create the structures observed in everyday service delivery. The models support the analysis of how the expectations of policy can be tracked through implementation into operational delivery, and illustrate how structural divergence – the differences between the structures outline by policy and those which emerge in practice – can arise. Information and information services are key resources in this process, enabling, or potentially disabling, the alignment between policy and practice. Traditional approaches to the development and implementation of information systems in social care have limited their responsiveness to the needs of the sector, focusing on administration and the reification of formal business processes. In order for the emerging technologies of care to afford, rather than constrain innovative policies, there needs to be equal innovation in the approaches taken to their development and delivery. This requires a deeper understanding of the complex environments they need to support, the way those environments are shaped and structured, and the role they play in the transmission and reproduction of those structures.

This work explores some of the foundations for that understanding.

> … then really the tools need to be fit for purpose – and really, for the people developing those tools not to be too precious about them – because, you know, what we do, we will have our perspective […] and obviously everyone else will have theirs, but – it is about achieving that balance. Of the system, the process, the practice, and bringing it together
>
> *Social worker in pilot team – post implementation interview*

7.1 Recipes for action: Policy implementation in the Public Sector

While the day to day activities of social workers are strongly influenced by their training in and understanding of social work as a profession, the research identified that the overarching rules which shape the delivery of public sector services, are primarily those set by government policy and enshrined in national legislation. These two factors define the powers which enable services, and describe the constraints within which they are expected to be delivered. Together they provide both signification (through the aims and intentions of policy) and legitimation (through formal adoption of rules into law.)

There is a large body of literature concerned with the study of policy implementation, which seeks to understand the ways in which the expectations of policy are realised – or fail to be realised - in execution at the front line. Implementation scholars have offered numerous explanations for how policy is implemented, focusing on the nature of social problems, the design of policy, the governance system and organizational arrangements in which policy must operate, and the will or capacity of the people charged with implementing policy (Spillane, Reiser and Reimer, 2002). Whether considering the value of 'top-down,' or 'bottom-up' approaches or even struggling to define the scope and meaning of the term 'policy implementation' in the first place (DeLeon and DeLeon, 2002), most of the scholars tackling the subject agree on the complexity inherent in its study.

(Van Meter and Van Horn, 1975) defined policy implementation as encompassing 'those actions by public and private individuals (or groups) that are directed at the achievement of objectives set forth in prior policy decisions.' (Bergen and While, 2005) observed policy related change in community nursing practice and suggested that policy implementation depends on both the degree of 'vagueness' of, and hence interpretative discretion allowed by, policy wording, and also on the degree of

willingness by practitioners to take advantage of this and 'bend' policy to their own practice needs (Bergen and While 2005). They proposed a new framework, based on Van Meter and Van Horn's work, but incorporating Lipsky's concept of 'street-level bureaucracies' - public services 'whose workers interact with and have wide discretion over the dispensation of benefits or the allocations of public sanctions (Lipsky, 2010).'

Lipsky's concepts of policy translated into action by those engaged in delivering it, clearly reflect those of the continual creation and recreation of social structures described in structuration theory, and echo the way that such structures are shaped by the level of agency available to those involved in shaping them. Bergen and While's framework similarly reflects some of the factors which have been identified in this research as being involved in the translation from policy to practice – particularly the interplay of potentially conflicting rules, legitimised on one hand through formal training and the culture of the practicing professions, and on the other through the creation of legislation and policy.

7.1.1 Macro-meso-micro interactions and relationships

The structuration perspective posits that while policy attempts to shape the day to day delivery of services, it is, in turn, shaped and influenced by the experiences of implementing it, along with the outcomes it engenders. The overlay of culture and national identity, within which the constructs of policy and legislation sit, are also factors which contribute to the overall structuration of profession, service and supporting organisations. The findings from the literature review - and those of the research itself - suggest that the structures of social care delivery are fundamentally embedded in the cultural environment within which they sit – perhaps even more fundamentally so than those of health care, a sector with which its services are closely aligned, and to which it is most often compared. The medical profession is, at its core, concerned with the diagnosis and treatment of physical – or mental – conditions, and the training undertaken by a Doctor or nurse can, to a certain extent, be viewed as applicable independent of the institutional context in which care and treatment may be applied (Hastings Center, 1996).

Care, however, is a more nebulous concept. Health and health services can, to a certain extent, present a globalised perspective; social care cannot be as easily divorced from cultural factors underpinning the structures of practice and which are expressed in both local and national policy. The context, particularly the institutional context, can construct the experience of social work quite profoundly … an example of social work

as a contingent activity, conditioned by and dependent on the context in which it engages (McDonald, Harris and Wintersteen, 2003).

This research supports earlier findings in identifying that the translation of public sector policy into operational practice is a complex process, fraught with challenge and subject to a range of both tangible and intangible factors. The expectations articulated in national policy tend to be conceptual models, presenting the intended outcomes and outlining the behaviours that are thought to be required in order to deliver them. Some policy statements may be accompanied by detailed guidance, be supported by strategy documents, or even implemented through nationally directed projects, but the majority of policy development is aimed at leading and directing local implementation. An early paper, written for the Rand Corporation by Berman (1978), considers the challenges of implementing policy in the arena of human services, and the difficulties in controlling the process leading from policy to outcome. He defines the *macro-implementation* problem as being the way that federal government executes policy so as to influence local delivery organisations to behave in desired ways, and the *micro-implementation* problem.as being the way that local organisations have to devise and carry out their own internal policies in response to those federal actions.

Berman's 'micro' problem is formulated at an organisational level, which means that, using the definitions outlined in the introduction to this work, he is actually describing a *meso-implementation* problem. He goes on to articulate what he considers to be the root of this problem: the way that an implementing organisation may respond to a demand for change (Berman, 1978).

Much of the policy implementation literature focuses on these interactions between the macro and meso layers, considering the translation from policy to process, and the distortion that can arise from the levels of ambiguity in the policy and its interpretation. These models have contributed greatly to the understanding of policy design, but they miss some of the critical variation generated by individual behaviour within the decision-making processes (Hicklin and Godwin 2009).

Beneath the meso level, as this work has attempted to illustrate, lies a third, *micro* layer of detail: the interpretation and application of organisational policies and procedures into the day to day activities of practice. Organisations are afforded various levels of agency to extrapolate the expectations of policy into the establishment of organisational structures: while some policies spell out requirements precisely, most leave the details to local managers, enabling them to impose new rules at a local level, and to adapt them

in ways that align with their own internal cultures and characteristics. The more ambiguous the intent of a policy, the more latitude (organisational agency) the administering agency has in defining a government program, and the more the implemented program depends on the characteristics of the administering organisations. (Berman, 1978)

The findings from this research suggest that structural divergence - the differences between the expected structures outlined in policy and those which emerge in practice – arises through a combination of factors at both the meso and the micro level.

At the meso-level, these include:

- The level of signification ascribed to the policy from the meso perspective

- The level of organisational agency afforded in the adoption, adaption, or translation of policy intentions.

- The scale (and appropriateness) of resources allocated to support change.

- The level of organisational agency to appropriate and redirect those resources

- The overall availability of resources to promote change in given timescales (including the knowledge and expertise to revise and develop relevant infrastructures and tools (both internally and externally))

- The ability to release front line staff from on-going activity to enable their engagement in implementation.

- The clarity of policy expectations and the level of detail in which they have been described.

- The prioritisation of the policy and its alignment (or conflict) with other policy initiatives.

And at the micro:

- Alignment of the policy change with professional perspectives (signification)

- Alignment of the procedural change with professional perspectives (legitimation)

- Local cultures of practice and the extent to which they have become embedded

- Managerial leadership and commitment to change

o Amount of resources (training, support, supervision) invested to achieve the change (domination)

o 'Fitness for purpose' of new tools and technologies

o Useability of new tools

These factors interact to create multiple variations in interpretation and implementation for even the most straight forward of policy initiatives. Enactment at the meso level generates structures specific to a given organisation (or group of organisations) which – in turn – contribute to the enactment of structure at the micro level, where the exercise of agency by each practitioner gives rise to a range of variances across the micro structures of day to day activity. The level of meso agency afforded by policy will influence the emergence of structural divergence - which may then be further developed by micro agency expressed at the point of implementation/delivery.
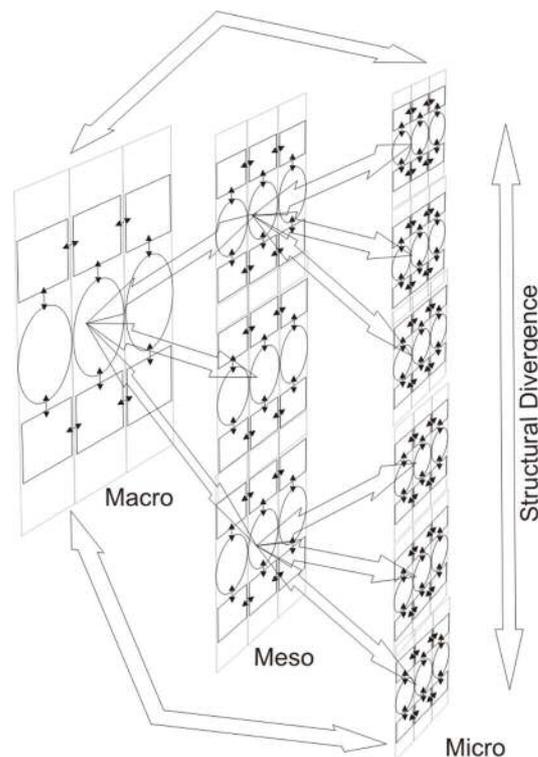
Figure 7.1 Structuration of a policy initiative across and between the Macro-meso-micro layers

The simple, theoretical model of interaction between the layers (see Chapter 3, Fig. 3.2), while potentially applicable to a single instance of structuration observed through a given practice lens, needs to be expanded into a far more complex model in order to

encompass the variances emerging at the operational front line - micro-structures which are shaped by the exercise of both meso and micro agency in the translation of policy into the activities of practice (Fig 7.1).

In the *Countyshire* ACT and Transformation project, an initial consistency in local practice was achieved through the establishment of a shared knowledge base, which articulated the meso expectations of the implementing organisation as they were expressed and then reinforced through guidance, training, peer interactions and support/feedback from the project implementation teams. The structures that emerged in day to day activity reflected the translation of the national expectations into the local expectations of the organisation. In the longer term the strutural divergence (and potentially convergence) of these structures will be both afforded and constrained by a series of recurrent and recursive meso and micro interactions, including inspection and regulation, performance and outcome monitoring at both local and national level, peer review, research, and public/community feedback. Over time these interactions may reinforce - creating strong cycles of routinisation – or revise the expectations expressed at both the Macro and the Meso level, thereby influencing structural decline or decay – which may, in turn, lead to the creation/introduction of new initiatives.

7.1.2 Culture, consequences and public opinion – longer term factors in the structuration of policy

In services and sectors (like care or health) where professional judgement and understanding is a core part of service delivery, the structuration of day to day activity is subject to additional rules, inscribed in professional and practice cultures through shared schemas and accepted norms, and which themselves influence and shape policy at all levels. The evaluation of practice in operation - through the monitoring of performance and outcomes, targeted research, and community and public perspectives – also provides recursive resources for the further structuration of policy, supporting the reproduction of favoured structures, and spurring the evolution of new rules to address less favoured practices. (Fig 7.2) Policy implementation is fundamentally an interpretive process; successful changes are not so much 'delivered' fully formed, regardless of context, as made sense of and agreed in local settings, taking account of local contours.(Freeman and Peck, 2008)
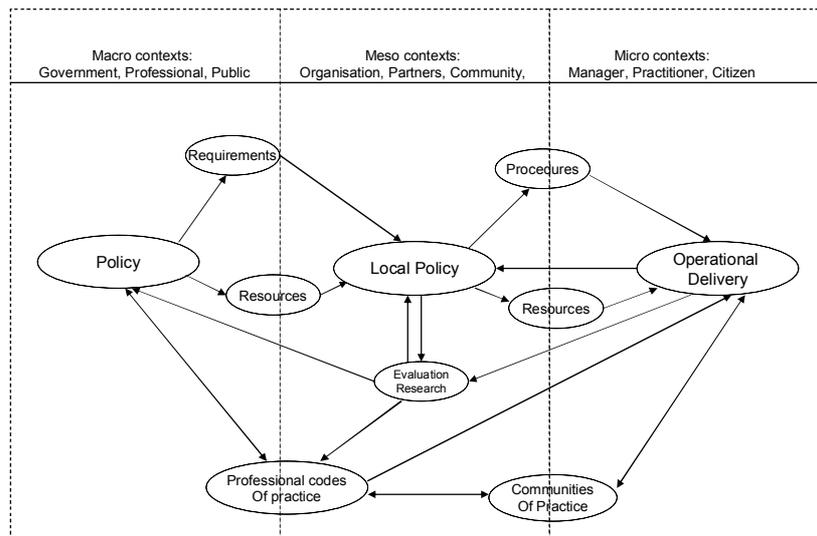
Figure 7.2: Structuration of policy implementation

These complex interactions take place over time, adding a temporal dimensionality to their analysis. The production and reproduction of operational structures occurs on a daily basis as practitioners interact with their clients. Micro structuration can therefore be observed within a narrow temporal bracketing, where meso and macro influences could be considered as established and 'fixed.' As the timespan of observation and analysis increases, the range of structurational factors also increases: the cycles of business planning and the implementation of developmental projects bring changes to local rules and influences the allocation and domination of resources. The shifting objectives of the Act project, and the instigation of the wider Transformation project in *Countyshire* illustrates how Meso structuration is similarly influenced through the emergence of new rules, and the allocation of resources arising from the macro cycles of national governance and policy development. (Fig 7.3)
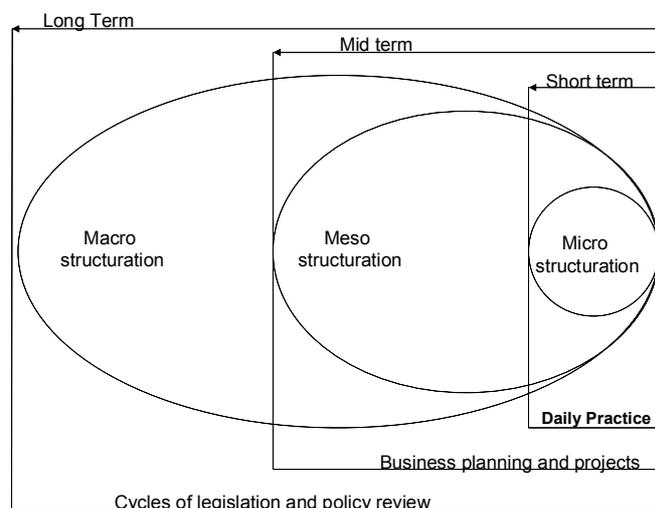
Figure 7.3: Temporal dimensionality of public sector structuration

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Considering these models in combination (Fig 7.1,7.2 and 7.3) contributes a greater understanding of how the expectations expressed in policy - translated through appropriation at the meso level, and implementation within micro structures - may become distorted and emerge in ways that poorly reflect the intentions of the originating initiative. This might initially suggest that the minimisation of structural divergence – ie delivering policy expectations - can only be achieved through implementation utilising a top down approach – through national projects, proscribed rules and controlled resources. Prescription in implementation, however, does not guarantee that the *intent* of a given policy can be achieved, as both the struggle to implement the National Programme for IT in the NHS, and the difficulties with the Integrated Children's System clearly demonstrate. Rigid directives and bureaucratically controlled resources can constrain innovation, and may well prevent the full implications of policy decisions from emerging. (Berman, 1978) stated that '...it is impossible to predict accurately the consequences of policy choices in non standard decisions situations or to control the process leading from policy to outcome.' The analysis in this study suggests that, given the evolutionary, iterative nature of public sector structuration, while the full consequences of policy decisions cannot be specifically predicted, there are opportunities to better understand, and subsequently manage, the processes of policy implementation so that the structures which emerge more closely reflect the expected outcomes.

As an example, in comparing the relatively poor success of the SAP initiative within *Countyshire* with the higher profile of, and engagement in the changes arising from 'Putting People First' and 'Transforming Social Care' differences can be seen to arise from the level of signification with which the organisation perceived the initiatives. Although some financial resource was made available for the implementation of SAP, and initial strides were made in implementing change within the county, the impetus become lost among a number of other policy initiatives considered to have greater signification. There was little reinforcement of expectation from regulatory bodies, and missed deadlines passed without censure or penalty; the organisation was asked to self-assess its compliance, and – since the criteria for success were very broad and vague – it was able to claim success even though front line structures were already reverting to reflect pre-SAP activities.

In contrast, the expectations laid out in 'Transforming Social Care' were high profile, perceived as having high significance from both practice and performance perspectives, and were required to be reported on – through outcome and performance measures – with very clear and challenging deadlines for compliance. The higher level of signification within the organisation generated a greater allocation of resource along with greater engagement and specific interactions at all levels to support the process of change. Structural divergence was consequently lower – although, as the research illustrates – the range of other factors involved resulted in the enactment of structures which did not fully reflect the original expectations of policy.
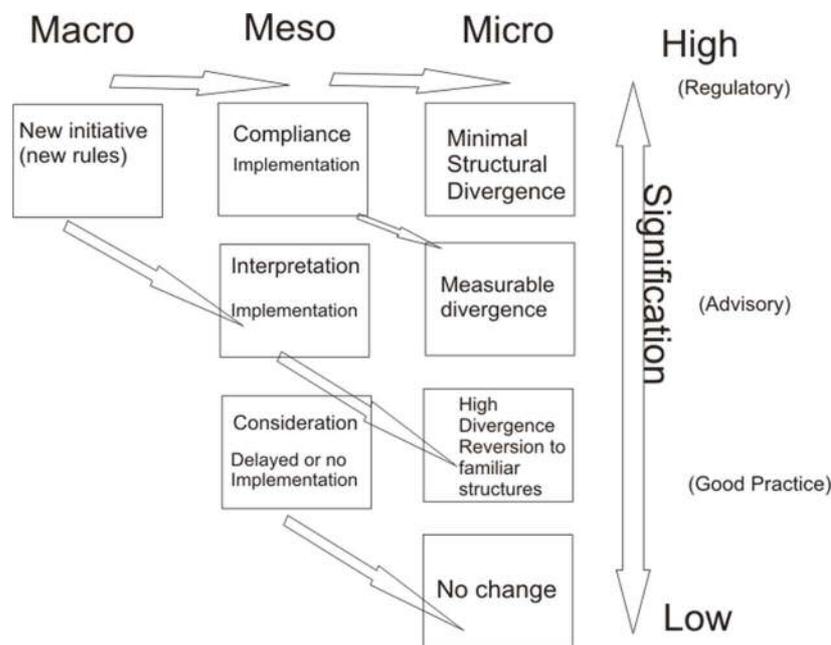
Fig 7.4: Organisational agency: Signification as a contributory factor in translating Macro (policy) initiative into Micro (practice) activity.

The level of signification associated with a policy initiative at macro level would, therefore, appear to be influential in the exercise of organisational agency concerning its consequent signification at meso and micro level, and similarly influential in affording or constraining the structural divergence that emerges from the policy's implementation. (Fig 7.4)

Clearly other factors, such as the legitimation underpinning the policy (ie the extent to which its requirements may be enshrined in law and regulation) and the level of macro resource allocated to support its implementation, will also contribute to decisions determining the intent to initiate change, but the findings suggest that it is the level of signification (and how that may or may not be sustained over time) that supports the alignment between macro and meso expectations of structure. When the signification of

policy also aligns with the interpretive schemas of professional practice, there is a greater likelihood that those expectations will be enacted by practitioners, enabling new structures to emerge as intended. The implementation of any given policy, and the level of structural divergence that emerges from it, will also be shaped by the domination of resources – not just in the allocation of funding and the establishment of project/implementation teams, but through the changing of the modalities that deliver and shape the authoritative resources which define practitioner agency and afford (or constrain) day to day practice.

7.2 Information resources and the contributions of technology.

Information is a key resource in the delivery of public sector services. Within the social care sector it can be subdivided into three primary types of information, each of which play a role as knowledge resources (identifying signification, assuring legitimation and enabling domination) in the structuration process.

1. Sector related, professional/practice knowledge – such as how need impacts on the quality of life and the interventions that may be effective in addressing that impact.

2. Personally identifiable information – data relating to specific individuals, including their needs, the care they are receiving and details of their families and carers.

3. Performance and business intelligence - providing insight into demand on and effectiveness of services, and the outcomes of interventions.

Information technology provides mechanisms for the capture, storage, retrieval and manipulation of the data which supports the construction of these information resources, with the organisational decisions concerning the allocation and domination of these resources being delivered through a range of modalities, such as security and access controls, functionalities of forms and tools, formats of data presentation, workflow rules and automated processing.

From a structuration perspective, human practice enacts structures through recurrent interaction with the technology at hand, so that, while the technologies of care may embody organisational rules and constraints, it is only through use of that technology that structures emerge. While use may capture the imprint of those structures within the record, it is the interaction with this imprint that recreates the structures as the record content is accessed and used.

Information technology developments are therefore primarily concerned with the storage and transmission of information resources in order for normative structures to be recreated through the interactions of human agency.   Data holds no 'sense' beyond the ordering of the resource, which may be pre-determined through the reification of rules, or imposed by human agency at the time of its capture or through further use. It only acquires meaning when viewed, interpreted and used.

Automation (particularly the automation of decisions) can be seen as the reification of human interaction where attempts have been made to reduce the level of agency to zero – ie all potential responses are thought to have been mapped, assessed and directed. The potential for automated processing can be therefore be measured by considering the level of human agency required for the enactment of given rules – in the realms of data sharing for example, current policy and approaches suggest that, while systems will enable the technical functionality for the disclosure or exchange of data, the actions that trigger these exchanges will generally remain within the control of either the individual, or the practitioner/service provider working on their behalf – whether that be through the consent of the individual for their data to be used as currency within a service transaction, or an assessment of risk by a practitioner that triggers the exchange.

Unlike many of the technology initiatives being introduced in manufacturing, or commodity sectors such as banking and retail selling, the opportunities for full automation in social care are scarce; the technologies of care are, on the whole, designed to support human decision making and enable agency rather than making attempts to replace it. The repertoire that technology can bring to the support and delivery of care therefore needs to be aimed at interactive, rather than passive use – such as tools designed to capture data in ways that increase its likelihood of use when re-presented, systems that help maintain the faithful reproduction of structures across time and space, or mechanisms aimed at enhancing the analysis of need.

The power provided by effective access to, and authoritative use of information has great potential as an enabler of individual agency in the new paradigms of personalisation, but – as this research has demonstrated – that potential, and the role of technology in enabling its realisation, may only be realised once there is a greater understanding of where information and information technology sits within a wider context - as a contributing component in the complex structuration of the technologies of care.

7.3 Structuration as a Framework for the support of change
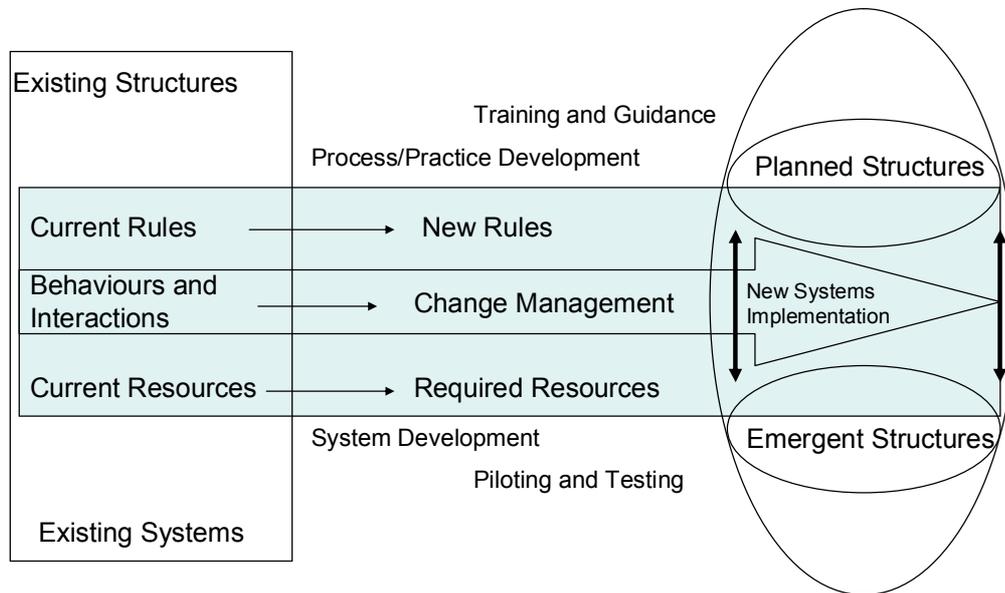
Figure 7.5: Utilising the ST analytical framework to support change over time.

Orlikowski's 'practice lens' (Orlikowski, 2000) permits the examination of how people, as they interact with a technology and associated information resources in their ongoing practices, enact structures which shape their emergent and situated use of that technology. But, as this research has demonstrated, the use of the technology represents only a small part of the overall structures present in the interactions between organisational business process and professional practice. Interwoven with the complexities of governance from which the micro structures of daily practice emerge are further factors that both enable and constrain the modalities of care. These include the tacit rules and knowledge resources of social work practice and its associated professions, and the cultures and ethos of the communities within which services are being developed and delivered. In enabling the analysis of both the components that create and the factors that influence the structures these interactions generate, the research has illustrated how the use of structuration theory provides a framework for reflective monitoring of business systems - in development, through implementation and in the management of change (Fig 7.5).

Information and IT feature as resources within that framework, both shaping, and being shaped by their use. Identifying and mapping these components supports the construction of models which interweave the interactions between material artefacts,

organisational culture and human behaviours, providing a better understanding of what may be needed to support the intended change. These models can then be utilised to measure both the progress and the outcomes of the intended change. They can also be used to help determine the information needed and the IT functionality required to support and (potentially) determine the shape of the structures that the change is being directed to create. By mapping the level of human agency within the overall framework, it may also be possible to predict where divergent structures may emerge (although not necessarily predict the nature of those structures!)

Delivering operational changes which are directed by and envisaged within new policy and associated initiatives can be a complex and uncertain exercise, not least because it tends to be untested change. The content and intent of the policy are inevitably subject to both organisational and professional interpretation in its translation from the generic to the specificity of practice, and until – or unless – that specificity is reviewed or evaluated and the policy revisited, the alignment between the intended structures outlined in the policy documents and those which have emerged through implementation is difficult to measure. The impact of this interpretative agency will vary, dependant on the level to which the associated rules and resources have been detailed, and the extent to which they are proscribed.

ST analysis has been shown to assist in the identification of known and unknown factors – potentially highlighting issues which may derail or distort project outcomes. It can be used to assess points of weakness in project design, as well as identifying points of strength, and can support the recognition of structural divergence as a project progresses. It can also help situate the opportunities - and potential dangers - of agency at both the micro and the meso level.

The lessons learned from the implementation of previous policy initiatives demonstrate the importance of understanding the resilience of established structures, the reluctance of human agents to embrace uncertain change, and the way that – given the agency to do so – practitioners tend to prioritise the interpretive schema of profession and culture over the formal rules imposed by the bureaucracies in which they work. The lack of clarity in the guidance about the detail of the SAP left front-line staff to use their own judgement … frequently, the decision was to continue to work as they had done before, a choice which was implicitly supported by management through their failure to challenge or support staff (Dickinson, 2006).

The theory of structuration distinguishes between discursive and practical knowledge, recognising actors as having knowledge that is both *reflexive* and *situated*, and that through habitual use becomes institutionalized. The implementation of new policy therefore needs to challenge the habitual by encouraging reflexive consideration of both the practical implications and the philosophical intentions that underpin the proposed change.

Orlikowski and Hofman proposed an improvisation model for change as an alternative to the more traditional approach. The model rested on two major assumptions which differentiate it from traditional models of change: first, that the changes associated with technology implementations constitute an ongoing process rather than an event with an end point after which the organization can expect to return to a reasonably steady state; and second, that the various technological and organizational changes made during the ongoing process cannot, by definition, all be anticipated ahead of time (Orlikowski and Hofman, 1997). Techniques such as participatory design, co-realisation, or soft-systems methodology can contribute to this kind of interactive, situated development, supporting the change process through the engagement of those who will need to enact the change.

7.3.1 Supporting transformation and innovation

The experiences gained through the ACT project, along with that of the wider organisational programme aimed at initiating the transformational activities required by national policy, illustrate the complexity involved in the translation of policy into front line practice. Traditional organisational development approaches tend to deconstruct the components of change, creating modularised projects with predefined deliverables. For some projects, particularly those undertaken in stable and clearly defined environments, this can be an efficient strategy. Change can be incrementally delivered in small, controlled steps, and success – or failure – can be measured against specific objectives. But as the complexity of the organisation increases, so does the complexity of change, and reductionalistic approaches, focused on the delivery of technical components, may not deliver the intended results. Drastic process-focused changes affect virtually all aspects of the organization, with multiple change initiatives being evolved in tandem. Consequently, any attempt to carry out change through isolated single efforts is likely to fail (Cao, Clarke and Lehaney, 2003).

Transformational policies often describe a high level 'direction of travel,' expressing desired outcomes without necessarily being able to articulate the details of how those outcomes can be achieved. Attempts to deliver these outcomes through traditional style

business projects that rigidly define products and lack the flexibility to adapt and respond can be costly and time consuming, with no guarantee that the required structures will emerge or that the intended outcomes will be achieved. The evidence gathered from the ACT project suggests that strict adherence to traditional project management techniques creates a very real risk of developing tools and infrastructure which constrain, rather than afford genuinely transformational processes.

In truly innovative and transformational projects, the implications of change only emerge through the implementation of that change; they require investment in evolutionary projects that can focus on and develop successes while being flexible enough to abandon approaches that lead away from the core expectations of the intended transformation. Such projects need to be agile and responsive, supporting recursive analysis and design – through cycles of prototyping, piloting, review and redevelopment. The implementation of these kind of projects is challenging in a public sector context, where, traditionally, minimal investment is made into research and development, and there is little tolerance for 'failed' projects – even if that failure generates learning and informs future development and subsequent initiatives.

Wholesale business transformation, however, becomes cumbersome and difficult to sustain unless there is recognition of this need for more agile, evolutionary approaches. Structuration theory highlights the way that a simple change in rules, or a revision of resources has the potential to impact on structures and the activities that generate them in unexpected ways. The level of unpredictability increases with the scale of the change involved, as actors interact with new rules, new tools and new technologies, and new structures emerge. Structural divergence can arise in the enactment of the change due to both meso and micro agency and the potential variance in interpretation. At the same time, there is an on-going risk of structural inertia, with the human agents involved struggling to engage with or appropriate the changes, reverting to established behaviours, and failing to innovate or to create lasting change,

Information services and their associated technologies are often thought to be purely technical concerns. Knowledge and understanding of informatics issues is not generally seen as part of the core competencies expected for front line practitioners or their managers in the public sector – yet policy presents a growing expectation that the use of both information and information technologies will be a fundamental component in the future delivery of services. Information systems can play both positive and negative roles in this process, either creating environments which support the intended changes

and allow the expected structures to emerge, or introducing restrictive and directive requirements that distort and divert the structuration process.

Once implemented and used in daily practice, information systems and tools act primarily as resources to support the enactment of rules in the reproduction of structure. These rules, embodied in tools and systems, are then fixed for the purposes of micro-practice, unchanging as practitioners interact with them   At the meso-level, however, through on-going review, or in the implementation of new projects, the translation of those rules into tools and systems can be more clearly seen as part of a recursive structuration process. The requirements for rules and resources are derived from the defined aims and expectations that practice and process aim to meet. These are interpreted, through system development, in tool review and in the development of new tools, which, through implementation, enable, or disable agency, and shape the interactions of the practitioners. Enactment of the technology in the field then contributes to the emergence of structure which may, or may not reflect the expectations of the initial design. Tools developed in isolation (i.e., purely defined by perceived information requirements and not linked to process/practice) are less likely to deliver the anticipated structures. In such cases the adoption of the technology is likely to be limited, and practitioners may revert to previous behaviours, constructing 'workaround' activities, such as additional tools, distorting defined processes, or simply failing to interact in ways that deliver to expectation.   In any system, a review of the limits of operational tools and the associated 'work-arounds' that develop may provide insight into the impact of policy restraints and the influence of learned behaviours in creating operational structures.

Utilising a Structuration framework for analysing the structures that information tools and their associated technologies of care are expected to support can:

- o enable recursive improvement in tools and systems, making them fitter for purpose.

- o assist in identifying the rules and interactions involved, and

- o support the process of change.

Associated analytical tools, such as the one used in this research, offer consistent mechanisms to support this kind of approach, being usable to both analyse and to subsequently evaluate requirements for change and the delivery of change management in public sector environments.

With the introduction of the Personalisation agenda, the requirement to implement this kind of transformational change has become imperative. While the agency to determine the availability of resources will remain within the public sector institutions – the agency to determine how those resources are used is expected, in a large number of cases, to transfer from the practitioner to the individuals receiving them. The definition of resources these policies currently use – that of financial provision – is limited and potentially limiting in relation to the emergence of the kind of structures that the policy intends. Analysing the issues through a structuration lens reveals the need to consider resources from a much wider perspective – to consider the influence of a meaningful knowledge base, both personal and professional; to understand the dynamics of social capital and the non-public sector aspects of care; and the role of the practitioner, as an assessor, as a broker of services, as an advocate, and as a care worker – in order to understand the dynamics that will shape, create, and maintain the desired structures over time.

The development of this understanding – through research, evaluation, analysis and evidence gathered over time, should, in turn, better inform the development of policy, identifying those factors which policy developers need to address, while empowering and encouraging implementers to not only challenge the implications arising from policy, but to develop responsive cultures that continually transform and innovate at the operational front-line.

Chapter Eight: Summary and Review

This final chapter summarises the main findings of the work as responses to the questions posed at the commencement of the research. Consideration is given to the implications arising from the work in relation to theory, policy and practice, and recommendations made for future research.

8.1 Review of Research Questions

The initial question that prompted these investigations was 'how can I design systems that enable practitioners to engage with and use technology more effectively?' Considering this problem opened up a much wider set of considerations that required a better understanding of what social care practice was, and the contexts in which it happened. This, in turn, lead to a reformulation of the question to: 'How do practitioners use information in practice, and how is that use shaped and directed?"

The key questions that underpinned this work were:

- What is 'assessment?' What does the activity involve and how is information accessed, collected and used within it?

- What are the contexts in which this activity sits, and what factors influence and shape its delivery? What part do information tools and services play?

- How do these factors impact on and interact with the implementation of organisational and system change?

- How is policy translated into operational activity, and what role does the development and implementation of Information services play in enabling (or disabling) this process?

- What can be learnt from the study of these interactions that might enable more effective innovation, inform future systems development and assist in the management of change?

These questions were addressed by considering the activities of front-line practice and the processes and organisational arrangements within which those activities sit, and through observing and participating in the implementation of a policy driven,

transformational project which impacted on practice, process, and the associated information services which supported both.

8.2 Reponses identified through this research

8.2.1 Assessment

'Social Care Assessment' is a term that has been linked to a number of activities within the sector, and is often used in ways that confuse or conflate those activities, so that definitions become blurred and the understanding of the term varies according to the context within which it is used. At the core of all these activities, however, lies two interwoven threads:

- assessment *practice*, which requires gathering of information, the analysis of the intelligence that this collection provides and the determination of actions and interventions arising from that analysis and

- assessment *process*, which determines the contexts and timing for the activities of practice, and establishes the points at which formal decision making occurs.

8.2.1a Assessment practice
Assessment practice underpins interactions between social workers (and other practitioners) and the individuals they support. The modalities of practice vary, depending on a number of factors, with the agency to pursue practice being dependant not just on the level that the contextual process allows, but also on the balance of agency between practitioner and client.

The different models of assessment considered in social work texts (see Chapter 1) can be observed and identified within the structures of day to day practice – not as exclusive alternatives, but as complimentary interpretive schemas, supporting the components of practice and contributing to an overall framework of assessment behaviour. Practitioners may use variants on the questioning model to elicit information, utilise the exchange model to provide the intelligence and context in which it sits, and employ co-productive narrative to generate outputs and agree outcomes – all within the procedural constraints of their employing agencies.   Considered from this perspective, it is the signification given to particular activities which enables desired (i.e. good practice) or undesired structures to emerge, with procedural tools and instruments acting as resources that afford or constrain the enactment of those structures.

Assessment practice requires that information be collected and collated from a number of sources, both from existing records and drawing on conversations with the individual being assessed, their carers and other professional who may be working with them. This collected view is reviewed and analysed by the practitioner, referencing key knowledge sources that may be explicit – such as guidance, research and policy frameworks – or tacit, including training, professional experience, and culture. This contextual analysis supports the generation of recommendations for support and intervention which, in turn, generate further knowledge, adding to both the specific intelligence concerning the individual and the broader intelligence which informs future professional practice (Figure 81.)
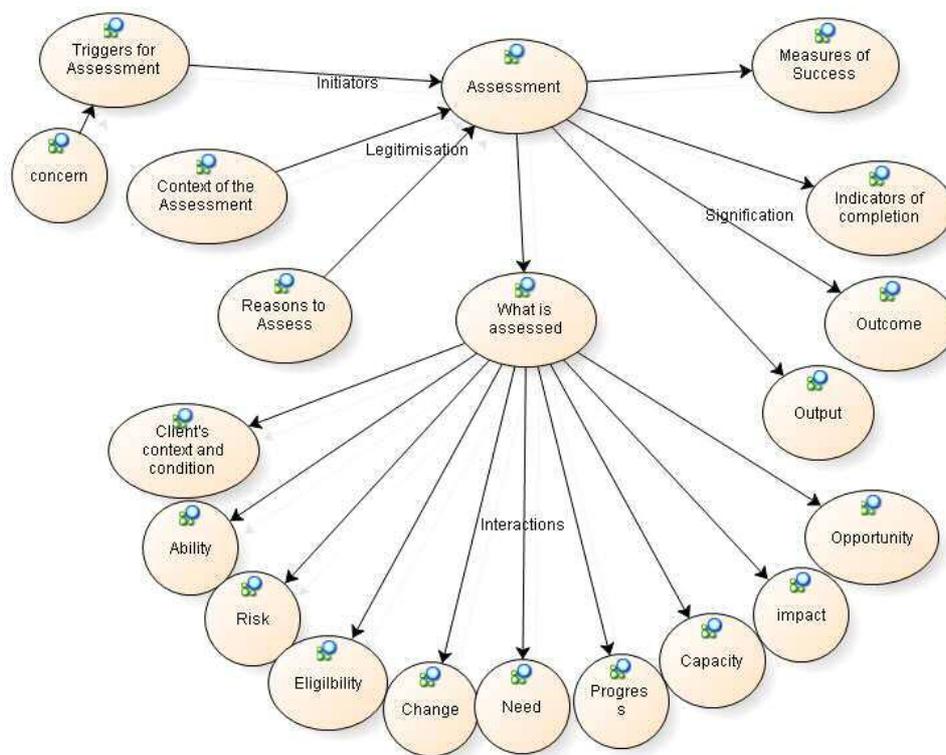
Figure 8.1. Micro-structuration of assessment practice – activities in practice space

Assessment *practice* is interactive, iterative, and intelligence driven. It utilises information in a dynamic way, supporting holistic, contextual views of need, circumstance and the effectiveness of interventions, adding detail and richness over time. Practice is underpinned by professional rules of conduct, by the ethos of practitioners and the evidence of research.

8.2.1b Assessment Process

Assessment processes create the day to day contexts within which assessment practice sits (Fig. 8.2). Practice spaces are linked by the formal steps of process which is, in turn, enabled (or constrained) by the collection and transmission of information resources, through the use of assessment tools and information services.

Assessment *process* is linear, progressing through a series of stages, each of which is supported by a timebased 'snapshot' of collected data, which records the basis on which the decisions concerning progress to the next stage - including the commissioning of any interventions and services - were made. Process is directed by organisational rules and their associated hierarchies, and directs, in turn, the allocation, authorisation and use of day to day resources in the support of practice and the commissioning of service delivery.
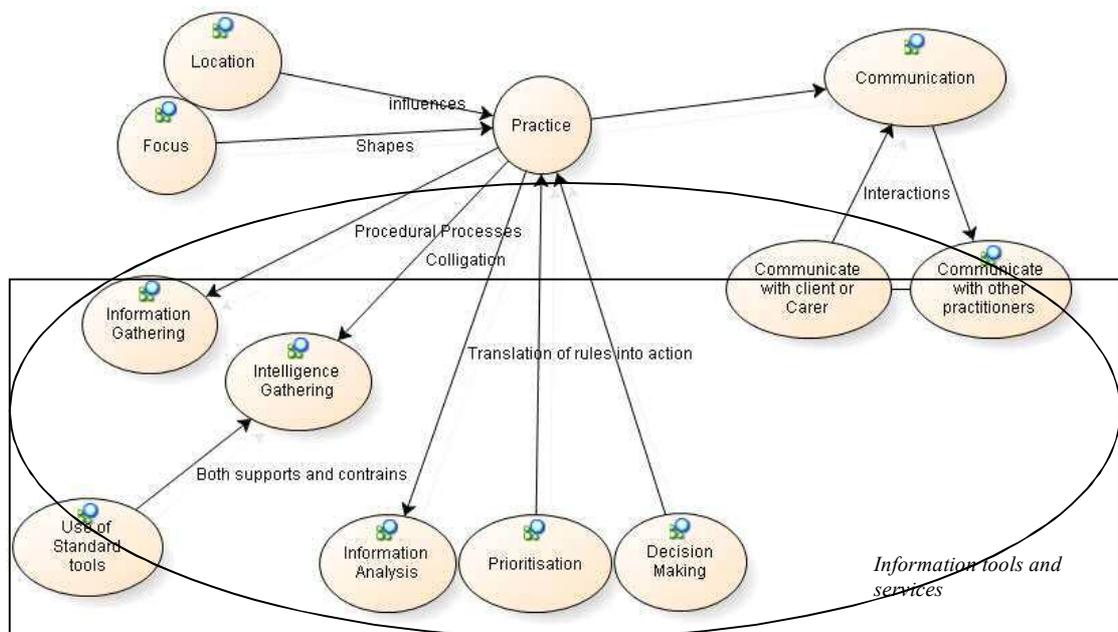
Figure 8.2. Meso structuration: assessment practice interlaced with assessment process.

8.2.1c Assessment tools

Assessment tools (forms, scales and instruments) can be seen as information artefacts which support the consistent reproduction of structure through both the presentation of rules, and constraining agency concerning the interpretation of those rules. As a repository for resources they support signification by enabling the collection and storage of, and access to, data. Thus the design of an instrument may either afford, or constrain

the effectiveness of practice (ie the ability of the emergent structure to deliver the intended outcomes), acting as both a mechanism for presentation and a filter for meaning and interpretation. Structures of signification are crystallised at the point of data capture, and thereafter act as resources in the production and reproduction of structures in practice (actions and activities)

These resources (artefacts-in-use) are both income and outcome of organizational structuring: they enact and influence structuration by providing constraints and opportunities for action, but at the same time (albeit in different time frames) they are influenced by structuration because their organizational meaning and relevance results from organizational decision processes (Masino 2003).

8.2.1d Information and Information Services

Information (ie facts as data) acts primarily a resource, rather than an embodiment of rules – and can be both allocative (ie generating command over material phenonema,) and/or authoritative (ie generating command over persons or actors.)

Knowledge (ie facts in context) supports the reproduction of rules as well as providing resource – adding both context to information resources and capacity to enable agency. 'Knowledge' will include tacit rules of society and community (both general and local/organisational culture) rules of practice and policy, information resources via training and research (in its widest definition), and resources of context (determining both levels of agency and perspectives of power.)

Tools and information artefacts, whether in paper or electronic form, can present rules, acting as enabling (or disabling) resources - but structures can only be observed in the interaction of individuals with those tools/artefacts, utilising the rules and resources of knowledge to impart legitimisation and the agency of interpretation to add signification.

Practitioners create (and recreate) what they know. The expansion of knowledge (which may be seen as a change in modality) will impact on both agency and the structures within which that agency is exercised. Work currently being undertaken in the private sector to explore the value of tacit knowledge and develop systems to capture and transfer the skills and understanding of the workforce, offers potential for the public sector to develop similar systems and so learn from their own practice. This includes potential for the knowledge and research underpinning assessment frameworks to be unlocked and made available to practitioners in more effective ways.

Knowledge Management is an interaction between human agent and constructed interpretative schemas, leading to the resources of knowledge – that, in turn – support the production of activity/structures. Information services, and knowledge management in particular, can therefore be seen as mechanisms that support the extension of social integration over both distance and time.

This was recognised by Giddens in one of the very few references to IT in his structurational writings where he notes that: "… mediated contacts that permit some of the intimacies of co-presence are made possible in the modern era by electronic communication…" (Giddens, 1984). The use of Information Services supports levels of social integration previously impossible without co-presence, enabling the consistent and coherent reproduction of structures across time and through the virtualisation of space/distance.

8.2.2 *Implementing policy – managing Change*

Assessment activity is subject to a great many controlling factors, ranging from the prevailing culture and ethos of the practitioners undertaking the work (*assessment practice)* through to the dictates of policy and the requirements of procedure, (*assessment process)*. Policy, in particular, is a shifting, and constantly developing influence, shaped by a combination of event, political theory and evidence arising from research. Its implementation may be supported, or hindered by the formal requirements of legislation, and the translation of policy into practice can be complex. Implementation often results in structures that do not live up to the initial expectations expressed by the policy makers. It can also acquire a high level of unpredictability as the various other factors that shape front line practice impact on and interact with the changes that policy attempts to introduce

The rules that direct the structuration of front line public sector services derive from a range of sources, of which policy forms only a part (Fig 8.3). Note that 'Culture' is used here to encompass professional, local team and organisational cultures, as well as general community and public cultures.
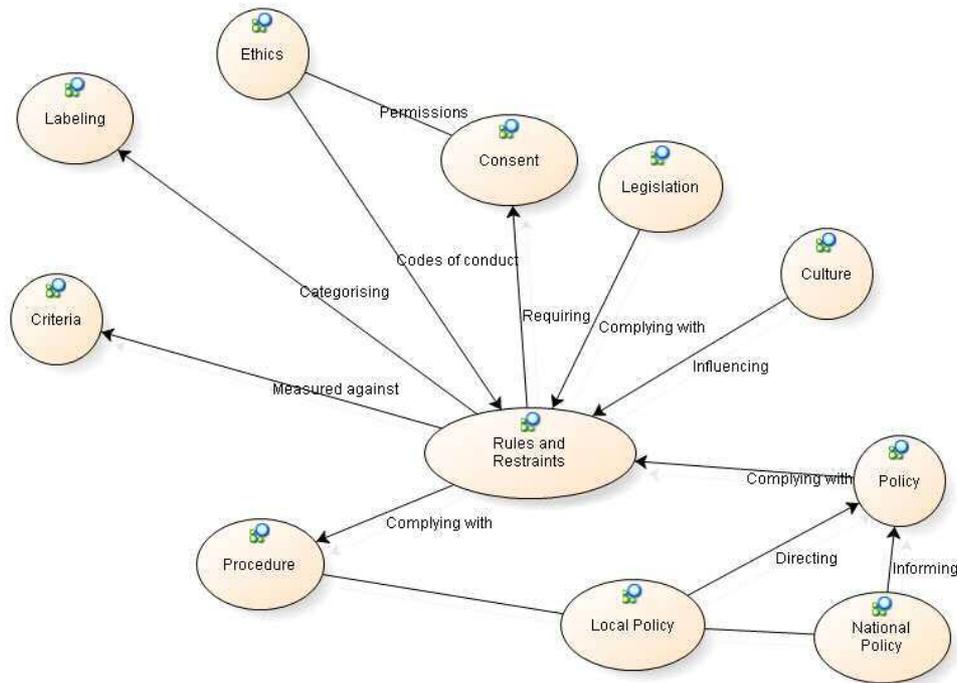
Figure 8.3. Macro Structuration: sources of explicit and tacit rules.

Policy undergoes a process of translation as it moves from high level vision and guidance, through local interpretation, and into active implementation. Levels of local organisational agency contribute to the extent of that translation – both in the immediate interpretation of policy intent, and in the allocation of resources to support its implementation. A lack of appropriate resources, conflicts with other rules (or a failure to account for or address them) or insufficient signification given to the intended change, can result in a high level of divergence between the intentions of policy and the structures that emerge from its implementation. Failure to implement a policy change may manifest through the re-emergence of old, established structures (as was common in SAP implementations), or a reduction in the effectiveness and responsiveness of services – but even 'successful' policy implementation may result in the emergence of new, unpredicted structures as other structuration factors shape activity at the front line.

By understanding the contexts and cultures that will impact on the implementation of policy, policy developers may be better placed to direct and shape the emergence of the structures they wish to create. At the same time, an increased awareness of how local innovation may shape and influence policy – through perspectives of success, perhaps, or through the introduction of new technologies of care – may allow policy developers to enable and support such innovative developments in ways that encourage the overall structures they wish to create.

Information systems development in the public sector often struggles to respond to this fluid, and somewhat unpredictable environment, and systems can be seen as barriers to change rather than mechanisms for supporting it. Rigid, traditional project based approaches tend to demand pre-definition of intended structures and often the technology involved lacks the flexibility to support innovation or to adapt as new ways of working and an associated shift in structures emerge. There is a need to understand the various components that might contribute to developing that kind of flexibility, creating robust and responsive technology infrastructures that can maintain the consistency and continuity of information resources while still being able to respond to policy change and allow new structures to emerge in use. The design of these components needs to be driven by socio-technical considerations and co-realised through involvement of all the relevant users; practitioners, administrators and service users as well as process and practice analysts and technical designers.

The study has illustrated the complexity of the public sector environment, which, although needing to respond to both policy requirements and the needs of the community which it aims to support, struggles to innovate and to effectively implement change. Through examining the factors which influence and shape the day to day delivery at the front line, and exploring the role of information services in enabling – or disabling – those structures, the nature of that struggle becomes clearer. The structures produced and reproduced at the operational front line arise from the structuration of social systems which have become stabilised and institutionalised over time. The technologies of care form an integral part of those systems, acting as both allocative and authoritative resources, and serving as repositories of rules and their associated schemas. In introducing change – particularly innovational change – there is a need to recognise this process of structuration, in order to address the relevant factors that will enable the required structures to be produced and then consistently reproduced over time. While changes can be made, and innovation delivered without taking some of these factors into account, the structures which emerge may demonstrate unexpected levels of structural divergence from those which had been intended. Although it may never be possible to implement such structural changes without some level of resultant divergence, the research suggests that a closer alignment between intentions and results may be achieved if the changes made recognise and address the structurational factors involved, and take into account the need to balance the expectations of policy, the demands of business delivery and the principles of practice and practice culture.

A failure in that balance can be observed in the imposition of structural rigidity (as in the approach to implementing ICS,) limiting learning and innovation and/or restricted the exercise of practice; but also in policies which have afforded high levels of meso (or even micro) agency, enabling the diversion and re-allocation of resources (ESCR) or the subversion of expectations (SAP). Policy development should address the achievement of that balance through the allocation of relevant resources and an investment in research across the sector, while organisations need to acknowledge the contributions of assessment practice and enable their business processes to support the generation of practice space. Equally, practitioners need to recognise the role of process in supporting and enabling the delivery of care. The growing emphasis on personalised services - and the use of co-productive approaches to providing and commissioning care - creates opportunities to develop a greater understanding of the way that process and practice interweave, and with them similar opportunities to re-visit the approaches to developing the information systems to support them. Structuration provides a way of exploring these macro-meso-micro interactions and potentially supports, through the use of action research and co-realisation approaches, constructive discourse concerning assessment policy, process and practice, and the development of IS tools to support them – achieving the requirements of change by enabling the co-production of relevant and effective technologies of care.

8.3 Implications for theory

The theory of structuration is seen to be able to provide a valuable conceptual framework to relate all aspects of the four dimensions of organisational change and approaches to change. The work has illustrated the benefit of utilising the theory as a mechanism to frame the study of information and information systems within organisational and cultural settings, creating a synthesis of IS and organisational study observed through a practice lens and exploring how information systems and organisational behaviours interface and interact This approach would benefit from further exploration, particularly concerning its application in other sectors and in relation to other types of practice.

There are also opportunities to further develop the analytical framework, adding tools to support the modelling of available and required resources, and using the approach to develop practical tools for application in change management, to assess the potential stability of innovational approaches, and to support the co-productive design of systems.

Given the complexity of the structures observed and the interactions involved, there would also seem to be merit in exploring the opportunity of synthesising structuration concepts with those emerging from complexity theory. The use of bracketed structuration models (micro, meso, macro) as a mechanism for analysis may provide a means of modelling complex systems, and addressing some of the issues inherent in more traditional reductionist approaches when considering issues of internal and external agency, and the emergent characteristics of those systems as a whole.

8.4 Implications for policy

Current public sector policies tend to assume the implementability of the changes they promote. With an increasing expectation that information and information services will underpin the solutions to those requirements for change, there is a greater need to develop strategies which can enable such solutions to be developed and delivered at the front line. Policy therefore needs to address, rather than assume, the information requirements of its delivery, promoting strategies which enable effective IS developments in the sector, and allocating relevant resources - while recognising that the levels of local agency it allows will impact on the range and variation of the solutions which may emerge. It also needs to support and enable local innovation – the learning from which should be fed back into the overall policy development process.

8.5 Implications for practice

The learning from this study provides knowledge and input to a number of areas of practice, including those of policy implementation, IS development and implementation, social care informatics, and social care delivery.

Policy implementers can learn from this work, recognising the role of organisational agency in interpreting and translating the expectations of policy into day to day activities, and understanding the need to position those expectations within the tacit rules of professional and organisational cultures. In addition, analysing the requirements for all of the needed resources – which include the tacit knowledge of practitioners and the time and input required to change culture as well as processes – will help support more effective implementations, along with encouraging more innovative developments in response to the need for change.

The work suggests a need for IS developers and implementers to be better able to respond to the needs of practice, taking more agile and evolutionary approaches, rather than becoming trapped in the traditional, product focused projects traditionally

employed. Greater engagement in participatory design and co-production techniques can assist in the creation of more effective services, and an increased awareness of how these services contribute to the overall structures of day to day activity will help to ensure that new implementations are designed to enable and support both business process and practice at the front line.

Social Care informatics is an emerging area of practice that arises from the increasing recognition of the value in and contribution of information and information services within the sector. This research contributes to the understanding of those issues, and provides a foundation, not just for further research, but for better informing Informatics managers and practitioners within the sector. The models and tools developed in the work have the potential to support and inform these practitioners, at a time when demands for such services are increasing.

This work also reviews and revises the current social care models of assessment practice, with the division between process and practice providing a constructive way to position the procedural aspects inherent in day to day activity. It also identifies the need to understand the information requirements of practice, and to support the meaningful transfer of this information through the occurrences of practice space within business process models. The study signposts the emerging requirement for practice to enable the shift in agency from practitioner to the person being supported, and the need to develop technologies of care which will support this, while still enabling practitioners to capture and record their professional perspectives and concerns.

8.6 Recommendations for further work:

There would be value in exploring the reproducibility of this work, and the applicability of some of the emerging concepts in other settings. This could include:

- The further examination of the concept of 'practice space' as well as consideration of the models of assessment practice – both in social care, and in other parts of the public sector, such as health, education, or housing.

- An exploration to identify any hierarchies inherent in the structurational factors identified, with consideration of how weighting, precedence, or perceptions of value might influence their interaction.

- A review of the impact of Personalisation on the positioning of social care assessment practice.

- An exploration of the role of information and the technologies of care from the perspective of the service user, particularly in the light of the move towards self-directed planning and support.

- The applicability of the Structuration analysis to multi-agency working, in particular supporting the development of Information Services, the implementation of policy, and the management of change.

Options exist for further research into the technologies of care, including the interactions between information systems/services and practitioners and service users.

- The use of mobile technologies to enable practice

- The development of more person centred technologies, and the way they may be used by individuals and supporting practitioners co-productively

- The potential of knowledge management techniques and theories in enabling both users and practitioners to access to knowledge resources.

There is also need to generate further understanding of how the development of more agile, evolution approaches to systems design and implementation in the public sector might be supported and sustained.

The cyclic process of investigation, analysis, intervention and review which underpins the majority of action research approaches would appear to present strong parallels with the practice associated with assessment and case management in social care. The similarities between the action research cycle and the models of social care assessment practice (particularly Smales' 'exchange' model (Nicholas, Qureshi and Bamford, 2003), as well as those found in the definition of social diagnosis (Richmond 1917)) suggest that the understanding of these practices may benefit from further exploration of these apparent parallels. This comparability would warrant further exploration, particularly in considering the development of potential informatics tools for practitioners.

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Appendix A: An Informatics overview of the History of Social Care in England

A.1 The evolution of social care policy in England.

A.1.1 Creating 'Care in the Community' – the development of Social Care legislation in England. (1940-1999)

Mary Richmond and her peers were building on a long established tradition of supporting the more vulnerable members of the community, one which emerged from a history of charitable works and an expectation that, first the church and later the state, held a level of responsibility towards the welfare of the old, the poor, the physically disabled and the mentally challenged. The English Poor Laws of the seventeenth and eighteenth centuries, and the Lunacy Acts of the late nineteenth century represent early attempts to define and legislate this responsibility. But the current understanding of 'traditional' Social Care in England has a much shorter history, one that parallels the development of National Health Service, and probably starts, as does the history of the NHS, in 1948.

The National Assistance Act 1948 stated that, 'it shall be the duty of every local authority to provide residential accommodation for persons who, by reason of age, illness, disability or any other circumstances, are in need of care and attention which is not otherwise available to them'. This, together with the accompanying introduction of welfare benefits, encouraged the beginning of the move from institutional to community-based care (MIND, 2009). In the same year, the Children Act of 1948 required the establishment of a children's committee and a children's officer in each local authority. Like much of the legislation shaping Children's services through the twentieth and into the twenty first century, the Act was influenced by the death of a child. It followed the creation of the parliamentary care of children committee in 1945, a body set up after the death of 13-year-old Dennis O'Neill at the hands of his foster parents.

Developments in services and policy through the fifties and sixties began to move the focus of attention from hospital based treatments and residential institutions towards the delivery of care and support in the community. The gradual reduction in the number of large scale, psychiatric institutes was probably the most public evidence of this trend, but by the late nineteen sixties, the precepts of care in the community were beginning to

be established and have formed the foundation of social care policy in the UK ever since.

The modern social care sector began to take shape over the 1970s, with Social Services departments established in Local Authorities, and supporting the development of care resources, such as home care provision, residential units, children's homes and fostering and adoption services. Policy and legislation began to proliferate, creating even greater complexity within the sector. In the mid 1980's these initiatives were primarily focused on the provision of services for individuals with mental health issues, although both policy and legislation continued to address the wider issues of disability, age, and the support of vulnerable children. High profile public incidents created demands for further reform. The murder in 1948 of social worker Isabel Schwarz by a former client led to the Griffith's report, 'Community Care: Agenda for Action' (Department of Health 1988a) - a forerunner to the Community Care Act of 1990(HM Govt, 1990), the legislation that laid the foundations for community care and established all the legal changes necessary to make Local Authorities the agencies responsible for assessing adults' needs, designing care packages and ensuring their delivery.

The following decade brought a range of additional powers to Councils with Social Services Responsibilities,[2] along with a series of initiatives attempting to redress the division between health and care that the Act had created. The 1990s were also characterised by a performance regulated, publicly accountable positioning of public care services, which became a major influence on the modalities of care. The expectation that Local Authorities collect and publish performance metrics in order to evidence the delivery, quality and cost effectiveness of services has significantly underpinned service developments, organisational arrangements, managerial approaches, the shaping of business processes and – probably most significantly from the perspective of this thesis – the development of information systems and services. While policy initiatives tend to assume that implementation will be supported by relevant metrics the timescales they impose often mean that systems to capture them cannot be effectively developed or updated by the required deadlines (ADASS and Department of Health, 2007). Additional difficulties arise when the policy concerned is

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[2] Not all Councils in England have responsibility for care services: in areas where there are several 'tiers' of Local Government Authority (Parish, District, County) the responsibility for care generally lies with the top tier, whose remit covers the widest geographical area. This can both support (through the economies of scale) and potentially hinder (by separating responsibility for care from those of providing housing and other services) the delivery of effective co-ordinated services. Recent local government reform has attempted to address some of this division of responsibility through the creation of 'Unitary' Authorities, which combine the powers and responsibilities of the top two tiers into a single authority.

aspirational and the details required for operational implementation are unclear. At best, collecting data for performance measurement becomes an additional task, rather than being imbedded in daily practice, but on occasions the lack of relevant resources (whether that be trained staff, usable systems, meaningful information, or effective business processes) has meant that the structures intended by policy become seriously distorted, or fail to emerge at all. As each Local Authority is individually responsible for the instantiation of policy, the ability to implement will vary from Council to Council; some may achieve the intended change, some may struggle, and – in some cases – some may attempt change only to have habitual structures remerge.

Legislation continued to try and address public concerns, while policy struggled to focus service delivery at the front line, and to empower the service user. The 1998 White Paper *Modernising Social Services* presented proposals for the development of Children's services, approaches to improving protection services, increasing partnership working, and improving standards of care (Department of Health, 1998). It is interesting to compare the proposals in this White paper with the ones laid out by Griffiths just over a decade previously. The focus on assessed needs remains, but the key role of the Local Authority in leading on care in the community is greatly diminished. The concepts of 'integrated care' emphasises an increasing expectation of engagement with the health deliveries of the NHS, and the requirement for quality and standards has been expanded from the domain of the residential care home to cover public care services as a whole.

The paper also reinforced the need to collect and collate performance metrics to monitor compliance with policy – and so remained a key focus for information system development within Local Authorities, often taking precedence over developments to support front line practice.[3]

1999 saw a change in focus within the Department of Health. An emphasis on Health led issues began to take priority and the underlying thinking in policy development began to shift towards a health led, health dominated model. Issues impacting on the social care sector began to appear more frequently within health policy documents, reflecting an expectation that health and social care would, by this time, have established effective working partnerships. While this was probably true in some

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[3] Author's personal observations, having been responsible at the time for the delivery of social care information services to a small, unitary authority. The collection of statutory performance data was identified as a priority requirement, and resources were specifically dedicated to enable the delivery of the new performance framework (PAF)

places, the majority of Local Authorities had, and would continue to have, difficulties in maintaining sustainable, operational partnerships with their local health partners. This mismatching of expected, and actual structure inevitably arises from issues encountered in implementing earlier, or associated policy initiatives, although it may partially result from selective prioritisation within the implementing organisations – given the agency to choose which policy initiative takes precedence, stakeholders may focus their resources on delivering their priorities and not those of their partners.

A.1.2 Initiatives for the twenty-first century.

The National Service Framework for Older People was published in 2001. It described standards of care for all older people, whether they lived at home, in residential care, or were being cared for in hospital, and aimed to improve both health and social care services (Department of Health, 2001a). This was a significant document for social care, although it took some time for the implications to become apparent. The framework described systems wherein an individual was assessed in a way that was proportional to their needs, and in a coherent and coordinated way across the range of organisations that might be involved in their care. It also introduced the concept of *Single Assessment* (SAP), initially applicable to those 65 and above, but potentially extendable to all Adults in need of care support (Department of Health, 2001a). The approach depended on the development of close, integrated working between social care, health, and other agencies (such as housing) and the use of common, shared tools. Although this document was focused around health services, it was generally Local Authorities that took responsibility for leading developments in Single Assessment. The initial deadline for the delivery of the approach was 2004, but despite extensive work took place across the country, the actual implementation was patchy. Some Health and Care communities adopted the idea with enthusiasm, others lost impetus and some projects fell by the wayside altogether. The requirement for a single, shared tool meant that the concept was unwieldy and supporting processes almost impossible to maintain without implementing shared technology across the relevant agencies. Without the necessary infrastructure, many of the organisations involved reverted to their own, internal processes, exercising their agency to choose the level of their input and engagement.

As Clarkson and Challis observed:

> Moves towards integrating the roles of professionals such as social workers and community psychiatric nurses, through the key-worker system were consistently

hindered by the lack of joint structures and training. And there was little guidance on how to avoid the inevitable communication difficulties between professional groups from across the health and social care divide (Clarkson and Challis, 2004).

The incompleteness and lack of follow through in SAP implementation has made it difficult to identify whether the approach was effective in achieving its intended benefits. Although there is some evidence that more older people were receiving multi-disciplinary assessments, there appears to have been little change in the health needs of those in receipt of Social Care (Sutcliffe et al. 2008).

Despite the limits of its success, (and the equally limited evidence of its effectiveness in delivering the expected benefits) the concepts underpinning SAP - and the need for technical, as well as business integration to support integrated working – were major influences in the shaping of subsequent policy, and in influencing expectations concerning information systems development within social care.

The Single Assessment Process was directed at the support of Older People. The White paper describing a strategy for learning disability services - 'Valuing People (Department of , 2001b)' - was also published in this year, and in April 2001 English Local authorities began using the Framework for the Assessment of Children in Need and their Families. The framework guidance had been first published in 2000, and was designed to support the comprehensive assessment of children looked after by Local authorities (Looked After Children, or LAC), which was to be delivered through the use of a range of documents and forms.

2001 was also the year in which *Information for Social Care* was published. The lack of alignment across the growing range of policy documents created tensions between compliance with the intended strategy and the delivery of the new processes. Although Information technology holds great potential to improve the delivery of service and support efficient and effective care, the timescales for system development and the rigour needed to deliver those benefits can limit the ability of services to respond to new initiatives. If new policy does not assess the impact of change on existing systems, and the systems themselves are inflexible and difficult to reconfigure, there is a risk that the systems act to reinforce old structures, restricting rather than supporting the agency needed to create new.

2002 saw the Publication of the Fairer Access to Care Services policy (FACS) which defined a series of criteria for determining eligibility for care, and was intended to

create consistency in the allocation of care resources across the country.[4]   It had been intended to publish the FACS Guidance earlier, but it had deliberately held back in order to support the introduction of the Single Assessment Process, and the strategy laid down in 'Valuing People.'

FACS was quickly taken up and its criteria were soon embedded into local policy and practice, although possibly not as consistently as the formulators of the policy had intended. Its almost universal appropriation, and the way it subsequently shaped the language and expectations of practitioners provides an interesting contrast to the struggle to implement the Single Assessment Process, which proceeded it.

The second important policy/strategy development of the year was the establishment of the 10-year National Programme for Information Technology in the NHS. The programme was ambitious; it established overall priorities for systems development and absorbed a great deal of resources at both National and local level. Social Care, however, was excluded from its scope, even though many of the contemporary policy documents had been promoting increased partnership and integrated working between the two sectors.

The tensions between health and social care tend to emerge when there are issues around responsibility and ownership. The formalisation of solutions to these issues, however, can sometimes increase, rather than diffuse the tension. The Community Care (Delayed Discharges Etc) Act was passed in 2003, placing new duties on the NHS and Local Authorities in England relating to communication between health and social care around the discharge of patients. The Act requires payments to be made when the discharge of patients is delayed for reasons relating to the provision of community care services or services for carers. The onus therefore fell on Local Authorities to ensure that services were available, while the NHS was required to notify councils of any patient's likely need for community care services, and of their proposed discharge date (Department of Health, 2004b). In theory this would appear to be a sensible approach; in practice it tended to refocus attention away from the provision of appropriate services and towards actions undertaken in order to reduce financial penalties.

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[4] At the heart of the Fair Access to Care Services guidance is the principle that councils should operate just one eligibility decision for all adults seeking social care support – namely, should people be helped or not? In carrying out their duties under section 47 of the NHS and Community Care Act 1990, councils should keep assessment in proportion to individuals' needs using the general principles of assessment included in the guidance, and/or by reference to the most appropriate assessment framework (such as the single assessment process for older people). Services are matched to eligible needs through the use of statements of purposes, which all providers should make available (Department of Health, 2002b)

As Adult services wrestled with the implications of performance monitoring, eligibility criteria, and partnership working, public attention focused on how 'the system' was seen to be failing children. In England, the tragic death of Victoria Climbie in the February of 2000 had lead to an intensive inquiry, which published its findings in January 2003 (Lord Laming, 2003). In Scotland, the enquiry into the death of Caleb Ness in Oct 2001 identified similar concerns (O'Brian, Hammond and McKinnon, 2003). The Bichard Inquiry, which investigated the background to events surrounding the murders of Jessica and Holly Wells in 2002, identified further issues (Bichard, 2004) The findings of these inquiries and the structures they evidence, will be considered in more detail later in this appendix. At this point, it is probably sufficient to identify that these findings greatly influenced (although not entirely directed) subsequent legislation and policies. Their primary influence impacted on Children's services, although changes to the modalities of care for Children inevitably affected the delivery of Adult services.

A new Children's Act, agreed by parliament in 2004, created the legal foundations for a number of new initiatives and a range of changes in the way that Children's services were to be delivered (HM Govt, 2004). This Act included provisions for the establishment of a national Children's database, along the lines of one proposed by Lord Laming in his report on the death of Victoria Climbie. Once again, the death of a child marked a major shift in policy and approach; thirty years after the original Local Authority Social Services Act, English legislation and policy stepped away from the concept of mono-managed 'social service' departments to define a requirement that split Children and Adult services into separate areas of political and managerial responsibility. The legislation required the appointment of a Director of Children's Services, who was to oversee *all* services relating to Children's health and well-being within the Local Authority, including Universal services such as Education and some aspects of leisure. This, predictably, led to the creation of similar posts for Adult Services; the overall remit of these Adult Directors varied from council to council, but often included a range of community focused services, such as libraries, heritage services, lifelong learning, and – where relevant – housing services.

Although this change helped addressed some of the issues and concerns raised in the Laming inquiry, the associated separation of responsibilities for child welfare policy from those for children's health disrupted the continuity between the two. The Department of Children's Schools and Families added Children's social care to their

portfolio, but responsibility for Children's health was retained within the Department of Health, requiring partnership working at national, as well as a local level. The concept of 'social care,' both as a service sector and as a profession, continued to be relevant, and - while Children's services strove to deliver support at a more universal level, and much of the emphasis of Adult policy became focused on enabling individuals to care for themselves - the fundamentals of supporting the vulnerable within the community remained.

The research described within this thesis started in 2005, at a point where many of these new policies and arrangements were in process of being introduced, and the implications of the change they were intending to sponsor had not yet become apparent. Since that time, and as a backdrop to the progression of the research, there has been additional legislation, further developments in policy and a number of initiatives intended to shape even greater change in social care. Much of that change is promoted as being transformational, aimed at achieving radical shifts in the modalities of care. Some of may be - but looking at the history of care policy and the concepts and expectations it has expressed, these 'new' approaches might also be viewed as further attempts to find ways to shape and achieve long desired structures which have not yet emerged through the structuration of public sector care.

The next two sections of this appendix outline the relevant legislation and policy initiatives which have been published since the inception of the research, the organisational response to which has shaped both the undertaking and the direction of this work.

A.1.3 'Putting People First' - from working in Partnership to the emergence of Personalised services for Adults.

Adult Social Care policy continues to sit within a complexity of other policy strands, many of which impact on the expectations expressed within the core documents. Health policy, with a focus on performance in acute services and the delivery of treatment, rather than care, creates tensions when working to integrate services between the health and care sectors. Local Government policy influences the prioritisation of resources and the focus of local community developments – and Children's policy impacts on the interface between Adult and Children's services. Co-ordination across all these strands is necessarily complex and often takes place at the local level; although the overall direction of policy is set by a central government strategy, the details of individual

initiatives are often developed in isolation and their impact are not always fully assessed.

While policy concerning Children's services has begun to focus on directed intervention and integrated working delivering universal objectives, the move in Adult policy has been towards enabling greater choice and control for the users of care services. This move has been promoted as being 'transformational' and is seen as a major change in policy direction – but while some of the language may have changed, the core of the approach continues to echo earlier themes.

In some ways, this is a further attempt to generate the kind of structures envisaged at the time of the earlier reforms - one equally subject to the range of factors influencing and shaping the structures observed in 'traditional' assessment and delivery of care. Arguably, one of the factors that may enable these personalised services to finally emerge may be the readiness of practitioners and the community they support to embrace the shift in personal agency involved – an outcome, not of the 'step change' demanded by policy, but of a slower enactment of change through the evolution of culture, attitude and social conduct over time.

2005 saw the publication of the Green Paper, Independence, Well-Being and Choice, which set out, 'a vision for adult social care' over the next 10-15 years and how this might be realised (Department of Health, 2005). This was the first paper to acknowledge the existence of a Director of Adult Services (DASS) following the changes in responsibility brought in by the Children's Act 2004. It reinforced the need to work with partners to plan and provide services, and to improve shared working between health and care. In contrast with the Griffths report of 1998, the language focuses on the support of and benefit to individual people, rather than on organisational and governance changes. This shift in language is probably as important as the content of the document, since the use of language in policy documents and the terms new initiatives present greatly influence the culture and thinking of care communities, shaping some of the normative elements of structure (Giddens, 1984) and being used to promote social activity that is socially valued.

2005 was also the year that the NHS Information Centre for Health and Social Care (NHS IC) was established. The Centre was categorised as a special health authority, one of a group of arms-length bodies that provided central services within the NHS. Unlike many of these bodies, which have a purely NHS and health focus, the remit of the NHS IC explicitly includes social care   It holds responsibility for collating data and

producing reports which provide the basis for decisions about the provision of health and social care. Although the Coalition Government has begun to take a deliberate step away from the centralised imposition of performance management, the requirement to collect, collate and analyse activity and performance metrics remains an important factor in the overall structuration of formal care services.

Policy impacting on Adult Care continued to be published in parallel rather than integrated strands – a number of initiatives relating to Health, Mental Health, Social Care, and Adult Safeguarding appeared between 2006 and 2009, all of which had impact on Care Services. While many of these documents reflected the intentions of the Government's over arching strategies, some policies risked perpetuating the early tensions between health and care; others potentially created tension within the care sector itself. Local Authorities continue to wrestle with reconciling the new personalised approaches with the demands of safeguarding, and issues of capacity and consent.

The 2005 green paper was followed by a 2006 white paper: 'Our health, our care, our say: a new direction for community services,' which promised 'a radical and sustained shift in the way in which services are delivered, ensuring that they are more personalised and that they fit into people's busy lives (Department of Health, 2006).'

Meanwhile, the Department of Health had been considering the potential extension of the Single Assessment Process across the whole of Adult Care. This work was to be influenced by a number of factors, among them the development of the Common Assessment Framework for Children – although the product that began to emerge from the development was very different from the Children's CAF. The Adult Common Assessment framework was closer in principle to the original SAP, the intention being to establish a consistent framework of assessment to support joint working and information sharing between health and social care. Drafts of the Adult CAF consultation document began to circulate in 2007, along with proposals to fund a series of 'demonstrator' projects to explore how an Adult CAF might be implemented on a local basis.

2007 also saw the introduction of a new term: Personalisation.

Personalisation does not just concern social care but is a central feature of the government's agenda for public sector reform. The prime minister's strategy unit report 'Building on Progress: Public Services' described it as "the process by which services are tailored to the needs and preferences of citizens. The overall vision is that the state

should empower citizens to shape their own lives and the services they receive (Prime Minister's Strategy Unit, 2007)."

Its application to adult social care was described in Putting People First: A Shared Vision and Commitment to the Transformation of Adult Social Care (Department of Health, 2007) - a document that has been described as a ground-breaking concordat between central government, local government and the social care sector. This short document laid out a number of objectives that reinforced and progressed the approaches identified in the earlier White paper, emphasising joint working, shared responsibilities, personalised care, and a move towards preventative services. This officially introduced the idea of a personalised adult social care system, intended to give people maximum choice and control over the services they receive. It links to wider cross-government strategy including the notion of "place-shaping" and the local government white paper 'Strong and Prosperous Communities (Department for Communties and Local Government, 2006).'

Independent living, participation, control, choice and empowerment are key concepts for personalisation and they have their origins in the independent living movement and the social model of disability. The current personalisation policy has been influenced very strongly by the practical work of the In Control initiative, established as a social enterprise in 2003 (In Control, 2011), which has been pioneering the use of self-directed support and personal budgets as a way to reform the current social care system.

The initial focus for implementing personalisation lies with social care, although proposals have been made for extending the approach into health, particularly in relation to the management of long term conditions. The development of person-centred care has been a major theme in health and care policy documents for a number of years: the concepts under-pinning personalisation takes this even further, promoting both self assessment and self-directed support.

Other initiatives also moved forward. The Adult CAF consultation was delayed, but the calls for expressions of interest in becoming a demonstrator site went ahead; the selected sites were named during the consultation period in early 2009, and started work on their projects – even though the outcome of the consultation had not been published. The initial intention behind an adult CAF was to create a national mechanism to support and deliver local integration between health and care; this intention remained as a key deliverable, but the work had to adapt as the implications of Personalisation continued to emerge.

In this brave new world of personal choice and control, however, a number of issues remain. The complexity inherent in enabling these kind of personal, individual services while ensuring consistency, effectiveness and sustainability across the care sector has been recognised. Managing risk and ensuring that the safety of the vulnerable remains a concern and the focus has moved from the 'protection of vulnerable adults' to 'Safeguarding Adults'(Department of Health, Home Office and Ministry of Justice, 2008) – a change which reflects the broader approach being implemented within Children's services.

Another issue to be accounted for is the position of and input from informal carers. Carers want recognition of their work and expertise, better service coordination, better information, improved joint working between staff and agencies, health and social care. Like Putting People First, the Carers' Strategy was agreed by several government departments and was the result of a wide consultation.

This strategy – also published in 2008 – identifies the proposed use of an Adult CAF, mentions the intended review of FACS, and lays out the objectives of the Putting People First document (HM Govt, 2008). The emphasis in the implementation section is on the monitoring of local performance in relation to the strategy and the expectations that the funding for related transformational development will bring benefits to carers. Here the policy document describes an expectation of changed structures, but does not specifically address what might need to be in place to enable them to emerge, providing a good example of how policy focuses on setting direction and intent, leaving local interpretation to determine the necessary resources and the levels of agency required to shape the intended vision.

A.2 From Colwell to Climbie and beyond – the issues emerging from the Safeguarding agenda

> On 28 June 1944, Dennis O'Neill, who had been in the care of Newport Borough Council for nearly six years, was placed into foster care at the 70-acre Bank Farm in Minsterly, Shropshire. His younger brother Terence joined him at "the very bare, comfortless and isolated" farmhouse the following week. Seven months later and two months shy of his 13th birthday, Dennis was dead (Community Care, 2007).

It is important not to neglect the role of public perception and the impact that well publicised systemic failures have had on both the production of policy and the delivery of care. Care is an emotive subject, and reactions to evidence of neglect or abuse tend to include both anger and horror. When the evidence points to failures in the systems

intended to protect the vulnerable, anger can turn to outrage – which, in turn, generates public outcry and demands for 'something to be done.'

The history of social care policy is littered with publicly reviewed failings of this kind. Most have been focused on the tragic deaths of children, but similar concerns have been raised in regard to vulnerable adults. Potential risks to the public from those with mental health issues have also been highlighted by tragedy, and instances of institutionalised abuse and poor quality care have been brought to public attention by investigative journalism and documentary makers. Changes in policy have often shaped in response to recommendations made by public inquires – although in some cases the proposed change may already have been in the pipeline, and policy makers have often taken the opportunity to bring in wider reform on the back of responding to particular concerns.

These inquiries have a long and persistent history. The Children Act of 1948 was developed by the parliamentary committee set up after the death of 13-year-old Dennis O'Neill; major reforms in both service and practice resulted from the Maria Colwell inquiry in 1973; the Every Child Matters initiative followed the publication of the Lamming Report; and further reform was demanded after investigations into the death of baby Peter in 2007. In between lie many others: the Bichard inquiry into the deaths of Jessica and Holly Wells, the deaths of Caleb Ness and Carla-Nicole Bone in Scotland, and a whole catalogue of local reviews undertaken after the deaths of children in care or considered to be 'at risk'.

Adult tragedies have been less well publicised, but have still been influential. Campaigners against elder abuse used the case of Margaret Panting – an elderly lady who died following horrific abuse by her carers in 2001 – to argue for a change in the law, influencing the creation of the Domestic Violence, Crime and Victims Bill (2003). The murder of Steven Hoskin, in 2007 raised further issues about the engagement with and protection of vulnerable adults.

Two common themes, running through many of these inquiries, are issues of intra and interagency communication and information sharing.

The Colwell report noted:

> What has clearly emerged, at least to us, is a failure of the system compounded of several factors of which the greatest and most obvious must be that of the lack of, or ineffectiveness of, communication and liaison. A

system should so far as possible be able to absorb individual errors and yet function adequately (Field-Fisher, 1974).

A statement which is echoed in the serious case review for Steven Hoskin, thirty four years later.

> Both reviews conclude that all the agencies involved were focused on a "time and task" approach to their work. In the metaphor used by Dr Flynn, all had certain pieces of the jigsaw but all failed to fit the jigsaw together. Poor communication and information sharing across agencies was another main conclusion of both reviews (Flynn, 2007).

Policies published after the Colwell inquiry were intended to promote structures that enabled communication and supported interagency working. Yet the structures that emerged from these new rules became the ones that were to fail in the case of Victoria Climbie. While this may have been the result of predetermined structures being unable to respond to unpredicted circumstances, it is more likely evidence of the way that the crystallisation of policy into local organisational governance and procedures - intended to engender particular structures and behaviours - can become constraints over time, mis-shaping structures as new resources and new societal rules impact on their reproduction.

The issues around the introduction of and use of new technology is illustrative of this:

> 'What we see here is an important and significant shift. Whereas in the case of Maria Colwell the problems were derived primarily from failure to communicate between case workers, in relation to Victoria Climbié the problems were much more in relation to wide-ranging and complex system failures, of which communication between individual workers is simply a part.
>
> The failures were not so much in sharing information but managing information, and it is in this respect that the notion of 'systematic care' is seen as so important for ensuring that information and knowledge are managed rigorously... All of these have seen important developments over the intervening thirty years. The growth of information technology, the increasing hypercirculation of knowledge and communication, and the need to try to manage this, have all become important organisational issues (Parton, 2004).

This shift in the nature of available resources, and the consequent struggle to appropriate them highlights the need to understand the role of information and information technology in the support and delivery of services. The failure these inquires identify do not necessarily arise from inadequacies in policy, but lurk within the structures that emerge from it, both during their production and in the evolution/degradation that takes place in their reproduction over time. The agency given to organisations in prioritising their response to policy demands, the availability and adequacy of resources available to support the implementation of change, and the

tensions inherent in the complexity of rules, regulations, practice perspectives and organisational behaviours that shape social care, have all contributed to the outcomes in these tragic events. Weak structures may be adequate to support the majority of normal business, yet can fail catastrophically when tested by unpredicted events. Strong structures may also fail – but subsequent inquiry should be enabled to evidence the specific failures in those structures, rather than point at failings in the system as a whole.

Policy is clearly a huge influence on the structures that deliver and support Social Care. It provides signification for activity, defining the rules within which organisations are expected to work, describing expectations of activity and performance, and helping to shape language, culture and behaviours. Legitimation of those rules comes through legislation and regulation, and through the actions that drive implementation, both nationally and locally.

The expectations of public sector policy, however, often remain unfulfilled. Insufficient, or inadequate resources – funding, training, tools, the capability or availability of the workforce – can inhibit or distort the emergence of desired structures. Conflicts and tensions created by the requirements of parallel, unaligned, policies, or through the constraints of organisational, professional – and potentially community and national - cultures can deflect or derail the intentions of change. And the agencies allowed in implementation – at an organisational, as well as individual level – can impact on both the shape and the sustainability of structures as they are created and recreated in the day to day activities of practitioners and administrators.

Looking back over the history of social care policy in England, it can be seen that these shortfalls in implementation are themselves part of the modalities of care – that, along with public opinion, political direction, and societal expectations - the feedback arising from performance monitoring, the observations of regulators and the outputs of service evaluations, reviews and research are key contributions to the on-going evolution of policy and the structures it attempts to create.

A.3 Repositories for Rules and Resources
Implementing Information Systems in Social Care

> Information is a fundamental and crucial element in the delivery of quality social care services. If those services are to meet the needs and expectations of service users and to be delivered in a timely and cost effective way, then it is vital that appropriate information is available and accessible to the range of players with an interest in social services, from the general public and service users, through

care workers and care providers to senior managers and elected member (Social Care Information Policy Unit, 2001)

A3.1 Information for Social Care and the ESCR

IT systems were initially introduced into the social care environment in the UK to serve as administrative tools, aimed at improving efficiencies within the service and supporting the production of statutory returns to government and inspection bodies (Ames, 1999; Custance, 2005) Mainframe-based client indexes began to appear in the 1970s. Then 'stand alone' databases were developed in the 1980s to meet the needs of specialist services such as child protection or family placements. From the late 1980s more integrated management information systems were introduced … which attempted to capture the decisions, activity and costing implications for the whole organisation (Gould, 2003).   Individual and local projects explored the support of frontline practice in both health and social care to varying degrees, and learning could be found by reference to similar projects undertaken in the USA (McCoy and Vila 2002) and in Europe (Steyaert and Gould 1999; Haux et al. 2002)   However, it was not until 2001 that government policy formally recognised that 'Information is a fundamental and crucial element in the delivery of quality social care services' (Social Care Information Policy Unit, 2001).

Information for Social Care was the first UK policy document to specifically address the use of information and information technology within the care sector. It was produced by the Social Care Information Policy Unit (SCIPU) – a group of policy advisors based within the Department for Health, and who were, at the time, responsible for the collection and collation of national statistics relating to care. The paper set out a direction for information system development within social care, core to which was the development of fully electronic care records, moving the focus of case recording from paper to computer. It was developed following the publication of the NHS's equivalent Information strategy '*Information for Health'* (NHS Executive, 1998) although its approach and content – focusing on local development of holistic electronic records – was very different from the ambitious national infrastructure being proposed for the National Health Service.

Health and social care policy initiatives in the UK, and elsewhere, had begun to make the provision of integrated services for health and social care … a major priority.   Plans for implementing these initiatives generally associate the current state of service fragmentation with the lack of information integration and propose that service

integration can be achieved through the development and deployment of a common information infrastructure (Hartswood et al. 2003).

> The electronic healthcare record is a necessary tool supporting the person (citizen) centred shared care. It is not a stand alone system in a physician's room or in a hospital clinic, but a collection of health data about an individual's life that is stored at the point of care. There are ... challenges to a wide use of EHR that can be categorised as organisational and cultural issues, legal issues, market issues, leadership and vision of decision-makers, and the user acceptance issues. Presently, what is widely implemented are hospital administrative systems, electronic medical systems in use in primary care and clinical information systems in hospitals that are normally stand alone and do not communicate. (Hartswood et al. 2003)

Information for Health (NHS Executive 1998) described the conceptual difference between the records in these independent, specific systems(EPR), and the integrated, holistic record (EHR) that the strategy aimed to deliver:

> Electronic Patient Record (EPR) describes the record of the periodic care provided mainly by one institution. Typically this will relate to the healthcare provided to a patient by an acute hospital. EPRs may also be held by other healthcare providers, for example, specialist units or mental health NHS Trusts.
>
> The term Electronic Health Record (EHR) is used to describe the concept of a longitudinal record of patient's health and healthcare – from cradle to grave. It combines both the information about patient contacts with primary healthcare as well as subsets of information associated with the outcomes of periodic care held in the EPRs. (NHS Executive, 1998)

Information for Social Care (Social Care Information Policy Unit 2001) introduced an additional concept - that of the Electronic Social Care Record (ESCR.) The detailed definition of what this should look like was published slightly later (Social Care Information Policy Unit, 2003), allowing time for consultation and engagement with local Authorities and other stakeholders.

The development of the ESCR was to:

- Provide the record that can be shared and accessed by service users or someone acting on their behalf
- Enable the social care record to be used as a comprehensive individual record within social services
- Be the basis of the record that is shared with partner agencies, and in particular form the social care element of the electronic health record
- Have encryption standards built in to protect confidential information
- Comply with Caldicott and BS7799 standards[5]

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[5] BS7799 was the then current standard for information security, The Caldicott initiative (Walker 1999) – originally a requirement in Health and later expanded in scope to include Social Care – focused on the

- Be the means of managing information at the level of the individual case record
- Define the target for electronic records
- Form the basis for management information to be produced
- Form the basis from which workflow can be applied to improve the way processes are carried out.(Social Care Information Policy Unit, 2003)

Unlike the strategy for Health, which was to be implemented through a large scale national development project, the focus of the social care work was on developments within individual Local Authorities, with far less central involvement and no intentions – at that stage - to develop national standards or infrastructural services. Capital grant money had been identified to support the initiative, and as part of the conditions of receipt, Local Authorities were required to produce and publish a Local Implementation Plan, setting out their local strategies and evidencing how they would comply with the national approach. Integration with health partners was expected to happen at the local level, emerging from the work being undertaken to implement existing policy and practice initiatives. (Department of Health, 2001a)

One of the innovative features in this new approach was its emphasis on document management, and using it to support a holistic capture of an individual's case. For some authorities, the introduction of an EDMS (electronic document management system) took precedence over other requirements, while others looked to replace what they saw as outdated case management systems with newer, more strategically compliment ones. This work was not only being undertaken at the same time as the implementation of the National Service Framework for Older People and its associated Single Assessment Process (SAP), but also coincided with the early piloting/roll-out of the Integrated Childrens system, so the attempt at an overarching strategy was both timely and welcome, even if a great many Authorities struggled to understand how the various pieces fit together.

As part of the IfSC implementation, the SCIPU reserved funding to support a number of 'demonstrator projects.' Among the successful bids made for this funding was the Virtual Electronic Social Care Record Demonstrator project (VESCR) put forward by Newcastle. This project developed a prototype record, exploring the issues underpinning the development of a fully electronic record for social care. It demonstrated the value of practitioner input in participatory design and helped identify

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ethical/legal use and management of personal information. These requirements would later develop into those for more comprehensive Information Governance Frameworks

the potential offered by the use of technology to both information specialists and practitioners. (Wilson et al. 2004)

Other demonstrator projects looked at a range of diverse issues and technologies, including information sharing, mobile working, business process mapping, multi-agency working in children's disability and Adult mental health services, and support for the Single Assessment Process.[6]

The overall response to *Information for Social care* varied, but a number of Local Authorities began to undertake work to extend the use of IT into front line services. In some cases this included drawing on work previous undertaken in looking at developing electronic patient records for health (Hartswood et al. 2003; Joint Computing Group of the General Practitioners Committee & Royal college of General Practitioners, 2003; (S. Walsh, 2004; Vikkelso, 2005). Apart from the work undertaken in Newcastle (Staton et al. 2004; Mcloughlin et al. 2005) and an informative survey that was undertaken in 2007 (ADASS and Department of Health 2007) much of this work has not been generally documented, formally evaluated or researched, and the success, or otherwise, of Electronic Social Care Record developments is therefore difficult to measure. This is a stark contrast to the extensive literature available concerning the implementation of EHRs in the health sector,(such as (Hartswood et al. 2003; Gans et al. 2005), or (Ludwick and Doucette, 2009)) and the closely scrutinised progress of the NHS's national programme (Hendy et al. 2005; Coiera, 2007). The majority of the literature which does exist generally focuses on the implementation of integrated systems to support Single Assessment (SAP) (Abendstern et al. 2008) or mental health services (Hardstone et al. 2004) rather than on the issues within Social Care.

A3.2 Losing Impetus, regaining direction

Shortly after their publication of the ESCR guidance, the resources of the SCIPU were absorbed into the newly created National Health Information Authority. (NHSIA) The NHSIA's primary focus was on Health developments, laying the foundations for the National programme for IT in the NHS (NPfIT.) The NHSIA was itself subsequently dissolved into a number of bodies in 2004, among which was the National Information Centre for Health and Social Care (NHS IC) which became responsible for collecting,

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[6] I was project manager one of these projects at the time, which provided me with some interesting insights into this attempt to provide some strategic direction for ICT within social care. The use of funding to support 'demonstrator' projects set a precedence for later work, and a similar approach would later be used to progress work around the Adult Common Assessment Framework (aCAF).

collating and analysing Health and Care data. Another of the bodies that emerged from the dissolution of the NHSIA was Connecting for Health (CfH) - an organisation which took up the responsibility for delivering the NPfIT. Social Care was seen as out of scope of the National Programme, and while both the NHSIA and later the NHS IC continued to support the performance returns, the overall strategic direction and leadership that the SCIPU had provided was lost.

This 'sidelining' of the Information for Social Care policy created a number of issues, and the subsequent division of responsibility for Adult and Children's care added to the confusion. Unsurprisingly, a number of Authorities saw the requirements for an ESCR as a low priority, and reduced or abandoned their developments. Work to integrate Health and Social Care (initiated in local projects as part of SAP) stuttered and lost momentum. System suppliers took the lead in translating the implications of policy into the design of technology, and local resources tended to be targeted at supporting the existing information structures (focused primarily on the production of performance information) rather than enabling new ways of working to emerge. A number of the studies which were undertaken during this period highlight the challenges - not only in implementing innovative information systems, but of addressing the issues of culture, practice, and organisational change.

> In order to close the implementation gap for SAP, that is, to reduce the distance between policy objectives and achievements, practitioners working in increasingly pressurized NHS and community care settings need effective support in order to change the way they practise. Practitioners cannot be expected to make this transition unaided and without this support, are likely to respond by limited or non-participation in the process as seen in this evaluation and previous work (Dickinson, 2006)

Nationally, the sector struggled to find a 'voice' for Informatics issues, reflecting a more general struggle for the needs of Adult Social Care to be heard above the demanding voices of their Health partners. Developments continued at a local level however, with discussion and dissemination of learning being facilitated through the use of networks and communities of practice, such as the Information Management Groups (IMG) sponsored by the Association of Adult Directors of Social Services (ADASS), and the various system user groups – and newer bodies, such as the Care Record Development Board (CRDB), began to recognise the need to include Social Care issues in their work.

The CRDB was an advisory body, set up to consider the information governance issues beginning to emerge from the work of the NPfIT. Their primary focus was on the

design and implementation of the National Care Record service, but their remit included consideration of other information developments, including issues arising from information sharing and partnership working. They set up a number of subgroups, including a SAP working group, and in 2005, they sponsored the establishment of an Electronic Social Care Record Implementation Board.(ESCRI)

This Board was set up to:

- Take forward policy in relation to the ESCR and SAP

- Ensure consistent implementation of ESCR by Councils with Social Services responsibilities.

- Establish national standards for the electronic exchange of information between health, education and social care agencies to support the implementation of ESCR and other electronic care records and to recommend these to the CRDB.

- Provide a forum for the discussion of policy issues and to resolve problems or where necessary to recommend to the CRDB.

- Ensure that the ethical principles established by the CRDB are interpreted and applied to the ESCR and to refer to the ethics advisory group as appropriate.

- Set the ESCR work within the context of the implementation of the green paper 'Independence, Well-being and Choice' and subsequent work on the future of social care. *Terms of Reference for the Electronic Social Care record Board, agreed by the CRDB at their meeting May 2005* [7]

While the creation of this board was generally welcomed, its lack of resources limited its ability to deliver; it did, however, assist in raising awareness of the issues at a National level, including the recognition that the original ESCR definition was no longer entirely fit for purpose. The ESCR Board was supportive in the early Adult CAF developments, and – by working with CfH – was able to initiate small scale pilot projects investigating the potential of links between Social Care Systems and the Personal Demographics service (PDS) through the National 'Spine' These projects highlighted the complexity of the integration required, including the level of technical compliance required within a Care system in order to connect to the national Services. By 2010, although some success had been achieved, they were still struggling to deliver robust products which could be distributed on a wider basis.

As the National debate continued, local developments explored innovative approaches and new ways of working. Mobile technology (such as tablet PCs and digital pens) was used in a range of scenarios, and with varying results. Local integration projects – such

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[7] The author was a member of both Boards at the time.

as the SAP solution implemented in Cheshire – began to show benefits for both Social Care and their Health partners. Pan London Initiatives challenged both traditional solutions and the traditional thinking that underpinned them. But the survey conducted by the ESCR Board in 2006 identified that:

> ... the overall picture is that whilst almost all authorities have at least partially implemented electronic case management records (94% of respondents), fewer have widespread use of them (16% of respondents have fewer than 10 users). One of the main issues identified was social care staff resistance to moving from paper to electronic records. The extent of electronic document Management system implementation is also lower, with only 13% of respondents having implemented scanning of external documents. (ADASS and Department of Health, 2007)

This lack of progress is unsurprising. Practitioners have generally been slow to engage with technology and reluctant to appropriate the systems they have been offered; technology has often been seen as an additional burden that reduces their contact with clients, rather than a tool to support them in their day to day working. Many of the system models that were being created were based on technology, rather than information solutions, aimed at addressing the technicalities of data sharing and monitoring performance data. There have been some developments supporting processes and associated tools, but very little research into the attributes of practice and the practicalities of front line delivery.

In 2008 the Care Record Development Board was replaced by a statutory Advisory body – the National Information Governance Board for Health and Social Care. (NIGB) Although this was a welcome move, widening the scope of the group to all aspects of Information Governance, and acknowledging Social Care as an integral part of its remit, this temporarily left the ESCRI Board without a clear governance framework. After some debate, the Board was dissolved, and its work passed to a new initiative – the Strategic Improving Information Programme for Adult Social Care (SIIP) This programme reported through the Department of Health to the Director General of Social Care, and was charged with coordinating all the Informatics developments underpinning the Transformational programmes arising from current policy. Although the SIIP was only in existence for two years[8] it was able to sponsor a review of both *Information for Social Care* and the ESCR. Revised guidance, outlining the concept for a virtual Adult

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[8] The SIIP was replaced in 2011 by the Outcomes and Information Development Board – part of the revision of Departmental governance structures which took place following the election of the Coalition Govt in 2010

Care Support Record and an associated information framework, was published in 2011. (Hill and Allman, 2011)

A3.3 New technologies, new thinking

The output from the SIIP has not yet had time to have significant impact on the use of information and information systems at the front line of Care. Like its predecessor, its resources are limited; the issues it needs to address are complex and challenging; and rapid developments in technology – along with the perceptions and expectations of staff users and public – demand equally rapid and innovative thinking so that the new systems they promise will be both robust and safe.

There is a very real demand for IT to support the effective delivery of social care services. (Hudson, 1997) made a plea for attention to be given to developing computer support systems that will 'address the day to day realities of actually doing practice and which will also accommodate the measurement and assessment needs of all actors within the organization; clients, practitioners, supervisors, managers, administrators, and program evaluators.' (p 13) That plea was later echoed by the Adult CAF consultation document when it said:

> Evidence and reported experience from the implementation of the Single Assessment Process (SAP) is that improvements in information and data sharing need to be based on the appropriate development of IT solutions. Lack of appropriate systems or connectivity between the systems used by different organisations can severely restrict access to shared data and hamper its routine and effective use by care professionals. (Department of Health, 2009)

The requirement, however, is not just for the development of technology, but an associated change of culture and attitude towards its use. Gatehouse and Ward observed that the advantages (of IT systems) were barely recognised in social service departments where paper case files 'still dominate the daily business of practitioners and teams and computer- systems are still viewed as the private bureaucratic sphere of administrators and managers.' (p. 41) The real transformation will occur when 'all staff regard the records in the computer based information as the case files on children while the paper case files are merely stores of paper documents (mainly correspondence and rough notes) which cannot easily be held electronically' (Gatehouse and Ward, 2003, p 16).

The definitions for the ESCR had envisaged even those paper documents being accessed and stored electronically – and the ACSR framework now includes consideration of how web-based systems might enable clients to have access to and

exercise control over their own records, creating an environment for coordination and co-production between practitioners, service users, and their carers.

Lessons learned from experiences in health need to be built on: there is much that could be drawn from the challenges described by Iakovidis in his review of the implementation of EHRs across Europe (Iakovidis, 1998), or those which have emerged from the implementation of health systems since (such as (Ludwick and Doucette, 2009)) The most important lesson is that the success or otherwise of such systems is not primarily an issue of technology: it is much more about gaining an understanding of what the technology is needed to support, and the contexts of culture, organisation and practice into which it needs to fit.

Appendix B: Background paper for workshops, shared with participants ahead of the event.

The objectives of the workshop are:

> To clarify and document the assessment process from a practitioner's point of view

> To gain a better understanding of what assessment is and what information tools may be needed to support it

> To enable participants to reflect on their own practice, share experience and exchange ideas.

The outputs from the workshop will be used to inform the development of IT assessment tools to support the implementation of the Integrated Children's' System. They will also form part of a wider research project, which is looking at the assessment process from an information management/IT implementation perspective.

The day will be informal: lively input will be encouraged and all outputs will be anonymised prior to any publication.

A selection of participants will additionally be asked to support the research by providing a 'walk-through' of a recently undertaken assessment. This will probably involve half a day sat with the researcher and dates for these one to one interviews will be agreed at the end of the main workshop.

Questions you may want to consider before the day:

> What is assessment? How would you define it, and how do you do it?

> When does it start and when does it end? What's the end result, and how do you know you've got there?

> What information do you need to undertake one, what else do you collect and what other resources do you draw on as you work?

> How do you know if the work is good/right? How do you measure success – by output, or by outcome?

> Do you use the experience gained in previous assessments to inform the next one that you do? How might the experience of other practitioners help you? (And how would you capture that information?)

If this is not the first assessment that this client has had, how do you use the information from previous assessments to inform the current work? What do you look for in a case file to help you with your analysis of need and the decisions you have to make?

Does you analyse need as you go along, or collect all the evidence and then identify need?

How is need differentiated from eligibility? What is seen as good practice? Are overall needs assessed before eligibility is taken into account? Does awareness of service/intervention availability affect the outcome?

Do you prefer structured or unstructured interviewing? Do tools currently in use support both?

How easy is it to capture and record the information you need?

What information does the assessed person's perspective provide? (And/or that of their carers?) How do you balance fact, observation and perceptions and how are these used in your analysis?

What role does supervision and the supervisor play in the process? Does it reinforce or challenge the way you work and how does it influence outcomes?

Can 'assessment' be isolated from other work, or is it entangled with other things? If it is, what are those things and how do they influence/direct the assessment process.

Can siblings be assessed independently of each other? If not, how does assessing a family differ from assessing an individual?

How much of the information you need is collected:

      Before you see the client?

      While seeing the client?

      After the first interview?

      In a second or subsequent interviews?

Have approaches to assessment changed during your time in practice? If so, how and do you know why? Has this been an improvement, or caused difficulties?

How different is *each* assessment – does your practice adapt to circumstance and how do you determine if it should?

There will probably be a lot more questions that arise on the day – your thoughts and inputs on all of these, along with anything else you may want to raise/add will be greatly welcomed.

Thank you for taking part in this work.

Appendix C: Practitioner Survey: Use of technology and information systems in the support of Assessment practice

Introductory text:

The following survey is being undertaken in order to help inform current developments in approaches to assessment and the tools used to undertake it. The information it collects will be analysed to help understand current practice and to create a picture of what tools are used and how. This analysis will also be used to inform a piece of research focusing on the roles of process and practice in assessment.

Information collected through this survey will be collated to provide an overall perspective; the analysis provided will be anonymised and individual responses will not be identified, although there may be comparisons of profiles between teams. If you indicate that you wish to be identified for further skills training or for access to Care knowledge, then these requirements will be extracted during analysis and actioned independently from the overall survey results.

There are no right or wrong answers to these questions: we ask you to give honest responses based on your experience and the way that you undertake work on a daily basis. We would welcome any further comment you may have to make about what could be done to improve the assessment experience for both practitioners and clients, as well as any issues you may wish to raise about the tools you use (particularly the IT) and how they might be improved.

Summary of responses (Countywide):

Total responses received: 141 from approx 200 relevant staff. A 70% return.

Responses by Team:

Team (Gouped)	Responses
(Not specified)	12
Adult Reviewing Team	26
Hospital Teams	3
LD North	9
LD South,	1
OPPD MH	1
OPPD MH South	5
OPPD North, region 1	13
OPPD North, region 2	18
OPPD North, region 3	13
OPPD South, region 1	20
OPPD South, region 2	19
PHILLIS	1
Total	141

Age by gender:

Age Group	Gender			
	F	M	(blank)	Total
a) Under 25	2			2
b) 25 to 29	8	2		10
c) 30 to 34	11	1		12
d) 35 to 39	15	1		16
e) 40 to 44	21	3		24
f) 45 to 49	9	5		14
g) 50 to 54	21	2		23
h) 55 to 59	6	4		10
i) 60 and over	9	3		12
j) Not stated	14	2	2	18
Total	116	23	2	141

Time in post by Length of time qualified:

	Qualification held											
Length Employed	Not qualified	Qualifying	Less than 1 year	1-5 years	6-10 years	11-15 years	16-20 years	21-24 years	21-25 years	Over 25 years	Not given	Total
Less than 1 year	9		5	5	6	3	1		1			30
1 to 5 years	17	2	1	19	9	3			2	1	7	61
6 to 10 years	10		2		7	2	1			2		24
11 to 15 years	2	1			1	2		1		2		9
16 to 20 years	1				1		2			4		8
21 to 25 years									2			2
Over 25 years	1									1		2
Not given	1		1	1	2							5
Grand Total	41	3	9	26	25	10	4	1	5	10	7	141

Qualification:

Social Work qualified:	64
OT qualified:	27
Other qualifications:	28
No qualification declared:	30

(NB- 1 with SW and OT qualifications, 4 with SW and other, 3 with OT and other)

Other qualifications declared include:

Advanced B-Tec Diploma for Occupational Therapy Assistants

Advanced GNVQ Health and Social Care
BTEC Professional Development Award
Certificate in Health and Social Care, National Association of Children.
City and Guilds D32 D33 D34, NVQ assessor and Verifier in Care
Diploma in Rehabilitation Studies (RNIB)
Diploma in Social Care
Diploma In Welfare Studies
Diploma of Higher Education in Occupational Therepy
Enrolled Nurse
NCQ 3 in care & NVQ A1 assessor
NVQ 2 and 3 in care
NVQ 2 Care
NVQ 3 Social Care
Registered Nurse
SEN

Of the total respondents:

Currently (or previously) undertake assessments: 132

The remaining 9 breakdown as follows:

Admin	1
Assistant Team Administrator	1
Clerical	2
Clerical Assistant	1
Community Care Worker	1
Resource Finder	1
Team Administer	1
Team Manager	1

Which client group(s) do you work with?

Children in Need	0	Children in Care	0	Children/Young people with Disabilities	4	Children/Young people with mental health issues	1
Young Offenders	0	Care leavers	0				
Adults with Disabilties	119	Adults with Mental health Issues	59	Adults with Long term medical conditions	89	Older People	124
Older People with mental health issues	81	Carers	7				

(NB- A large majority of respondents worked with more than one client group)

Use of technology

While at work I:

Have access to my own desktop PC	102	Share a nominated desktop PC with someone else	3	Share a nominated desktop PC with several people (up to 5)	0
Don't use a PC	0	Have access to PCs in the office but don't have one I think of as 'mine.'	1	Have a tablet or laptop PC that I can connect to the network in some way	32

No response given: 3

I use a Personal Computer to:

Maintain client and case records on Care First	133	Record Assessments on Care First	127	Prepare reports and documents in Word	105
Maintain Client information in other systems (specify below)	18	Record Assessments as reports in Word	57	Send e-mails	137
Access the Intranet	122	Access the Internet (Web)	119		
Keep lists and records in Excel	50	Access financial systems	9		
Other (specify)	Authorisation, application and closure of cases. Managing duty and recording accordingly. Equipment Requisitions Input decisions as manager, authorise services, use reports to manage performance. Power Point				

Tick the statements you think best describe you:

I consider myself to be IT literate:	81
I know how to do some things on a PC, but I need further training:	64
I use the computer for one thing, but I know very little about what else it does:	6
I don't use a computer at all:	0

I am very confident using a computer:	59
I'm confident using a computer for the few things I know, but not confident to explore further	68

I don't feel entirely confident when I use a computer – I manage, but I'm never entirely sure what I'm doing	12
I don't feel at all confident using a computer – I'm always afraid something's going to go wrong	0
I avoid using a computer – I have no confidence using it and don't know how	0
I don't use the computer much, but would if I had more training and understood it better	0
I don't use computers because I don't know anything about them	0

(30 respondents made requests for further IT training.)

	Every day	Several times a week	Once or twice a week	Very occasionally	Only when I absolutely have to	Never
I have access to a PC at Home and I use it:	42	51	23	10	4	6

5 respondents left this question blank, and can therefore be assumed to not have access to a Home PC

Use of Care First:

	Every day	Several times a week	Once or twice a week	Very occasionally	Only when I absolutely have to	Never
I use Care First:	124	15	0	0	0	1

Only 1 respondent did not complete this question.

Which of these describes you best?

I enter data into Care First myself	132
I type my notes into word and then admin update Care first for me	17
I hand write my notes and then admin update Care first for me	20
I rarely use Care first - I go to the paper files instead	1
I use the PC a lot, but I only use Care First occasionally	0
I don't use the PC much, I do everything on paper	0

I would use Care First more if: (tick all that apply)

The screens were more logical and friendly	63
I had more training and confidence in my computer skills	17
I could access it without having to go to a specific office	13
My manager expected me to	5
I wasn't expected to get admin to do it	14
It had tools that helped me do my work	15
The information on it was up to date and accurate	19

		14
I could get at the information I needed quickly and easily		14
Other (specify)		13

'Other' comments given for this section were:

CareFirst would be more useful if had more relevant screens, less cumbersome and more practical.
Could not use it any more than I already do.
I am familiar with all aspects of CareFirst and provide support to STARR Team
I feel I know my way around CareFirst
I use CareFirst all of the time
I use CareFirst regularly but it would be more useful if it was more user friendly as above.
I use it all the time regardless.
I am an expert in CareFirst, and use it most weekends.
If it was more friendly ie undo accidental deletions etc.
It is not possible for me to use it more.
My problem is the difficulty of knowing how to access all the different sites where information we need is held. There seem to be bits in many different places. It is not user friendly. CareFirst itself is not too bad for the limited activities I use currently
Not sure I would use carefirst more, but I might be more effective
We have to use it considerably

Process
(Analysis excludes those who do not or have not previously assessed)

I undertake assessments when:

	Frequently	Occasionally	Seldom	Never	No response
I am allocated a new case by my manager	105	5	1	1	20
I receive a call or am sent a referral while on a duty desk	36	25	8	19	44
I am allocated a review	63	24	9	7	26
It's scheduled as part of a long term case I am supporting	51	17	7	7	47
A service provider recommends that a client's package of care needs to change	47	32	4	2	44
I am contacted for further support by a client on my current caseload	60	28	3	5	33
I am asked to provide specialist support to another service or agency	35	23	11	15	45

Assessment should be proportional to need. I find that I:

	Frequently	Occasionally	Seldom	Never	No response
Assess the client as having no significant support needs	4	39	60	10	16
Signpost the client to other agencies or voluntary support groups	50	53	15	0	11
Identify preventative services that will maintain the client at a low level of need	18	54	34	7	16
Can quickly recommend standard packages of care that support the clients presenting request	68	34	6	4	17
Need to investigate in greater detail because the client has greater need than they realise	54	55	7	0	13
Need to arrange immediate services (before completion of the assessment) because the client cannot cope without them	41	50	18	5	15
Identify risks of harm and abuse during the assessment process	38	57	23	3	8

I identify the need for specialist assessment (another professional's input):

	Frequently	Occasionally	Seldom	Never	No response
As part of the current assessment process	34	20	2	0	73
• To inform my assessment	50	43	9	0	27
• To assist the client in understanding their needs	37	51	19	0	22
• To clarify the requirements for the care package	38	54	13	1	22
as a recommendation as part of the care package (ie an outcome of my assessment)	47	45	6	0	31

When I have completed my assessment I :

	Frequently	Occasionally	Seldom	Never	No response
Collate and summarise all identified needs	115	1	0	1	12

Include in my summary the links between the outcomes the client has identified as self perceived needs and how/if these will be addressed by the client/family and friends/community resources/other agencies.	103	15	0	2	9
Ensure that I have appropriate evidence to demonstrate that FACs criteria has/has not been met.	117	6	0	0	6
Collate and recommendations for services/interventions (To inform the care plan)	113	5	1	0	10
Write additional reports describing my findings and the basis for my recommendations (eg for submission to a resource panel)	34	28	32	22	13
Prepare a full care plan, including identifying proposals for service packages before availability is known	65	24	14	12	14
Wait until I know if services are available before completeing the care plan	48	32	19	12	18
Summarise the outcomes the care plan is intended to support	93	13	1	3	19
Prepare a separate/additional report for the client, presented so that they can understand what I have done, what I am recommending and why	40	16	29	27	17

As well as undertaking the assessment I:

	Frequently	Occasionally	Seldom	Never	No response
Have to go back to the client to renegotiate the care plan because the resources/services initially identified are not available	14	51	34	15	15

Have to go back to the client to renegotiate the care plan because the resources/services initially identified were not acceptable to them	6	58	33	14	18
Directly commission the services identified within the care plan	49	24	16	19	21
Negotiate changes to existing services	53	43	9	6	18
Pass the care plan on (or make a referral) to someone else to commission the services I've recommended	24	43	23	18	21
Include support from myself or someone else in my service as part of the care plan	24	36	28	20	21
Support the client in commissioning their own services (using direct payment schemes)	20	63	18	11	17
Undertake a follow-up review shortly after the services have commenced	87	12	8	6	16

Practice

When I'm assigned a new case I:

	Frequently	Occasionally	Seldom	Never	No response
Can tell how detailed an assessment I need to do by looking at the referral and the presenting issue	51	46	11	5	16
Collect all the information I need to assess my client when I visit them	93	23	2	2	8
Identify the client's communications needs prior to my visit and ensure that suitable arrangements are in place if needed	109	8	2	1	9
Make contact with relatives and carers to get a full picture of the clients circumstances	98	22	1	0	8
Have to make further enquires from other professionals to 'fill in' gaps	42	31	3	1	52

in my understanding about the client					
• Their GP	34	64	17	3	11
• Their health visitor	15	37	28	20	29
• Housing officer	14	36	39	15	25
• Specialist medical practitioner (e.g. consultant)	26	45	21	14	23
• Occupational Therapist	45	54	6	4	20
• Mental health Worker	29	54	17	8	21
• Other (give examples)	29	12	1	5	82

Advocate Allocated worker within department only. Benefits Agency, our finance sections, advocacy services etc. Care Agencies Care Agency Care Provider and day services or home care Care Suppliers CLDN. Behavioral therapist, Psychiatrist Colleagues Day Services and Residential Providers District Nurses, Home Care Services District Nurse District Nurse and McMillen Nurses District Nurse, Care Agency, Phisio District Nurses District Nurses - Community Psychiatric Nurses District Nurses Commuity Psychiatric Nurses District Nurses, ICT District nurses, Intermediate care, Other social workers, Home Care Assessors, Voluntary Organisations eg age Concern, Alzheimers Society, Police. Environmental Health Offices, District Nurse, Specialist Older People Mental Health Nurse Team, Day Centre Staff, Voluntary Sector staff involved, Care Worker, Previous social worker. St Cross and Walsgrave Hospital eg staff nurse/support worker, Police, Care	Physiotherapist. H/S Providers, Day Care Providers Home Care Agencies Home Care Supervisors Home Care, Other Service Providers, employment Agencies, Day services, Respite services Learing Disability Nurses Make contact with relatives etc - only if consent Managers of Care Homes, Managers of Day Care Centr Neighbour, Daycare Centre,Residential Staff and Staff at Respite Placement. Physio/contenance advisor Physiotherapist Psychologist and Physiotherapist Refferers eg Accommodation Wardens SALT Secure Providers Service Providers Social Worker Social Worker Carer Speech and Language Therapist, Nursing/Ward Staff, Care Home Manager,/ Key Worker,

Agencies, Day Centres/ Care Homes.		

When picking up a case that's had previous involvement, before I meet the client I look at :

	Frequently	Occasionally	Seldom	Never	No response
The previous assessment	114	4	1	0	10
The first assessment (if more than one previous)	49	39	16	0	25
All the previous assessments	59	35	16	3	16
The original referral	78	25	7	2	16
The current presenting issue	117	0	0	0	12
The chronology of events	90	18	4	1	15
The current Care plan	102	14	4	0	9
The first care plan	26	34	31	14	24
The family structure	88	24	4	0	13
The carers assessment (if there is one)	78	28	11	2	12
Reports from other professionals	86	29	4	0	10
The clients perspectives and aspirations	105	11	2	0	11
Other things in the file (list)	22	11	5	0	91

Activities All biographical information required for all files eg housing type, recordings of contacts etc. Correspondence Corrspondence, Financial Information, Categories (Equipment already in place, type of and ownership of property. Whether risk assess has bee provided. Equipment already supplied, plans of adaptions. Equipment on site, Adaptions to property Equipmetn in situ, Accomodation, Previous Involvement, however I do not usualy get a file view, sometimes get it myself if it is a client that has been on the books for years ortherwise rely on CareFirst Existing and former service packages and cost/contributions. Final Assessment GP Letters, List of Equipment I rarely get to see a paper file prior to my first visit.	MHA Reports Observe client completing activites OT Assessment, other refferals from agencies, and input from agencies in the past, drugs, warning indicaters on the file. Other paper work eg PFCT/equip list on CareFirst pova Previous reccomendation for housing adaptions/Equipment. Professional Reports, Consultant Reports Restricted activities. Pova reports, any letters eg from ILF Fund. Restricted reports POVA Reports Service Package This is incredibly hard to do on the current CareFirst system. You can spend hours trying to pinpoint when/what and who made important decisions. Very frustrating when you have to provide evidence of what has happened befor. A system to assess important events and decisions/recommedations would help.

If is an assessment I rarely use the file often it is unavailable, ie I have not got time to look for it or I could not find it.	

When I assess, I:

	Frequently	Occasionally	Seldom	Never	No response
Gather all the information and ask all my questions before I make any analysis or decisions	97	16	3	1	12
Assess need and circumstance as I go along, adjusting my conclusions as I find out more information	83	22	9	1	14
Identify what the service user is hoping to achieve by asking us for help	115	2	0	0	12
Where there is a carer involved, make sure that their views and expectations are included when I determine what the service users needs are	117	3	0	0	9
Determine if the client is eligible for services before I ask any detailed questions about needs	31	33	22	20	23
Begin by looking at self perceived need and ask the client to identify what they want to achieve or change.	96	15	2	0	16
Only ask detailed questions about issues that the client needs help and support with	33	31	31	15	19
Try and get a detailed, holistic view of the clients needs and circumstances, including where they are coping well	115	5	0	0	9
Find it hard to balance between limiting my assessment to immediate need and getting a holistic view	17	44	30	16	22
Focus on matching the clients needs against services that I know are available.	32	36	23	17	21
Research any medical conditions the client may	73	36	12	0	8

have in order to inform my assessment					
Consider long term outcomes as part of my analysis	101	16	0	0	12
Consider whether the client can produce their own assessment and identify suitable support if necessary.	28	34	25	21	22
Discuss/identify ways that the client might address their needs without requiring formal intervention or support	68	45	5	0	11
Try to ensure that clients are offered assistance designed to maximise control over their own lives (eg direct payments and/or Telecare)	109	11	1	0	8

I identify and account for any risks of:

	Frequently	Occasionally	Seldom	Never	No response
The client's needs increasing over time	38	4	1	0	85
• If support is not provided	111	5	2	0	10
• Because of a deteriorating condition	112	6	0	0	11
• Because their circumstances are not stable	107	7	2	0	12
The client coming to harm, or being abused	89	23	5	1	11
The carer's needs increasing if support is not provided to the client	112	7	1	0	9
Conflict between the wishes of the client and the expectations of the carer	90	23	6	1	9

If there is a carer I:

	Frequently	Occasionally	Seldom	Never	No response
Ensure that their views and wishes are recorded in a way that	114	5	0	0	10

can be distinguished from those of the client					
Find I need to speak to the client without the carer present to get a true picture of need	26	76	16	1	10
Find I need to speak to the carer without the client present to get a true picture of need	31	72	13	3	10
Recommend a separate carers assessment	79	37	2	2	9

Describe the factors that you consider when recommending a separate carers assessment:	(Text comments not included in this appendix)

While in a client's home, I record on:

	Frequently	Occasionally	Seldom	Never	No response
Paper	106	6	3	0	14
A mobile device (e.g. tablet PC)	14	10	4	52	49

I do my recording by:

	Frequently	Occasionally	Seldom	Never	No response
Using a detailed, structured, paper form that I fill in as I go along	41	15	15	34	23
Using a form as a check list in discussions with my client and making notes alongside the questions	56	18	12	22	22
Making detailed notes during my visit	47	38	10	11	23
Making quick notes and then using them to write up the assessment afterwards	82	22	7	1	16

Visiting with my client and only making notes once I leave the house	1	11	33	58	26
Recording interviews (sound or sound and vision) and transcribing the contents afterwards	0	2	2	101	24

I assure myself that I have delivered a quality assessment by:

	Frequently	Occasionally	Seldom	Never	No response
Checking that the review that follows confirms that I identified all the clients needs and made suitable recommendations for services	103	8	4	2	12
Discussing the case with my supervisor and getting their support for my decisions	84	33	4	0	8
Discussing the case with colleagues and drawing on their experiences	65	50	5	0	9
Checking that the client feels that their needs have been listened too	117	5	0	0	7
Identifying that the client is satisfied with the outcome (even if no services are provided)	113	8	1	0	7
Looking at similar assessments undertaken with other clients to see if the care provided delivered the expected outcomes	13	33	21	16	46
• My own clients/caseload	28	37	17	7	40
• other client records	13	22	27	21	46

I think the quality of my assessment practice would improve if: (tick all that apply)

I had access to the client's medical information	66
I know which other professionals were involved with the client	93
I could read the other professionals notes before I made my visit.	72
I could easily find out what care is already being provided and by whom	90
The client had a more formal/structured way (e.g. a self assessment form) of identifying what they need before I went to see them	64
I could refer to what plans had been implemented for clients in similar circumstances - and see what the outcomes of those plans had been	49
I had more direct access to relevant research - and could find what I needed to know more easily	70

I had an easy to read diagram of the Service user's family that showed me how they interrelated and interacted	36
I had a timeline/chronology of significant events in the service user's life	53
Other (all suggestions welcomed)	22

(Text Comments supplied but omitted from this appendix.)