TRENT FOCUS GROUP

University of Sheffield

Department of Sociological Studies

Developing Research at the Social Services and Health Interface

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A scoping exercise covering social services in the Trent Region

A study commissioned by the Trent Focus for Research and Development in Primary Care

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http://www.Trentfocus.org.uk

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http://www.shef.ac.uk/uni/academic/R-Z/socst/research.html

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DEVELOPING RESEARCH AT THE SOCIAL SERVICES AND HEALTH INTERFACE IN PRIMARY CARE

A STUDY FOR THE TRENT FOCUS GROUP

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EXECUTIVE SUMMARY

DEVELOPING RESEARCH AT THE SOCIAL SERVICES AND HEALTH INTERFACE IN PRIMARY CARE : A STUDY FOR THE TRENT FOCUS GROUP

Study Aims

To assess the scope for the Trent Focus primary care research network to involve social services staff in joint R&D training and development initiatives.

- Who are the key groups of social services staff already involved in 'interface' work with primary care?
- Which research skills and topics do these staff groups (and their managers) see as appropriate for development through joint work with primary care networks?
- What characterises current, successful models of research collaboration between social services and primary care?
- What are the perceived barriers to this kind of collaboration?

Study Design

- Telephone interviews with senior managers in social services departments (10 of 14) and health authorities in Trent (6 of 11, predominantly in Public Health).
- Telephone interviews with social services representatives on PGC/T boards (19 covering 25 PCG/Ts)
- Telephone interviews with operational managers in social services (6 Departments, covering Metropolitan, Unitary and County, 19 interviews)
- Focus groups with social services staff who undertake joint work with primary care (three covering mental health, child care and elderly people).
- Analysis of relevant documentation, including:
  Literature review
  Social Services Structure Plans
  Social Services Policy Documents
  Project outlines

Interface Working of Social Services in Primary Care

Three main functions are seen as particularly relevant to the interface of health and social care:

Assessment for social care
Co-ordination of social care
Provision of social care

At three levels of the social services' workforce:

Practitioners
Operational Managers
Strategic and Policy Staff

Five main areas are seen as the most important ones for this work:

- Working in multi-disciplinary teams
- Undertaking multi-disciplinary assessment of need
- Co-ordinating packages of care which comprise both health and social care
- Providing social care within a package of joint care

- Strategic planning for health and social care

The Structure of the Departments in the Study

- Fourteen Social Services, six Unitaries, four Counties, and four Metropolitan authorities.
- Almost no element of uniformity in structure, speciality, nomenclature or policy. Variety is the most noticeable factor.
- A summary description is in the report, which may be useful for health services staff.

The Research Underway

Internally funded and sponsored ‘research’ covered five areas, none of the work was generalisable research.

- Needs analysis, mapping exercises
- User/carer surveys
- Exploratory studies
- Action research linked to service development
- Evaluation of a project/service development

This research is generally local and opportunistic.

Hosted research is also happening, but this is difficult to find as it is not logged centrally and it is based in a wide variety of University Departments

Research Collaboration

Research collaboration discussions took place in a variety of planning and policy meetings, there was no example of a specific research forum

- Joint planning forums
- Mental Health, NSF implementation groups
- Joint Commissioning Teams

It all took place as a result of external approaches

- Informal, personal based links
- Approaches from Universities
- Approaches from major charities (e.g. Mental Health Foundation)

Funding Sources

There is no funding! Small sums of a few thousand do come from three main areas:

- Underspends from mainstream funding or specific grants
- Specific grants or programmes with small sums built in (e.g. Mental Health Grant, Quality Protects)
- Multi-agency initiatives, such as Health Action Zone evaluation work, Health Improvement Plans, Single Regeneration Budget projects

Current Levels of Research and Experience

The very limited research training going on is individually based and nearly all results from Masters programmes or other external training. There is very little research experience of any sort. Where there are some forms of ‘research section’ the focus is on management information and reporting to the Department of Health.

Research Interest and Priorities

- A strong emphasis on user/carer involvement
- Research linked to strong personal commitments, seen as locally relevant.
- Research that addressed the Quality Protects programme in children's services

A range of interesting proposals for research were made by focus group members

Barriers to Research

The predominant barrier to research appears to be cultural: it is not part of the current job, despite some pockets of strong personal interest, and an awareness by senior managers and policy staff that it is of increasing importance.

Discussions about research development between social services and health will sometimes raise problems of the value of different methodologies, when a predominantly evaluative tradition meets a predominantly generalisable one.

Many of the staff see themselves as fully occupied with no time to do research.

The main barriers identified by staff are the following, with the most important listed first:

Culture (including intrinsic reward issues) and Reward systems (extrinsic)

- Praise from colleagues lacking (NB need to understand research work, in order to praise)
- Not seen as 'part of job', not built into everyday understanding of what the job is.
- Not a significant part of qualifications
- Not a significant factor in promotion

Supervisor attitudes

- Not a priority and cannot make it a priority without reducing service unacceptably
- Lack of skills to support it
- May be threatened by new skills, knowledge and attitudes

Personal skills needing development

- Research formulation (researchable questions)
- Research design
- Research techniques, especially qualitative interviews and small scale statistics work
- Research management (handling day to day work: access, ethics, timing, etc)

Personal attitudes

- Research is something that others do
- Research should be something that others do (outside the agency) as it makes it more valid
- Questions we need to answer are very big, holistic, cannot partialise
- Cannot measure and quantify the work we do, measures are not appropriate

Support staff and materials

- Secretarial (for calls, admin, tape transcription etc)
- Information and Communication Technology (for word processing, internet, calculation)

- Statistical consultancy

Services are changing

- The fluid and changing nature of services at present makes it difficult to focus research

RECOMMENDATIONS

Bearing in mind the early stages of research development, the widely varied nature of social services, the commitment of some pioneers, and the current policy and practice concerns of the services ...

Strategy

- Build initial contacts with the currently interested individuals, and develop an ad hoc network of interested parties
- Offer opportunities in tune with practice and operational priorities in the service, at a suitable beginning level.

Potential Contacts, Links, Collaborators

- Staff already revealed by the study who have expressed interest, and where they exist, their supervisors, and others named by them as interested.
- PCG/T representatives, and those named by them as interested
- Research and Development Alliances where they exist

Priority Focus

- Training and other work should pay attention to four key interface areas (there is a danger of all work in social services being defined as 'interface')
  - Social care staff who handle referrals from health care workers
  - Social care staff who do initial assessments which directly involve health information
  - Social care staff who co-ordinate complex packages of care that directly involve health services
  - Planning and policy staff who are directly engaged in developing policy in interface areas and/or incorporating research into policy in areas such as Best Value reviews or joint inspections from Audit Commission and the Social Services Inspectorate.

- Key areas for training include:
  - Literature search and critical appraisal skills
  - Using existing data: improving it, checking it, analysing it, presenting it
  - Focusing multi-agency evaluations: providing 'researchable questions'
  - The possibility of developing research from needs assessment work

Training Process

- Training should involve at least some health services staff alongside social services
- Supervisors of practitioners should be offered some information about the training content when their staff go on training (at a minimum some literature to read, at most some period of joint training with their staff)
- Mentoring as one of the models of training should be considered
- 'Signpost' help, directing people to opportunities and sources of help would be welcomed

- All training should carefully include the perspective of users and carers

Future Development

- Government programmes are key drivers in social services, Trent Focus could try and develop specific links to the objectives in Quality Protects, Best Value and other programmes.
- An eye should be kept on the new Quality proposals for the social services http://www.doh.gov.uk/scg/qualitystrategy/index.htm
- The Association of Directors of Social Services' research committee may be a useful future partner
- Academic partners in R&D Alliances could provide a source of good research models, and be encouraged to develop better links with services
- Building links with the programmes within the social work post-qualifying training framework may be sensible

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INTRODUCTION

This study was commissioned by Trent Focus in May 2000, with the aim of assessing the scope for extending primary care-based research training and development initiatives to Social Services staff working at the primary care-social care interface. In order to do this, we have examined both the current range of research capacity and activity in Social Services organisations in Trent, and the views of Social Services managers and practitioners regarding current priorities for research training and development. Our findings are based on telephone interviews and focus group discussions with a wide range of Social Services managers and practitioners across the Trent Region, including Social Services representatives on Primary Care Group and Primary Care Trust boards; they also draw on analyses of current Social Services policy documents, and on discussions with Health Authority representatives.

The context for the study is the range of current policy initiatives which emphasise the need for joint working between health and social care organisations, as well as an increasing emphasis on research awareness, evaluation and performance review. In the NHS, "A First Class Service", and "Our Healthier Nation" highlight the need for collaboration; "Modernising Social Services' reinforces the same message. The requirement to work together is reflected more tangibly in quality assurance mechanisms. The Social Services national Performance Assessment Framework, for example, includes indicators which reflect shared working; it also highlights joint lead responsibilities in cutting health inequalities, in addressing mental health issues and in promoting independence. In the NHS, developing seamless services between the health and social care systems, shaped by the needs of service users, is described as a core principle. Creating opportunities for users to influence services is another important policy imperative which is beginning to influence research and development priorities and commissioning processes. Quality initiatives such as National Services Frameworks in health, and Quality Protects in Social Services, also provide a clear remit for health and social care to work together, and require organisations to monitor progress. Multi-agency initiatives such as Health Action Zones and Sure Start have encouraged imaginative service developments at a local level, with strong elements of evaluation and review. Joint working in these contexts has the potential to create an improved basis for collaboration in research and development too, although these opportunities have yet to be fully explored.

In this context, it is becoming increasingly important for social care organisations to develop internal resources, and cultures, which are conducive to research and evaluation. Local Authorities are now required to make decision-making processes more transparent and to assess how they commission services through the 'Best Value'requirements introduced in 1999. Best Value reviews require local authorities to compare services with others, to challenge current arrangements, to consult with service users, and to enable competition for service provision. These processes require new levels of commitment to evaluation, data collection and analysis; however, as our findings indicate, resources to support these levels of research and evaluation are still severely limited.

Nevertheless, a number of current developments are already addressing the gap between research and practice in social care. Prominent initiatives include the Centre for Evidence Based Social Care (CEBSS), based in Exeter and funded by the Department of Health; the national "Research in Practice" network, developed by the Association of Director of Social Services and funded by participating agencies; and Making Research Count (a research dissemination
project linking a number of Universities with individual Social Services departments). Similarly, planned changes in social work training already place heavy emphasis on evidence-based decision making and on partnership working, as illustrated in the national training strategy circulated by the recently-established Training Organisation for the Personal Social Services (TOPSS) ; new post qualifying awards are also preparing experienced practitioners to evaluate and use research more extensively in their practice. Recently, the Quality Strategy for Social Care has put in place a more forceful approach to assessing and using research findings, through the proposed Social Care Institute of Excellence (SCIE); like the National Institute of Clinical Excellence (NICE) in health, SCIE is intended to develop guidelines and service frameworks for practice. Care pathways and interface working will feature as work for both institutes, fuelling a demand for research designed to address issues at the health / social care interface. The new funding arrangements and strategy for Research and Development in the NHS harmonise with the reforms described above, recognising the need to build research capacity within services.

Our report opens with a review of recent literature concerning Social Services research (Chapter One). Chapter Two describes the methodology we adopted, and Chapter Three provides an up-to-date picture of the staffing structures and resources relevant to the primary care-social care interface. Chapter Four presents our findings concerning current research activity in Social Services organisations in Trent; Chapter Five goes on to describe the current levels of research training and experience in Social Services contexts, along with perceived barriers to research development and priority topics for research training and development. Finally, Chapter Six presents our conclusions and recommendations.

CHAPTER ONE

Literature Review

Introduction

In searching for relevant literature, we accessed a range of databases (BIDS, Cinahl, Assia, PsyINFO) as well as peer-reviewed journals in social work and social policy, and a wide range of academic and social work-related web-sites. Keyword searches were used to identify literature related to the context of joint working in primary care and social care, to inter-professional training issues and to the specific themes of Social Services research capacity, training and development.

There are many articles which report the findings of studies in specific areas of social work; there is also a range of recent, substantial articles concerning *the need to increase research and evaluation activity and utilisation in social services.* However, there are very few articles which actually *describe or evaluate research training or development initiatives.* Accordingly, we adopted fairly broad criteria in selecting articles to include here: they are not restricted to analyses of Social Services research activity, or of research training or development initiatives, but also include analyses of other relevant policy and practice developments and debates.

We have also chosen deliberately to include some work which refers to evaluation and audit issues, and not only 'research' in the sense of studies which produce generalisable findings. This applies to our later ‘findings’ chapters, as well as to the literature review. Our rationale is that there are specific skills which are common to research, evaluation and audit processes: therefore it is relevant to identify current capacity and scope in Social Services for audit and evaluation. It is also important to acknowledge that the term ‘evaluation’ in particular sometimes has broader connotations in Social Services contexts than in health service contexts (see for example Shaw and Shaw, 1997, Shaw 1999). Finally, experience of audit and/or evaluation can be an important ‘way in’ for practitioners to develop both research awareness and activity.

The sources which proved to contain substantial threads of debate concerning Social Services research and the primary care/social care interface were these:

- the Journal of Interprofessional Care: a special issue on Research and Professional Practice **(11,1 1997)** and occasional articles subsequently;
- Research, Policy and Planning (the Social Services Research Group journal): occasional articles from the mid-1980s onwards, a special edition in 1998 (**16,2 1998)** and a themed edition on Evidence-Based Practice **(17,1 1999**);
- Health and Social Care in the Community: occasional articles, especially concerning interface and policy issues;
- the British Journal of Social Work, and Social Work Education: occasional articles, including analyses of research training initiatives;
- Sociological Research On-Line: occasional articles;

- Organisations combining academic, policy and practitioner perspectives, with detailed material on their web-sites as well as in publications: the National Institute for Social Work (NISW), the Centre for Evidence-Based Social Services (CEBSS) and Research in Practice, (RIP).

The discussion which follows does not claim to present an exhaustive picture of the available literature; however, it does identify and addresses three themes with particular importance for this study:

- The context for research and evaluation in Social Services;
- The recent impetus for increased research activity and EBP within Social Services:
- Relevant developments at the primary care / Social Services interface, including multi-agency initiatives and their implications.

1.1 The context for research and evaluation in Social Services

Debate about strengthening Social Services research is not new: in 1980, for example, the (then) DHSS published a working party report entitled '*Directions for Research in Social Work and the Social Services*', identifying the need for systematic research in areas such as the specific skills required in different settings, or the implementation of case review systems. A commentary from a BASW officer, in response, made a strong case for social researchers 'to engage practitioners in acquiring skills, research skills, even if crude… to inform their role both as practitioners and as social reformers.' (Etherington, 1984:26).

The language of social reform has given way to more cautious and less overtly political terms now: inclusion, effectiveness, partnership, user-involvement. However, many of the debates and concerns remain recognisable ones. The 1990 DOH publication *Taking Research Seriously* acknowledged the under-use of research in Social Services, highlighting the need for more effective dissemination and discussion of research findings. The 1992 *Survey of Resources* for personal Social Services (PSS) research, carried out by the Thomas Coram Research Unit (quoted in Iwaniec and Pinkerton, 1998) found that R & D resources were less than 1% of service delivery costs (1998:13). The DOH commissioned more than half of all PSS research, with only 2% provided by local authorities themselves. Iwaniec and Pinkerton note from the survey that:

> 'the academic and conceptual framework of Social Services, and therefore of PSS research, was found to be still underdeveloped. There were no powerful long-established institutions providing leadership… The *British Journal of Social Work* was seldom read by social care workers, and *Community Care,* though widely circulated, gave little space to research findings. However, they found that there was eagerness for sound knowledge to improve practice and to use new validated ideas…'
> (Iwaniec and Pinkerton, 1998:14).

In 1994 the DOH published a further report – *A Wider Strategy for Research and Development Relating to Personal Social Services* – which emphasised the need to promote a research culture at all levels, and to lay a basis for academic-practitioner partnerships.

Recent literature concerning the context for research in Social Services can be grouped under three general headings:

- perspectives which highlight the difficulties and complexities inherent in the Social Services context, concerning the development of research awareness and activity;
- perspectives which emphasise the opportunities for researcher/practitioner dialogue and for practitioner research;
- perspectives which emphasise the urgent need to develop rigorous research strategies (making explicit comparisons with health research models).

In terms of **difficulties and complexities,** Fisher (1997), for example, notes the argument that the context within which social workers practise is ‘intrinsically antagonistic to thoughtful practice’. He cites the following in support of this argument;

> 'Less than two years' basic training, little incentive for professional development and the reduction of individual authority in favour of bureaucratic decision-making structures.' (1997:107)

Social workers will talk, with justification, of not having time to access or read research studies; however, resistance to acting on research findings goes deeper than a simple lack of time or interest. It has also been suggested that some aspects of professional social work training and experience raise specific difficulties concerning research methodology. The complexity of the assessment and decision-making process, in the child protection field for example, can lead social workers to discount the relevance of what they see as simplistic research findings. An instance of this is the well accepted finding that children are more likely to be sexually abused by step-fathers than by birth fathers (see, for example, Finklehor, 1986), a finding that ‘fits’ with the ‘on the job’ experience of most experienced social workers. The finding, it can be argued, does not help the individual social worker in assessing an individual case, when it is self evident that many step-fathers do *not* abuse their children, whilst equally many birth fathers *do.*

This sort of example illustrates the difficulties involved in relating generalisable research findings from quantitative studies to practice at an individual level. Of course, findings that claim to have general applicability can be useful in directing social work practice to pay more attention to identified tendencies, or patterns. However, it has been suggested that social workers remain more open to findings from qualitative rather than quantitative studies, since ‘the practitioner is dealing with situations that are unique, whereas researchers are looking for generalisations’ (Fisher, 1997, 105). But these views are increasingly being challenged, and we discuss the issue of appropriate methodologies and definitions of ‘evidence’ further, below.

Many of the points made above in relation to social work practitioners have also been applied to Social Services managers. Some have argued that research which is explicitly relevant to current concerns is more likely to be listened to; Bradley (1997), for instance, argues that:

> 'Research which appears immediately relevant to national or agency debates is likely to be drawn into…discussions and can inform or confirm decisions. The observation is that where research provokes some anxiety about policy or practice the agency may decide to take on board the findings as a protective mechanism.' (1997:3)

However, Bradley also points to the many reasons why managers may feel unable or unwilling to commission or use research; these are not confined to lack of time or resources for research, but also include discouraging experiences:

> 'Research was cited [by managers] which had overrun the time limit, was out of date before it was written up and which had no obvious feedback loop into the agency. More than ever before, [managers] could not afford to spend money on research which did not provide evidence which could be translated into practice….practitioners would not co-operate unless they could see some benefit to their practice.
> (1997:41)

In organisational terms, the Personal Social Services, in common with all other public services, have undergone enormous change since the late 1980s. Key changes have included the privatisation and contracting out of much service provision, the creation of internal markets, the development of arms length inspection, and measures to give service users more say in the provision of services. The move to a more managerialist emphasis, illustrated by changes in job titles from Team Leader to Team or Service Manager, has been accompanied by increasing pressures to respond to the demands of central government - consolidated in substantial requirements for standard setting, for meeting targets and for producing management information. Commenting on these pressures, Schneider (1994) cautioned that the increasing emphasis on providing quantitative management information could obstruct opportunities for a more rigorous focus on qualitative research about outcomes (1994:2). Four years later, Marion Barnes (writing an editorial signalling the demise of the Journal **Social Services Research** in 1998), elaborated on this point:

> 'The type of post [Social Services Research Officer] that I was appointed to in 1979 is now very rare in Local Authority Social Services departments. As budgets were squeezed, research officer posts started to appear expendable. As the discourse of value for money started to take hold, the skills of research officers seemed suitable for transforming a research role into that of a performance review officer, inspection officer or complaints manager. Few in-house researchers remain and the level of activity that is recognisably research, rather than the generation of performance management information, is much reduced.'
> (1998: i).

Barnes saw a causal link between the development of performance review and the decrease in in-house research. However, this would now be challenged by many who support initiatives such as Quality Protects and Best Value, and we return to this point in discussing our own findings in Chapters Four, Five and Six.

In terms of **opportunities for researcher/practitioner dialogue and for practitioner research**, there is widespread agreement that a number of factors, related to concepts about ownership, relevance and topicality, are likely to increase the chances of research being effectively utilised. Bond and Jones (1995) describe a research dissemination project based in the Leicester University School of Social Work; this aimed to provide encouragement and recognition for practitioners to take part in research – as well as using research findings – through a series of workshops and a national conference. Pursuing related themes at a more general level, Berger (1997) examines three ways in which the gap between research and practice may be overcome. The first of these can be summarised as 'practitioner friendly research' in which the researcher studies 'client populations and intervention processes that are directly relevant to practitioners and [creates] practice-significant paradigms, epistemology and research strategies.' (op.cit:113) The second route lies in practitioners conducting research as part of their professional practice, and the third in getting practitioners and researchers 'to work together in research centres within schools of social work and to develop a school/field research partnership' – very much the approach taken in the example described by Bond and Jones (Berger, op.cit:113). These approaches have clear parallels with the ways in which primary care research initiatives and networks have developed. A more extensive example of just such a partnership, at a national level, is *Research in Practice,* the Association of Directors of Social Services initiative aimed explicitly at the implementation of research in childcare (Atherton, 1999; Research in Practice 2000a and 2000b).

Finally, authors who **emphasise the urgent need to develop rigorous research and evaluation strategies** in Social Services reflect contrasting perspectives. Macdonald (1997), for example, has argued strongly for the inclusion of systematic reviews on the NHS Cochrane collaboration model, and for the wider use of outcomes research (including randomised controlled trials) in Social Services research. (Oakley (1998) pursues a related but more general argument concerning experimental methods in social research). The DOH funded Centre for Evidence Based Social Services in Exeter recently carried out a large survey of social workers (Sheldon et al, 1999), and noted patterns very similar to those observed in the 1992 Thomas Coram survey which we quoted above:

> 'All subjects were enthusiastic about the *idea* of evidence-based practice, but virtually none of the professional-grade staff sampled had been able to read anything apart from *Community Care* (which bits we do not know) since qualifying. Only 16.5% knew of any experimental study of the effectiveness of social work, and very few respondents (12.7%) could name, describe or, to be frank, hint at, any client-opinion study (all against very liberal, sub-Paxman criteria).'
> (Sheldon and Macdonald, 1999).

The consistency of findings like these clearly emphasises the need for increased attention to research awareness and development in Social Services. However, references to some quite sensational examples to bring this point home are more questionable: these are not a good reflection of the dilemmas most social workers would recognise in relation to their own daily practice (see for example the extract from an interview concerning suspected child abuse in Orkney, Sheldon and Macdonald op.cit: 9).

In contrast, Shaw and Shaw (1997) make the case for an approach to social work research which explicitly builds on professional skills in reflexive practice, aiming to be

> 'simultaneously true to social workers' accounts of their practice, while offering a critical starting-point for evaluating and refashioning that practice.'
> (Shaw and Shaw, 1997:847).

They provide a critique of the 'empirical practice' approach represented by Sheldon and Macdonald, suggesting that this is both unfairly dismissive of the scope of rigorous qualitative research, and too simplistic in its approach to the relationship between evidence and changes in practice (1997:851-2). Their own in-depth analysis of fifteen practitioner interviews demonstrated the difference perceived by social workers between formal evaluation (often seen as ill-resourced and ill thought-out) and a more critical approach to their own practice, strongly and explicitly related to professional values. Rather than presenting a picture of social workers and organisations as resistant to research processes, therefore, this 'humanist' approach sets out to acknowledge and build on those aspects of social work practice which already embody skills in critical reflection. Shaw and Shaw conclude by outlining a number of areas in which methods for 'evaluating in practice' might be developed further, for example by developing distinct and specific models of process evaluation and outcome evaluation (op.cit: 866-7). This is an approach with strong parallels with Michael Bloor's more general argument (which draws on specific case-study examples) for a strong researcher-practitioner relationship, as the basis for improved research awareness and dissemination (Bloor, 1997).

1.2 The current impetus for increased research awareness and research activity within Social Services:

Research awareness and evidence-based practice

How are these differing perspectives being played out currently? Policy developments during the 1990s have certainly provided the social work profession with a continued impetus to base their work more explicitly on the findings of research. Successive publications from the Department of Health have illustrated increasingly sophisticated attempts to disseminate research findings and to encourage policy makers and practitioners to consider actively how the findings relate to them. Fisher (1997) discusses how the publication *Protecting Children* (Department of Health, 1988) served as an example of a 'research translator' for practitioners and managers. It did not describe research studies as such, but distilled their findings to produce what was hoped to be a guide to best practice, based on evidence.

Messages from Research, (DOH 1995, subsequently referred to as *Messages*) was an example of departments being asked to apply research findings for themselves, and as such was an implicit challenge to the defensive reaction of 'that doesn't apply to us' or 'we already do that here'. *Messages* did this by including a series of 'Is it true for us?' exercises, aimed at policy makers, management level and practitioners. In a sense it was a challenge to provoke the profession (and other agencies involved in child protection work) into responding: a challenge to prove that their work was based on the best available knowledge.

At a more general level, in a *Research, Policy and Practice* special issue (Vol. 16 No 2, 1998), articles on health policy (Hunter, 1998), evidence-based practice (Sheldon, 1998) and integrating health and social care (Challis, 1998) all underline the increasing dialogue across the health/social care boundary, concerning research awareness and development. A subsequent themed issue of *Research, Policy and Planning,* on evidence-based practice, includes a brief overview of current funding and organisational issues in social work research (Broad, 1999); this touches on the fragmented nature of current funding for social work research, as well as on more contentious issues, such as the potential tension between 'emancipatory' research initiatives (concerning ethnicity, for example) and existing funding priorities. In the same issue, Adams et al (1999) review social services research initiatives in Kent; they also report the findings of a 1995 survey of practitioners and care managers in Kent, concerning research awareness and utilisation (this was based on 90 questionnaire returns from an original circulation of 300). Key findings echoed those of Sheldon et al (op.cit), in terms of generally low research awareness; the authors also comment that research agendas 'appear to be driven primarily by planners and managers, with little recognition of the concerns of, and time constraints on, practitioners' (Adams et al, op.cit:8).

Finally, during 2000 the Barnardo's Research and Development team completed a review of attempts to integrate research findings into social practice and management (Barnardo's Child Care, 2000; see also Joseph Rowntree Foundation website,
http:www.jrf.orf.uk/knowledge/findings/socialcare/910.htm).
This report stresses a number of points: the importance of increasing resources for research dissemination; the existence of a degree of tension between researchers' needs and those of practitioners, and the need to reconcile these; the importance of recognising that research is one of a range of influences on social care practice, which include custom, legislation, charismatic leadership and public opinion.

Research development and activity

As we noted in the introduction to this chapter, there are few published analyses of social work research training and development initiatives. However, two recent papers do illustrate contrasting initiatives which are both relevant to this study. Bhatti-Sinclair (1999) examined a initiative designed to develop the clinical audit model within social work, with specific reference to evaluating practice with black and minority ethnic client groups.

This study was based on interviews with 37 patients and 91 staff (social work, clerical, managerial and clinical), drawn from four general practices and two hospital departments. The paper illustrates the ways in which an audit process was able to identify specific user needs which were not addressed adequately by existing services. The distinctions between audit, evaluation and research are also discussed, and audit is identified as an approach which can be implemented with a clear developmental and 'action research' emphasis. This is a different emphasis from the one common in many health service contexts, and one seen as capable of incorporating key social work values (such an anti-oppressive practice) – as a concluding comment from the author illustrates:

> 'an approach [clinical audit] which is widely used internally and multi-professionally within health should be considered seriously within social work, particularly as it may attract training and developmental resources to the discipline. Audit is promoted as a team-building approach and one which can be used to address racist attitudes and hierarchical structures of management and control.'
> (Bhatti-Sinclair, 1999:317-8).

Taking the discussion to a more comprehensive level, McCrystal (2000) describes a planned Practitioner Research Training Programme based in the Centre for Child Care Research at Queen's University, Belfast. This has been informed by previous discussions of the scope of practitioner-researcher collaboration (see for example Cheetham, 1997). Like Sheldon et al (op.cit), this Centre conducted a survey of social workers, seeking to assess their attitudes to the proposed Training Programme itself, as well as general levels of research literacy, competency and interest. Some findings were very similar to those from Sheldon et al: a majority of the 144 social workers in the survey perceived a clear need for research to inform practice, but in reality over half were not reading any source of research findings at all. In terms of perceived preferences for research training, analysis of findings (listed by 65% of respondents) and qualitative methodologies (listed by 58%) were the most popular topics. McCrystal notes that 37% of respondents to the survey were already undertaking a piece of research as part-fulfilment for a qualification, and that it is important for any new research training initiatives to identify and build on the grounding in research skills that masters or doctoral programmes offer (op.cit:371).

Moving on from these two specific examples, the debate between contrasting perspectives on social work research continues. Making explicit comparisons with health research models, Sheldon and Macdonald (op.cit) have developed their own proposals further by arguing very strongly for the importance of developing systematic review skills and techniques in Social Services research. They also document the current predominance of small-scale, qualitative studies in social services research, and seek to challenge this:

> 'The strictest [research] designs are usually in single figures over a ten year period and are almost always American… *The British Journal of Social Work* (arguably the premier national journal) has published 356 articles in the last decade. Of these 152 (43%) contain *some* empirical material, with the majority falling into our 'weak empirical' category,

> in that they are based on small samples and/or do not adequately address issues of representativeness. This search further revealed only 5 outcome studies, 3 service-effectiveness reviews and *no* controlled trials. … We *have* a continuum [of methodologies]; the problem is that it is wedge-shaped… When studying the effects of interventions we must learn to live with a *hierarchy* of research methods and attributive confidence, for only experimental, or at a push, comparative approaches, have the bias-reduction properties to encourage us to head off in one direction rather than another with any sense of security.' (Sheldon and Macdonald, 1999:3).

At the same time, the ESRC-funded web-based seminar series, 'Theorising Social Work Research' (NISW, 2000*)* has begun to articulate a broad approach, explicitly encouraging collaboration rather than competition between academic centres with differing emphases and perspectives. The draft strategic framework produced from the seminar series in March 2000 stresses the small and fragmented academic base for social work and social care research: eleven 'highly rated' social work research centres (in the 1996 Research Assessment Exercise); a total of £2.7m in HEFCE funding for social work research (in 1997-8); and *no* public body or funding agency charged with the specific task of promoting social work research. The framework document also points out the need to assert and consolidate well-established, but under-recognised, areas of knowledge and experience:

> 'Because social work has not been recognised in disciplinary terms in many parts of the academy, and because of a characteristic humility in presentation and lack of theoretical bite, social work's track record … often remains unacknowledged. We therefore watch other disciplines promoting theoretical knowledge for involving users… for instance, in the sure and certain knowledge that we have a twenty year history in this aspect on which we have not sufficiently capitalized.'
> (NISW, 2000)

This specific example is an important and topical one, given the current emphasis in NHS R & D on promoting user-involvement. The draft strategic framework goes on to identify the nature of the relationship between service users' movements, and the social work research community, as the key question to address in specific terms.

Finally, the August issue of the British Journal of Social Work is entirely devoted to papers on social work research. Challenging a perceived positivistic emphasis in the CEBSS initiatives, researchers such as Parton (2000:449-463) and Sheppard et al (2000: 465-488) articulate an alternative approach, based on realist epistemological principles and on concepts of reflexivity (c.f. Shaw op.cit. and also Pawson and Tilley, 1997). Drawing on an ESRC-funded empirical study of twenty one social workers, Sheppard et al do not reject the idea of using rigorous evidence to inform practice, but instead elaborate and test techniques for examining 'process knowledge' (seen as just as essential as the 'product knowledge' emphasised by Sheldon et al). However, it is clear that these responses to the CEBSS emphasis still need to be developed in greater depth, in order to be assessed fully.

1.3 Developments at the primary care/Social Services interface, including multi-agency initiatives:

Both national policy and local practice currently demonstrate an emerging basis of joint working between social services and primary care organisations, although recent research suggests large variations in the precise extent and form of collaboration – with continuing reference to attempts to bring down the ‘Berlin Wall’ (see for example Hudson 1999; Hiscock and Pearson, 1999). Simic (1997) sees current changes in primary care as presenting clear opportunities for a more user-oriented and community-based focus for social work. Glendinning et al (1998), Rummery (1999) and Hudson (1999) have all identified successful models of joint commissioning between primary health and Social Services, although within a very uneven overall picture. Peckham (2000) sees PCGs as embodying real potential for improved collaboration between health and social care: ‘never before have primary care practitioners and social services representatives been formally integrated within the NHS; (Peckham, 2000:7). Callaghan et al (2000) examined relationships between Social Services and new PCGs in four localities; among other points, their study stressed that collaboration is still at a very early stage, with many features yet to be clarified (including, for example, an apparent lack of engagement between council members and PCGs). A larger-scale study by Hudson (2000) examined the role of the Social Services representative on PCG boards, finding evidence of increasing influence on processes of commissioning, service delivery and health improvement. However, research and development was not mentioned or addressed specifically in any of the above studies.

Emerging analyses of inter-agency working in initiatives such as Health Action Zones do make some reference to research-related issues: Amery (2000:28) for example notes the creation of common datasets and evaluation methodologies. However, as our own findings indicate (see Chapter 5), work like this is at an early stage and progress is uneven across different localities.

1.4 Conclusion:

In conclusion, we can identify a number of themes which are important in terms of this study:

- available survey data shows that social workers do recognise the importance of research, but that in practice the majority do not access research findings regularly;
- survey data and small-scale studies do, however, show a consistent interest in developing research skills and research utilisation, suggesting that there is genuine scope for new training and development initiatives;
- at a theoretical level, current debate displays contrasting perspectives; although some emphasise the value of health research models, others raise fundamental questions about appropriate research strategies and methodologies. Any new research training and development initiatives in Trent will need to acknowledge these debates, and to monitor them as

they develop. Current web-based resources do provide a readily-accessible means of achieving this.

CHAPTER TWO
Methodology

2.1 Introduction

The design of the study was influenced by the need to access information from 14 different Social Services Departments, all with differing structures, and the requirement of Trent Focus to invite the Social Services representatives on each of the 51 Trent P.C.G/T. boards to be involved in an interview. We were also keen to adopt a design which would allow scope for raising awareness about the potential scope for increased Social Services involvement in collaborative research development processes.

The timetable for the study was heavily influenced by the need to avoid trying to arrange interviews or focus groups during the main summer holiday period. However, even though we had anticipated this problem, some interviews still proved very difficult to arrange. In addition, the cascading of information about the focus groups within Departments was clearly affected by holiday absences; whether this would have occurred more effectively at another time of year is a moot point. Lastly, two of the three focus groups were arranged in mid September 2000, on the two dates when the whole region was most heavily affected by the 'Fuel Crisis' and when many social workers became involved in, or were planning for, emergency measures. This eventually resulted in one of the focus groups being cancelled and the other attracting a membership of only two social workers. However, in lieu of the cancelled focus group, short telephone interviews were held with four of those invited.

Our eventual design incorporated two phases of work.. The first was designed to collect basic information and to address key issues across the region, through

interviews with senior managers in social services departments, managers or researchers in health authorities and social services representatives on PCG/T boards. The first phase also included the collection of key data on individual Social Services departments, including staff numbers, organisational structures and interface activities. The second phase was designed to build on this overview, through focus groups with practitioners and through interviews with operational managers in each of the major areas of social services activity: children and families, disabilities, mental health and older adults. The aim of the second phase was to gather the views of these groups concerning research activity within Social Services.

2.2 Phase One: Mapping Issues, Contacts and Resources

Objectives:

- to identify the range and number of social services personnel working at the primary health care–social care interface;
- to develop an overview of current social services perspectives on research training, experience and interest, in connection with work at this interface;
- to identify key contacts for interviews in Phase Two;
- to identify a small reference group of respondents, willing to comment briefly on the findings of the study;
- to identify and summarise relevant papers, reports and research projects.

Methods:
The following staff were invited to take part in a telephone interview:

- a senior manager from each of the fourteen Social Services Departments within Trent. The Director of Social Services in each Authority was asked to nominate a senior manager who would be in a position to provide an overview of the Department's structure and other issues such as the Department's research capacity and attitude towards research activity.

- the Social Services P.C.G./P.C.T. board representative on each of the 51 P.C.G/Ts in Trent;

- A senior manager with a remit for research from each of the 11 Health authorities. In practice, most of these were based in Public Health.

All Departments were also asked to provide basic data, including recent Community Care Plans, structure charts and numbers of staff.

Commentary:
We did not anticipate that interviews would be achieved with all of the above; we also expected that there would be some overlap between the senior managers identified and the P.C.G representatives, especially in the smaller departments. In the event this overlap only applied to three potential interviewees. Our agreed objective was to achieve interviews with 50% of P.C.G representatives and to ensure that a minimum of two interviews were carried out from staff in each Department.

It took some time to identify potential interviewees for the first phase of the study. Although Directors all responded to our request to identify a senior manager, in practice it often took considerable time to make contact with the designated person. In respect of the P.C.G./P.C.T. representatives, it quickly emerged that, although a national P.C.G Database was being created, it did not yet hold accurate or complete information on Board membership. The only way of gaining access was to contact each of the Boards individually for names and contact details. Similarly, Health Authorities did not have uniformity in their structures, and the identification of the most suitable person to interview was not always straightforward.

All potential interviewees were provided with a one page outline of the study objectives and methods, and a letter outlining the areas for discussion in the telephone interview. All were contacted by telephone and at least three attempts were made to arrange telephone interviews. Reasons for interviews not taking place included lack of response (albeit not a significant problem), long term sickness, and, most commonly, inability to identify a mutually convenient time to arrange an interview. Interviewees were always offered a choice of interview times. No-one refused to co-operate with the study, although for some it was clear that setting aside time for the interview was, perhaps understandably, very low down the priority list in what appeared to be very heavy work schedules. On several occasions firm interview times were arranged but at the pre-arranged time the interviewee was not available, having been diverted by other work pressures.

Interviews took place with senior managers in 10 of the 14 Social Service Departments within Trent region. Two of these interviewees were also P.C.G. representatives. In one case the Director was interviewed and in the others the Manager nominated was either the Head of Adult Services or a second or third tier manager with a strategic role across the Department, typically including management of the Performance Review Section. In all cases interviewees were well placed to provide an overview of the department and were able to comment on the Department's attitude to and capacity for research, although they might lack detailed knowledge of individual projects.

Nineteen interviews took place with P.C.G/T board representatives, covering a total of 25 P.C.G.s (50%). It emerged that there is wide variance over the choice of representatives, ranging from Assistant directors/Heads of Service through to

operational managers with specific service area responsibilities or locality based middle managers. Some interviewees provided information about the reasons for their choice:
for example, one Department has decided that Older People's services is the key issue for work with P.C.G.s and so their three representatives are the three geographically based operational managers for older people. Other departments have taken a different view; that all service areas need a voice and so have chosen a variety of representatives from across service areas or a representative that works in an area of the department that straddles all services. A third group has chosen to keep representation at a higher level (Assistant director/Head of Service) so as to ensure a strategic/cross service approach. Overall, there is far greater representation by managers within Adult services and there seems to be an assumption by at least some managers that older people's services is the key area for dialogue within P.C.G.s

The total of 29 interviews from both sources meant that, with the exception of Barnsley, at least one interview (and normally two or three) was held with a manager of every Social Services department within Trent. Coverage in Nottingham and Nottinghamshire was lowest, with only one interview carried out in each case. Although descriptive data, such as the structure of the department, were available we may have only gained a partial picture of what was happening within these three departments. However, an attempt was made to rectify this imbalance by identifying staff from these Local authorities for Phase Two of the study.

A total of six interviews were carried out in Health Authorities, out of a possible eleven. These were mainly based in public health with either the Director of Public Health or a research officer, with the exception being the Chief Nursing Advisor in one authority.

Lastly, only partial success was achieved with the collection of secondary data. This was partly because some Departments were in the process of restructuring and did not have up-to-date structure charts, and some did not have any copies of current Community Care Plans available. The collection of data on numbers of qualified staff also proved problematic because in many Local Authorities information systems on workforce data are still being developed. Some figures provided had been reliant on recent voluntary returns by staff and were considered to be incomplete. It was also not possible to find accurate numbers for total numbers of staff working in different areas of all Departments, although some Departments were able to provide this level of detail.

2.3 Phase Two: In-Depth Follow-up

Objectives:

- to examine issues of research training, experience and interest within each of the main areas of social services activity at the primary care-social care interface;
- to examine any existing projects or models of research support, training or partnership identified in Phase One.

Methods:

7 Telephone interviews took place with operational managers in key areas of interface activity. 24 operational managers were identified (either via written documentation from the Department or via the Phase One interviews) with 6 from each of the key interface areas of:

- Adult mental health
- Children's services
- Adult disability and/or older people
- Learning disability

Although older people (identified as a key area of interface activity) formed only a small part of this sample this was counter-balanced by the fact that a considerable number of interviewees in our Phase One interviews were managers within Older People's services and some of these included operational managers. The sample was also spread evenly across the three different types of Local Authorities (Counties, Metropolitans and Unitaries).

- 3 focus groups were arranged with practitioners (social workers) in the areas of children and families, adult mental health and older people.

Commentary:

The methods for arranging this phase of the interviews was the same as for Phase One of the study with interviewees being sent individual letters and an outline of the study objectives. Interviews for this phase proved even harder to set up than for Phase One, partly because managers at this level do not have their own secretarial back up, via which contact times can be arranged, and partly because this interview phase ran into the main summer holiday period. Work load pressures also appeared to be very heavy for this group of staff, with several finding it difficult to set aside time for the interview or cancelling interviews due to other commitments.

Nineteen interviews were eventually successfully completed, achieving a sample which was fairly evenly spread across the four areas of interface activity outlined above. Although this figure was slightly lower than the study was aiming for, the information gained from this group of staff was relatively homogenous and we felt a reasonable level of confidence that we had a representative view of what the issues where for operational staff.

The focus groups were arranged by cascading invitations to each department, usually via the contacts which had been made in Phase One. This system had only limited success, and it quickly emerged that most Departments needed several telephone reminders before any nominations for focus groups were received. This appeared to be partly due to the complexity of the management structure in some Departments, which meant that it took some time for invitations to reach practitioners, and partly due to an uncertainty over which practitioners should be nominated.

The focus group for children and families staff attracted seven staff, and the one for mental health workers (which was severely affected by the 'Fuel Crisis') had an attendance of two. However, contact was also made with eight other staff who had wanted to attend and who were interested in involvement in research. In the case of the cancelled focus group four practitioners were interviewed by telephone and several others expressed interest in the issues.

CHAPTER THREE

Structure, Staffing and activities at the interface with Primary Care

3.1 Note on terminology

It is important to be aware that there is no uniform terminology within Social Services in relation to job titles, and some other specialist terminology can have slightly different meanings in different settings. This means that the same job title, such as Care Manager or Service Manager can indicate something different from one Authority to another. Most commonly, the post will vary in terms of its geographical range of responsibility and whether the post covers managerial responsibility for both the commissioning and the provision of services or not.
In order to minimise confusion, the terms senior manager and operational manager have been used within the body of this report.
Secondly some terms used vary according to which area of the service is being referred to, although the functions being carried out may be very similar. For example, the term key worker is used both in child protection work and in Mental Health (Care Programme Approach) while in other adult services the terms care co-ordination or care management are more commonly used.

3.2 Departmental structures

There are fourteen Social Services Departments in total within the geographical boundaries of Trent. These comprise four Counties, four Metropolitans and six Unitary authorities**.** The Departments vary enormously in terms of population covered and their rural - urban profile and these two factors in particular influence the size and structure of each Department. All Departments are divided below Director level into Adult and Children's services, with Adults services broadly covering the four service areas of older people, physical and sensory disability, mental health and learning disability. Other specialist areas such as HIV/AIDS and substance misuse are also located within Adult services. Children's services include child protection and family support services (including those for children with disabilities), Child and adolescent mental health, fostering, adoption, residential care and other resources such as family centres.
The management structure for the commissioning and the provision of services varies, and partly depends on the size of the department. Many departments are now moving away from the purchaser/provider split that was created in many Adult services (and, to a lesser extent, in Children's services) through the 1990s, although most maintain some separation of management responsibilities for the two aspects of the service.

3.3 Management structures

In some of the larger Local Authorities (Counties and Metropolitans) , there will tend to be a four tier model:

Adult or Children's Services manager
Service manager for each service area
Team managers (covering geographical areas)
Social workers

Within Children's Services the most common model is two services areas; one covering access, assessment and care management (including children with disabilities) and the other covering resources such as residential care, fostering and adoption and other specialist services such as the Youth Offending Team. In some of the larger departments there may be further specialisation of the assessment and care management function into teams covering core assessment activity and teams doing longer term work, including 'looked after children' (those children in the public care system).

Some departments use a locality based structure where a district or Locality Manager may be responsible for teams covering different services areas in a particular geographical base, although even here there will normally be one Locality Manager for children's and one for adult services.

Another variation is an access based model where all new requests for service/ enquiries come to access teams (probably specialising in children's or adults) who carry out initial screening and assessments on all service groups. Referral on to specialist services is only made where there is a need for complex or comprehensive assessments and co-ordination of a package of care.

3.4 Structures within service areas

- **Mental Health.** This service tends to operate the most multi-disciplinary models and most areas operate Community Mental Health Teams including social workers, community psychiatric nurses and community occupational therapists and psychiatrists. Most do not have unified management structures with Health but are often in the process of planning for these.

- **Learning Disability.** This service also often operates multi-disciplinary teams, of combined social work and nursing teams, but not a unified management structure. Lead commissioning by Social Services will result in major changes in this service in the near future.

- **Physical disability and Older people.** A variety of structures, with the service for older people being characterised by the large volume of demand for service in comparison with other service areas. With some exceptions multi-disciplinary teams are not currently the norm in this service, but there is some co-location with social workers being based in G.P. surgeries in some areas and hospital based teams dealing with areas including hospital discharge.

- **Children's services.** Social workers within family support and child protection services do not generally work in multi disciplinary teams, apart from in some specialist areas such as child and adolescent mental health.

- **Performance Review section.** This is often located outside the Adult and children structure, directly accountable to the Director. This section is now very concerned with the implementation of the Best Value Plan, in addition to the Performance Assessment Framework. Often policy and planning and performance review are located together with strategic lead for things like health partnerships. Many departments have Planning or project officers, sometimes located within this sort of centralised section and less commonly within the Adult or Children's services. Sometimes such posts are short term secondments to implement specific service developments.

3.5 Social Services functions

These can be summarised as three key functions:

- Assessments of need are a core activity across all service areas. They relate to Social Services' responsibilities under various key pieces of legislation (most notably The 1989 Children Act, the 1990 Community Care Act, the 1983 Mental Health Act and the 1970 Disabled Person's Act). Assessment of need in children's services includes child protection enquiries as part of their duties under the Children Act.

- Provision of social care - Social Services Departments provide some care directly (commonly known as 'in-house provision') and commission the remainder from independent providers (including the voluntary or not for profit sector and the private sector). The proportion provided directly varies widely between Local Authorities but the commissioning and contracting of social care from other organisations has formed an increasingly important role over the last ten years.

- Management or co-ordination of packages of care, including child protection plans, family support for children in need, key worker under CPA, complex elderly, disability or learning disability packages of care.

3.6 Staffing

Most qualified staff are found in strategic and management posts, and practising as social workers in care management teams, also known as fieldwork or assessment teams. Social workers in the specialist areas within children's services, including fostering and adoption and the Youth Offending Teams will also mainly be qualified. Managers within the Residential sector and Day services (both children's and Adults) are also increasingly likely to be qualified, although the vast majority of other staff in these sectors of social care provision will not be.

The total number of professionally qualified social work staff across Trent region is approximately 3,000, although this figure is an estimate due to the constraints in gathering accurate data referred to at 2.2. The number of staff within each Department varies from 18 staff in Rutland, through to 350 staff in a large county such as Leicestershire, with a medium sized Metropolitan council such as Doncaster having approximately 120 qualified staff.

3.7 Working at the interface

The study exposed some difficulty in defining those working at the interface, partly because many interviewees were reluctant to exclude anyone from this definition. However, most were able to identify those who they saw as key groups of staff or key areas of service (some involved unqualified social care providers -eg. the home carer - district nurse interface). Interface activity was also likely to involve social care providers not directly working for Local Authorities, but commissioned by them.

Within each main service area there tend to be key interface activities and key groups of staff. However, within all areas of social work, key activities were noted where the interface between primary health care and Social Services is particularly crucial. These include:

- **Referrals.** Primary Health care workers are the major source of referral to Social Services in most, if not all, service areas.
- **Initial assessment activity.** Social workers depend on primary health care workers for information sharing during the key initial assessment period.
- **Co-ordination of care (including review).** The management of complex packages of care (including child protection and family support packages as well as care packages for adults) usually depends on co-ordination between the health and social elements of the care.
- **Strategic planning** for health and social care relating to the activities referred to above.

The key areas of interface within each service area were identified as follows:

Children's Services.

- The interface between social workers, health visitors, midwives and school nurses in assessments of need, child protection enquiries and co-ordination of child protection plans.
- The interface between social workers, health visitors, community nurses and (sometimes) G.P.s in assessment and care packages for children with disabilities.
- The interface between social workers, health visitors, school nurses, child and adolescent mental health workers (plus other agencies such as Education) in planning care for looked after children.

Older people's services.

- Information sharing between social workers, G.P.s and district nurses during the referral and assessment stages, including community based assessments and planning for hospital discharges.

- The day to day working relationship between providers of care in complex care packages, such as between home carers and district nurses.

Learning disability services.

- Assessment and care co-ordination activity between social workers and community nurses for learning disability.
- Interface activity with other health professionals involved in assessment and interventions, including speech and language specialists and psychologists.

Adult mental health services.

- Information sharing at the referral and initial assessment stage between G.P.s, community psychiatric nurses, and social workers.
- Assessments under the Mental Health Act involving G.P.s and Section 12 doctors.
- In Mental Health it was also noted that there is a definition issue about what is primary care and what is secondary care and the pathway between the two.
- Co-ordination at both assessment and intervention stages between specialist workers from Health and Social Services involved in substance misuse work, frequently involving independent sector agencies as well.

CHAPTER FOUR

Infrastructure to support research activity and current research projects

4.1 Internal capacity to support research activity

Structures or staff to support research or evaluation activity were very limited in almost all Departments. Only one Department has a Research section as such, while one or two others have one or more posts for either research or evaluation officers, although there was no uniformity about their brief. More common was a number of Departments who have one or two staff, probably within their Performance Review section, who have some sort of research, research dissemination or evaluation brief within their job descriptions. This may include carrying out programmes of social care audits, or contributing to joint reviews of specific services. However, senior managers indicated that these activities were probably not their priority activity. For most managers audit and monitoring, either for internal purposes or for Department of Health requirements, took priority over research.

4.2 Budgets to support research activity

No department (with the possible exception of Derbyshire), has a budget for Research and Development or even for a programme of evaluation work. The overall picture is that Social Services Departments are very poorly resourced to carry out any sort of systematic research activity.

In the absence of Research and Development budgets within Social Services, most routes to funding tended to be opportunistic. Some interviewees mentioned the difficulty of planning research activity in the absence of any clear funding routes, set against the need to have ideas, if not bids, ready in case some funding was identified.

The most commonly cited source of internal funding was from underspends on mainstream funding, caused, for example, by delays in new developments. More recently, money has been identified from specific grants such as the Mental Health Grant, the Partnership Grant and Quality Protects and it appears that service areas which can access these grants are beginning to incorporate evaluation activity into their planning

In spite of the constraints, more research activity is taking place than might be expected and many managers appeared very adept at identifying small pots of money for one-off projects. Most mentioned using 'slippage' (underspends) to fund evaluations. A common view was that this type of funding, although better than nothing, did not allow services to forward plan and that pieces of work that are commissioned have to be carried out on very tight timescales, often before financial year ends.

Local authorities that are either wholly or partly within Health Action Zone areas, or which have managed to attract regeneration monies, all gave examples of using these grants, often for mapping exercises or for evaluation of specific projects. One department had built a research component into its Quality Protects Plan and its Partnership Grant bid. Others had used Joint Finance money or funds from the ACPC (Area Child Protection Committee) budget (small sums only).

Most projects are small scale, from perhaps £1,000 to £10,000 and no projects were cited where the figure exceeded more than £20,000.
It was also noted that many small projects, such as user/carer surveys, were undertaken at 'nil cost' using existing staffing. These were often staff who did not have an explicit research or evaluation remit, such as first line managers. Other examples of 'nil cost' activity was where planning or project officers, often based in the Performance Review section, but sometimes seconded on a temporary basis, undertook evaluations of new service developments.

4.3 Dissemination of research

All Departments had some sort of system for the dissemination of research, usually from within the Department, but occasionally as part of a corporate, Council-wide service. Performance Review Sections were most commonly referred to as responsible for this activity, and most operational managers mentioned this as useful, given that time pressures for them meant little spare time to seek out research independently. However, most managers felt only partly satisfied with their systems for dissemination and were circumspect about its effectiveness in communicating with operational staff.
Use of the Internet was increasing amongst many strategic staff and operational managers, but as yet access was fairly limited in most Local Authorities. However, most senior managers mentioned programmes for expansion in Internet availability.

4.4 Research support from P.C.G.s

Only a minority of P.C.G. representatives considered that collaborative research was on the agenda of their P.C.G. The dominant picture was of P.C.G.s that had been primarily absorbed with infrastructure concerns and there was little evidence of Research and Development being on the agenda of Board meetings. Where it did take place Social Services staff felt that it was medically oriented and did not really relate to interface activity with social care. However, many of those interviewed felt that working together was at a very early stage and that joint commissioning would stimulate activity around mapping needs and evaluation of joint service developments.

4.5 Research links with Health Authorities

Only one of the Health Authorities contacted had a separate research section; in general, Public Health was the focus for collaborative research or evaluation initiatives of the kind relevant to this study. However, established or emerging R & D Alliances were mentioned as important developments in Nottingham, Lincolnshire, Leicester and Sheffield. These are addressing the new NHS R & D funding context, which emphasises the importance of local ‘health communities’. Social Services departments have not been among the core of organisations leading these emerging networks, although there is now a clear plan to include them.

In contrast, Health Authority interviewees described many examples of ongoing research or evaluation projects already based on joint health / social services involvement – including for instance:

- Sure Start, HAZ, Connexions and Teenage Pregnancy local evaluations;
- some development work on multi-disciplinary evaluation frameworks, linked to the Nottingham HAZ (and led by an appointed 'evaluation manager' linked to the HAZ);
- some substantial academic studies, including a randomised controlled trial of 'hospital at home' developments in Leicestershire (led by the Nuffield Centre for Community Care, and including Social Services involvement).

All Health Authority interviewees mentioned well-developed academic links: with Sheffield University School for Health and Related Research and with Sheffield Hallam University School of Health and Community Studies; with the Nuffield Centre and the University Department of General Practice in Leicester; with the Department of General Practice at Nottingham University.

4.6 Types of research activity within Social Services

The research activity referred to can be divided into a number of 'types', none of which fell into the category of 'pure', or generalisable research. Most projects were small, short term projects of perhaps three to six months duration, although a minority were part of longer planned projects lasting two years or more. The following types were identified:

<ins>Analysis of need</ins> **- usually in relation to a particular service type, or a particular identified part of the local population. These were usually scoping exercises or surveys, often carried out in conjunction with Health colleagues. Sometimes they relied on secondary data and sometimes primary data was collected by means of questionnaires or other survey methods.**

Examples:

1. A mapping exercise carried out by the Geography Department at Sheffield University using secondary data from Sheffield Social Services, Community Health and the Education Department to 'map' children in need, according to a variety of criteria.
2. A Special Needs Housing Survey carried out for Rotherham Housing and Social Services Department by a Consultancy Agency, using a combination of secondary data and surveys to identified populations.

<ins>User / carer surveys</ins> **- including satisfaction surveys and other attitudinal surveys. Questionnaires were the most common method used, but telephone interviews and focus groups were also mentioned. These were typically not commissioned pieces of work but were carried out by Social Services staff either within the Performance Review section or by operational**

managers, on a 'no budget' basis. These included regular programmes of satisfaction surveys to existing users, often based on the formula from the Joint Review process. Other surveys were set up to gather views in relation to a particular service area, including proposed policy changes or service developments.

Examples:

1. **Leicester City have random 'telephone days', where they phone back every person who has made contact with the Department during that day to ascertain their views about how easy it is to access the service.**
2. A survey of service users in the Physical Disability service in Leicestershire to ascertain views about day services, initiated because of a decline in the numbers using the service.

Exploratory studies - either exploring a particular service area or area of need where there is felt to be a lack of knowledge, or exploring a particular phenomenon which is not felt be understood. These sorts of studies are more likely to be commissioned from outside, since they tend to be precipitated by an awareness of lack of knowledge within the organisation. Sometimes these sorts of studies will be carried out or commissioned in conjunction with voluntary organisations, charities or campaigning groups, who may have brought the issue to the attention of the Social Services in the first place.

Examples:

1. **Leicester City and, more recently, Leicestershire have commissioned Nick Jewson at the University of Leicester to do a study exploring the needs and experiences of ethnic elders. The Local Authority commissioned this work after an approach by the Ethnic Elders Group, who were concerned about the social care needs of ethnic elders in the city.**
2. The Area Child Protection Committee in Rotherham paid for social work time to do an analysis of child protection cases doing an analysis of the factors involved in re-registration of children who have previously been removed from the Child Protection Register.

Action Research - linked to a service development. Service developments, including changes in the models for providing services, are commonly piloted in order to analyse the effectiveness of the service change.

Examples:

1. Within North Lincs two G.P. practices are employing a community occupational therapist to apply a screening tool to identify vulnerable older people. The scheme is linked to a control group of Social Services users.
2. See Sample projects below - Study Six.

Evaluation of a project or service development - was probably the most commonly cited area of research activity and increasingly evaluation is being built into any policy change or service development.

Examples:

A joint approach to the evaluation of rehabilitation in the area of progressive neurological disease. This is being carried out by Professor Ward at Nottingham University and the Queen's Medical Centre and involves Southern Derbyshire and Nottingham City in collaboration with the Health Authority.

4.7 Sample projects.

In addition to the projects cited above as examples, we have included more detailed information about six studies, including how they were commissioned, funding, the aim of the study and, where known, where it will be reported to.

Study One

The Southern Derbyshire Dementia Outreach Project, a joint project involving South Derbyshire P.C.G. and the Social Services Department. The project is a pilot study involving Dementia sufferers in two G.P. practices and involves providing intensive specialist home care services with the objective of preventing hospital admissions. The project is being evaluated by Derby University and the evaluation is jointly funded.

Study Two

The development of a common assessment tool regarding children in need by North Lincs. The research arose out of a review of the Local Authority's child care services and in particular of the balance between child protection and children in need services. Funding was obtained from the Department of Health which was matched by money from internal budgets. The work was commissioned by the Children's Planning Forum, a multi agency forum involving Health, Social Services, Education and other key agencies.

The work was undertaken with Harriet Ward and Mark Peel at Leicester University involving the development of a common assessment tool for thresholds of interventions for children in need. Health visitors, other referring professionals and parents have all been involved in the process.

User involvement was achieved by developing a parent's focus group- this consisted of forty parents recruited through Home Start and from local schools. They gave views on when they thought one should become concerned about a child.

The project has also commissioned two retired SSI inspectors to do an inspection of their child protection work to ensure that the assessment process is not resulting in less safe child protection work.

Study Three

The 'Pathways into Residential and Nursing Care' Study in Nottingham City. The impetus for this project came initially from a stakeholder event for older people involving the Local Authority, the Health Authority and the P.C.G. The objective of the project is to analyse the factors leading to admission to long term care with a view to planning more effective home based and rehabilitative services. The project is funded through the Partnership Grant and has been commissioned from the Nuffield Institute in Leeds.

Study Four

Lincolnshire Health and Social Services Mental Health services have commissioned work from the Sainsbury Centre to develop and train staff in the use of a joint risk assessment tool. The work has been jointly funded by Health and from the Social Services Mental Health Grant. The project is a piece of action research involving the development of joint procedures, using a validated risk assessment tool, training of staff in its use, implementation and an evaluation of the effectiveness of both the tool itself, and of changes in practice as a result of its use.

Study Five

Learning Disability services in Lincolnshire are working in conjunction with QUEST, based in the University of Hull, to develop their evaluation and monitoring of services. They are using a tool developed by QUEST to evaluate the quality of residential services and are piloting its use in the evaluation of services provided to people in their own homes. The work is being undertaken by a social worker who has been seconded to QUEST but is a jointly commissioned piece of work. She is actively involving carers in the planning process, and looking at the effective involvement of service users. This may involve running a parallel planning process for service users so that they can work at their own pace.

Study Six

The Child Behaviour Initiative, including a major piece of Action Research on intervention strategies with 0 to 10 year old children. The research was stimulated by a finding that over a third of under 11 year olds in a particular area of the city were being referred for special education needs on behavioural grounds. The initiative was a joint Health, Social Services and Education one, with funding provided by Social Services and Education and matched by the Department of Health specific grant for Child and Adolescent Mental Health. The University of Leicester are undertaking the evaluation of this work. The initiative involved employing nursery nurses to work with identified parents.

4.8 Types of collaboration

Collaboration arose in a variety of ways, normally from existing cross agency forums but, less often, as a result of a discrete event, such as a conference. Joint planning forums involving Health and Social Services, possibly with other partners, were probably the most common route for commissioning research. Within Mental Health there is normally a National Service Framework implementation group and other service areas may have their own specific strategy and planning forums.

The Area Child Protection Committee, in some areas, collaborates over research activity and other multi agency forums such as the Drug Action Team and the Steering groups for the recently formed Youth Offending Teams may also commission research, although in our interviews we found little evidence of such activity.
Informal links, based on networks between individual staff in agencies and universities tended to stimulate ideas about possible research and development activity and it was clear that once partnerships had been established for one project, this tended to stimulate further activity.

Research activity was also stimulated by partnerships with the voluntary and independent sector, and local providers who were part of national organisations, such as the National Schizophrenia Fellowship, the National Children's Bureau could be a source of both ideas and resources.

Approaches from Universities or from major research based charities such as the King's Fund, were cited in some cases, although some Departments had no history of this sort of collaboration.

4.9 Examples of studies involving active user/carer involvement

In Derbyshire, joint initiatives have been undertaken actively involving service users in the monitoring of their own services. The Sainsbury Centre has been used to train service users in monitoring work, commissioned by Southern Derbyshire Mental Health Trust. In one area members of the community mental health team from both agencies contributed professional time to work with service users to develop their own satisfaction questionnaire. The users then used this to interview other service users. The outcome was reported to the P.C.G. by the service users themselves.

Lincolnshire have a 'Work Action Group' which is a coalition drawn from mental health service users, specialist mental health staff from the Local Community Trust and from Social Services, and representatives from the voluntary sector. The School of Nursing at Lincoln County

Hospital (Damian Mitchell) also has links with the project. The group is actively seeking funding for research into what employment schemes are available for mental health users and what sorts of schemes are most effective.

Commentary

It should be noted this was not a systematic list of all research going on. This would be difficult to achieve since there are no research sections and often, those interviewed did not have the information to hand.

There is no system for collation of research projects within departments which meant it was necessary to rely on interviewee knowledge. Many interviewees started off by saying there was very little research activity and then remembered more as the interview progressed.

There is no clear definition of research within Social Services and there was some confusion by a minority of those interviewed. For example, reference was made to projects that 'had an element of research within them' and sometimes piloted service developments were referred to even though it was unclear whether there was any element of evaluation within them.

There was wide variation between Local Authorities in the amount of research activity taking place, although this may partly be explained by varying knowledge on the part of those interviewed. Research activity was generated in a number of ways and tended to depend on very local circumstances, including personal networks. There was very little evidence of pooling of ideas, funding or resources between Local Authorities and only limited evidence of collaborative research across Local Authorities.
It was evident from some interviews that particular senior managers were very resourceful at exploiting links and made maximum use of opportunistic links with academic partners and others.

CHAPTER FIVE
Research: training, experience, interest and barriers

5.1 Background information on social work qualification routes

All social workers undertake a two year training programme to obtain the Diploma in Social Work. This can be a two year non-graduate diploma (around half of the output of 4,000 pa), or as part of a three year degree (around a quarter of the output) or as a two year post graduate degree (with some of these at Masters level and some at Diploma) following on from a range of undergraduate programmes. Research skills do not feature strongly as part of the training, except for the fairly basic dissertations that may be part of the undergraduate programmes, and the more in-depth ones that will be part of the Masters post-graduate programmes. Evidence-based practice is just starting to be more prominent on the programmes, and some critical appraisal work is starting to be taught. The post-qualifying framework is a recent development; there are research courses accredited as Advanced Awards at this level (for example the MA in Applied Research and Quality Evaluation at the University of Sheffield) but there have been hardly any candidates through these programmes as yet. Although it is planned for the future (when the General Social Services Council is established) there is no compulsory registration or continuing professional education.

5.2 Training

The vast majority of interviewees had no personal experience of research training, with the exception of a handful of staff, mostly based within Performance and Planning sections, who had undertaken further study, for example via the Open University.
Training in R&D for staff generally was not common, although one or two interviewees mentioned commissioning specific training for key staff, (eg. in design and use of questionnaires for user surveys). Staff completing the M.B.A. were expected to carry out a small research project but this was not particularly identified by interviewees as contributing to the department's skill base. Overall, managers felt it unlikely that they could provide or purchase much in the way of training. North Lincs., who actively seek partnerships with universities to carry out collaborative research involving practitioners, see practitioners as gaining skills through active involvement in the research process and had direct experience of doing this in collaboration with David Thorpe at Lancaster University.
P.C.G. representatives did not appear to see the P.C.G. as an avenue to training and most did not know whether or not they could access the training budget.

5.3 Research experience

Overall, there is very little direct experience of research amongst Social Services staff. A minority had undertaken small scale studies in the course of post qualifying studies, although these may not have involved empirical study. All staff have experience of audit, either through carrying it out or, more commonly, being asked to provide data. There was some evidence, by both operational managers and practitioners, of cynicism about audit and management information. Both groups of staff felt unconvinced that such activity led to any improvements in the quality of service and some complained about lack of feedback . At management level, and particularly for those who have held posts in Planning and Performance sections, there is fairly widespread experience of carrying out Service Reviews, sometimes jointly with Health colleagues. However, for managers the most common current experience is of commissioning research activity. Those managers interviewed who had no experience of this thought it likely that they would be undertaking this area of work in the future and some had clear ideas about what sort of research they wanted to commission.

5.4 Interest in research

All managers interviewed felt that the current national and local agendas for Health and Social Care meant that they would need to be more involved in research activity in the future; this was viewed positively by all those interviewed. Examples cited suggested that they often saw this in terms of the following areas:

- Mapping of need;
- Involving users and carers;
- Identifying of most effective models of service delivery;
- Evaluation.

Best Value and, to a lesser extent, the Performance Assessment Framework, were cited as key stimuli to a more robust evaluative culture and most senior mangers felt that this was well understood by senior management and by staff in key performance posts. However, several commented that the challenge now was to involve operational staff, both managers and front line practitioners, in this new way of thinking.

5.5 Research interest and priorities

Without exception, those interviewed, as well as those attending focus groups, had ideas about what research they would like to see, indicating that there was clear awareness of the need for and the relevance of research. There was also, however, an awareness that it was unlikely that staff would, in the short term, be able to obtain or commit resources for the research ideas that they had.

There was a high level of concern about the effectiveness of services, and whether specific interventions achieve what it is believed they are achieving. The need for more evidence-based practice appeared to be well understood and there was a concern to link research ideas with current government priorities.

There was a strong emphasis on user/carer involvement in research, including involvement in the commissioning and design of research. Research ideas were also often linked to personal commitments and interests, or to issues which appeared to be locally relevant.

Specific research ideas put forward covered the following range:

- Research looking at collaborative models of service, including co-location, multi disciplinary teams.

- Research on specific interventions, such as the effectiveness of rapid response teams, early interventions.

- Research to map need and plan services around hard to reach or socially excluded groups.

- Specific areas of local concern, such as teenage pregnancy, services for ethnic elders, causes and effective interventions in substance misuse.

5.6 Training needs

Two levels of training need emerged, one for staff generally and one for the minority of staff who were seen as already having some skills.

A need for general awareness training for all staff was identified, to raise awareness of the need for and relevance of research within Social Services and with Health partners. It was felt that there was a need to demystify research and to raise confidence about ability to both understand and to become involved in research.

More specific training needs were outlined for staff who might be expected to become directly involved in research. These may be staff who already had skills. Several key areas emerged;

- Understanding of, and the ability to use, existing data effectively. This was felt to be a key skill for both staff within Performance Review sections and for operational managers who were increasingly being expected to become involved in the analysis and use of data.

- Literature searching and reviewing. Critical appraisal skills.

- Formulating research proposals and skills in research design.

A common view expressed was that Social Services would benefit from a more robust approach to research activity, and that training was one route to achieving this.

5.7 Barriers to research

The predominant barrier to research appears to be cultural: a dominant view that it is not part of the current job. This view predominates, despite some pockets of strong personal interest, and an awareness by senior managers and policy staff that it is of increasing importance.

Discussions about research development between Social Services and Health will sometimes raise problems of the value of different methodologies, when a

predominantly evaluative tradition meets a predominantly generalisable one. Staff were aware of this difference, and although they saw the value of generalisable research, there was a strong view that more specific applied research questions were the priority in the social care arena.

Many staff see themselves as fully occupied with no time to do research. This was the most frequently voiced barrier, and operational managers in particular appeared to find it difficult to see beyond this.

The main barriers identified by staff are the following, with the most important listed first:

Culture (including intrinsic reward issues) **and Reward systems** (extrinsic)

- Praise from colleagues lacking (NB There was a need for all staff to understand research work, even if they were not directly involved in it)
- Research is not seen as ‘part of the job’ and is not built into the everyday understanding of what the job is.
- Research training is not a significant part of current qualification routes.
- Experience in research is not a significant factor in promotion. Promotion routes are predominantly into management, and there is very little tradition of remaining in practice at an advanced level, with a research element to one's work.

Supervisor attitudes

- Research is not a priority and supervisors/managers cannot make it a priority without reducing service unacceptably
- There is a lack of skills by supervisors to support research activity by practitioners.
- Supervisors may be threatened by new skills, knowledge and attitudes.

Personal skills

Staff generally feel they are lacking in the following skills areas. Typically, they have ideas about what they want to do, or what needs looking at, but are not confident about how to do it.

- Research formulation (researchable questions)
- Research design
- Research techniques, especially qualitative interviews and small scale statistics work
- Research management (handling day to day work: access, ethics, timing, etc)

Personal attitudes

The following views were expressed in both interviews and focus groups, albeit by a minority of those involved in the study as a whole.

- Research is something that others do
- Research should be something that others do (outside the agency) as it makes it more valid
- The questions that we need to answer are very big, holistic, cannot partialise
- We cannot measure and quantify the work we do, measures are not appropriate

Support staff and materials

- Secretarial (for calls, administration, maybe transcribe etc)
- Information and Communication Technology (for word processing, internet, calculation)
- Statistical consultancy

Services are changing

- The fluid and changing nature of services at present makes it difficult to focus on research. However, these changes may make a research culture more achievable in the future.

CHAPTER SIX

Conclusions and Recommendations

An executive summary of the report and this chapter provides an overview of the scoping exercise, the main points of the study, and a clear outline of all of the main findings and recommendations. This chapter reviews briefly the key issues in the study, summarises the main barriers to research, and provides recommendations for the promotion of research at the health / social services interface in primary care.

Trent Focus asked the study team to answer four key questions:

- Who are the key groups of social services staff already involved in 'interface' work with primary care?
- Which research skills and topics do these staff groups (and their managers) see as appropriate for development through joint work with primary care networks?
- What characterises current, successful models of research collaboration between social services and primary care?
- What are the perceived barriers to this kind of collaboration?

In order to do this the study gathered and analysed data from interviews with social services and health personnel, an analysis of relevant documentation, and focus groups with social services staff. It covered 10 of 14 Social Services Departments in the Region, and 25 of 51 PCG / Ts.

· Main Interface Areas

Three main functions were seen as particularly relevant to the interface of health and social care: assessment for social care, co-ordination of social care, and the provision of social care. Within each of these functions there are social services staff with interlinking roles with health staff at practitioner, manager and policy / planning levels. Some staff are working in multi-disciplinary teams, some are undertaking multi-disciplinary assessments of need, some are co-ordinating packages of care which comprise both health and care, some are providing social care within a package of joint care. In addition there are some social services staff who engage in strategic planning that spans health and social care. These staff are employed by Departments that have very little in the way of a uniform structure, speciality system, or nomenclature usage. Their policies vary widely. The most notable factor is variety.

· Research in Social Services

Social services do not in general engage in much research work, and none of the work that we could find was generalisable research. It is small in scale and oriented towards providing planning information (mapping exercises) or programme evaluations of various sorts. It is generally local and opportunistic.

Hosted research is also happening, but this is difficult to find as it is not logged centrally and it is based in a wide variety of University Departments

Research collaboration discussions took place in a variety of planning and policy meetings, such as Joint Commissioning Teams, and there was no example of a specific research forum. All such collaboration took place as the result of external approaches.

There was very little funding for the research endeavours that did take place internally. It was provided via underspends from programme budgets, within specific grants that required or allowed some element of evaluation, or as a result of multi-agency initiatives such as Health Action Zones.

There was very little specialised knowledge of research, and the 'research sections' that existed provided management and central government planning data.

Research interest was nonetheless strong amongst some staff, and they emphasised the importance of user/carer involvement in research, the need for it to address local issues, and to fit in with the major Government initiatives that they were working within, such as the Quality Protects children's services programme.

- **Barriers to Research**

The predominant barrier to research appears to be cultural. It is not part of the current job. This makes it a low priority despite some pockets of strong personal interest, and an awareness by senior managers and policy staff that it is of increasing importance. Regarding research at the interface the discussions about research development between social services and health sometimes raised problems of the value of different methodologies, when a predominantly evaluative tradition met a predominantly generalisable one.

The issue of lack of time was a strong factor in the feeling that it was difficult to do research, as many of the staff saw themselves as fully occupied already and research as something that could simply not be fitted in to the working day.

The cultural barrier to research was seen as particularly important. Both intrinsic rewards and extrinsic rewards for undertaking research were seen as very low. Research work was rarely praised, it was not built into jobs, it was not a significant part of the qualifications staff had obtained, and it was not a significant part of promotion.

A second significant barrier was the attitude of supervisors, who generally endorsed a view that research could not be undertaken because of service pressures, had few skills to support research, and who were sometimes threatened by the new skills, knowledge and attitudes involved in research work.

These two issues would need to change for research to be more prominent, but also it was clear that staff needed a range of personal skills that were lacking, including research formulation, design, techniques and management. The attitude of many staff would also need to change as, inevitably in the context described, research was seen as something done by others. It was also seen as something which could be opposed to basic practice beliefs, for example that it is inappropriate to even try to measure or quantify significant areas of social care work.

Staff were also aware that if they were to try to undertake research there would be little support staff or material for them, and finally there was a belief that the changes occurring in services at present would make it difficult to provide a focus for research work.

It was clear that there were significant and important barriers to research endeavours, and any attempts to tackle these must be realistic about the scale of the task involved.

· Recommendations

Bearing in mind the early stages of research development, the widely varied nature of social services, the commitment of some early adopters, and the current policy and practice concerns of the services, there are both strategic and practical implications from this exercise.

At the strategic level it is important to build initial contacts with the small numbers of currently interested individuals and begin to develop an ad hoc network of interested parties. Any offering of research support needs to be in tune with the practice and operational priorities of social care, and ideally the developing network needs to include staff at all the levels identified in each of the main interface areas. As we mention later there may also be a number of other partners who could be useful allies in research development.

This study was looking at the interface between social care and health, and it was clear from our discussions with social care staff that the nature of that interface needed to be clearly articulated. There was a tendency for staff to consider any work which even slightly touched on, or considered, health to be ‘interface’ work, and this could easily lead to dispersal of effort and less effective impact. As such work should focus clearly on:

- Social care staff who handle referrals from health care workers
- Social care staff who do initial assessments which directly involve health information
- Social care staff who co-ordinate complex packages of care that directly involve health services
- Planning and policy staff who are directly engaged in developing policy in interface areas and / or incorporating research into policy in areas such as Best Value reviews or joint inspections from Audit Commission and the Social Services Inspectorate.

We have suggested that it is important to build on the enthusiasm of some staff and to link work developing research with social care priorities. This leads to the following areas being priorities for any training support for research:

- Literature search and critical appraisal skills
- Using existing data: improving it, checking it, analysing it, presenting it
- Focusing multi-agency evaluations: providing ‘researchable questions’
- The possibility of developing research from needs assessment work

If the training is to be successful then it needs to acknowledge the interface element right from the start and be multi-agency, it needs to address the barrier issues that have been found in this study, and to build on the positive elements that have been found. It is therefore important that training takes up the following issues.

- The involvement of at least some health services staff alongside social services
- Offering supervisors of practitioners some information about the training content when their staff go on training (at a minimum some literature to read, at most some period of joint training with their staff)
- Considering mentoring as one of the models of training
- Providing ‘Signpost’ assistance, directing people to opportunities and sources of help
- Making sure that all training carefully includes the perspective of users and carers

Finally if this work is to progress over the coming years it will need to continue to be informed by the major policy developments within social care. It therefore needs to take account of the main Government programmes, and to establish links with the major policy and academic partners that could be involved.

Government programmes are key drivers in social services and Trent Focus could try and develop specific links to the objectives in Quality Protects, Best Value and other programmes. Important developments are also just beginning, such as a Social Care Institute for Excellence and a General Social Care Council, under the Quality proposals for social care (http://www.doh.gov.uk/scg/qualitystrategy/index.htm). These proposals should have an important influence on the culture and actions within social care regarding research. There are also three potential partners that Trent Focus might develop links with to promote a shared agenda regarding research. The Association of Directors of Social Services’ research committee, academic partners in R&D Alliances, and the programmes within the social work post-qualifying training framework may each prove useful allies in the substantial task ahead.

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