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Title

Personalised social care for disabled adults: A problematic concept for frontline practice

Michele Foster PhD, B. SocWk (Hons)
Research Fellow
Social Policy Research Unit
University of York

Jennifer Harris PhD, BA (Hons) C.Q.S.W
Senior Research Fellow
Social Policy Research Unit
University of York

Karen Jackson BA (Hons) MA
Research Fellow
Social Policy Research Unit
University of York

Hannah Morgan BA (Hons) MA
Lecturer in Applied Social Science
Lancaster University

Caroline Glendinning BA, DipComWk, M Phil
Professor Social Policy
Social Policy Research Unit
University of York

Correspondence to Caroline Glendinning, Social Policy Research Unit, University of York, York YO10 5DD, UK. E-mail: cg20@york.ac.uk

Abstract

This paper explores the complexities and contradictions of frontline practice that pose problems for personalised social care through enhanced choice. It draws on semi-structured interviews with community care workers, social workers, occupational therapists and care managers in two social care departments. Practitioners interviewed were asked about their current assessment and documentation system, including the assessment documents currently used; how they approached information gathering and the topics they explored with service users; and their experience of documenting assessment and care management. The paper argues that the validity and sustainability of personalised social care in frontline practice relies on developing a thorough understanding of the complex and implicit assessment processes operating at the service user/practitioner interface and the inevitable tensions that arise for practitioners associated with the organisational context and broader service environment. The findings demonstrate the variability among practitioners in how they collect information and more importantly, the critical role practitioners occupy in determining the kinds of topics to be explored during the assessment process. In so doing, it shows how practitioners can exert control over the decision-making process. More importantly, it provides some insight into how such processes are shaped by the constraints of the organisational context and broader service environment. Complexities and contradictions may be an inherent part of frontline practice. The issues discussed in this paper, however, highlight potential areas that might be targeted in conjunction with implementing personalised social care through enhanced choice for disabled people.

Key words: personalised social care, choice, community care, disabled adults

Introduction

A foremost policy agenda currently in the UK is the reform and personalisation of public services. The central theme is that of choice and more specifically, the extension of choice to users of public services as a key mechanism for achieving equality amidst increasing diversity of need (Clarke 2004). This covers many dimensions and models of choice. Collective choice whereby individuals are consulted and provided with opportunities to participate in the organisation and delivery of services is one example. Another example is giving individual consumers of public services the opportunity to articulate their preferences and exercise their choices. Within social care services, the discourse of personalisation of services has generated increasing interest in user-centred assessment for disabled people, focused on the desired outcomes of service users. A commitment to assisting individuals to exercise choice concerning the types of services they prefer; collaborative and consultative decision-making processes; and funding arrangements that respond to, and uphold service user choices are core components of the personalised care approach (Policy Commission on Public Services 2004; Social Service Inspectorate 2002). By its very nature then, the concept of personalised social care for disabled people heralds a new role both for the individual service user and the frontline practitioner. Moreover, the interpretation and implementation of this policy relies substantially on the process and context of frontline practice (Leadbeater 2004; Policy Commission on Public Services 2004).

For some years, direct payments have been strongly advocated by both disabled people and, latterly, by the English government, as a means of enabling disabled and older people to exercise greater choice over the support they receive. Recently, the English Green Paper on Adult Social Care (DH 2005) and the Prime Minister's Strategy Unit proposals for 'Improving the Life Chances of Disabled People' (Cabinet Office 2005) have introduced plans for individual budgets, whereby individuals will have control over the budget allocated for their support but without actually receiving the cash. The budget would be available to meet the needs of the individual in whatever way s/he wished. The Strategy Unit also proposes that eligibility for individual budgets or direct payments should be based on requirements that arise from disabling barriers and impairment (Cabinet Office 2005).

However, access to both direct payments and individual budgets depends in the first instance on assessment, to identify the range of requirements and areas of support which resources will be allocated to cover. Although the Strategy Unit proposes an increased role for self-assessment (Cabinet Office 2005), this may be problematic for some groups of disabled people (particularly those with very high support needs) unless they also have access to high quality, well-funded, independent advocacy services. It is, therefore vitally important to understand the conduct of assessments, who they are carried out by and the organisational financial and managerial frameworks that shape the environments within which assessments are conducted. Without a nuanced understanding of issues and appropriate attention to them, it may be difficult to achieve the ambitions of delivering greater choice and personalised services.

As we consider these recent policy developments then, the point at issue is that an ideological shift that seeks to re-orient frontline practice towards personalised social care simply through offering new mechanisms for enhanced choice and user involvement is not sufficient to ensure implementation of policy in line with such values. Assessment processes involving the allocation of resources are subject to professional interpretation and implicit processes of decision-making and these are in turn, shaped by organisational and broader policy frameworks (Foster & Tilse 2003). In that respect, personalised social care represents a problematic concept for frontline practice. Understanding those problems is an important part of realising the goal of personalised social care for disabled people.

The central argument developed in this paper is that for personalised social care to be a valid and sustainable concept and practice in social care, a thorough understanding is required of the complex and implicit assessment processes operating at the service user/practitioner interface; the contexts within which these processes occur; and the inevitable tensions that arise for practitioners seeking to implement personalised social care. This includes gaining a better understanding of the centrality of practitioners' selective and interpretative activities and the inextricable link between these processes and the contexts within which choices and decisions are made. The paper draws on an analysis of semi-structured interviews with practitioners within social care services conducted as part of a broader research project that focused on developing and implementing outcome-focused assessment with disabled adults of working age. By way of introduction, the paper discusses the emergence of personalised social care in policy and practice. A brief overview of the research and a summary of the key findings are then provided. Using the summary of findings as a backdrop the paper discusses three central themes associated with current practice in social care, these being (1) assessment as a selective and interpretative process wherein practitioners occupy a pivotal role in selecting pertinent issues for assessment based on their interpretations of the situation; (2) assessment as organisational work and how in responding to organisational expectations concerning documentation, practitioners often pursue multiple and contradictory purposes; and (3) assessment within the broader service environment and the inherent tensions and implications that arise for practitioners. Drawing on relevant literature, the paper concludes with a brief discussion of the key challenges and opportunities associated with the implementation of personalised social care within frontline practice.

Personalised social care: emergence of policy and practice

Personalised social care through enhanced choice is viewed as a key mechanism for targeting established policy goals such as independence and empowerment of service users (Barnes 1998; Hardy *et al.* 1999; Leadbeater 2004). For the policy makers, moreover, choice is a way to bring about reform of public services in the wake of an expanding service economy and increasing diversity of needs and aspirations, concomitant with growing expectations among consumers for more responsive, accessible and flexible public services (Clarke 2004). Although Clarke (2004) argues that the concept of choice has been promoted less in social care than in health and education, several initiatives have sought to enhance choice and user involvement in social care as a basis for improving services. At the collective level, there are examples of consultation involving disabled and older people and carers in the design, planning and delivery of services (Bewley & Glendinning 1994; Thornton & Tozer 1995; Barnes 2005) and consultation involving organisations of disabled people, older people and carers about the importance of collecting information on the outcomes or effects of services on the people who use them as part of assessing the contribution of social care (Qureshi 1999). Similarly, the current ‘best value’ principle encourages local authorities to consult and canvas opinions about how services might be improved (Policy Commission on Public Services 2004). At the individual level, the introduction of direct payments commencing in 1997 has sought to give users of social care more economic choice, that is, the power to purchase the types and mix of services they prefer rather than being reliant on standard services approaches (Glendinning *et al*. 2000; Spandler 2004). More noticeable, however, are efforts to incorporate the concepts of choice and user involvement within the assessment process as part of personalised social care (Nicholas, 2003). A greater focus on the desired outcomes of service users as opposed to simply ‘needs-based’ assessment is a key feature of the process.

A key development in community care following the NHS and Community Care Act 1990 was the shift from service-led assessment to a ‘needs-based approach’ (Barnes 1998; Middleton 1997). As Barnes (1998) points out, the intention was for practitioners to acquire an appreciation of the individual’s circumstances in order to determine what services were appropriate to need, rather than to fit the individual to a service. However, despite the shift in emphasis, ‘needs-based’ assessments focused primarily on meeting practical, self and home care needs of service users within the physical environment where such tasks were carried out;

and further, frontline practitioners remained the 'gatekeepers' (Barnes 1998). In line with this shift in policy, local authority social services departments developed their own assessment forms based largely on the prescribed areas of need, although the expectation was that other personal and social information (e.g. employment, education, relationships) would be collected to develop a personal profile of the individual rather than a profile of potential areas of need (Rummery 2002; Barnes, 1998). Since these developments, the policy of personalised social care through enhanced choice has gathered momentum and contributed to increasing demands for assessment systems that explicitly promote individual aspirations and choices (Hardy *et al.* 1999). Implicit in this re-orientation is that a 'needs-based approach' to assessment is a potential barrier to choice given that it is likely to be professionally dominated. This has led to more recent exploration and development of outcome-focused assessment systems with carers (Nicholas 2003) and disabled adults of working age with physical and sensory impairment (Harris & Morgan 2002). In contrast to 'needs-based' assessments, which rely substantially on professionals to define the problems and level of service, outcome-focused assessments seek to involve service users in identifying the outcomes that they want to achieve with the assistance of services.

An increased focus on service user outcomes might well represent an appropriate strategy to achieve personalised social care through enhanced choice for disabled people. Yet, the complex and often contradictory nature of assessment processes (Hardy *et al.* 1999; Middleton 1999; Milner & O'Byrne 1998; Rummery 2002) presents particular challenges for this policy goal. Rather than a 'taken for granted' process, assessment is a dynamic activity, on the whole, negotiated privately between the service user and frontline practitioner. As part of this process, frontline practitioners interpret, and use their discretion to make decisions about various rules (e.g. eligibility). Indeed, such discretion is central to managing the uncertain and indeterminate nature of their work (Evans & Harris 2004). Moreover, assessment processes are embedded within, and influenced by unique organisational and broader policy contexts (Simpson *et al.* 2005; Foster & Tilse 2003; Kuipers *et al.* 2004). However, relatively few studies have examined the micro-dynamics of assessment, how professional discretion is used, what assumptions and beliefs underpin it or how practitioners manage the tensions between professional, user and organisational interests (see Davies et al 1997).

The study reported here offers new evidence on these processes and their consequences, in the light of current pressures to introduce greater choice and personalisation into social care. Of particular note currently is that although choice and user involvement are being promoted as a way to transform social care services, increasingly, a manageralist agenda incorporating more explicit 'eligibility criteria' and performance management is also shaping frontline practice (Beresford & Croft 2004). Within this context, the quality of the assessment and care management process relies fundamentally on the practitioner (Middleton 1999). Further, the practitioner's capacity to manage the inherent complexities and contradictions has a significant impact on the service user/practitioner relationship (Beresford & Croft 2004). As personalised social care generates an interest in developing outcome-focused practice with disabled people, it is timely to explore the current assessment process in social care and the tensions that arise for practitioners as a prelude to understanding and addressing the imminent challenges.

Background and data sources

In 2002, the Social Policy Research Unit at the University of York commenced a study to develop and implement an outcome-focused approach in social care with disabled adults of working age. This extensive multi-site study incorporating multiple methods sought to investigate the current ‘needs-based’ approach to assessment and documentation in social care; and to pilot and subsequently implement an approach that aimed systematically to identify the outcomes of social care services that were desired by users. Throughout all phases core data sources included assessment and care planning documents, semi-structured interviews with practitioners and consultation with service user groups. The particular focus of this paper was a series of semi-structured interviews with 28 practitioners working with disabled adults in two purposively chosen teams in social service departments. This sample included all the social care practitioners working within the two teams at the time of the interviews. Practitioners included community care workers (CCW, n=7), social workers (SW, n=4), occupational therapists (OT, n=10) and care managers (CM, n=7). The semi-structured interviews were designed specifically to explore practitioners’ current ‘needs-based’ assessment and documentation system prior to the introduction of an outcome-focused approach. Practitioners were asked about assessment documents currently used; how they approached information gathering, including the topics they explored with service users; and their experience of documenting assessment and care management. There are necessarily limitations associated with these ‘official’ accounts given that data represent practitioners’ accounts of what they said they did as opposed to what they actually did as part of assessment. Moreover, they report only practitioners’ accounts of their practice in relation to the assessments they actually carried out. It is likely that a number of initial requests for assessments would have been screened out by bureaucratic and other preliminary gatekeeping activities (Rummery 2002) and this may also have influenced practitioners’ practices (and their accounts of those practices).

The semi-structured interviews were transcribed and the analysis conducted by the first author (MF). Analysis sought to elucidate the approach to assessment and care planning with service users and professionals’ experience of translating assessment and care planning into written documents. A thematic analysis of the interview transcripts was conducted based on these concepts of interest. This involved reading and reviewing transcripts and applying descriptor codes to segments of the text and repeating the process prior to codes being finalised and applied across the complete data set (Mason 1996). Analysis then involved identifying and refining the themes by conducting code-based searches across the data set. During the analysis, particular attention was given to the complexities and discrepancies within and between the transcripts as a basis for identifying the key themes.

Summary of key findings

From practitioner accounts, a Community Care Assessment (CCA) and a Care Plan (CP) were two key documents used by practitioners during assessment. The

CCA was an assessment framework devised by the social service departments in keeping with the guidelines and prescribed assessment areas for a ‘needs-based approach’ introduced with the 1990 Act. The CP was primarily used to document a summary of the needs identified during assessment, and the course of action to be taken. In that sense, the CP represented a basis for decision-making about services and monitoring progress. The CCA and CP were not atypical documents within social care departments at the time of the interviews. All practitioners interviewed reported using the CP as part of documentation. There were, however, variations in practice concerning the use of the CCA during assessment. Some practitioners reported that they relied closely on the CCA, using it with service users during assessment, whereas others reported a more conversational assessment approach informed by the key themes contained within the CCA framework.

More importantly, for the purposes of this paper the analysis revealed three key themes concerning the assessment process. Firstly, despite the existence of a CCA, practitioners tended to focus on what they perceived to be the relevant issues for discussion during assessment. Moreover, the selection of issues was inherently linked to practitioners’ assumptions about the purpose of assessment based on the initial referral, and their perceptions of the individual service user. Secondly, practitioner accounts highlighted the complexities and inherent contradictions involved with documentation of the assessment process; and thirdly, they indicate the challenges posed by the constraints of the broader service environment. The remainder of this section discusses these themes in more detail as a basis for understanding the problems facing personalised social care with disabled people. In selecting quotes consideration was given to representing the different sites and a range of interview participants.

Assessment as a selective and interpretative process

The analysis revealed variations in how practitioners collected information during assessment. It also revealed the critical role of practitioners in selecting topics to be explored during assessment and how selection was linked to assumptions about the initial referral and interpretations of the service user. Variations in collecting information reflected two main approaches. Some practitioners reported a more structured process of exploring the needs of service users according to the key topic areas within the assessment framework. A more structured approach was justified by one practitioner as a way of not overlooking issues during assessment and conversely, by another as a way of fulfilling the professional role within the organisation. In contrast, others reported a more conversational approach with service users, informed by the key topics within the framework. As the last quote below illustrates, one practitioner preferred the informal approach because it encouraged the flow of conversation with the service user and did not reduce assessment to simply a means of collecting information.

> "I take this [community care assessment] with me and I also take a copy and I give the copy to the service user and I say, this is what I have to ask you, and it may not all be relevant, but bear with me…this way…you're not going to miss anything" (OT10).

> “Well, usually I fill out all of the headings…but I think that’s probably because of the type of assessment that we do in care management…we need to really cover everything and gather as much information as possible so we usually do work through every single heading” (CM1).

> “I won’t go through it like a logical step-by-step…you get quite a lot of information [when] people just start talking and if I stop somebody to say ‘hold on, we’re on this question’, then it stops the flow and you don’t get the same information” (SWCM1).

Practitioners subscribing to both approaches described examples of using their discretion to shape the discussion during assessment. On the whole, however, this was more apparent for those using the informal conversational approach. For example, practitioners using this approach described a process whereby they selected the appropriate topics from within the framework to explore with service users. In some instances the selection was linked to assumptions about the referral. A very specific referral involving assessment for equipment to assist with personal care, for example, may mean discussion is restricted to those topics relevant to addressing this issue alone. A selective process was advocated in such circumstances because the nature of the work and their involvement was perceived as ‘low-level’ rather than in-depth.

> "I think sometimes they wonder why you're asking so much…they asked for a stair lift, [so] why do you want to know this and that and the other…this is why I try to do it in a fairly informal manner and explain that I do need to carry out an assessment" (CCW4).

Concomitant with this, practitioners based the selection of topics on their interpretations of the level of intrusiveness and sensitivity of the assessment process for service users. For example, exploring a range of other potential areas of need or personal information was seen to be too intrusive when involved with 'low-level' assessments such as assessing equipment needs. On the other hand, the sensitivity of the assessment process for the practitioner could also influence the selection of topics for discussion. Some practitioners, for example, described mental health as a particularly difficult issue to address in the assessment process. In that sense, selection of topics could also be associated with a practitioner's unwillingness to explore particularly sensitive issues with service users

> "I think some of the headings are intrusive and because of the fairly low level assessments I'm carrying out I wouldn't like to go into everything like personality and preferences and I don't go into cultural…employment, education, because the majority of people I see are retired that's not always relevant" (CCW7).

> "I feel…sometimes I'm sort of slightly imposing on…people…domestic assistance, personal assistance I find reasonably easy to…ask somebody…mental health…I sometimes find that one difficult to fill out…often I'll just put…no need identified or something like that…because they've neither brought it up or I've not particularly picked up on anything." (OT8)

When asked generally about the topics within the CCA that were most relevant during assessment, practitioners identified personal assistance, physical health communication, domestic assistance, significant life events and technical aids/equipment. Other topics within the CCA framework such as culture, mental health, personal counselling, significant life events, personality and preferences, employment/education and social/recreation were on the whole, reported by practitioners to be less commonly discussed.

It was not clear how far these priorities actually reflected those of the people being assessed. However, the consistency with which they were mentioned suggests a high likelihood that they were influenced by professional assumptions, with correspondingly profound implications for the subsequent opportunity to identify personalised service responses.

Practitioners also perceived an in-depth assessment to be appropriate when confronting complex and less supportive situations and conversely, less appropriate for a disabled person who was independent and participating in society. Some practitioners, for example, suggested that the assessment and documentation system was more suitable for the complex situations such as an older disabled person living alone, or when someone was at risk of admission to residential care. It was not necessarily suitable for use with more independent people. The perception that assessment could be intrusive in these situations was justification for a more selective process.

> "I think the sorts of people it does work well with are…elderly people living on their own without much family support…it doesn't work so well with…those people who are very self-sufficient…very independent types…like their autonomy don't want to be labelled as disabled…possibly don't respond well" (OT8).

These distinctions were not straightforward, however. Practitioners also distinguished between younger and older service users, with some suggesting that younger service users engaged more easily with the assessment process than older people. In describing this distinction, practitioners suggested that younger people were more often interested in participating in assessment and tended to be clearer about their needs and wishes compared to older people. Further, when it came to the written document prepared by practitioners for service users, it was suggested that older people tended to be less interested in the documented assessment and care plan compared to younger people. Given that personalisation of services is inextricably linked to service user participation, the responses of practitioners are critical for actively engaging service users.

> "I find it easier…with younger people because they're more clear about their aspirations…when I was working with older people it was harder to…draw out what they wanted to do" (CM6).

> "I think the older people struggle with any kind of documentation that you send them…The younger people seem to want to be…more involved and seem to want to participate more so they perhaps pay more attention to the documentation" (OT9).

Interestingly, the analysis indicated that practitioners' assumptions about the service user needs based on the initial referral could be challenged during the assessment process and indeed altered, depending upon the practitioner. For example, a seemingly simple referral (e.g. assessment for equipment) could end up being a much more complex assessment. Yet as one practitioner suggested, ultimately, the quality of the assessment and level of service recommended depends upon the individual practitioner. Implicit in this is whether practitioners utilise their discretion positively during the assessment process to explore other areas of potential need with the service user as a result.

> "[Sometimes]…you go out for something really easy, like a chair for example, a special chair, and you find a whole [range] of problems…" (OT5).

> "I mean a good assessment is only as good as the professional who is undertaking it…[it is] down to the worker really to…tease out those difficulties or…those goals and objectives…" (OT3).

These examples highlight largely unexplored, albeit important, issues concerning how practitioners account for diversity in assessment processes, how they use their discretionary power to negotiate inherently complex processes and what implications their discretionary practices have for user choice and personalised service responses. Personalisation of services in the end relies on practitioners negotiating the tensions between their role as an agency representative and their role as an advocate for the service user. By exercising their power over the assessment process, practitioners can limit the assessment and therefore, access to services or conversely, they can look beyond the referral priority and engage service users in considering other priorities and service responses.

Assessment as organisational work

The importance of understanding assessment also as organisational work and not simply a professional activity was a further theme that emerged from the analysis. Beyond negotiating the dynamics of the service user/practitioner relationship, it was evident that practitioners were expected to fulfil certain organisational expectations concerning documentation of assessment. In this case, the data also drew attention to the multiple purposes of organisational records and their centrality to the decision-making process. For example, the CP was perceived by practitioners to be a particularly useful and important document since it summarised what needs had been identified with the service user, what was to be achieved and what was to be the course of action in meeting those needs. A copy of the documented CP was commonly provided to, and signed by the service user. To that extent, it also represented a source of information for the service user, an evidence base for decisions about the allocation of care and a means of monitoring progress. At the same time, practitioners also perceived the CP as a legal safeguard that could be useful in minimising professional and corporate risk. At this point, the data gave an indication of the potential tensions between assessment as a professional activity and assessment as organisational work.

From the analysis it was apparent that practitioners saw the systematic documentation of assessment, and particularly the CP, as a way of encouraging a shared understanding and ownership with service users and simultaneously, avoiding misunderstandings between service users and themselves.

> "[The care plan]…cuts down a lot of misunderstandings and misapprehensions of…what's been agreed between professionals and clients" (CM1).

> "[The care plan] is good…it reminds me of what I've said, and it is an agreed thing and we do get people to sign their copy so they can't turn around in six months and time and say 'oh I didn't agree to that'." (OT5).

Two overarching themes concerning the documentation of assessment were also evident despite variations among practitioners in their approaches to collecting information. In the first instance, documentation was conducted separately from the service user, usually in the office. Practitioners' justifications included that this was less disruptive of the actual assessment process. Secondly, documentation provided a further opportunity for practitioners to exercise their discretion. As with the assessment process itself, practitioners' documentations were influenced by their interpretations of the relevant topics and their assumptions about the initial referral. This often resulted in some of the topic areas within the assessment framework being overlooked or even deleted during documentation.

> "I would always bring it back to the office because I find the flow of conversation would be too restrictive if I was completing it in front of someone, but I do take notes with service users…to see what I need to transfer onto the care plan" (SWCM2).

> "I do leave things out. I think that's a slightly contentious issue. Some managers insist that everything's filled in but…if the referral is only for something very simple, equipment or something very straightforward, then I don't think it is necessary to go into a lot of personal detail" (OT10).

More importantly, although the CP was viewed positively as a written record of what was to be achieved, some practitioners also perceived it to be a legal document and safeguard, in the event of disagreements. One practitioner, for example, suggested that the documented CP was a means of "covering my back". When talking about the potential legal implications, practitioners reported being more cautious about their recording. The potential legal implications were a further justification for completing documentation in the office rather than with the service user.

> "A lot of the Care Plan is very relevant because it's a legal document in the sense of this is what we're expecting to happen…within the framework of a contract with another person, other agency or in-house even" (CM5).

> "I think to be honest it needs quite a lot of thought and it needs a bit of sensitive filling …I'd rather take my time over it [because] it's quite a damning document in a way" (CM4).

Given these issues and the selective and interpretative processes of assessment, it is not unreasonable to suggest that documented records may be less than systematic in recording data on all issues of significance to the service user, including some issues that may be crucial to the aspirations of service users but that are not recognised as such by practitioners. Other issues may be recognised as important but nevertheless incompatible with the wider organisational and resource environment within which assessments and social care resources are allocated; this is discussed next.

Assessment within the broader service environment

Practitioners' accounts suggested that they were all too aware of the inherent constraints of the broader service environment within which assessment occurred and how this influenced the process. In that sense, the data highlighted the inextricable link between process and context. More specifically, it was evident from the analysis that practitioners' awareness of the constraints and limitations of the resource context influenced the assessment process and their decision-making. For example, the analysis suggested that for some, the work was ordered to comply with managerial priorities, such as prioritising help with personal care over other expressed or potential needs. Help with personal care needs was perceived to be easier to acquire within the current service environment, whereas the perception was that other areas of need were likely to be more difficult to address due to a lack of resources. For some practitioners, the constraints and limitations created an incentive for satisfactory rather than optimal responses, such as focusing only on the services available rather than addressing the needs of service users.

> "[There] is probably a tendency on the assessment for a focus on personal care as the big one. Whether that's to do with the forms or whether that's to do with a culture of there's no point in asking for that because we won't get it, I don't know" (CM2).

> "I think it [the current system] is a bit narrow. I think sometimes…we've got blinkers on and we look at it from what we've got rather than what people need" (OT6).

The inextricable link between practitioners' interpretations of the broader service environment and the assessment process itself was also demonstrated. One practitioner described the assessment process and documentation as a reflection of what could be done rather than what the service user wanted. Another practitioner suggested that managerial agendas (e.g. budget restrictions) could be a barrier to inclusive decision-making, the exercise of choice, and service users receiving appropriate care. In this particular example, illustrated in the last quote below, the multiple uses of documentation and the conflicts that arise for practitioners were also highlighted.

> "It's about what we're saying we'll do really, not what they're saying they want to do...so you're only writing down the needs that we're going to meet really aren't you?" (OT6).

> "Sometimes but not often [you] get the feeling that somebody's got the wrong service for the wrong reasons…as to what's been offered…what's been refused…what choices have been offered…because for a start everybody's really scrutinising what care managers do because of the budgets but it's not just budgets, it's about forty year old people ending up in nursing care that shouldn't be there" (CM4).

Discussion

Current policy proposals aim to enhance choice for users of social care services, through mechanisms such as direct payments and individual budgets. One consequence of these measures is a transformation in the role of care managers, with a much greater emphasise on brokerage and advocacy activities and correspondingly less scope for the exercise of professional discretion. It remains to be seen how far this transformation, with its implicit shift in power relationships between professionals and disabled people, can be achieved. Moreover, assessment will remain central to the processes of allocating resources for social care and this will continue to provide scope for the types of discretionary, implicit and balancing activities revealed by this study.

The findings highlight the critical role of practitioner discretion in managing complex assessment processes at the service user/practitioner interface (Milner & O'Byrne 1998). The results also concur with the view that practitioners vary in their systematic pursuit of information when conducting assessments (Shepphard *et al.* 2001). These issues are of critical importance given that the assessment process shapes decisions about care and access to services (Milne & O'Byrne 1998) and will continue to do so in determining access to alternatives such as direct payments and individual budgets. Based on the current study, it would seem that practitioners' selective and interpretative processes also have significant implications for the exercise of choice and equity. Yet, practitioners' discretionary power can be used effectively to support rather than compromise choice, depending upon how the power is used (Clapton & Kendall 2002). Indeed, practitioner discretion may be positively utilised to individualise assessment and care management in an otherwise managerial controlled environment (Evans & Harris 2004) and to challenge rather than control 'gatekeeping' (Clapton & Kendall 2002).

The relationship between the individual service user and the practitioner is also fundamental to the assessment process and as Holland (2000) suggests, often it is the individual's performance during the assessment process that influences practitioners' interpretations. The analysis in this study suggested that there was a perception among some of the practitioners that older people did not necessarily articulate issues as readily as younger people, or display as much interest in assessment documentation compared to younger people. Yet, as Hardy and colleagues (1999) have found, an inability to articulate needs can be due to a sense of powerlessness resulting from a complex and confusing process. By its very nature, an assessment approach that places emphasis on user-identified outcomes and choice may inadvertently reward those who are more motivated and capable of formulating and articulating goals (Kielhofner & Barrett 1998). In the broader sense, it may also have implications for equity if service users are unable to engage with such an approach (Lent & Arend 2004). The information needs of service users need to be understood and addressed by practitioners, managers and policy makers so that all service users fully understand the purpose and implications of assessment. Further, within frontline practice, practitioners and managers need to give due consideration to the process and time involved in assisting all service users to articulate their aspirations.

Practitioners in the current study believed that documentation of assessment and care plans was representative of shared ownership. It was also valued as a means of clarifying for practitioners and service users what was to be achieved and the course of action to address identified needs. However, the documentation of complex and dynamic assessment processes into organisational records is not apolitical given it involves complexities of power and political issues (Knight & Caveney 1998). For some practitioners in the current study documentation was also seen as a legal safeguard. Another acknowledged it as a source for management to scrutinize the work of practitioners. Written records are central to organisational strategies for co-ordinating and ordering the work carried out (Hall 1999; Jones & May 1992; Morgan 1990). In the current environment furthermore, documentation is a record of worker activity and therefore, central to organisational systems for monitoring outcome and evaluating performance (Morgan 1990). In that respect, the documentation that practitioners complete as part of the assessment process provides detail about the processes and outcomes of their work, and allows management to monitor performance. This in turn can have wider organisational consequences, including financial consequences.

In community based services, statements of individual goals are increasingly utilised for evaluation purposes and organisational planning (Elsworth *et al.* 1999). This has led to speculation that their use in evaluation can create incentives for practitioners to focus on the more achievable goals (MacPherson *et al.* 1999). The current study suggested that some practitioners document only those needs that they perceived could be met within the current service environment. There is a particular challenge for changing professional assessment practice here, given the current aspirations to offer disabled people opportunities to devise new and imaginative ways of meeting their support needs that are not constrained by current patterns of services (Department of Health 2005).

It cannot be assumed then, that practitioners are not self-interested, given that their efforts must produce something useful or acceptable to the organisational and policy environment to ensure continued support and survival (Jones & May

1992). More importantly, organisational records provide the framework for administration and decision-making. What is recorded, and equally significantly, what is not recorded, is likely to have implications for equity (Hall 1999; Jones & May 1992). Given that organisational records are the evidence base for decision-making, there is a need to make sure that service users are appropriately supported not only to understand the importance and multiple uses of organisational records but also, where necessary, to challenge what is recorded.

Practitioners' accounts of assessment also reflected a lack of resources in the current service environment. This is one of the many common limitations impacting on the range of choices available to organisational decision-makers (Hall 1999). Moreover, the findings revealed not only how the lack of resources, but also the expectations about the use of resources (i.e. budgetary constraints), could deny the exercise of choice and lead to inappropriate care for service users or care based on organisational priorities. As Hall (1999) argues, the availability and accessibility of resources are part of the broader environment that is perceived, interpreted and evaluated by those working within the organisation. The end result is that practitioners may tend to manage the assessment process according to "earmarked resources" rather than assisting service users to exercise choice over the services they receive (Chevannes 2002, p.176). This might explain the emphasis reported by some practitioners on personal care services given that such services have become the cornerstones of social care. Equally, it might explain why practitioners document the needs to be met rather than what the service user wants. Again, changes to professional practice will be required if, as proposed, the resources that are available to individual disabled people for use as an individual budget, and the mechanisms by which those resources are calculated, are to become more transparent.

Frontline practitioners will inevitably face multiple and persistent challenges given that they must consistently reconcile their roles as assessors within the service user/practitioner relationship, with the expectations and constraints that accompany their organisational roles and the broader service environment. That said, a policy agenda of personalised social care through enhanced choice necessarily warrants a review of the service system if practitioners and service users are to be provided with the means of achieving this goal. This study has indicated some of the practise, cultural attitudes and organisational constraints that need to be addressed so service users are provided with genuine choice. In particular, professionals will have to take much greater account of the limits of users' knowledge and their sometimes low aspirations and expectations, and support them in feeling confident about making choices (Barnes & Prior 1995). Likewise, practitioners are unlikely to feel comfortable exploring outcomes beyond those issues identified in the initial referral if the service system does not encourage this. More importantly for practitioners, however, service user expectations and entitlements within a model of personalised social care require open public debate if equity is valued, along with enhanced choice.

Conclusion

The complexities of assessment and the constraints associated with the organisational and broader service environments discussed in this paper are arguably inherent in frontline practice. Yet, the issues discussed also represent potential areas that will need to be targeted for change, if the vision of personalised social care is to be fully realised. Moreover, it is suggested that frontline practitioners occupy a central role in managing these complexities and contradictions, and are fundamental to any change process. Frontline practitioners are routinely relied upon to interpret and implement policy in individual contexts and in so doing they retain an element of power, regardless of organisational and policy efforts to shift the balance of power away from frontline practice (Evans & Harris 2004). With enhanced choice a key mechanism for achieving personalised social care for disabled people, much can be gained by understanding the intricacies of frontline practice. Understanding practitioners' roles concerning negotiation and prioritisation of the various complexities and differences within assessment, and how practitioners' manage the contradictory and uncertain organisational and broader service environments, including how they reconcile the tensions between individual and collective needs, are key considerations. These are crucial issues, moreover, for service users, frontline practitioners, managers and policy decision-makers to consider if personalised social care is to be a valid and sustainable concept within frontline practice.

References

Barnes M. (1998) Whose needs, whose resources? Accessing social care. In M. Langan (Ed) *Welfare: needs, rights and risks.* Routledge, London, pp.81-126.

Barnes, M. (2005) The same old process? Older people, participation and deliberation, *Ageing and Society*, **25**(2), 245-60.

Barnes M. & Prior D. (1995) Spoilt for choice? How consumerism can disempower public service users. *Public Money & Management* July-September, 53-58.

Beresford P. & Croft S. (2004) Service users and practitioners united: The key component for social work reform. *British Journal of Social Work* **34,** 53-68.

Bewley C. & Glendinning C. (1994) *Involving Disabled People in Community Care Planning*. Joseph Rowntree Foundation, York.

Cabinet Office (2005) *Improving the Life Chances of Disabled People,* London: Strategy Unit, Cabinet Office.

Chevannes M. (2002) Social construction of the managerialism of needs assessment by health and social care professionals. *Health and Social Care* **10**(3), 168-178.

Clapton J. & Kendall E. (2002) Autonomy and participation in rehabilitation: Time for a new paradigm? *Disability and Rehabilitation* **24,** 987-991.

Clarke J. (2004) *Consumers, Clients or Citizens? Politics, policy and practice in the reform of Social Care.* Paper prepared for Socialforskninginstituttet (SFI) symposium on Consumerism and Social Care, Copenhagen.

Davies A. Ellis K. & Rummery K. (1997) *Access to Assessment; perspectives of practitioners, disabled people and carers,* Bristol: Policy Press.

Department of Health (2005) *Independence, Well-being and Choice. Our vision for the future of social care for adults in England*, London: Department of Health.

Elsworth J. Marks J. McGrath J. & Wade D. (1999) An audit of goal planning in rehabilitation. *Topics in Stroke Rehabilitation* **6**(2), 51-61.

Evans T. & Harris J. (2004) Street-level bureaucracy, social work and the (exaggerated) death of discretion. *British Journal of Social Work* **34**, 871-895.

Foster M. & Tilse C. (2003) Referral to rehabilitation following traumatic brain injury: A model for understanding inequities in access. *Social Science and Medicine* **56**(10), 2201-2210.

Hall R. (1991). *Organizations: Structures, processes, and outcomes*. Prentice Hall, Englewood Cliffs, New Jersey.

Hardy B. Young R. & Wistow, G. (1999) Dimensions of choice in the assessment and care management process: The views of older people, carers and care managers. *Health and Social Care in the Community* **7**(6), 483-491.

Harris J. & Morgan H. (2002) *Outcomes for Disabled Service Users Interim Project Report*. Social Policy Research Unit, The University of York/Department of Health.

Holland S. (2000) The assessment relationship: Interactions between social workers and parents in child protection assessments. *British Journal of Social Work* **30**, 149-163.

Jones A. & May J. (1992) *Working in Human ServiceOrganizations*. Longman, Melbourne.

Kielhofner G. & Barrett L. (1998) Meaning and misunderstanding in occupational forms: A study of therapeutic goal setting. *The American Journal of Occupational Therapy* **52,** 345-353.

Knight T. & Caveney S. (1998) Assessment and action records: Will they promote good parenting? *British Journal of Social Work* **28**, 29-43.

Kuipers P. Carlson G. Bailey S. & Sharma A. (2004) A preliminary exploration of goal setting in community based rehabilitation for people with brain impairment. *Brain Impairment* **5,** 30-41.

Leadbeater C. (2004) *Personalisation through Participation: A new script for public services*. Demos, London.

Lent A. & Arend N. (2004) *Making Choices. How can choice improve local public services?* London: New Local Government Network

Macperhson R. Jerrom B. Lott G. & Ryce M. (1999) The outcome of clinical goal setting in a mental health rehabilitation service. A model for evaluating clinical effectiveness. *Journal of Mental Health* **8**(1), 95-102.

Mason J. (1996) *Qualitative Researching*. Sage Publications, London.

Middleton L. (1999) *The Art of Assessment*. Venture Press, Birmingham.

Milner J. & O'Byrne P. (1998) *Assessment in Social Work*. Palgrave, Hampshire.

Morgan G. (1990) Introduction. In G. Morgan (Ed) *Organizations in Society*. MacMillan, London, pp.1-16.

Nicholas E. (2003) An outcomes focus in carer assessment and review: Value and challenge. *British Journal of Social Work* **1**,31–47.

Nicholas E. Patmore C. & Qureshi H. (2000) Consulting older community care clients about their services: Some lessons for researchers and service managers. *Research, Policy and Planning* **18**(1), 4-11.

Policy Commission on Public Services (2004) *Making Public Services Personal: A new compact for public services*. Policy Commission on Public Services Report to the National Consumer Council, London.

Qureshi H. (1999) Outcomes of social care for adults: Attitudes towards collecting outcome information in practice. *Health and Social Care in the Community* **7**(4), 257-265.

Rummery K. (2002) *Disability, Citizenship and Community Care: A case for welfare rights?* Aldershot: Ashgate

Sheppard M. Newstead S. DiCaccavo A. & Ryan K. (2001) Comparative hypothesis assessment and quasi triangulation as process knowledge assessment strategies in social work practice. *British Journal of Social Work* **31**, 863-885.

Simpson G. Foster M. Kuipers P. Kendall M. & Hanna J. (2005) An organizational perspective on goal setting in community-based brain injury rehabilitation. *Disability and Rehabilitation* **27**(15), 901-910.

Social Services Inspectorate (2002) *Modern Social Services: A commitment to reform.* London.

Spander H. (2004) Friend or foe? Towards a critical assessment of direct payments. *Critical Social Policy* **24**(2), 187-209.

Thornton P. & Tozer R. (1995) *Having a Say in Change: Older people and community care*. Joseph Rowntree Foundation, York.

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