Lost in Translation: An Ethnography of Self-directed Support in Scotland

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Abstract

Self-directed support (SDS) is Scotland's approach to social care and was enshrined in legislation with the passing of the Social Care (Self-directed Support) (Scotland) Act 2013. This policy is underpinned by a shift towards personalised social care services with the intention that people who require support can exercise as much choice and control as possible over their receipt of social care. With a clear emphasis on co-production and outcome-focussed support, SDS is intended to support people to participate in society whilst also protecting their human rights, including the right to independent living. Although the positive transformative potential of the policy is evident from its overarching principles and values, it is widely acknowledged that SDS is not being delivered as was intended. Within the growing SDS literature, scarce attention has been paid to the daily work of practitioners, who are tasked with translating SDS legislation into everyday practices. Consequently, in order to bridge this gap, this thesis places an emphasis on what practitioners *actually do,* by exploring how their SDS knowledge is translated through their everyday activities.

An ethnography was undertaken in a Scottish local authority adult team to explore the everyday implementation of SDS. The fieldwork included practice observation, formal and informal interviews, document analysis, and auto-ethnographic reflection, all of which took place between December 2019 and January 2021. The mobile methods captured desk work, meetings, informal interactions, and home visits within fieldnotes, a reflective log, and interview transcripts. The fundamental question being addressed was not whether SDS works, but rather *how* SDS works. Consequently, the *work* of practitioners has become the unit of analysis and the central focus of this thesis. The findings were analysed through Freeman and Sturdy's (2014) embodied-inscribed-enacted knowledge framework, which provides a powerful tool to identify and capture practitioners' SDS knowledge during policy translation. Practitioners embody SDS knowledge through their emotions, feelings, and embrained information. They inscribe SDS knowledge into documents and artefacts as they construct the policy reality, and enact it through their everyday encounters as they create and recreate a collective SDS world.

The thesis renders the unseen backstage SDS practice visible, providing a window into the black box of social work practice, or what has been described as the 'the invisible trade' (Pithouse, 1998). The findings highlight the contested nature of SDS implementation and reveal a concerning gap between social work practice and policy expectations. Practitioners are pulled in different directions due to competing functions in daily work, and the thesis therefore shines a light on the complex position occupied by social workers. Although SDS processes and procedures attempt to standardise work, highly bureaucratic tasks seem to have encroached on their practice, depleting the time available to build relationships with supported people. The evidence suggests that relationship-based practice thus takes a back seat, and high eligibility criteria, thresholds, and procedural demands are placed upon practitioners instead. Workers feel frustrated and constrained by these bureaucratic boundaries imposed through local authority processes and procedures, impacting their sense of professional identity and autonomy.

Amid this global pandemic the importance of social care and SDS delivery has never been more apparent, which is why an overdue but much-needed board discussion regarding a Scottish National Care Service has been sparked. This thesis contributes to the current national conversation regarding the future direction of SDS amid the shifting social care landscape.

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List of Abbreviations

ALLIANCE	Health and Social Care Alliance Scotland
COSLA	Convention of Scottish Local Authorities
GIRFEC	Getting it Right For Every Child
HSCP	Health and Social Care Partnership
ILF	Independent Living Fund
MSMC	My Support My Choice (report produced by ALLIANCE and SDSS)
SDS	Self-directed Support
SDSS	Self-Directed Support Scotland (Organisation)
SHRC	Scottish Human Right Commission
SSSC	Scottish Social Services Council

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Author’s Declaration

I declare that this thesis is my own original work and all material that is not mine is acknowledged, identified and referenced.

Chapter 1: Introduction

1.1 Chapter introduction

This thesis offers a granular analysis of the complex everyday implementation of self-directed support (SDS) in a community adult social work team in Scotland. This introductory chapter begins by describing my interest in the topic and revealing the roots of the research problem. It then provides an overview of the history and origins of personalisation, followed by describing Scotland's distinct personalisation approach, and the focus of this research, SDS. The chapter concludes by delineating the structure of the thesis through outlining a summary of each of the subsequent chapters.

The research idea emerged from the tension and disjuncture which I personally experienced whilst attempting to make sense of SDS in a practice setting. During my master's studies in social work I read, studied, and wrote about SDS legislation and the philosophy which underpins the policy, developing an insight into the theoretical ideologies surrounding SDS. Equipped with this knowledge, I undertook placements outside of the university in statutory social work settings and quickly realised that successfully making sense of SDS policy theory and successfully applying SDS in practice were radically different propositions. As I gained experience in a practice setting, I began to no longer make sense of SDS as I once had in university, yet I became increasingly knowledgeable about getting SDS done in practice. This was puzzling, because the more I practiced SDS the more I could do the work, yet somehow the less I could make sense of it as I once did. As a master's class, together we would regularly reflect on our experiences of disjuncture in relation to SDS within different local authorities and third sector placements across Scotland. The reoccurring SDS discussions surrounding the disconnect between theory and practice across the country troubled me both intellectually and ethically. These conversations with my peers provided a fleeting glance into the black box of backstage social work practice, or what has been described as the 'the invisible trade' (Pithouse, 1998). It was at this point that I began to consider what happened in the space between the paper policy document and the actual receiving of services. This tension between policy theory and practice reality, with the social worker occupying the complex in-between space, contributed to the establishment of my research focus and problem for this thesis.

1.2 The genealogy of personalisation

Chapter 2 provides a literature review focussed on the current implementation of SDS in Scotland, but before that it is crucial to acknowledge early on in the thesis the history and origins of personalisation which have laid the foundations for the present SDS narrative. The evolving international disabled people's movement and the coinciding international policy and legislation changes are a complex series of events which continue to occur gradually, at different times and in a variety of places. It is therefore beyond the scope of this thesis to provide an in-depth examination of broad historical developments. Nevertheless, this section aims to provide an overview in order to contextualise current day SDS policy without oversimplifying many of the significant events relating to people with disabilities.

1.2.1 Contested definition

To begin with, it is important to consider the definition of personalisation, which has been described as an 'umbrella term' encompassing a range of different approaches within social care; for example, direct payments, individual budgets, and SDS (Pearson, Watson & Manji, 2018: 664). Commonly, this umbrella term is used to describe different social care policies where people are presented as having increased choice and control over how to spend their individual budget and personalise their delivery of services (Pearson *et al.*, 2018). Personalisation policies claim to shift away from paternalistic service delivery where the professional holds the power and expert knowledge, and instead move towards empowering the citizen in receipt of services. Given that it is a broad term used to describe different approaches, the important differences underpinning each country's policy interpretation of personalisation must be acknowledged (Beresford, 2009). Consequently, the Scottish SDS legislation reflects the Scottish Government's move to reshape social care and instil concepts from the wider personalisation agenda. Although the SDS policy legislation and guidance documents described in the following section 1.2.3 are a matter of public record, the developments which preceded the endorsement of SDS and personalisation policies in general are contested and subject to significant debate.

The contested nature of personalisation is evident from the differing standpoints of the various personalisation commentators. For example, the concept has been linked to ideas regarding choice, control, autonomy, co-production, privatisation, marketisation, neoliberalism, budget cuts, and personal responsibility (Elder-Woodward, Jim, 2016; Hatton *et al.*, 2008; Kettle, 2015; Manji, 2018; Needham, 2011; Needham & Glasby, 2015; Pearson, 2004; Pearson *et al.*, 2018; Poll *et al.*, 2006; West & Needham, 2017; Whitaker, 2014; Young, 2020). These terms in themselves are in fact contested concepts. West (2013: 33) stated that the concept of personalisation is therefore an 'empty signifier' with no clear or particular meaning. It has been presented as a radical transformation policy which shifts power to the people using services, but is simultaneously presented as a policy which undermines the welfare state through funding cuts, passing the responsibility to the individual. Thus, ‘the elasticity of personalization ensures that a wide range of divergent interests have been able to sign up to and advance it, without needing to reconcile internal tensions’ (Needham, 2011: 55).

1.2.2 Contested context and historical origins

This section provides a brief history of, and draws attention to, the competing narratives told regarding personalisation as it evolved, which laid the foundation for SDS. Historically, people with disabilities were denied their basic rights and segregated and excluded from mainstream society, often being ‘contained’ in residential institutions and long-stay hospitals (Drake, 1999). In the 1960s, ‘many disabled people were faced with the choice of managing with little or no service input or being shut away in a geriatric ward’ (Campbell, J. & Oliver, 1996: 29). Successive policies oppressed and hid individuals, but with the growing welfare state and social services gradual changes occurred in the UK’s approach (Drake, 1999).

In the late 1960s a small group of disabled students in USA at Berkeley University began a campaign for independent living, calling for direct cash payments instead of the general state provided provision (Barnes & Mercer, 2006; Campbell, J. & Oliver, 1996). They were successful in gaining direct payments which empowered individuals to arrange their own bespoke social care support tailored to their needs, thus living ‘independently dependent’ (Barnes & Mercer, 2006: 31). These individuals employed personal assistants who were able to customise support for the person. This led to the creation of the first Centre for Independent Living in Berkeley in 1972. Morris (1993: 21) defines the independent living movement as more than just doing things yourself, and states that is it underpinned by the following four values:

1. All human life is of value.
2. Everyone is capable of exercising choice.
3. Disabled people have the right to control their own lives.
4. Disabled people have the right to fully participate in society.

Throughout the 1960s the disabled people’s movement for independent living gained momentum and challenged the dominant medical model of disability, instead promoting the social model of disability (Barnes & Mercer, 2001). Although the disabled people’s movement comprised campaigners with distinct ideas, the social model of disability was a uniting factor. The social model supports the idea that people are disabled by socially constructed barriers in society, rather than by their impairment or difference, thus disability is social oppression (Watson, 2004). It reframes disability as something resulting from society, therefore claiming that the problem lies with society, rather than the individual. Progress is thus sought through removing social constructed barriers to enable those with impairments to fully participate in society, and work towards achieving equality.

The movement continued to grow and there were over 300 CILs across the USA in the 1990s (Barnes & Mercer, 2006). In the UK in the 1970s and 1980s, advances were first made in Hampshire, where the local authority made payments to trust funds to enable individuals to buy support and live in the community. The independent living movement has therefore played a crucial role in influencing and progressing policy and legislation in social care. Importantly, the group was dominated by white middle-class people with physical disabilities, so not all disabled people were equally represented within the independent living movement (Barnes & Mercer, 2006).

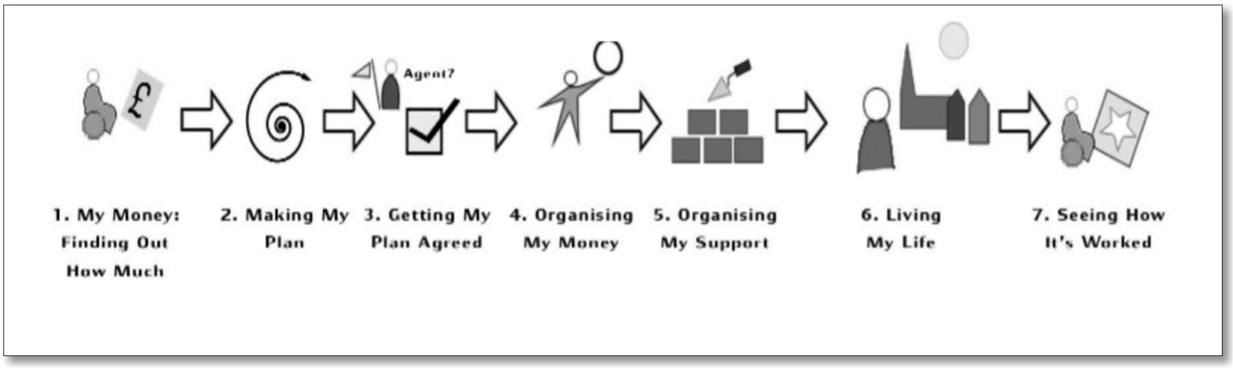
During the 1970s and 1980s pressure was put upon the UK government to shift towards considering community-based services rather than institutions. This led to a gradual process of deinstitutionalisation in the late 1980s which resulted in the widespread closure of long-stay hospitals and large-scale institutions for those with disabilities (William, 2013). Power (2014) notes that although changes enabled people to be physically located in the community, often they remained segregated and limited to particular spaces, such as day care centres and special schools. Whilst deinstitutionalisation indicates some progress, it is not synonymous with concepts of independence, control, and the end of institutional life, as people still resided and occupied spaces controlled by professionals such as group homes and day care centres (Duffy, 2014; Means, Richards & Smith, 2008).

The independent living movement continued to grow whilst institutions closed during the 1980s and 1990s. Although few people were able to gain access to them, direct payments were legally permitted under the Social Work Scotland Act 1968 (Pearson, Ridley & Hunter, 2014). The introduction of the National Health Service and Community Care Act 1990 fundamentally altered the role of frontline social workers. It enshrined into legislation their responsibility to conduct an assessment of need and to commission the delivery of services in the community (Glasby, 2017). This was the birth of the care market, with services commissioned and outsourced to private services rather than the local authority offering state-run provision (Walker, 1993). Further changes in the 1990s included the Community Care (Directed Payments) Act 1996 which gave local authorities the power to provide direct payments. Direct payments were therefore not mandatory, and were provided at the discretion of the professional. In the mid 1990s uptake remained low, with the majority of people receiving generic community care commissioned by the local authority rather than direct payments (Needham & Glasby, 2014).

Direct payment legislation was strengthened throughout the 2000s, and there was a shift towards the use of the term 'personalisation' within the policy and legislation framework and narrative (Pearson *et al.*, 2014). The Community Care and Health (Scotland) Act 2002 made it a duty to offer direct payments in an attempt to increase numbers of those receiving this form of social care. Nevertheless, uptake in Scotland remained slow often due to overly bureaucratic systems, funding constraints, and a rejection of care markets by professionals (Pearson, 2004; Pearson *et al.*, 2014). The ingrained local authority culture was difficult to shift, with professionals preferring public service provision and evidence also suggesting that workers withheld information on direct payments from supported people (Pearson, 2004; Pearson *et al.*, 2014).

With the growing UK governmental shift towards personalisation in the 2000s, a prevailing narrative of cost effectiveness emerged which ran in parallel with the disabled people's movement for independent living (Glasby & Littlechild, 2016). It has been argued that personal budgets would help to reduce costs and provide a cheaper mechanism for delivering community care than generic services. The 2006 social work report entitled *Changing Lives: Report of 21st Century Social Work Review in Scotland* (Scottish Executive, 2006) positioned personalisation at its centre, with a focus on individuals managing their own lives. Particular emphasis was placed on supported people participating in the design and delivery of social care services through consumer choice (Scottish Executive, 2006). During the 2000s the social enterprise In Control (see Poll *et al.*, 2006) was established in partnership with central and local government, and organisations working with supported people. The In Control project developed a new model for social care delivery called SDS, which involved the seven steps model centred around an individualised personal budget, illustrated in Figure 1 below (Duffy, 2008). This seven step framework was originally developed by Simon Duffy (one of the founders of In Control) in North Lanarkshire in 2000, and was then adopted and promoted by In Control from 2003. In Control gradually grew its membership to reach a total of 122 local authorities across the UK having joined the programme by 2008, with a total of 7,000 people in receipt of personal budgets (Duffy, 2008). In Control therefore significantly affected the direction, interpretation, and design of the personalisation agenda across the UK, particularly through the promotion of personal budgets derived via a resource allocation system (Hatton *et al.*, 2008; Pearson *et al.*, 2014).

Figure 1: In Control's seven step SDS model (Duffy, 2008: 134)



Pearson *et al.,* (2014: 5) identify an important difference in terminology, noting that 'direct payments' emerged from the disability movement, but 'personal budgets' were developed from the personalisation agenda and are 'associated with the philosophy of normalisation integrating disabled people into society, rather than challenging its barriers and discrimination'. Personal budgets are based on resource allocation systems and points-based systems calculated by algorithm within an assessment, whereas direct payments focus on allocating a budget sufficient to meet needs, and not linked to points. Many commentators argue that the personalisation agenda is a divisive issue which has hijacked the language of the independent living movement and eroded its associated values, replacing them with capitalist neo-liberal agenda through a care market (Ferguson, I., 2012; Pearson *et al.*, 2018; West, 2013). Personalisation shifts the responsibility to the individual away from the state, thus reducing the role of the state in social care. Pearson *et al.,* (2018) argue that the reduction in social care funding and the austerity measures which coincided with SDS delivery significantly impact the ability to effectively implement this policy.

The 'elasticity' (Needham, 2011: 55), 'empty signifier' (West, 2013: 33), and 'hybrid rationale' (Needham & Glasby, 2014: 15) of the concept of personalisation have been pointed out. Some commentators emphasise the connection between reduced public spending and SDS, whilst others highlight the links between the independent living movement and SDS (Glasby & Littlechild, 2016). Nevertheless, the personalisation agenda moved forward, joining together a diverse range of opposing perspectives and stakeholders. In 2010, the SDS strategy was published as part of the Scottish Government's reform of health and social care. The national SDS implementation group supported the delivery of the SDS policy through the introduction of linked legislation. The Social Care (SDS) (Scotland) Bill was introduced in the Scottish Parliament in March 2012 and the Act came into effect from April 2014.

1.2.3 The Scottish context: what is self-directed support?

SDS is Scotland’s approach to social care, which was enshrined in legislation with the passing of the Social Care (Self-directed Support) (Scotland) Act 2013 (hereafter referred to as the Act). This policy is underpinned by a shift towards personalised social care services with the intention that people who require support can exercise as much choice and control as possible over their receipt of social care (Scottish Government, 2010). The Scottish Government describes SDS as encompassing:

> *[…]the ways in which individuals and families can have informed choice about the way support is provided to them. It includes a range of options for exercising those choices. Through a co-production approach to agreeing individual outcomes, options are considered for ways in which available resources can be used so people can have greater levels of control over how their support needs are met, and by whom* (Scottish Government, 2010: 229).

The SDS policy reform signalled an ideological shift towards co-produced and outcome-focussed social care which moves away from the traditional care culture in which the professional is positioned as the expert holding power and control. There is a clear emphasis in the Act on the importance of co-producing the assessment, outcomes, and care plan, and it introduced new legal duties for local authorities stated in the statutory guidance (Scottish Government, 2014b: 9-11), including to:

- Have regard to the general principles of collaboration, informed choice and involvement as part of the assessment and the provision of support;
- Take reasonable steps to facilitate the person's dignity and participation in the life of the community;
- Offer four options to the supported person;
- Explain the nature and effect of the four options, and "signpost" to other sources of information and additional support.

The overarching ideas of choice and control apply regardless of which SDS option is chosen. The options on how to spend the budget which practitioners have a duty to offer are outlined below:

1. A direct payment to the individual;
2. An individual service fund (a budget held by the local authority and allocated to a provider of the support person’s choosing);
3. The local authority managing the support and budget on behalf of the supported person; or

4. A mix of these options for different types of support.

SDS is intended to support people to participate in society whilst protecting their human rights and right to independent living. The Act outlines a set of principles and values which explicitly link SDS delivery to a human rights approach. The four statutory principles specified in the SDS Act are: (1) participation and dignity; (2) involvement; (3) informed choice; and (4) collaboration. These principles carry legal weight and guide the local authority in its implementation of the relevant legal duties when delivering SDS. There is also the expectation that the professionals tasked with implementing SDS will also consider the following values: respect; fairness; independence; freedom; and safety (Scottish Government, 2014b). Finally, the guidance highlights that practice should be underpinned by the human rights-based PANEL principles (participation, accountability, empowerment, and legality).

The introduction of SDS has been guided by a number of evolving policy and guidance documents, including: the SDS ten-year national strategy (Scottish Government, 2010); the SDS Implementation Plan (Scottish Government & COSLA, 2019), which includes the Change Map (see Appendix 1); the Reform of Adult Social Care Programme (Scottish Government, 2019a); and the SDS Framework of Standards (Social Work Scotland, 2021). The frontline work of staff has been steered by the SDS practitioner guidance (Scottish Government, 2014a) and the statutory guidance (Scottish Government, 2014b). Each of these documents reiterate and emphasise the importance of informed choice and co-production via the four options set out above. Furthermore, the values and philosophy which underpins SDS are threaded through each document.

In this opening chapter it is pertinent to introduce and contextualise several large-scale Scottish national reviews which all highlighted concerns regarding SDS implementation, in order to lay the foundations for this thesis's inquiry. The relevant findings from these reports are drawn upon in the subsequent literature review chapter. Firstly, Audit Scotland published an initial report in June 2014 examining the progress made in implementing SDS (Audit Scotland, 2014). This was followed up by the Audit Scotland SDS progress report published in 2017 which sought to establish whether local authorities and the Scottish Government were making sufficient progress in implementing SDS to achieve the aims of the ten-year SDS strategy (Audit Scotland, 2017). Interviews were conducted with supported people, their families, third sector organisations, and staff at all levels in five sites (East Ayrshire, Glasgow, Highland, Perth and Kinross, and Western Isles). The review involved the completion of online surveys by both staff and supported people. In 2019, an Impact Report presented Audit Scotland's continuous monitoring of progress, highlighting actions which had been taken and making recommendations for ongoing tasks (Audit Scotland, 2019).

Secondly, the Care Inspectorate led a thematic review of SDS which was carried out jointly with Healthcare Improvement Scotland and published in June 2019 (Care Inspectorate, 2019). This review examined the delivery of SDS in six health and social care partnerships to evaluate how the principles and values of SDS had been embedded into practice. The research sites were East Lothian, East Ayrshire, West Dunbartonshire, Shetland, Moray, and South Lanarkshire. The review carried out a series of inspection activities, including a questionnaire for supported people; a staff survey; examining care file records; speaking to supported people and unpaid carers; and speaking to managers and staff.

Thirdly, the Scottish Government announced that there would be an Independent Review of Adult Social Care in September 2020 to conclude in January 2021, which was to be chaired by Derek Feeley (Feeley, 2021). The aim of the review was to recommend improvements to adult social care, and specifically to explore the outcomes achieved by people in receipt of services, their carers and families, and the experience of people working in social care. The review was multifaceted, and included an open enquiry allowing individuals and organisations to submit views and evidence. Next, there were themed stakeholder engagement events, and meetings with stakeholder groups and organisations.

Finally, the Health and Social Care Alliance Scotland (the ALLIANCE) and Self Directed Support Scotland (SDSS) conducted a research project called *My Support, My Choice* (MSMC) through conducting interviews, focus groups, and surveys with supported people and their families. This produced a central report (ALLIANCE & SDSS, 2020c) and a collection of thematic reports published separately exploring the experiences as users of SDS of people with learning disabilities, black and minority ethnic people, people with lived experience of mental health problems, blind and partially sighted people, and women. Additionally, a further group of reports were published focussing on people’s experiences in specific local authority areas.

1.2.4 Current concerns surrounding SDS

Although the positive transformative potential of the policy is evident from its design and overarching principles and values, the abovementioned national reviews all acknowledge that the SDS policy is not being delivered as was originally intended. Audit Scotland (2019: 5) state that ‘there is no evidence that authorities have yet made the transformation required to fully implement the SDS strategy’ and also highlight that ‘not everyone is getting the choice and control envisaged in the SDS strategy’. Similarly, the thematic review concludes that ‘most partnerships had yet to fully implement self-directed support, meaning that its true potential was not being realised’ (Care Inspectorate, 2019: 9). Furthermore, the recent Independent Review of Adult Social Care finds that ‘the experience and implementation of self-directed support must be improved, placing people using services' needs, rights and preferences at the heart of the decision making process' (Feeley, 2021: 61). Given the concerns surrounding social care delivery, the literature review presented in Chapter 2 considers the limited (but growing) evidence base by bringing together the relevant data to explore SDS policy implementation, specifically in Scotland. The dominant themes emerging from the SDS literature are presented thematically in the subsequent chapter.

To further contextualise this thesis, this project's ethnographic data collection finished in February 2021, followed shortly thereafter by the publication of the Independent Review of Adult Social Care (Feeley, 2021) and the SDS Framework of Standards (Social Work Scotland, 2021). Additionally, the Scottish Government conducted a National Care Service consultation which began in August 2021 and closed in November 2021 that sought views on proposals to improve social care delivery. This research therefore has the opportunity to contribute to the current conversation on the present condition and future direction of health and social care in Scotland, given the ongoing national dialogue surrounding the National Care Service and SDS.

1.3 Research questions

The central research question which guided this research was:

- *How* do practitioners translate SDS?

Furthermore, the subsidiary research questions were:

- What are the daily micro SDS interactions and encounters in practice, and therefore what forms does SDS work take?
- What people, objects, and spaces are involved in SDS translation work?
- How do practitioners make sense of SDS? Thus, how is SDS embodied, inscribed, and enacted?
- When SDS moves, what parts are successfully reassembled and translated, and what parts are invisible and missing?
- Finally, how does this understanding of SDS influence future practice and implementation?

These questions were answered using an ethnographic study on an adult social work team in one Scottish local authority. The rationale for the ethnographic methodology will be described in Chapter 4. The overall structure of the thesis will now be outlined in the following section.

1.4 Structure of the thesis

This thesis is composed of eight chapters. Following this introduction, Chapter 2 presents a narrative review of the pertinent literature surrounding SDS. It explores the dominant themes emerging from SDS implementation and delivery. The concluding section of the literature review outlines the evolving focus of this thesis, which aimed to explore *what social workers actually do* and *what SDS practice is* during the behind-the-scenes interactions in a social work office. The research emphasis centred around making the invisible everyday SDS work visible in order to enhance understanding of the policy implementation and translation.

Chapter 3 explores the concepts and ideas drawn from the interpretative policy studies which guide the theorisation of policy as a process within this thesis. Concepts and ideas from this field were fundamental in influencing and guiding the research focus towards the everyday situated activities of the frontline workers who are understood to be translating and assembling SDS policy in daily activities. This body of literature emphasises the central role of practitioners' knowledge during everyday work within the policy-making process, thus specifically framing *policy* as *practice.* Freeman and Sturdy's (2014) embodied-inscribed-enacted theoretical framework is presented as a means to inquire into and understand social workers' diverse forms of SDS policy knowledge and policy work. In it, policy is understood as a complex, fluid, multiple, and continuously evolving process which is never complete. As such, it is argued that through adopting this lens, SDS will framed from a previously unseen angle, thus offering a unique contribution to knowledge in the field.

Chapter 4 draws upon Silverman's (2017: 476) 'natural history' approach to document the evolving and fluid nature of this study's research methods. The chapter presents a detailed discussion of the ethnographic research process and the relevant methodological considerations, evidencing the thorough and robust research design which underpins this thesis. Furthermore, in response to the global COVID-19 pandemic which began during data collection, the chapter also explains the reasoning behind the unforeseen modifications to the study design to include auto-ethnographic data. A reflexive examination of positionality is then presented, ensuring that consideration has been given to the influence of the researcher's presence on the generation of data and knowledge.

Chapter 5 is the first of three chapters presenting the research findings. This chapter specifically explores the significance and forms of embodied SDS knowledge amongst social workers. The social worker's body is seen as a site where emotions and feelings manifest in relation to the policy, and also as a space where SDS understandings and typifications are stored. This chapter attempts to open the black box and make visible practitioners' often unheard embodied feelings and taken-for-granted everyday embodied understandings of SDS. The first part of the chapter considers the embodied emotions associated with SDS work which impact on practitioners' sense of professional identity. The second section then explores the unconscious embodied case knowledge gained during daily socialisation which supports practitioners when navigating SDS. These non-verbal and embodied translations of SDS can only be captured through being there *in situ* with the workers to expose how workers respond to cases through their embodied instincts, intuitions, values, biases, feelings, and emotions.

Chapter 6 is the second of the three findings chapters and examines the forms of inscribed SDS knowledge which illustrate the way in which social workers translate SDS through the process of writing and reading. Recording, documenting, and completing paperwork is a fundamental part of day-to-day work in the adult social work team; thus, these often-unnoticed pieces of daily work are rendered visible in this chapter. Looking at the data through the lens of inscription reveals how social work practice is negotiated through documents, and how documents are powerful objects which influence, steer, and create daily work within the office. This chapter specifically homes in on a case study example of a social worker writing an SDS assessment, rendering the backstage process of inscription observable. The social worker is positioned as a translator who refines and distils gathered information. Finally, the absence of inscription, and specifically the lack of documentation, is explored. Overall, this analysis aims to partly open up the black box of producing assessments and care plans through revealing some of the steps which must be taken before delivering the final document.

Chapter 7 is the final findings chapter, which examines the daily practice enactments which expose the collective interactions, performances, and negotiation of SDS policy. These daily evolving actions reveal the ways in which practitioners enact SDS through their daily *work and doings,* and are where the policy is continuously produced, revealing the contested nature of SDS implementation. The focus here is not the individual social worker, but instead the micro-level situation, or the event, or the encounter. The chapter is divided into three sections, each of which focus on different practice spaces. Firstly, encounters with supported people are examined. Secondly, the daily office talk with colleagues is explored, and thirdly, the chapter examines resource allocation meetings.

Chapter 8 provides an analysis of the three findings chapters and presents the main findings, discussing their implications in relation to the wider SDS practice landscape and research. This concluding chapter looks forward by considering the potential implications for future practice, and acknowledges that although there is a vast gap between practice and SDS legislation, there is also an opportunity to take alternative approaches to SDS implementation. It highlights that whilst the exact National Care Service structure remains undecided, there is recognition that change is required, and improvements are needed. The chapter concludes by emphasising that whichever direction is adopted, it is crucial that the current system is not simply allowed to continue in its current form.

Finally, it seems pertinent to acknowledge and clarify what this research is, and what this research is not. As the following chapter will explore, little pre-existing literature which foregrounds the daily activities of the social workers implementing SDS was found in the literature search. The study therefore aimed to move beyond hearing descriptions of social work activities in interviews, and instead examine how practitioners enact and *do* SDS. Consequently, the importance of practice observation was quickly realised, resulting in the choice of an ethnographic approach to render the frontstage and backstage SDS work visible. Yet, the purpose of this research was not to evaluate, scrutinise, or inspect the specific practice of the team who participated in this study, nor was the aim to identify forms of SDS best practice in order to produce a blueprint for delivery. Crucially, this research captures rich data revealing how one specific team, at a particular time, translated SDS. The thesis focusses on depth rather breadth, complementing the existing SDS literature through telling another piece of the policy story, which was yet to be reported. Although this study does not claim to illustrate a national picture of SDS manifestation, it is well placed to highlight potential opportunities for SDS practice development, whilst also emphasising the possibility of negotiating an alternative SDS future.

Chapter 2: Literature Review

2.1 Chapter introduction

The opening chapter set the scene through outlining the historic origins of personalisation, followed by providing an overview of the values and philosophy which theoretically underpin the SDS. This chapter builds upon these foundations by presenting a narrative review of the dominant themes emerging from the SDS literature. Through exploring the available empirical data, this review moves beyond discussing the historical and theoretical underpinnings of SDS to consider the practical translation and delivery of the policy. At the outset, it is important to point out the severe scarcity of robust evidence and data, which means that much remains unknown regarding the policy implementation. This literature review acknowledges that the recording, collection, and analysis of SDS evidence and data at both a local and national level is currently problematic and needs to be developed to capture an accurate picture of SDS progress and performance (ALLIANCE & SDSS, 2020c; Audit Scotland, 2017; Care Inspectorate, 2019). Nevertheless, the available literature provides crucial insights into SDS delivery, and overall, the findings suggest a vast implementation gap between policy rhetoric and practice. Finally, with these evidence gaps in mind, a conclusion is drawn indicating the focus of this thesis.

2.2 Search strategy

At the time of writing, although there are a limited number of empirical peer-reviewed publications examining SDS, the policy has attracted significant attention from a range of governmental and third sector stakeholders who are invested in examining, informing, and influencing policy delivery and progress. The grey literature therefore offers valuable insights into the phenomenon of SDS, and these sources include third sector publications, Care Inspectorate reviews, and government policy documents and guidance. In terms of the literature review process, a narrative review was chosen to facilitate the inclusion of a diverse body of research beyond peer-reviewed academic publications. As Hammersley (2001) argues, the dominant and often preferred systematic literature review reduces and narrows the focus, privileging studies which fit strict criteria. Given the wealth of valuable grey literature on SDS, the decision to undertake a narrative review was guided by the topic and the type of available evidence. A narrative approach produces a ‘map’ or ‘mosaic’, or acts as a ‘bridging function’ enabling the researcher to ‘focus on different parts of a single picture’, and is guided by a flexible iterative search and analysis of literature (Hammersley, 2001: 548). The search strategy and design is described below, to evidence the rigorous approach taken in the study despite the reliance on the reviewer's judgment and decision-making.

The Glasgow Caledonian University library search engine was utilised in combination with electronic databases including Proquest and Social Care Online. Furthermore, specific journals which focus on disability and social policy were searched for linked papers. The reference lists within relevant papers were also examined to ensure that all appropriate material, including grey literature, was included. A substantial body of grey literature formed an important part of this narrative review; therefore, searches were conducted on Google, the Scottish Government website, and third sector websites. Search terms remained broad and included the terms "self-directed support", "personalisation", "personal budget", "managed personal budget", "individual budget", "direct payment" and "Scotland". To begin with, research and reading was extensive so as to enhance understanding surrounding the origins of personalisation; however, given that personalisation has been interpreted differently depending on the country in question, Scottish SDS publications took priority and remained the focus of this review. The search was not limited by dates, but literature specific to SDS tended to date from the present day back to 2013, when the policy was enshrined in legislation. As the policy is dynamic and continuously evolving, recent research was prioritised in order to focus on contemporary developments. The fieldwork for this project took place between December 2019 to January 2021, and the literature review has been continuously updated, so sources published post-data collection have also been included. Following the online search, abstracts and sources were read and the relevant papers were included, drawing out the key themes. The findings and evidence from this literature search are presented thematically below.

2.3 Thematic narrative review

2.3.1 Meaningful choice and control

The evidence suggests that not all individuals are receiving the choice and control outlined in the SDS legislation. In theory, SDS offers people greater choice, control, and flexibility over their social care through four possible options; however, the research indicates that in practice, the traditional care delivery culture has been resistant to change (Rummery *et al.*, 2012). The type of social care provision supported people have therefore continued to receive has predominantly been direct delivery from the local authority through option 3 (Pearson & Ridley, 2017; Pearson *et al.*, 2018). The thematic review highlights that option 3 remains dominant and easily available, although option 1 has also generally become well-established in local authorities (Care Inspectorate, 2019). Additionally, option

3 was more likely to be utilised by older people (Care Inspectorate, 2019; ISD Scotland, 2020). Furthermore, the Care Inspectorate highlight that often, option 2 and 4 are not available (Care Inspectorate, 2019). The literature suggests that the lack of guidance regarding the implementation of option 2 has resulted in challenges for frontline practitioners managing delivery (Pearson *et al.*, 2018). Option 2 should enable the supported person to direct the local authority or chosen provider regarding how their budget is spent without directly managing the finances, thus reducing personal risk whilst offering greater choice and control to the supported person (Dalrymple, Macaskill & Simmons, 2017; Kettle, 2015). Inconsistent and conflicting local interpretations of option 2 have, however, resulted in considerable disparity in understanding and delivery amongst practitioners (Kettle, 2015; Manthorpe *et al.*, 2015). Consequently, there is 'unfulfilled potential to develop the flexibility and person-centredness which option 2, uniquely, represents, and by means of which people could truly enjoy greater personal choice and control over their own lives' (Dalrymple *et al.*, 2017: 2).

SDS clearly emphasises the process of co-production between the practitioner and the supported person as a key mechanism promoting choice and control, specifically in relation to the assessment, care planning, and delivery of services. Nonetheless, Flemig and Osborne (2019: 680) found that some social workers 'failed to differentiate between "asking" supported people for their opinions (consultation) and users having direct control over the design and delivery of their services, in partnership with professional staff (co-design)'. Additionally, the MSMC survey revealed that only 42% (181 people) reported that a professional had discussed all four options with them. Moreover, a third of people reported that they were able to choose their own support, whilst a quarter had it chosen by family or friend, and 27% stated that a professional chose it on their behalf (ALLIANCE & SDSS, 2020c: 50). Further, 'interviewees felt that their social worker had decided what SDS option they would choose before completing the needs assessment' (ALLIANCE & SDSS, 2020c: 50).

Within Scotland's local authorities there is insufficient recording of, and documentation evidencing, discussions regarding SDS options and the subsequent supported decision-making between the professional and the supported person (Care Inspectorate, 2019). The thematic review therefore concluded that it was "impossible to determine the extent to which choice and control was being offered and delivered through SDS" (Care Inspectorate, 2019: 9). The Care Inspectorate also recognises that limited recording is taking place regarding the supported person's outcomes, which means it is not possible to review the types of outcomes which SDS is supporting people to achieve, or to determine whether outcomes and needs are being met by SDS (Care Inspectorate, 2019). Further data is therefore required regarding conversations and outcomes in order to evaluate the progress and impact of SDS implementation across different local authorities, and amongst specific groups of supported people.

Independent advocacy, support networks, and accessible accurate information are all known to enhance an individual’s ability to make meaningful, informed choices regarding their social care (ALLIANCE & SDSS, 2020c; Care Inspectorate, 2019; Mitchell, 2015). Despite the critical role of advocacy in helping individuals to maximise their choice and control, ‘supported people, unpaid carers and staff were not as aware of independent advocacy as they should have been’ (Care Inspectorate, 2019: 16). The evidence suggests that advocacy services are often overprescribed and underfunded, and are thus unable to meet demand, impairing individuals’ ability to make informed choices (ALLIANCE & SDSS, 2020c; Care Inspectorate, 2019). The Independent Review of Adult Social Care acknowledges that both independent advocacy and brokerage offer impartial information; however, they are underutilised (Feeley, 2021). The report therefore recommends increasing the availability of these services in combination with reopening the Independent Living Fund (ILF), all of which is aimed at increasing meaningful choice and control. Overall, this situation therefore raises issues surrounding the levels of meaningful choice being offered to supported people.

2.3.2 A mainstream approach

Although the introduction of the SDS Act marked a mandatory shift to provide all social care across Scotland in line with the new legislation, there are ongoing concerns regarding the extent to which SDS has become the ‘mainstream approach’ and been fully embedded into practice and delivery (Audit Scotland, 2017). Dalrymple *et al.,* (2017: 13-14) noted that some social work practitioners have remarked ‘we are putting that person through the SDS route’, and that ‘SDS isn’t going to work for everyone’. It is argued that these attitudes result in specific groups simply being denied access to SDS, including people living with homelessness, people with experience of criminal justice services, people with mental health conditions, people over 65 years old, people living with dementia, and people in residential care (Dalrymple *et al.*, 2017). Similarly, the MSMC research evidenced that different groups of supported people felt they had varying access to SDS; for example, ‘people in some local authority areas reported that they were informed by social work departments that SDS is not available for people who are homeless’ (ALLIANCE & SDSS, 2020c: 43).

At present there is a severe scarcity of robust national-level data which has been recorded, gathered, and reported to explicitly capture the experiences of SDS amongst specific groups (ALLIANCE & SDSS, 2020c). The Information Services Division (ISD) is responsible for gathering national statistical data regarding health and social care. These statistics are available from ISD publications (IDS Scotland,

2019) and an online interactive dashboard (ISD Scotland, 2020). Overall, the specified mandatory data requested from each HSCP does not enable a comprehensive analysis of who receives social care across Scotland, and how. The ISD, for example, does not publish statistics for the number of men and women accessing SDS, nor an overall age breakdown of supported people; neither does it gather or provide a disaggregated breakdown of data regarding the socio-economic backgrounds, ethnicity, religion or belief, or sexual orientation of people accessing SDS (ISD Scotland, 2020). Without these statistical insights, accurate, in-depth longitudinal scrutiny of different groups' access to social care is limited. This robust analysis is required to ensure that the key principles of equality and non-discrimination are being upheld. Overall, it is apparent that public bodies are not gathering or reporting enough data on who their supported people are, or what their needs are, so policy as it relates to specific groups is not fully evidence-based, nor is it possible to fully ascertain how needs are being responded to.

The Care Inspectorate specifically highlights the insufficient recording of data at a local level by frontline workers regarding supported decision-making on the four SDS options, and surrounding individual outcomes (Care Inspectorate, 2019). It is evident that the recording, collection, and analysis of data at both local and national levels is currently problematic and needs to be improved to capture an accurate national picture of progress and performance of SDS.

Finally, the research presented in this literature review focusses on those already in the system, for example supported people who are receiving an assessment or who are already in receipt of support. Yet, there has been limited exploration of those still outside the SDS system who have been refused support, or who have been attempting to gain an assessment and a budget. Further research is required to understand the experiences of such people outside the system and the social care routes taken by those who do not have access to SDS.

2.3.3 Conversations and language

The language which a practitioner utilises, verbally and/or via the written word, is deeply instilled into everyday activities and is thus often taken for granted (Thompson, 2011). As Thompson (2011: 63) highlights in the following quote, language is not neutral, and has the potential to both promote social justice and inequalities:

> *Language is closely associated with power, with the way we make sense of our lives and of the social world, and even how we make sense of ourselves – that is, our identity […] Language can be used to solve problems, to build positive and*

> *constructive relationships, to inspire and motivate and to liberate. However, it can also be used to create problems as well as solve them, to incite hatred and to create great pain and suffering.*

The SDS policy reform signalled a shift away from previous models of social care and language which came to be considered disempowering, task-orientated, and deficit-focussed (Manji, 2018; Witcher, 2014). SDS represents a conscious shift towards re-balancing power between the professional and the supported person through the co-production of outcome-focussed practice and language which is consistent with the social model of disability (Manji, 2018). SDS therefore requires practitioners to focus on a supported person's overarching social care outcomes, rather than only considering the amount of hours and types of tasks they require. However, the evidence suggests that outcome-focussed language and processes have not been achieved, and that previous culture and models of social care delivery have been hard to shift (Rummery *et al.*, 2012).

The clash of old and new approach results in practitioners conversing in 'two different languages' (Care Inspectorate, 2019: 10). The thematic review highlights that staff adopt empowering outcome-focussed language when supporting a services user; however, workers are forced to engage with a deficit language when writing an assessment and requesting a budget (Care Inspectorate, 2019). Although frontline workers are encouraged to implement an outcome-focussed approach, often the systems and processes hinder their ability to fully adopt the new SDS culture. There is 'a tendency for these systems to tie thinking back into the language of "hours" under a "time and task" model rather than emphasising individual budgets and creativity' (Critchley & Gillies, 2018: 27), and therefore practitioners speak a language of 'commissioning and procurement' (Critchley & Gillies, 2018: 29). In order to empower practitioners to fully implement the SDS policy, the processes, procedures, systems, and forms must reflect the SDS philosophy, rather than drawing dialogue back to that of a deficit model (Morrow & Kettle, 2021).

The SDS implementation plan for 2019-2021 endorses the practice of 'good conversations' (Scottish Government & COSLA, 2019). This emphasises the importance of dialogue between the professional and the supported person as a method for ensuring the co-production of personal outcomes as a means to increase choice and control over social care (Scottish Government & COSLA, 2019). Overall, the literature suggests variations in communication between workers and supported people, with some reports of clear and coherent interactions and information, but other descriptions of misinformation, unclear processes, and a failure to discuss budgets and SDS options (ALLIANCE & SDSS, 2020c). The MSMC study emphasises the importance of information being provided in a range of accessible formats, and reinforces the value of face-to-face conversations to allow individuals to make informed choices (ALLIANCE & SDSS, 2020a). Thus, the language, conversation, dialogue, and talk utilised by practitioners in different spaces when engaging with distinct parts of the process merit more detailed exploration.

2.3.4 Bureaucratic processes and systems

SDS processes and systems have received repeated criticism for long waiting lists and multiple layers of decision-making, which result in a slow, drawn-out procedure, often when an individual is at a point of crisis (ALLIANCE & SDSS, 2020c; Care Inspectorate, 2019; Manthorpe *et al.*, 2015; Mitchell, 2015). The MSMC research states that 54% of individuals (176 people) reported that waiting times made the SDS process more difficult, with many participants waiting over six months for a needs assessment, and some even waiting more than a year (ALLIANCE & SDSS, 2020c). Participants also highlighted unanticipated waiting times at different stages of their SDS journey, including waiting for a response between phone calls or after an assessment. Others reported delays in receiving their agreed budget and lengthy waits to access the support provision once a budget had been agreed. In the Independent Review of Adult Social Care, a support worker who is assisting an adult with complex needs to access support through SDS stated that:

> *After six assessments and two complaints against the local authority, this person who has met substantial and critical criteria to access support, is still waiting on a care package. I am aware of another two adults with complex needs that have died waiting on a SDS care package. The current provision of adult social care has been in crisis long before the pandemic* (Feeley, 2021: 84).

Each of the 32 local authorities in Scotland have interpreted this national policy locally, resulting in wide variations in assessment processes, care plans, service providers, eligibility criteria, resource allocation systems, and review processes (Morrow & Kettle, 2021). Consequently, sets of procedures across Scotland are complex and inconsistent (Audit Scotland, 2017). Manthorpe *et al.*, (2015: 41) state that practitioners face ‘dual imperatives’, as they must ‘convey that the SDS is personalised, flexible and easy to manage, with their own obligations to ensure there is probity when dealing with public funds and managing office systems that may not have adapted fully to new policies’. This links to the observation made in the previous section 2.3.3, of practitioners pulled in different directions by clashing obligations resulting in two different SDS languages. Given that office systems and databases have not yet been adapted to adequately reflect the SDS philosophy, practitioners’ ability to effectively implement a transformational policy is limited (Care Inspectorate, 2019). The evidence suggests that practice is subject to a systems-led approach rather than an outcomes-focussed approach which prioritises choice and control for the supported person: ‘Reviews were often driven by process and too focussed on whether the level of care and support needed to increase or decrease, rather than about options, choice and control, and outcomes’ (Care Inspectorate, 2019: 21). A systems-led approach not only reduces choice and control and reinforces disempowering language; it also reduces the autonomy of the social worker (Audit Scotland, 2017; Care Inspectorate, 2019; Manthorpe *et al.*, 2015).

2.3.5 Eligibility criteria and resource allocation systems

Under the Social (Work Scotland) Act 1968, local authorities have a duty to conduct an assessment of need to determine whether social care support is required. The information and evidence gathered for an assessment is utilised to determine levels of risk and whether a supported person meets the thresholds for support outlined in the local authorities’ eligibility criteria (Slasberg & Beresford, 2016). Risk is categorised as critical, substantial, moderate, or low within the National Eligibility Criteria Framework which guides local authorities. Each of the 32 local authorities interpret this framework differently, resulting in variations and inconsistencies of risk thresholds across Scotland. Indeed, the evidence suggests that thresholds for gaining support are extremely high, with local authorities often only offering provision for those already in crisis. An assessment identifies the levels of risk, which are then linked to a resource allocation system which calculates the correlating individual budget (Duffy, 2010). Consequently, if an assessment indicates high levels of critical risk in a number of areas, a larger budget will be generated through the resource allocation system algorithm. Thus, a budget is produced in relation to a points-based RAS, rather than the primary focus being on allocating a budget which is sufficient to meet the person’s needs. These various local interpretations of the national risk framework in combination with 32 different resource allocation systems has created a fragmented and uneven SDS landscape across Scotland (Eccles, 2018). Slasberg and Beresford (2016) argue that individuals are therefore subject to a ‘postcode lottery’ when seeking social care provision. Further inconsistencies exist because each local authority has distinct guidelines and restrictions regarding how supported people can spend their budgets (ALLIANCE & SDSS, 2020c; Rummery *et al.*, 2012).

A lack of transparency has been identified in relation to SDS decision-making and the distribution of budgets, which results in supported people’s concerns about the ‘fair allocation’ of support (Slasberg, 2013). The research indicates that supported people feel detached and distanced from decision-making fora and processes, which obstructs their choice and control (Care Inspectorate, 2019; Audit Scotland, 2017; SDSS and ALLIANCE, 2020; Young 2020; Dalrymple et al., 2017).

In combination with their high thresholds for accessing support, each local authority also caps or limits the total SDS sum available to a supported person due to finite government funding. Current practice is that the budget for an older adult (aged 65 or over) is often capped at a lower amount than is available to younger adults (Morrow & Kettle, 2021). It is, however, difficult to find research evidencing thresholds based on age. Not all local authorities publish their eligibility framework and benchmarks, although some have put this information in the public domain to increase transparency. For example, the published guidance from South Lanarkshire Council states that 'the average cost of a residential care home placement is used as a benchmark for council's maximum contribution towards the care of an adult over 65, which is currently £480 per week', and that for 'adults under 65 the maximum benchmark will be £1,310 per week' (South Lanarkshire HSCP, no date: 14).

The precedent for differing thresholds based on age originates from a legal challenge called *Mrs Q v Glasgow City Council* (2018) CSIH 5. This case law illustrates a dispute over the maximum allocation of resources for an older adult residing in the community (Morrow & Kettle, 2021). It was argued by the supported person's family that the local authority should provide Mrs Q with one-to-one support in the community rather than a nursing home placement. Additionally, they claimed that by not supporting Mrs Q to remain at home, the local authority were neglecting their duty to deliver suitable services under section 12A of the Social Work (Scotland) Act 1968, as well as failing to consider Mrs Q's Human Rights. In response, Glasgow City Council argued that Mrs Q required 24-hour nursing home care, and that this setting would meet her needs. The court agreed and sided with the local authority, who won this case. It was ruled that Glasgow City Council were obligated to contribute the cost of the nursing home placement. As a result, SDS budgets for those aged 65 are often capped at the cost of nursing care (Morrow & Kettle, 2021). Further research is needed to understand how widespread these thresholds based on age are across Scotland, and how they influence decision-making on residential care once an older person exceeds their capped budget. Dalrymple *et al.,* (2017: 20) state that 'cost pressures add to a sense that SDS is, per se, "too expensive"; and are used to justify proposals […] to forcibly replace "community care" with "residential care" when the cost of the former exceeds the average cost of the latter'.

If an individual has complex needs, including children and young people, often the required budget will exceed benchmarks and thresholds. A recommendation for a long-term residential placement can be made if the assessment indicates that supporting the individual in the community with the available budget would be too high risk. Some families can choose to top these budgets up from their own personal finances; however, the research indicates a clear correlation between disability and rates of poverty, so this may not be possible for all. Furthermore, this practice can create a system which offers more options to those who can afford them, rather than being based on outcomes and needs. The statutory guidance suggests that local authorities may wish to use the ‘equivalence model’ to determine the cost and budget for an individual on a case-by-case basis. The HSCP may ‘determine the cost of the service to be arranged and then provide the equivalent amount as a budget for the supported person to control’ (Scottish Government, 2014b: 36). This means that if a social worker can present evidence that a residential placement will be more expensive than supporting an individual in the community, then the supported person may be offered an amount above the normal benchmark to support them at home. The Independent Review of Adult Social Care recognises that HSCPs are ‘prioritising cost and eligibility considerations above working with people to plan their support and to ensure access to high quality support’ (Feeley, 2021: 28). It recommends a shift in professional practice, as ‘social workers, should be focussed on realising those rights rather than being hampered in the first instance by considerations of eligibility and cost’ (Feeley, 2021: 100). Furthermore, the Independent Review of Adult Social Care recommends that eligibility criteria and charging regimes need to be reformed and removed, and that the current system is driven by crisis and late intervention rather than prevention and wellbeing (Feeley, 2021). Finally, the report calls for a new, sustainable approach which invests in social care and engages in early intervention and prevention (Feeley, 2021).

2.3.6 The invisible work of informal carers

A recurring theme is the assumption by professionals that family members will provide unpaid care (ALLIANCE & SDSS, 2020c; Feeley, 2021; Young, 2020). This assumption that informal care is available from the supported people’s support network can reduce the amount of support the person is eligible for. It is important to highlight that unpaid care is often provided by female members in a household, disproportionality impacting women in society (Feeley, 2021). The invaluable contribution of unpaid carers is acknowledged in the Independent Review of Adult Social Care. Unpaid carers represent a larger workforce than health and social care staff combined, however ‘many unpaid carers are women, and they told us they are often overlooked and disregarded’ (Feeley, 2021: 13).

The Independent Review of Adult Social Care recommends that carers get more support to carry out their role and access respite; indeed, a recommendation is made to amend the Carers Act to facilitate respite more easily. Furthermore, it recommends that carers be given a stronger voice through being partners on the Integration Joint Boards in the proposed National Care Service. Paid carers, support workers, and personal assistants are also predominantly women who are on low paid incomes (Feeley, 2021). To support the professional development of staff, the Independent Review of Adult Social Care recommends a new national organisation for training and development, improved working conditions, implementing the Fair Work Convention, and a real living wage (Feeley, 2021). Investment in the workforce is viewed as crucial to improving gender equality given that the social care workforce is 83% female (Feeley, 2021).

2.3.7 Lack of flexibility

Each of Scotland's 32 local authorities have distinct guidelines in relation to how a budget can be spent, resulting in stark inconsistency across the country (ALLIANCE & SDSS, 2020c; Rummery *et al.*, 2012). For example, two people choosing an option 1 in different local authorities may have contrasting restrictions and guidance regarding what budget can be used to meet their outcomes. The research acknowledges that people feel that a lack of flexibility impairs their choice and control (Audit Scotland, 2017; Care Inspectorate, 2019; Manji, 2018; Young, 2020). A reoccurring concern regarding spending SDS budgets on respite has been raised by supported people and support networks within the MSMC research. This identifies the need for flexibility when using the respite budget with providers from outside local authority lists. Further, the report highlights confusion regarding the inclusion of travel costs within the SDS budget. Often when a personal assistant is required to travel to a rural location, the time and cost of transportation is not consistently included within the SDS budget. Research is therefore required to understand how the four different options are manifested in each local authority in order to reveal how much choice, control, and flexibility exists in relation to each option.

2.3.8 Risk and SDS

The wider social work literature highlights the complex relationship practitioners have with the ambiguous and multifaceted concept of risk. Hardy (2015: 1) states that:

> *Risk, in one form or another, is arguably the major issue with which contemporary social work is grappling. Not only must social work practitioners work with risk and assess and intervene to reduce it, but social work agencies must respond to and manage it, while social work research and education must produce and enable development of the knowledge and skills required to do so.*

As was highlighted in section 2.3.5, SDS assessments are underpinned by the National Eligibility Framework, which classifies a person's risk as critical, substantial, moderate, or low (Scottish Government, 2014a) to determine whether an individual meets the threshold for statutory social care intervention. The SDS practitioner guidance recognises that 'risk needs to remain central to the process', and emphasises that 'effective risk assessment and management is fundamental to achieving the right balance between protection and empowerment […]. It is the skill and professional judgement of the practitioner that helps people balance risk, protection and freedom of choice' (Scottish Government, 2014a: 29).

Importantly, SDS operates alongside adult protection and child protection legislation. Professionals have a duty to safeguard and protect, whilst simultaneously promoting independence, choice, and control. However, currently there is a knowledge data gap surrounding how these policies and pieces of legislation interact with one another. For example, there is a knowledge gap regarding whether local authorities integrate SDS and Getting It Right for Every Child (GIRFEC) into a single assessment. Although each child will have either a guardian or parent who legally makes welfare decisions on their behalf, little is known on how a child experiences choice, control, co-production, decision-making, and the balance of power in relation to their social care planning. At the time of writing a bill, the Disabled Children and Young People (Transitions to Adulthood) (Scotland) Bill is going through the Scottish Parliamentary processes. If it becomes law, it will require:

- the Scottish Government to present a strategy explaining how they are going to improve opportunities for disabled children and young people;
- a Scottish Government minister to be in charge of improving opportunities for disabled children and young people moving into adulthood; and
- local authorities to have plans in place for each disabled child and young person as they move into adulthood.

Social workers implementing SDS are thus 'in the business of risk work' (Stanley, 2018: 104). Although adult protection and child protection legislation should work together with SDS, they can at times contradict each other, and thus require a careful balancing act (Hunter *et al.*, 2012). Practitioners weigh up a mixture of evidence in order to form a professional judgement and assess the levels of support required in each individual case. Social workers are increasingly held accountable for their decisions, and therefore practitioners consider the potential risk to themselves and the local authority (Webb, 2006). As was highlighted in section 2.3.4, a considerable part of the SDS assessment process revolves around a structured standardised process, procedures, and protocols. As is widely acknowledged, there is growing pressure in our modern-day risk society to reduce professional discretion and instead focus on explicit forensic judgement (Beck, 1992; Helm, 2016; Webb, 2006). As detailed in the SDS practitioner guidance, it is anticipated that an 'assessment through co-production recognises the capacity, capability, strengths and personal assets people possess, which in turn informs risk assessment and, where appropriate, risk enablement' (Scottish Government, 2014a: 30). Nevertheless, the former deficit and risk-averse models of social care assessment which quantify need in terms of hours of support and types of care, rather than the co-production of desired outcomes, have proved hard to shift (Care Inspectorate, 2019). Further research is thus required to understand the complex relationship between risk, co-production, and power during the SDS decision making process.

2.3.9 Austerity

As was previously described, the origins of personalisation are ambiguous, and depend on the commentator's standpoint. SDS has therefore been linked with disability activism as well as the neo-liberal agenda (Ferguson, I., 2012; Morris, 1993; Pearson *et al.*, 2014). Those critical of SDS claim it acts as a mechanism to facilitate budget cuts and austerity, which have restricted the potential to deliver transformational change (Manji, 2018; Pearson & Ridley, 2017). Although SDS holds great potential for progress, it has also been said that it has created a market for care and 'backdoor privatisation' (Pearson, 2004: 10). Pearson *et al.,* (2018) argue that Scotland's social care budget has continuously decreased, impairing the effective implementation of SDS. Thus, 'the language and structures of self-directed support are used, but the underlying spirit is hostile to citizenship and hostile to community' (Duffy, 2014: 178).

Young (2020) discusses how the introduction of SDS took place against the backdrop of a reduction in learning disability services, day centre closures, and austerity measures. Many supported people who had existing care in place and transitioned to SDS reported that they received lower budgets, fewer hours, new charges for non-personal care, and more pressure for their family to provide informal care (Young, 2020). The shift from collective services to individual support has reduced the amount of community safe spaces for individuals (Young, 2020). The lack of transparency surrounding the SDS process, procedures, eligibility criteria and decision-making can lead to frustration, especially when attempting to understand how it works, or challenges when a budget is reduced (Young, 2020). Eccles and Cunningham (2016: 4) captured the views of practitioners, some of whom felt that local authorities and supported people may be pushed to commission the cheapest provider, rather than the most appropriate support. A market therefore supports reduced spending in line with austerity measures but can lead to compromises in the quality of care and services.

The Independent Review of Adult Social Care emphasises reframing social care as an investment rather than a burden, highlighting the importance of centring decisions on the person's needs rather than the market. It also recommends that a National Care Service oversee the commissioning and procurement of social care, rather than the current HSCP. Those critical of the review argue that the proposed changes will perpetuate the current social care system, or worse, result in further centralised control (Kempe, 2021). It has been suggested that the Independent Review of Adult Social Care is another public service improvement agenda, like those which have preceded it, with the aim of attempting to achieve more with less through privatisation. Furthermore, it has been argued that although the report recognises the need to reframe care as an investment rather than a cost, and thus endorses the Fair Work Convention, it fails to propose an increase in wages for workers (Kempe, 2021). Further work is therefore required to explore how these recommendations will realised and achieved. Additionally, a recent critique stated that the cost analysis and claimed expenditure for the proposed changes are not reflective of the true costs, which have been underestimated (Kempe, 2021).

2.3.10 Passing on the cost of support

In connection to austerity measures and budget cuts, the evidence suggests that supported people are expected to contribute towards the cost of their care, a situation which further challenges and contradicts the principles of SDS (Manji, 2018; Young, 2020). When an individual is eligible for a SDS budget, Scotland provides free personal care (which can include support with meals, dressing, washing, and continence management). Nevertheless, each local authority can charge a fee for non-personal care provision (i.e., support with food shopping, cleaning, or socialising) (COSLA, 2020). COSLA's national annual guidance on charging polices stipulates that charges must be 'reasonable' and within the person's ability to meet the cost, although there are no legal obligations for local authorities to charge for services (COSLA, 2020). The MSMC report states that older people 'spoke of their confusion regarding the overlaps between free personal care and SDS, and what was covered within social care support more broadly' (ALLIANCE & SDSS, 2020c: 35). Similarly, Young (2020: 203) found that supported people and their families were 'angry and resentful' regarding how care charges had been introduced. Furthermore, 'participants did not receive sufficient notification of the introduction of the client contribution' (Young, 2020: 203). Linked to this reduction in support, individuals reported that for social activities they had been asked to join their budget with another supported person who they did not know or wish to socialise with, for social activities, reflecting inadequate levels of support (ALLIANCE & SDSS, 2020b). Furthermore, if an individuals are required to merge their budgets to increase the number of hours of support in order to meet their outcomes, then this contradicts the flexible and personalised philosophy underpinning SDS.

More research is required to explore the impact of charges for non-personal care outcomes and whether it influences care planning for the supported person and the practitioner. It is important that

SDS packages are not reduced to personal care and a hierarchy of outcomes created. The Independent Review of Adult Social Care acknowledges the existing issues regarding charges and the varying rates across Scotland’s local authorities. The review recommends an end to all non-residential charges (Feeley, 2021).

2.3.11 Poverty

Families with at least one disabled member and single households with a disabled individual are more likely than non-disabled households to live in relative poverty (Scottish Government, 2019b). Overall, people living with disabilities and their families are at a significantly increased risk of unmanageable debt, food insecurity, and material deprivation (Scottish Government, 2019b). With tightening SDS budgets and high thresholds for gaining support combined with charges for some services, it is important to acknowledge and consider poverty levels when providing SDS. The MSMC research recommends that national and local public bodies ensure that SDS budget cuts do not negatively affect the physical and mental health of people on low incomes (ALLIANCE & SDSS, 2020c: 6). Similarly, the Independent Review of Adult Social Care recommends that people should no longer be charged for non-residential social care, and that ‘charges, if any, should be fairer and the same in different Local Authority areas’ (Feeley, 2021: 15). Further research is required to explore financial assessments and criteria for charging amongst local authorities, whilst also exploring the impact these high thresholds and charges have on supported people.

2.3.12 SDS in residential settings

There is an ongoing debate and considerable uncertainty surrounding the role of SDS for individuals in residential settings (Scottish Care, 2020). During initial SDS policy consultations it was suggested that SDS would not be used within residential or nursing home settings; however, this was successfully challenged on the grounds of equality (Scottish Care, 2020). Currently, the statutory guidance clearly outlines that SDS can be used within these settings, ‘where the supported person is assessed as requiring residential care all of the 2013 Act‘s options, with the exception of Option 1 (direct payment), should be offered to the supported person’ (Scottish Government, 2014b: 94).

In 2015, the Scottish Government established two pilot projects which explored amending SDS legislation to enable those living in residential settings to access Options 1, 2, and 4 (Scottish Care, 2020). Although these pilots finished in 2018, Scottish Care (2020) report that there has since been no conclusion or publication regarding the project. Scottish Care (2020) have been advocating for wider use of SDS within residential settings, and undertook research to determine the extent to which those in residential settings had access to SDS. In total, 70 responses were received from care home services across 23 local authorities, which together support around 4,100 residents (12.5% of the total care home population) (Scottish Care, 2020). Overall, the research highlighted that few individuals were in receipt of SDS services, including access to an SDS outcomes assessment, personal budget allocation, or rights in relation to review and reassessment. A total of 98% of responses reported that no residents received an SDS budget, and that only 1.25% had been given an outcomes assessment. Furthermore, 4 people, or 0.09% of residents, were reported to be in receipt of an SDS budget. This small study reveals limited implementation of SDS within a residential setting, potentially indicating unequal access to SDS combined with inadequate support to exercise the right to social care. Scottish Care (2020) also call for those in residential settings to have access to option 1, and recommend that the Scottish Government publish their findings from the pilot projects.

Given that SDS is often allocated to those at critical and substantial risk, it may be unlikely that those in residential settings would meet these high thresholds. Nevertheless, the Independent Review of Adult Social Care is promoting preventative work and early intervention, which could lead to changes (Feeley, 2021). Further work is required by local authorities to establish suitable processes and procedures to ensure that SDS does not bypass those in residential settings.

2.3.13 Workforce knowledge

Evidence suggests that some professionals have demonstrated limited knowledge, awareness, and understanding of SDS (Care Inspectorate, 2019; Pearson *et al.*, 2018). The thematic review states that **'**significant progress was still required to improve health professionals' knowledge of self-directed support and strengthen the role of frontline health staff in supporting the delivery**'** (Care Inspectorate, 2019: 11). Whilst workforce training has been recognised as essential in ensuring that practitioners have the necessary skills and understanding, little is known regarding the content and quality of training across Scotland within each HSCP (Manthorpe *et al.*, 2015). The MSMC survey asked participants how they first found out about SDS, and the replies indicated that 43% heard from a social work professional or occupational therapist, and 6% heard from NHS health staff, including nurses working in the community (ALLIANCE & SDSS, 2020c). This potentially evidences the lack of awareness amongst other community health social care staff. Similarly, little is known about how SDS is integrated into university curriculums across Scotland and throughout the various health and social care disciplines. Some have claimed that the health and social care integration agenda has diverted attention away from SDS, thus hindering and further delaying SDS implementation and knowledge (Audit Scotland, 2017). The Independent Review of Adult Social Care has suggested that a new national organisation for training and development could support all health and social care staff by providing consistent training across Scotland. Furthermore, the Independent Review of Adult Social Care acknowledges the importance of improving working conditions and implementing the Fair Work Convention alongside the real living wage (Feeley, 2021). Overall, the review prioritises investment within the workforce to improve conditions and knowledge. It also highlights that these steps are essential to improving gender equality, given that the social care workforce is 83% female (Feeley, 2021). It is evident that significant progress is still required to strengthen frontline understanding of SDS.

2.3.14 The rural-urban divide

Resources are often scarce and constrained in rural areas across Scotland, meaning there is a stark rural-urban divide. In rural areas service providers willing to provide a package of care are scarce, combined with poor transportation links for workers and supported people (Care Inspectorate, 2019). Moreover, there are difficulties with the recruitment and retention of staff, and ‘Because of these issues, some staff were reluctant to discuss self-directed support and the four options for fear of building up false expectations’ (Care Inspectorate, 2019: 20). Furthermore, some people in rural areas felt forced to take option 1, whilst others reported that professionals had suggesting moving to a new house to increase access to support (ALLIANCE & SDSS, 2020c). Generally, people faced difficulties in recruiting, retaining, and training personal assistants and support workers so they are suitably skilled to provide care (ALLIANCE & SDSS, 2020c).

2.3.15 Coronavirus and SDS

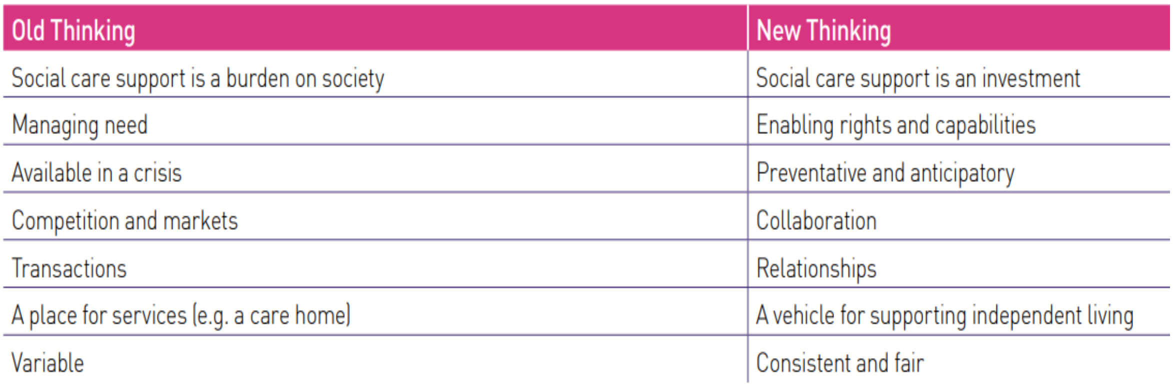
The Scottish Government provided the social care sector with £100 million of additional funding to support delivery during the pandemic (Scottish Government, 2020). The emergency Coronavirus Scotland Act (2020) was introduced which reduced the requirements on local authorities to carry out assessments in order to enable a response to the demands arising as a result of the crisis. Nevertheless, the Scottish Human Rights Commission (SHRC) revealed that there had been significant reductions and changes to care packages which undermined disabled and older people’s human rights (SHRC, 2020). The SHRC called upon local authorities to reinstate care packages, stating that ‘many individuals have had their care and support packages removed suddenly, without dialogue and without the usual assessment processes which would act as procedural safeguards’ (SHRC, 2020: 54). Similarly, the organisation Inclusion Scotland found in a recent survey that 79% of respondents receiving social care support prior to lockdown had lost some or all of their support during the March

2020 lockdown (Wham, 2020). The pandemic is suggested by some to have heightened and intensified many of the existing and underlying issues associated with personalisation policies (Dickinson, Carey & Kavanagh, 2020).

2.3.16 A human rights-based approach

The Independent Review of Adult Social Care calls for a paradigm shift whereby social care support is underpinned by a human rights-based approach (Feeley, 2021). The report advocates for a move away from ‘old thinking’ to ‘new thinking’ through placing human rights at the heart of services, so that supported people and staff feel valued and that their rights are being upheld, thus improving social care support (see Figure 2). Similarly, the SDS Framework of Standards (Social Work Scotland, 2021) and the MSMC survey (ALLIANCE & SDSS, 2020c) also stress the importance of a human rights-based approach when delivering SDS.

Figure 2: Independent Review of Adult Social Care: shifting the paradigm (Feeley, 2021: 4)



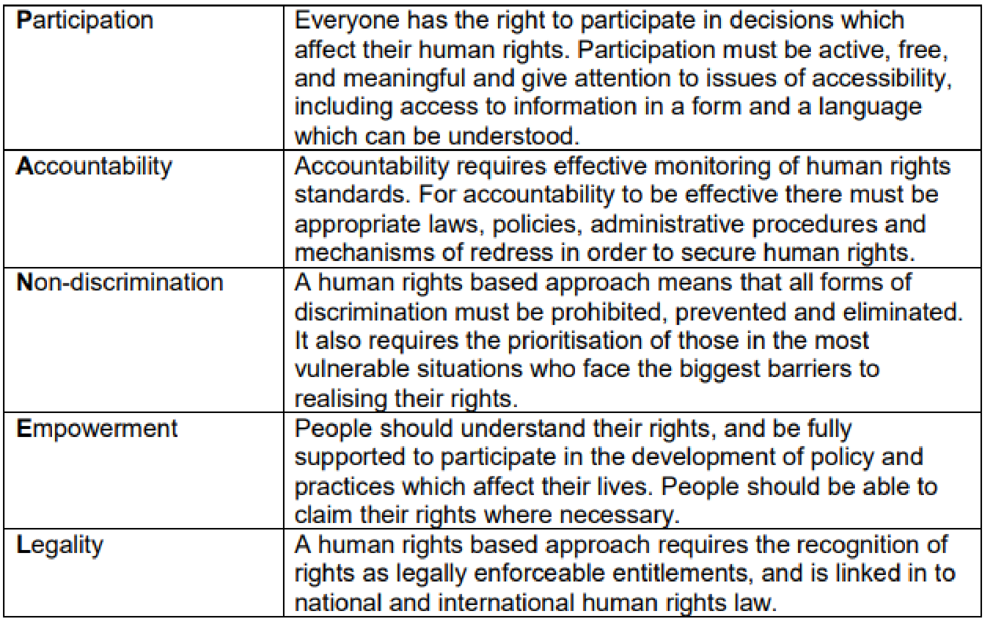
Old Thinking	New Thinking
Social care support is a burden on society	Social care support is an investment
Managing need	Enabling rights and capabilities
Available in a crisis	Preventative and anticipatory
Competition and markets	Collaboration
Transactions	Relationships
A place for services (e.g. a care home)	A vehicle for supporting independent living
Variable	Consistent and fair

In Scotland, human rights are protected by legal requirements outlined in the Human Rights Act 1998 and by the Scotland Act 1998, which stem from the European Convention on Human Rights. When considering the practical application of human rights legislation, it can be useful to consider the non-legalistic PANEL principles: participation; accountability, non-discrimination; empowerment; and legality (Scottish Government, 2014b). Underpinning SDS with a human rights-based approach is not a new way of thinking. The statutory guidance published in 2014 which accompanied the SDS Act advocates for the use of the PANEL principles in order to apply a human rights-based approach (see Figure 3). The SDS Act has therefore been described by Dalrymple, Macaskill, and Simmons (2017: 10) as an Act which places ‘a set of human rights principles at the very heart of a fundamental framework of delivering and accessing social care support’. As was highlighted in the introductory chapter, SDS has also been linked with the independent living movement, which is a practical expression of disabled people’s human and civil rights (Elder-Woodward, James, d'Aboville & Duncan-Glancy, 2015).

Together, these values underpinning SDS also undoubtedly link to the social work values which form the foundations of practice and any intervention (Thompson, 2015).

Importantly, although human rights are enshrined in legislation and included within key guidance documents, the evidence presented within this literature review highlights that the new desired ways of thinking and the human rights-based approach are yet to be achieved and embedded into practice. Understanding the practical application of this approach is crucial, particularly for social workers who are often placed in complex spaces in which they are required to simultaneously empower and protect. Although the human rights-based approach now seems to be taking centre stage, a lack of clarity remains regarding how it translates into practical ways of working for those in health and social care. This approach therefore merits further exploration.

Figure 3: PANEL principles in the SDS statutory guidance (Scottish Government, 2014b: 18)



Participation	Everyone has the right to participate in decisions which affect their human rights. Participation must be active, free, and meaningful and give attention to issues of accessibility, including access to information in a form and a language which can be understood.
Accountability	Accountability requires effective monitoring of human rights standards. For accountability to be effective there must be appropriate laws, policies, administrative procedures and mechanisms of redress in order to secure human rights.
Non-discrimination	A human rights based approach means that all forms of discrimination must be prohibited, prevented and eliminated. It also requires the prioritisation of those in the most vulnerable situations who face the biggest barriers to realising their rights.
Empowerment	People should understand their rights, and be fully supported to participate in the development of policy and practices which affect their lives. People should be able to claim their rights where necessary.
Legality	A human rights based approach requires the recognition of rights as legally enforceable entitlements, and is linked in to national and international human rights law.

2.3.17 SDS progress

This literature review has focussed on areas of concern surrounding the delivery of SDS. Given the lack of robust national-level and local-level data, it is not possible to ascertain the extent and effectiveness of the SDS policy (Care Inspectorate, 2019; ISD Scotland, 2020). Without these statistical insights, accurate, in-depth, and longitudinal scrutiny of accessibility to social care for differing groups will remain limited. Although this review demonstrates that SDS has not yet achieved what it originally set out to do, it is important to acknowledge that SDS policy and legislation has enabled some support to be effectively delivered and achieved in line with the SDS philosophy. The thematic review states that although SDS is still not available to all, 'in situations where self-directed support was effectively implemented, supported people found it transformational and experienced positive personal outcomes' (Care Inspectorate, 2019: 9).

Although they were not the focus of this review, independent organisations are integral in supporting local authorities with effective implementation. The MSMC research found that 71% of research participants strongly agreed or agreed that access to independent information and support make SDS easier to navigate. Often, local authorities value and rely on these organisations to assist supported people with navigating the different SDS options (ALLIANCE & SDSS, 2020c; Audit Scotland, 2019; Critchley & Gillies, 2018). Social Work Scotland commissioned a small-scale learning review which resulted in the development of a national framework of standards for SDS. These standards recognise the crucial role of independent advice, support, and advocacy in supporting choice and control, and exercising human rights (Social Work Scotland, 2021). Furthermore, the Independent Review of Adult Social Care (Feeley, 2021:17) also highlights the potential impact of independent organisations:

> *A network of support and brokerage services is in place in parts of Scotland that can help people prepare for assessment, including identifying what goals or outcomes people want to achieve with support. This has been crucial in highlighting the choices and possibilities people have across the self-directed support options but it is not available to everyone and not everyone who would benefit from this support knows about it.*

The Scottish Government-funded programme *Support in the Right Direction* coordinated by the delivery partner Inspiring Scotland has been supporting local independent organisations with funding since October 2012. This programme aims to support 30 local projects across 31 local authority areas providing independent support for people, families, and carers in accessing and navigating SDS (Inspiring Scotland, 2021). The programme has received £7m in investment from the Scottish Government, and supported 7,653 people and informed 45,067 since it began (Inspiring Scotland, 2021). This programme seems to be a successful example of supporting independent organisations to play a key role in supporting SDS delivery. They are doing essential work in breaking down the barriers to accessing support at a national level. This is an important finding because it illustrates the potential which can be unlocked by successfully implementing SDS.

2.4 Chapter conclusion: what is the relevance of this evidence?

This chapter has woven together many of the common narratives found within the Scottish SDS literature, demonstrating that SDS is yet to be implemented as was originally intended. The review illustrates the tensions and conflicts between the philosophy of SDS and its practical delivery or receipt of support. Upon close examination, SDS in practice is complex and messy, manifesting in multiple ways across Scotland. Thus, there is no single SDS narrative or story to tell, but instead a fraught terrain for both supported people and social work practitioners to navigate. Although SDS is an ambiguous phenomenon, through examining the literature some common points of agreement can be identified. It is apparent that the level of agency of the supported person has been called into question, with reports of constrained levels of choice, control, flexibility, and co-production. Additionally, practitioners are challenged with high levels of bureaucracy and complex local authority processes which hinder their ability to practice in line with SDS legislation. Local authority resource allocations systems and eligibility criteria mechanisms appear to create a practice focussed on budgets, systems, and risk-aversion rather than the rights of the supported person. Evidence suggests that staff are pulled in different, conflicting directions in adopting either an empowering outcome-focussed language or a deficit language depending on the task. The ongoing COVID-19 pandemic continues to place strain on the fragile health and social care sector, which was already in crisis and underfunded due to years of austerity measures. This review has therefore revealed a vast gap between policy rhetoric and practice delivery. Despite the issues that the review has observed in relation to SDS delivery, the Independent Review of Adult Social Care's support for SDS suggests that it is likely to remain the dominant form of social care delivery in Scotland.

Taken together these themes shed light on policy implementation, and specifically emphasise the key role of social workers in SDS translation and implementation. Social workers are tasked with implementing an empowering, person-centred, human rights-based policy, but must battle with issues related to the distribution of power, eligibility criteria, resource allocation systems, and bureaucracy. There is a clear need to understand the daily work of practitioners when implementing SDS in practice. This chapter has focussed on the many problems and issues surrounding SDS implementation, but has said relatively little about the daily work and activities of frontline social workers in translating and implementing the policy and legislation - because relatively little is revealed in the literature regarding what frontline workers *actually do* when translating SDS. Current accounts of practitioners capture workers reflecting back on SDS experiences, events, and interactions which have already occurred, rather than observing SDS practice inaction (Audit Scotland, 2017; Care Inspectorate, 2019). Thus, much of a social worker's day-to-day SDS *work* is rendered invisible within the literature. The daily mundane encounters, interactions, meetings, dialogue, and actions remain unaccounted for in the literature, yet are fundamental in understanding the fruition of SDS. Thus, only half the story of practice implementation is being told, and what social workers *actually do* and *what SDS practice is* during the behind-the-scenes interactions in a social work office remain unknown.

The idea that the daily actions of social work practitioners are hidden is not a new notion, as it was described as 'an inherently invisible trade' in Pithouse's seminal work first published in 1987 (Pithouse, 1998). This ground-breaking study suggested that practice is often unobserved and remains ambiguous to the public due to the confidential nature of social work. Pithouse advanced understanding of the invisible practice through capturing what it felt like to do social work and be a social worker amongst bureaucratic systems. The present thesis is therefore interested in making invisible everyday SDS work more visible in order to enhance understanding of the policy manifestation. In the following chapter, the research focus is further developed through exploring the ideas from interpretative policy studies which guided the conceptualisation of policy translation within this study (Chapter 3).

Chapter 3: Theoretical Frame

3.1 Chapter introduction

The previous literature review chapter revealed the complex and contested nature of SDS whilst also acknowledging the crucial role practitioners play in negotiating and translating SDS into practice. Despite the central role of social workers, gaps in knowledge and understanding still exist regarding daily SDS practice and work. This chapter explores concepts and ideas from interpretative policy studies which guided the theorisation of policy as a process within this study. This body of literature emphasises the central role of practitioners' knowledge during everyday work within the policy-making process, thus specifically framing *policy* as *practice* (Colebatch, 2005; Colebatch, 2006; Freeman, 2009; Freeman, Griggs & Boaz, 2011; Freeman & Sturdy, 2014; Kingfisher, 2013; Schon, 1984; Schorr, 1985; Wagenaar, 2004; Wagenaar, 2011; Yanow, 1996). Concepts and ideas from this field were fundamental in influencing and guiding the research focus towards the everyday situated activities of frontline workers who are understood to be translating and assembling SDS policy in their daily activities. Adopting this lens requires exploring:

1. what practitioners actually do; what encounters occur;
2. what knowledge people have;
3. how knowledge is enacted as individuals and as a group; and
4. how an institution impacts the wider context (Freeman & Sturdy, 2014).

Thus, framing policy as practice involves examining the local, everyday discourses, activities, and seemingly routine tasks surrounding SDS.

This chapter illustrates the evolving thinking and understanding of policy as practice through describing the influential narratives from the interpretative policy literature. Further, it argues that Freeman and Sturdy's embodied-inscribed-enacted theoretical framework offers a useful means by which to inquire into and understand social workers' diverse forms of SDS policy knowledge and policy work (Freeman & Sturdy, 2014). This framework supports a focussed theorisation of the policy practice experiences grounded in everyday work and experiences as a basis for explaining the evolving policy of SDS. Finally, throughout this chapter implicit and explicit connections to ethnography are apparent. These ideas are developed further in Chapter 4, which outlines the ethnographic method of study.

3.2 From policy transfer to policy translation

To begin with, it is important to set the scene by explaining the dominant positivist strand of policy theorisation, which is called policy transfer. The process of policy transfer is often described as a top-down linear narrative, which starts with the policy evolving from experts and ends with its direct transfer into practice by frontline workers (Clarke, Bainton, Lendvai & Stubbs, 2015). For example, this linear process is described in Clay and Schaffer's policy cycle model (Clay and Schaffer, 1984, as cited in Shore & Wright, 2011: 5), where firstly, the policy begins with a problem recognised by policy makers. Secondly, the policy makers identify an alternative response, which is ultimately implemented by practitioners and evaluated by policy makers. Then, the cycle begins again with the identification of a new problem. This neatly ordered sequence of events assumes that policy knowledge and policy making originates outside of practice and implementation. It renders policy as a complete and finished object or product, often in the form of a written document developed prior to practice, which is then directly transferred and adopted by practitioners (Clarke *et al.*, 2015). Policy is therefore described in a restrictive and constrained manner as a generalised programme, plan, or blueprint, which includes guidelines and intentions to be put in place. Within the policy transfer literature, linked concepts exist; for example, the lesson drawing approach (Rose, 1991; Rose, 2004), policy diffusion (Walker, 1969), and policy convergence (Bennett, 1991), all of which are founded on the assumption of importing a finished policy which will be transferred into practice by homogeneous rational agents. Critics of policy transfer approaches instead advocate for an interpretivist, non-linear definition of policy which emphasises that implementation is not the problem, but rather that policy is practice, and thus is a continuous, unfinished process to be understood (Clarke *et al.*, 2015).

The perceived shortfalls of the concepts surrounding policy transfer have been used to evidence the need for the emergent interpretative practice-based inquiry, which focuses on practice as a place of policy-making, and therefore calls for a bottom-up approach to policy analysis (Colebatch, 2005; Colebatch, 2006; Freeman, 2009; Freeman *et al.*, 2011; Freeman & Sturdy, 2014; Kingfisher, 2013; Schon, 1984; Schorr, 1985; Wagenaar, 2004; Wagenaar, 2011; Yanow, 1996). As Freeman (2002: 3) states, 'policy does not exist somewhere else in finished form, ready to be transferred', but rather meaning emerges during practice, where 'policy is the output of a series of communications, not its input. The issue is one of germination, not dissemination'. It is argued that it is not possible to distinguish between policy and implementation. Similarly, Hajer and Wagenaar (2003: 19) suggest moving away from a focussed inquiry of predefined problems, so that instead, 'a reformulated, deliberative policy science takes practices as its unit of analysis'. This field of practice-oriented inquiry of frontline daily work has been described as 'a practice turn', which means:

> *[…]no longer treating practice as the object of policy, something to which it is addressed and on which it works, but as its subject: that is, by interrogating more closely the practices of policy making themselves, to think about and ask after what it is that policy makers do when they go to work (Freeman, 2012: 19).*

The interpretative policy field rejects the idea of policy transfer with its linear concepts, and instead utilises the term policy *translation* (Freeman, 2009). A policy is often presented in a document; however, its contents need to be interpreted and converted into practice by different actors and within various spaces. In doing so, the policy is reconciled differently, and continuously changing and mutating. If understood in this way, policy is 'a selective and active process in which meanings are interpreted and reinterpreted to make them fit in their new context' (Lendvai & Stubbs, 2007: 35). A translation perspective provides a tool for exploring the 'messiness and complexity of policy processes' (Shore *&* Wright, 2011: 8). As the policy is assembled and reassembled by various actors as it moves through various spaces, 'some things are made visible while others are hidden or erased, and a critical policy research agenda must seek to trace these process' (Clarke *et al.*, 2015: 48). A policy translation position acknowledges that the meaning of policy is not formed prior to implementation and simply transferred, but is constructed and reconstructed during practice interactions. Policy implementation is therefore framed as a complex and uncertain process which is continuously evolving (Freeman, 2009).

3.3 Policy as meaning-making and moving

Yanow (1996) deliberately asks the provocative question: *'How does policy mean?',* and responds by arguing that policies have multiple interpretations and multiple meanings which occur through the language and practices of those who act upon them. This position situates practice as the central space for the multiple translations and meanings of evolving policy. Through framing policy as an interpretative process of translation, meaning is not a predefined notion but, rather, emerges during practice whilst in translation. Policy is consequently described as a 'meaning-making' and 'claims-making' process which expresses 'values, feelings, and […] beliefs' (Yanow, 1996: 6). It is continuously constructed, assembled, and reassembled with 'layered implicit meanings' (Innes, 2020). Freeman highlights that although translation is where meaning is made, it can also be where meaning is lost, contested, or misunderstood:

> *The relationship between a sign and what it signifies is neither determined nor mechanical. What things mean is a matter of convention (a social construct) and*

> *it is invariably inexact. Meaning may be shared, but it is not identical. This fundamental epistemological uncertainty, this requirement that every utterance be accompanied by some hermeneutic move on the part of the reader of listener, is a source of innovation and creativity as well as error and failure. Translation - the processing of what you say into terms that I understand - is ubiquitous and imperfect (Freeman, 2002: 6).*

Thus, the meaning of a policy is altered every time it is translated, and may take on a different or new significance as parts are lost or invented. It is therefore a continuous, uncertain, evolving meaning-making process which is never complete.

Studying these translations and assemblages of SDS offers a window into how the production and reproduction of knowledge and meaning enables certain agendas to emerge while others are actively silenced (Clarke *et al.*, 2015). Policy making and remaking is not objective or neutral as the linear policy transfer models suggest (Shore & Wright, 1997b: 8), but instead, 'meanings are inextricably linked with forms and relations of power and authority' (Clarke *et al.*, 2015: 20), and policy is thus a 'particular setting in which meanings are made, installed, naturalised, normalised and of course, contested' (Clarke *et al.*, 2015: 20).

The policy transfer literature implies that policy is imported in a singular motion from a finished object into practice. In contrast to this, the process of policy translation is not a singular one-way process, but is multiple and continuous. It is argued that multiple translations occur in multiple places and spaces, and thus policy moves: 'When policy moves, it is always translated: that is, it is made to mean something in its new context. Policy is never a singular entity: it is put together – or assembled – from a variety of elements that are always in process of being reassembled in new, often surprising ways' (Clarke *et al.*, 2015: 9). SDS is therefore conceptualised as alive, fluid, and moving, and as entangled with different actors, objects, spaces, and contexts.

3.4 Policy is practice work, but what is *practice work*?

As was noted in the previous chapter, social work practice has been described as 'an inherently invisible trade' because daily work is often unobserved and ambiguous (Pithouse, 1998). Furthermore, the current SDS literature perpetuates this idea and continues to render a practitioner's day-to-day work invisible and unknown. Consequently, in an attempt to bridge this gap, this thesis has placed emphasis on what practitioners *actually do* and how their SDS knowledge is enacted through their everyday activities. This focus on practice can be interpreted as an effort to theorise 'what is actually done in the doing of work and how those doing it make sense of their practice' (Orr, 1998, in Nicolini, 2009: 1321). The *work* of practitioners has become the unit of analysis or the central focus of this thesis. It is therefore important to define what is meant when referring to the concept of work. The daily work of a practitioner is much more than the visible, obvious, and quantifiable tasks of, for example, making a phone call, completing an assessment, conducting a home visit, or attending a meeting. Whilst these overt activities do form part of work, the backstage daily doings are much more complex. This research therefore draws upon Wagenaar's (2004: 643) broad definition that work is formed of:

> *[…]the hundreds of practical judgements, the everyday, taken-for-granted routines and practices, the explicit and tacit knowledge that is brought to bear on concrete situations, the moving about in the legal-moral environment of large bureaucracies, the mastering of difficult human-emotional situations, the negotiating of discretionary space, and the interactive give and take with colleagues.*

This broad definition resonated with me because it captures the complexity and unpredictable nature of work. Given this broad definition, SDS operates in an unstable, messy world, where neat policy transfer from a government policy document into practice is an illusion. Instead, SDS work is nuanced depending on the practitioner and the context in question (Care Inspectorate, 2019). Social workers are not implementing a finalised version of policy, but their daily *work* is where the policy is produced (Shore & Wright, 2011).

3.5 Knowledge: explicit and tacit

Practice has been conceptualised as a continuous process of policy-making whereby SDS policy knowledge is formed and comes together through multiple ways of knowing. The challenge is how to reconcile SDS knowledge in these spaces. Given the previously defined broad concept of work, this thesis is particularly concerned with the role of tacit experiential knowledge within frontline practice. The embodied-enacted-inscribed framework presents a useful way of conceptualising SDS policy knowledge during the active process of policy translation (Freeman & Sturdy, 2014). Before proceeding with an outline of Freeman and Sturdy's framework, it is important to define how this thesis characterises policy to support in understanding ways of knowing within frontline social work practice.

Knowledge has frequently been understood as either explicit or tacit (Collins, H., 1993; Collins, H., 2010; Lam, 1998; Lam, 2000; Nonaka, 1994). Explicit knowledge can be codified; for example, it can be expressed through the written or spoken form and therefore easily transferred, aggregated, and stored (Lam, 1998). However, as Polanyi's (1966: 4) seminal work on tacit knowledge states, 'we know more than we can tell', and therefore the explicit knowledge expressed through the verbal and written methods is only part of the phenomenon. In contrast to explicit ways of knowing, tacit knowledge is more difficult to capture, and refers to subconscious knowledge which individuals are often unable to articulate. Tacit knowledge denotes intuitive, embedded, embodied, or embrained thinking, which is difficult and at times impossible to codify; therefore, it is often gained through experience (Lam, 1998). By definition, tacit knowledge is more difficult to express and capture than explicit knowledge.

A similar distinction is echoed within the work of Ryle (1949), who conceptualises knowledge through the terminology *know-that* and *know-how*. The notion of know-that refers to facts, expert information, theory, and encoded material which has clear similarities to the definition of explicit knowledge. Likewise, the concept of know-how refers to skills, practical capabilities, and experiential and situated thinking which have evident parallels to tacit knowledge. An example of explicit knowledge is the written Scottish Social Services Council Codes of Practice for social workers (Scottish Social Services Council, 2016), whilst in contrast, assessing levels of risk to an individual and whether thresholds have been met during a home visit not only involves explicit knowledge, but tacit, intuitive and embodied ways of knowing as a worker makes sense of a situation. To further clarify tacit knowledge, other examples outside social work include riding a bike, learning a language, climbing sports, or playing a musical instrument. Given this definition of knowledge, if SDS policy-making through social work practice is to be thoroughly examined in depth, attention must be given not only to the more obvious explicit forms of knowing, but to the more abstract intuitive and tacit ways in which practitioners know. With this in mind, this chapter will now move to discuss Freeman and Sturdy's embodied-inscribed-enacted theoretical framework, which is argued to offer a way to inquire into and locate social workers' diverse forms of SDS policy knowledge (Freeman & Sturdy, 2014).

3.6 Theoretical frame: embodied-enacted-inscribed

Freeman and Sturdy (2014) developed a conceptual knowledge schema which draws upon the analogy of matter: solid, liquid, and gas. It is argued that knowledge also exists in three phases: embodied (liquid), enacted (gas), and inscribed (solid). Similarly, as matter moves and transforms from one type to another, so too does knowledge. This schema is not based on 'who knows what, how or why, but on the forms that knowledge may take' (Freeman & Sturdy, 2014: 1). It therefore acts as a powerful tool to identify where to look in order to identify knowledge as it moves through these various phases in practice, enabling consideration surrounding the role of knowledge in SDS policy. Each of these phases will now be described in turn in the sub-sections below.

3.6.1 Embodied knowledge

Embodied knowledge is held within the human body itself, and has been described as 'practical and gestural knowledge, deeply embedded in bodily experience' whereby the body knows how to act (Freeman & Sturdy, 2014: 9). The notion of embodied knowledge has been expressed by the French philosopher, Maurice Merleau-Ponty (1962, in Tanaka, 2011: 149) in the following way:

> *[…]to know how to touch type is not, then, to know the place of each letter among the keys, nor even to have acquired a conditioned reflex for each one, which is set in motion by the letter as it comes before our eye. … It is knowledge in the hands, which is forthcoming only when bodily effort is made, and cannot be formulated in detachment from that effort.*

The above is commonly considered to represent tacit ways of knowing; however, Freeman and Sturdy assert that embodied knowledge also comprises explicit forms of knowledge, particularly embrained knowledge. Embrained knowledge is 'dependent on conceptual skills and cognitive abilities' and thus is fact-based or know-that explicit ways of knowing (Blackler, 1995: 1023). Embrained knowledge is information that is present in the mind and which can then be expressed. The justification for including both tacit and explicit knowledge within this embodied definition is 'that it is impossible to draw any hard-and-fast distinction between "know-how" and "know-that" […] embrained knowledge is also always embodied' (Freeman & Sturdy, 2014: 9). The body is therefore a site of inquiry, where the individual, material, and social structures come together forming the lived experience. A practitioner thus experiences and senses practice and SDS policy through their body, which is the location of their feelings, values, and thoughts. This is not a fixed permanent state, but an evolving and continuously modified one, reinforced through daily experiences, encounters, and interactions.

Tied into ideas of embodied knowledge are concepts of mobility and distribution. When knowledge is held within an individual it is only as portable as the body itself, which constrains and limits the extent to which this knowledge can travel and to whom it can reach (Freeman & Sturdy, 2014). It is also 'liable to decay and degeneration, through forgetting, mis-remembering and ultimately death' (Freeman & Sturdy, 2014: 10). Nevertheless, embodied knowledge can be quickly updated, altered, and modified by exposure to new experiences. It therefore shares 'the frailty and the fallibility of the human body itself, but also in the adaptability' (Freeman & Sturdy, 2014: 10).

Embodied knowledge corresponds to the concept of sense-making which has gained growing recognition within the social work literature. A limited but increasing number of papers have specifically focussed on understanding sense-making to reveal how social workers in children's services draw upon their intuition, experiences, and tacit knowledge to form their professional judgements of cases (Avby, 2015; Cook, 2017; Cook & Gregory, 2020; Helm, 2016; 2017; Thompson, 2013). Cook (2017: 440) describes how a worker's 'immediate emotional responses, or "gut feelings" during the visit drew their attention to potentially salient information before it was rationally accessible'. Sense-making thus acknowledges that much of a practitioner's knowledge is not explicitly stated but is often tacit, consisting of embodied habitual activities which are practiced rather than explicitly accounted for. Social work practitioners often work with incomplete information, whilst navigating uncertainty and risk (Helm, 2016; Helm, 2017). Prior to forming a judgement, a mixture of evidence is considered by the social worker which can include, for example, verbal reports, written documents, or social encounters with professionals, families, or support people. A practitioner draws upon both explicit and tacit knowledge by gathering, selecting or omitting, and interpreting a range of information by attributing meaning to generate professional insights (Helm, 2016; Helm, 2017). This process of weighing up information prior to taking a decision is called sense-making (Weick, Sutcliffe & Obstfeld, 2005). Importantly, professional insights and the subsequent decisions made can have long-term impacts on the lives of individuals and their families. Sense-making has been explored within other disciplines, most notably organisational studies (Weick *et al.*, 2005); however, the phenomenon has gained momentum within the social work literature. Often, sense-making research and studies which aim to capture this local situated knowledge within mundane everyday encounters and tasks explore it through ethnographic methods (Cook, 2017; Helm, 2016). Capturing embodied knowledge is therefore present, relevant, and an area of existing interest within the wider social work literature.

3.6.2 Inscribed knowledge

Knowledge is understood to move and be translated, and therefore embodied and enacted knowledge may be inscribed or codified within tangible artefacts (Freeman & Sturdy, 2014). Inscribed knowledge may, for example, be written within a document, a case note, an email, a newspaper article, or represented in a graph, diagram, or picture (Freeman & Sturdy, 2014). The SDS strategy document and practitioner guidelines are relevant examples of inscribed forms of knowledge which represent a description of the policy combined with instructions or a blueprint for implementation. Likewise, a social work assessment is a form of inscribed knowledge which mediates and informs actions and interactions, often with the aim of standardising and measuring particular cases. The process of inscription therefore enables ‘everyday knowledge to become visible/audible to the state’ (Clarke, 2010: 664). Inscribing is thus a process of translation, and by transforming experiences and generating a document there is ‘an active process of the production of meaning’ (Freeman, 2012: 17).

Freeman and Sturdy (2014: 10) define inscribed knowledge as ‘remarkably stable’ and ‘easily reproduced and highly mobile’. Unlike embodied knowledge, which is fragile and personal, inscribed knowledge can overcome the limitations of a human body and be disseminated to high numbers of individuals in multiple spaces, enduring long periods of time unchanged. Artefacts aid in forming shared knowledge and understanding across a group of individuals or a community. Inscribed artefacts outline ‘particular ways of seeing, thinking and knowing’ (Freeman & Sturdy, 2014: 11), and therefore daily work and actions are textually-mediated through the ruling relations found within institutional documents (Smith, 2005). Importantly, artefacts can therefore ‘serve to constrain and discipline our interactions with the world and with one another’ (Freeman & Sturdy, 2014: 11).

As was outlined in the literature review chapter, the SDS policy reform in Scotland signalled an ideological shift towards co-produced and outcome-focussed social care (Audit Scotland, 2019). There is a clear emphasis on the importance of co-producing a number of key documents in collaboration with the supported person, including a person-centred assessment and an outcomes-focussed care plan (Scottish Government, 2014b). Consideration and attention to the ways in which both embodied and enacted knowledge are inscribed or not within these key artefacts could offer unique insights into SDS policy translation. Policy delivery may be understood in greater depth through ‘observing just what knowledge finds its way into inscriptions for policy purposes, and by attending to and following the movement of those inscriptions through the policy world’ (Freeman & Sturdy, 2014: 15). Lam (1998: 8) states that ‘codification inevitably involves a data sacrifice; some part of the knowledge will always stay behind in the knowing subject’. Consequently, when tacit knowledge moves from embodied or enacted forms and is translated into an explicit written document, some information remains unseen or lost. Thus, for example, when a social worker is making sense of a case and completing a case note, certain knowledge is selected, omitted, and interpreted (Helm, 2016). It is not simply what is written in an artefact which is of interest, but what is *not* written, along with how a document was produced and crafted; who takes responsibility for creating the content; and who is reading the document (Freeman & Maybin, 2011): ‘Like writing, then, reading is a function of power relations. Just as it matters who writes what, so it matters who reads’ (Freeman & Maybin, 2011: 164).

This framework acknowledges the importance of understanding how actors inscribe, use, and read artefacts, just as much as what they say and do. SDS policy is thus intensely bound up with material written documents. Consequently, exploring SDS policy manifestation will therefore involve the examination of inscribed documents within daily work.

The connected concept of ‘boundary objects’ offers a theoretical perspective explaining the role of artefacts, such as documents, which complements Freeman and Sturdy’s framework. Star and Griesemer (1989: 393) coined the term ‘boundary object’ to describe ‘objects which are both plastic enough to adapt to local needs and the constraints of the several parties employing them, yet robust enough to maintain a common identity across sites’. This highlights how some objects, for example the policy strategy document or an assessment form, facilitate communication across the boundaries between different social worlds. A boundary object connects actors from different social worlds through using similar language to facilitating learning, communication, and negotiation, however understanding and interpretation amongst these actors may not be same. The object will therefore appear different in every world it inhabits. Carlile (2004) acknowledges the following three roles of a boundary object: (1) to share and express knowledge and concerns between social worlds; (2) to gain a deeper understanding of, and learn about, the specialist knowledge from the other social group; and (3) to create a space of knowledge transformation to overcome problems at the intersection of the social worlds.

Social work, and SDS work, has been noted to involve highly bureaucratic and time-consuming processes, and numerous documents (Audit Scotland, 2017; Care Inspectorate, 2019). Artefacts circulate and are exchanged between actors, therefore practice is in part concerned with using documents and making documents. Inscribed artefacts can be endowed with significance depending on who crafted it, for whom, and under what circumstances (Freeman & Maybin, 2011; Freeman & Sturdy, 2014). These objects can actively shape the performance of daily practice, interactions, and encounters. It is therefore crucial to consider the network of inscribed objects which surround SDS in order to gain a full understanding of the phenomenon.

3.6.3 Enacted knowledge

Enacted knowledge refers to what we do with either embodied or inscribed knowledge, and is also defined as ‘knowledge-in-action’ which ‘represents the transformation of embodied and inscribed knowledge into a new, active form’ (Marais, Petersen & Quayle, 2021). Without enactment, knowledge remains ‘latent’, ‘unspoken’, ‘unexercised’, and ‘unused’, and therefore it is only through action informed by embodied and inscribed knowledge that knowledge develops meaning and significance (Freeman & Sturdy, 2014: 12). Enactment is not simply a transfer or reproduction of the existing knowledge which preceded it, but a space where new knowledge can be crafted and produced through the process of translation. An enactment is often an individual's interpretation of inscribed or embodied forms of knowing, and thus provides a space in which they may deviate or stray from the official line, or perhaps a space for creativity. Given the nature of enacted knowledge, it is 'transient' in that it only survives for the duration of the enactment itself (Freeman & Sturdy, 2014: 12). It is therefore 'fleeting, highly variable from one instance to the next and often unpredictable in form and expression' (Freeman & Sturdy, 2014: 12). Importantly, enactments can result in the production of new embodied or inscribed knowledge which endures longer than the enactment itself.

Freeman and Sturdy (2014) discuss the process of a meeting to highlight these points and the cycle of knowledge as it moves through the various phases. Prior to a meeting, individuals hold embodied knowledge combined with inscribed meeting minutes, agendas, and other documents. During the meeting discussions and enactments occur, generating new understandings, ideas, and knowledge which result in new embodied and inscribed ways of knowing. This example of a meeting highlights that the enactment of knowledge is often a collective activity between actors. Within the social work literature, Helm (2016; 2017) identifies that practitioners engage in a dialogic sense-making process with colleagues and supervisors to explore the meaning of a case. Sense-making can therefore be a group, collaborative, or collective enactment process, as well as an individual activity. As was previously noted, boundary objects connect different social worlds and are present in a variety of forms, which could include documents and pictures, but also intangible stories and narratives (Kalid, 2012; Mullan, 1999). The boundary object of storytelling therefore acts as a mechanism for transporting tacit knowledge (Kalid, 2012; Mullan, 1999).

Enacted knowledge corresponds to the work of sociologist Erving Goffman, who also offers a theorisation of social enactments and encounters which provides significant insights linked to the analysis of the enactments. Goffman's (1971) work employs a dramaturgical approach which views interaction as a theatrical performance, and it provides a useful distinction between backstage work and frontstage work (Goffman, 1978). The frontstage work typically features the 'bright-eyed, bushy-tailed performances' (Law, 1994: 176) resulting from an awareness that others are watching, thus behaviour is often intentional or purposeful. In contrast, the backstage work throws into the relief 'all the effort that goes into mounting those performances' (Law, 1994: 176). When considering SDS encounters, the backstage work within the social work office is where uncertainties and questions are discussed, and where understandings and judgements are forming, rather than the more polished frontstage narratives or performances. The backstage enactments could therefore provide a fleeting glance into the black box of social work practice, or what has been described as the 'the invisible trade'.

Goffman also proposes that when one actor comes into contact with another, each actor performs, wearing a mask to construct behaviour and identity, therefore engaging in impression management (Goffman, 1955; Goffman, 1970; Treviño, 2003). Spaces in society are not homogenous, and actors alter their mask, face, or performance in different settings (Goffman, 1971). If SDS enactments are understood in this way, then practitioners adjust their ways of being in frontstage and backstage enactments to preserve certain impressions in different spaces.

Goffman also asserts the existence of an interactional order whereby actors obey social conventions, rituals, and shared understandings (Goffman, 1970). These are not exclusively spoken conventions, but unspoken rituals which form part of the encounter itself, for example nodding, shaking hands, and wearing formal or informal clothing (Goffman, 1970; Treviño, 2003). Interactions therefore follow a pattern grounded in socially shared conventions, thus certain things can be said or done, whilst other things remain withheld and are unsayable. Goffman recognised that not all interactions are transparent, because actors often have to strategically manage what information is revealed to others, combined with managing their identity (Goffman, 1971). Furthermore, collective activities between actors are 'constantly monitored and regulated through the mutual surveillance and sanctioning of those involved at any given moment' (Freeman & Sturdy, 2014: 14). Strong sanctions may be exercised against an individual who is considered to have broken the rules on what is regarded to be normal or appropriate action.

Although on the surface Goffman's work may appear to be about the micro-level interaction between individuals, it is actually about the encounter or situation, and understanding how enactments are put together, which raises implications for our understanding of the social world (Atkinson, 2015). In exploring enacted knowledge, attention must be paid to the complex situation dynamics and the careful management and disclosure of knowledge and information. This may seem like an obvious statement, but it is important not to restrict the enacted knowledge to spoken interactions, and to be careful also to pay attention to the performance in its entirety.

This theoretical framework characterises knowledge as embodied, inscribed, and enacted, offering an insightful way of understanding where knowledge may be found, combined with its potential to transform into a new form. Viewing SDS through this particular lens offers a distinct way with which to capture the policy, which may shed light onto new or unseen manifestations of the phenomenon.

3.7 How to capture work and practice

This chapter provides a deeper understanding of where and what it means to focus on practice, although exactly *how* to capture policy as practice requires a comprehensive consideration of methods, which the following chapter provides. However, it is generally agreed that practice-based research of frontline workers utilises qualitative methods and interpretative methodologies (Colebatch, Hoppe & Noordegraaf, 2010; Nicolini, 2012; Yanow, 1996). As has been observed, 'It is simply not possible to interpret practical knowledge, discourse, emotions, artefacts, sociality, bodily dispositions and normativity without making use of ethnographic methods, in-depth case studies, and linguistic analysis' (Bartels, 2018: 81). As was evidenced in the literature review in Chapter 2, although the self-generated accounts of practice gathered during interviews provide valuable insights, they fail to reveal the taken-for-granted daily work. Instead, to capture policy as practice, work needs to be observed unfolding in action enabling the researcher to stay close to practice. Central to the 'study of work practice is that it must be done in the situation in which it normally occurs, that is, work must be seen as situated practice, in which the context is part of the activity' (Orr, 2016: 10). The following methods chapter claims that ethnography offers an effective tool for capturing workers in action, translating SDS in multiple spaces.

Whilst examining the fine detail of practice is essential to understanding SDS, Nicolini (2009) acknowledges the need to switch lenses, by not only 'zooming in' on practice work, but also 'zooming out'. Zooming in provides the micro picture of daily practices, whilst zooming out focusses on macro wider contextual issues, thus allowing consideration of how those individual practices fit together. Consequently, zooming in and out links these worlds together. In other words, by failing to zoom in, the research will remain abstract and suppress the complex ambiguity of daily work, therefore losing touch with the reality of SDS implementation. Furthermore, without zooming out the bigger picture is lost, and therefore the wider contextual significance of the findings is not considered. Both lenses have their positives and negatives: 'zoom in, and get a close look at select details - perhaps too close to make sense of them. Zoom out, and see the big picture - but perhaps miss some subtleties and nuances' (Moss Kanter, 2011: 112). Nicolini (2009) advocates a continuous shifting or constant back and forth between these two lenses, so that certain aspects are foregrounded whilst others are bracketed in an attempt to gain a balance. Practices and daily doings are not isolated individual performances; they are actions conducted within a specific context. This study therefore followed this motion of zooming in and zooming out to contextualise practice.

3.8 Research philosophy

Schwartz-Shea and Yanow (2012) encourage the researcher to consider where research questions, theoretical frames, methods, and ideas originate from, and assert that they stem from the researcher's embedded standpoint. Having described the guiding theoretical framework which focuses on knowledge and practice reality, this is an appropriate point at which to state the ontological and epistemological research philosophy underpinning this study. Put simply, epistemology is about 'how we know what we know' (Crotty, 1998: 8), and ontology is 'the nature of reality' (Lincoln and Guba, 1985: 37). My ontological position is indicated by the description of policy as an individual meaning-making process. It has been suggested that there is no single SDS reality, but multiple realities, each of which are constructed worlds, as 'Social reality is an interpreted world, not a literal world, always under symbolic construction' (Altheide and Johnson, 1994: 489). I therefore hold a constructionist ontology which entails an interpretivist epistemology, which is 'the firm belief that there is in practice neither objective reality nor objective truth. On the contrary, reality is constructed' (Sarantakos, 2013: 37).

Of particular significance are the application and implications of this philosophical stance to the phenomenon of SDS and this study. Given that numerous SDS realities and truths are continuously being constructed by social actors, my theoretical frame, research questions, method, and analysis operate from the premise that knowledge is situated and contextual. The aim of this study is to ensure that relevant and multiple realities are brought into focus, so that newly situated knowledge and understandings can occur. Importantly, the present research cannot reproduce realities, but can aim to capture perceived viewpoints.

3.9 Chapter conclusion

Overall, this chapter has explored the key concepts from interpretative policy studies which emphasise that policymaking occurs during the everyday work of practitioners, and thus that policy is practice. In applying a broad definition of work, it is evident that policymaking occurs via multiple actors in numerous spaces, highlighting the messy nature of the policy making process. SDS is thus understood as a complex, fluid, multiple, and continuously evolving process which is never complete. It is argued that through tracing and observing daily work and encounters, the often invisible translation will be rendered visible.

Freeman and Sturdy's embodied-inscribed-enacted theoretical framework offers a means with which to inquire and understand social workers' diverse forms of SDS policy knowledge and policy work. This conceptualisation of policy highlights that SDS is an ongoing, multiple, collective creation. Consequently, if we are to understand SDS policy, then we must pay attention to, and thoroughly examine, SDS practice work. The focus must not only explore the more obvious explicit forms of knowing, but look to understand the more abstract intuitive and tacit ways in which practitioners come to know. Freeman and Sturdy's characterisation of knowledge as embodied-inscribed-enacted serves to inform the researcher as to where to look. Practitioners embody SDS knowledge through their emotions, feelings, and embrained information. They inscribe SDS knowledge as they construct the policy reality, and enact it as they create and recreate a collective SDS world. Nevertheless, this framework is not an explanation of how SDS works, but a tool for seeing SDS's manifestation. The embodied-inscribed-enacted lens does not evaluate practice in itself, but has the potential to capture rich data revealing SDS translation. As such, adopting this lens will frame SDS from a previously unseen angle, offering a unique contribution to the knowledge in the field.

In following chapter, ethnographic methods are introduced and explored as an effective tool for capturing daily policy making work. It is argued that ethnography provides a tool through which the researcher can become immersed within the SDS phenomenon, capturing both frontstage and backstage activities, practices, narratives, and routines in an inductive manner. A detailed discussion of the ethnographic research process and the associated methodological considerations are provided, evidencing the thorough and robust research design which underpins this study.

Chapter 4: Methods

4.1 Chapter introduction

This chapter draws upon Silverman's (2017: 476) 'natural history' approach to document the evolving nature of this study's research methods. Adopting a natural history narrative means exploring the path taken towards the final research design, weaving together the continuous development of ideas, concepts, and influences. This approach 'argues for openness and clarity about what actually happened during your research', and therefore moves away from a 'bland account in the passive voice' (Silverman, 2017: 472). Consequently, this narrative illustrates how experiences during the research journey resulted in new insights and unexpected meanders which subsequently altered the evolving study design. Similarly, Figure 4 below presents Sarantakos's (2013: 128) flexible model for developing qualitative methods which emphasises the fluidity of research design and highlights the unlimited free movement between all stages. This chapter communicates the practical behind-the-scenes realisations of moving back and forth between these differing stages through Silvermans's natural history approach, rather than a sanitised description which deprives the reader of the messy but informative reality of research (Oakley, 2018). This approach has been successfully adopted within other ethnographic social work-focussed theses in order to provide methodological accounts of the decision-making processes as well as illustrating the evolving nature of the research project (Critchley, 2018; Morriss, 2014; Whitaker, 2014).

This chapter begins by describing the origins of this research through identifying the fateful moments which fuelled my curiosity and passion for the subject of SDS, thus planting the seed for this thesis. I then define the method of ethnography, situating it within the wider context of ethnographic social work literature. This is followed by justifying the specific multi-method combination of observations, interviews, and document examination, together with a description of the process of recording fieldnotes and a reflective log. Next, the step-by-step process of gradually negotiating access and ethical approval to gather data at the local authority site will be outlined. In response to the global COVID-19 pandemic which began during data collection, this chapter will also explain the reasoning for the unforeseen modifications to the study design to include auto-ethnographic data. A reflexive examination of my positionality is then presented, demonstrating that consideration has been given to the influence of the researcher's presence on the generation of data and knowledge. Finally, the iterative data analysis process of thematic coding to reach my research findings is presented, prior to concluding the chapter.

Figure 4 Flexible qualitative research model (Sarantakos, 2013: 128)

Steps of flexible research design

Topic and methodology	Selection of the research topic Selection of the research methodology
⇩ ⇩ ⇩	
Methodological construction of the topic	Framing of research questions; literature review; conceptualization; strategy and rationale
⇩ ⇩ ⇩ ⇧ ⇧ ⇧	
Sampling procedures	Choice of setting, key informants, study groups, events, methods of data collection, & of assistants
⇩ ⇩ ⇩ ⇧ ⇧ ⇧	
Data collection	Entering field; collecting data; re-defining, aligning methods/sampling; checking for soundness of data
⇩ ⇩ ⇩ ⇧ ⇧ ⇧	
Data analysis and interpretation	Analysing data, formulating/testing of hypotheses, aligning research process
⇩ ⇩ ⇩	
Reporting	Preparing a report for discussion, submission and publication

4.2 The emergence of the research topic

As I highlighted in the introductory chapter in section 1.1, my specific interest in SDS emerged from the tension and disjuncture I personally experienced whilst attempting to make sense of SDS in a practice setting. On reflection, I now recognise these pivotal experiences as what Giddens describes as 'fateful moments', which he defines as 'times when events come together in such a way that an individual stands at a crossroads in their existence or where a person learns of information with fateful consequences' (Giddens, 1991: 113). These formative experiences consequently ignited my enthusiasm for community social care.

I gained a specific interest in SDS whilst completing my master's degree in social work at Glasgow Caledonian University. I completed two different placements in statutory social work teams where I conducted a number of SDS assessments for supported people, and was able to shadow other social workers delivering SDS. At the same time, during my master's in social work I read, studied, and wrote about SDS legislation and the philosophy which underpins the policy, and developed an insight into the theoretical ideologies surrounding SDS as I did so. As time progressed in my placement, I felt a disconnect between the practice and the philosophy underpinning the legislation. During my placement, social workers would often say, 'SDS is great in *theory*, but it doesn't *actually* work like that'. Furthermore, as a master's class we would often reflect together on our experiences of disjuncture in relation to SDS within different local authorities and third sector placements across

Scotland. The reoccurring SDS discussions surrounding the disconnect between theory and practice across the country troubled me both intellectually and ethically.

As I gained practice experience in SDS implementation, I began to no longer make sense of SDS as I once had in university. Nevertheless, I became more knowledgeable about navigating the system, processes, and resource allocation meetings, and could therefore get SDS done in practice. This was concerning because the more I practiced SDS the more I could do the work, yet somehow the less I could make sense of it as I once did. The theory or SDS seemed at odds with the practice of SDS. On reflection I now recognise that whilst we were practising, I and a number of my fellow students experienced what Fenton has described as 'ethical stress', which is a form of stress experienced when practitioners cannot base their practice upon their values (Fenton, 2012; 2014; 2020).

I began to read more on SDS policy and legislation, combined with speaking to practitioners, students, and supported people. However, this resulted in more questions than answers, and highlighted to me how little research existed on the issue at that time. These conversations with my peers provided a fleeting glance into the black box of backstage social work practice, or what has been described as the 'the invisible trade' (Pithouse, 1998). It was at this point that I began to consider what happened in the space between the paper policy document and the receiving of services. This tension between policy theory and practice reality, with the social worker occupying the complex in-between space, contributed to the establishment of my research focus and problem, as addressed in this thesis.

4.3 Research focus and questions

The literature review presented in Chapter 2 demonstrated that SDS is an under-researched policy area, and specifically highlighted the knowledge gaps around *what social workers actually do* and *what daily micro SDS practices are*. My identified research problem, or area of concern, is the absence of understanding of the day-to-day SDS work of frontline social workers, including how they make sense of and translate the policy. Mason (2018) describes research questions as 'intellectual puzzles' that vary in form depending on the ontological, epistemological, and theoretical position of the researcher. These complex philosophical ideas are woven together with the broad topic area to form the bespoke intellectual puzzle which leads the researcher closer to a specific set of research questions and a study design. Chapter 3 outlined my theoretical framework and linked constructionist ontology and interpretivist epistemology which guided this study, and therefore my question formation. Mason (2018) emphasises that by knowing where one stands within this intellectual puzzle, the researcher is empowered to establish a rigorous and coherent set of research questions and study design.

When formulating my research questions, I began with an open exploratory question drawn from the ethnographic literature: 'What is it that's going on here?'. This is borrowed from Goffman (1974: 8), who states that:

> *When individuals attend to any current situation, they face a question: 'What is it that's going on here?' Whether asked explicitly, as in times of confusion and doubt, or tacitly, during occasions of usual certitude, the question is put and the answer to it is presumed by the way the individuals then proceed to get on with the affairs at hand.*

To further develop and deepen this question I drew upon the work of Becker (1998: 58), who recommends that research requires a central broad question beginning with 'how?' which is linked to the literature review findings. This broad question will explore what is occurring, and aims to understand the character of the phenomenon. Similarly, Creswell and Creswell (2018) recommend that it should be followed by a series of more specific subsidiary questions which unravel the ways in which the phenomenon manifests (Creswell & Creswell, 2018). Using this structure, the following questions have been identified to guide this thesis:

The central research question at the heart of this thesis is:

- *How* do practitioners translate SDS?

The subsidiary research questions are:

- What are the daily micro SDS interactions and encounters in practice, and therefore what forms does SDS work take?
- What people, objects, and spaces are involved in SDS translation work?
- How do practitioners make sense of SDS? Thus, how is SDS embodied, inscribed, and enacted?
- When SDS moves, what parts are successfully reassembled and translated, and what parts are invisible and missing?
- Finally, how does this understanding of SDS influence future practice and implementation?

These questions aim to draw out a rich description of the phenomenon and 'how' common activities sustain themselves, rather than explicitly focusing on the question of 'why' (Becker, 1998: 58). Overall, this study has been guided by the open 'how?' question, which kept me situated within the dynamics of practice, the details of interactions, and the negotiation of meanings (Becker, 1998). The 'how?' question requires a method or form of inquiry which enables the researcher to see the inner workings or ecology of practice and experiences. This brings us to the rationale for doing ethnography, which supports the researcher to observe, encounter, and interact with the phenomenon in various forms and spaces with differing people (Delamont, 2004).

4.4 Ethnography

4.4.1 Defining ethnography

Qualitative research enables the researcher to 'approach the world "out there" and to understand, describe and sometimes explain social phenomena "from the inside"' (Flick, 2007: viii). Social researchers taking an interpretivist approach give attention to, and examine, the underlying social and cultural meanings as people co-construct their reality. As Atkinson and Hammersley (2019: 8) state:

> *The social world cannot be understood in terms of simple causal relationships or by the subsumption of social events under universal laws. This is because human actions display agency, rather than being completely determined by prior factors, and are based upon, or infused by, social or cultural meaning generated in particular situations: that is, by intentions, motives, beliefs, rules, discourses, and values.*

As illustrated by the research questions, this thesis is concerned with capturing the social and cultural meanings surrounding how practitioners construct and make sense of their SDS work through their everyday activities. Additionally within the realm of qualitative research, ethnography is viewed as being best-suited to research projects which aim to capture in-depth insights and complex descriptions of the daily lives of others (Hammersley & Atkinson, 2019) because as Geertz (1973: 10) explains, the ethnographer is faced with:

> *[…]a multiplicity of complex conceptual structures, many of them superimposed upon or knotted into one another, which are at once strange, irregular, and in explicit, and which he must contrive somehow first to grasp and then to render.*

This method enables the analysis of multiple layers of SDS, and therefore seeks to capture what Geertz (1973: 10) famously describes as a 'thick description' of social worlds. This consequently provides a means for the researcher to immerse herself within the SDS phenomenon and capture both frontstage and backstage activities, practices, narratives, and routines in an inductive manner (Murchison, 2010; Prus, 2005). When considering prior work on the method of ethnography in more detail, it is apparent no singular definition of the approach, or exact description of what ethnographers do, have been provided. However, rather than undermining its value as a method, this highlights the diversity and fluid nature of ethnographic inquiry, which mutates and responds to the subject matter, drawing upon a range of data collection techniques. Although multiple descriptions exist, Hammersley and Atkinson (2019: 3) articulate exactly how I feel about ethnography inquiry, so it is worth quoting them at length:

> *[Ethnography] involves the ethnographer participating, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, and/or asking questions through informal or formal interviews, collecting documents and artifacts- in fact, gathering whatever data are available to throw light on the issues that are the emerging focus of the inquiry. […] ethnographers draw on a range of sources of data, though they may sometimes rely primarily on one – very often participant observation.*

Although observation is thus central to the role of an ethnographer, Hammersley and Atkinson (2019: 87) outline that there are different forms of covert and overt observation, including: (1) complete-participant; (2) participant-as-observer; (3) observer-as-participant; and (4) complete-observer. Thus, depending on the type of observation, this will alter how the researcher interacts with the phenomenon and what data is generated. Whilst observation is the primary tool, the ethnographer typically captures the phenomenon through informal and formal interviews, and analyses of objects, which are recorded in fieldnotes, audio files, and transcripts (Emerson, Fretz & Shaw, 2001). The data collection is organic and spontaneous in responding to the field. This approach therefore provides the potential for the ethnographer to move through different frontstage and backstage spaces, capturing the multiple ways of knowing, whether it is inscribed into documents, enacted in conversations, or embodied in intuition: 'It is of the very essence of ethnographic fieldwork that we need to be faithful - as far as possible - to the complexity of everyday life' (Atkinson, 2015: 38). Hence, this medley of methods provides an effective toolkit with which to holistically capture a phenomenon in its varying forms in depth. The intention is to consider the actions of individuals within their everyday situated context in a small-scale but detailed manner, so as to develop a thick description.

Qualitative approaches such as interviews (Hayes & Spratt, 2009; Spratt, 2000) and case vignettes (Forrester, McCambridge, Waissbein & Rollnick, 2008) have been utilised to capture practitioners' views on social work interventions, scenarios, decision making and general practice. Nevertheless, these approaches capture workers' reflections back on practice, with time to consider their responses. Importantly, how a social worker responds in actual practice time may differ from a description in an interview of how a practitioner thinks or would like to react. Furthermore, a researcher will not have participated in the events discussed within the interview; thus, it is impossible to know what information has been excluded or included, and how it has been constructed. The method of ethnography, however, provides the opportunity for the researcher to observe interactions, thus capturing encounters differently, and offering alternative frames and insights.

Given that practitioner sense-making is subsumed throughout this thesis, I decided that ethnography would be advantageous in providing me with the opportunity to physically share spaces with social workers to observe this naturalistic process. Through this method, I would gain the opportunity to observe off-the-cuff exchanges, interactions, and daily activities which would allow me to pursue and probe further in an organic manner, truly unpicking the translation and sense-making of SDS. As the literature review evidenced, there have been no prior observations of social work practice revealing *what social workers actually do* during implementation; therefore, this research argues that ethnography captures the SDS phenomenon in a different and previously unexplored form.

4.4.2 Ethnography within social work research

Within the social work literature there is a history of researchers successfully utilising ethnography in order to get close to practice. Pithouse's seminal work, first published in 1987, adopted an ethnographic approach to explore the statutory world of childcare practice and revealed the inherently invisible trade of social work (Pithouse, 1998). This ground-breaking study captured what it felt like to do social work and be a social worker amongst bureaucratic systems. Ethnography (or forms of ethnomethodology) continue to advance our understanding surrounding frontline practice realities; for example, the method has been used to explore social work practice within child welfare (Critchley, 2018; De Montigny, 1995; Ferguson, H., 2016; Leigh *et al.*, 2020; Scourfield, 2003), practice in children's residential care (Smith, 2014), social work practice in hospitals (Burrows, 2018), the experiences of asylum seekers when seeking support from social workers (Farmer, 2018), mental health care implementation (Jobling, 2014; Morriss, 2014), and substance abuse treatment (Carr, 2010). Some ethnographies focus on office dialogue, practitioner talk, and bureaucracy (Pithouse, 1998; Scourfield, 2003; Whitaker, 2014), whilst others reveal the sense-making, decision-making, and risk management processes (Broadhurst *et al.*, 2010; Helm, 2016; 2017), and another subset of ethnographic research shines a spotlight on what happens during home visits and face-to-face interactions with supported people (Ferguson, H., 2016; 2017). Whitaker's (2014) doctoral ethnographic research merits specific mention because it examines a social work team's understanding of personalisation for children in the English system. Although that research focuses on personalisation delivery for children within a separate jurisdiction, it is of relevance here because it demonstrates that ethnography is congruent with understanding the day-to-day doing of personalisation. The bulk of this ethnographic research explores child welfare rather than adult social work, highlighting one of the potentially unique contributions to the knowledge of this thesis. Overall, these wide-ranging ethnographic studies adopt numerous data collection techniques including observations, interviews, focus groups, and document analysis captured with audio recording, fieldnotes, and interview transcriptions. This demonstrates the fluid, flexible nature of ethnographic inquiry which can be adjusted to suit the subject matter.

This thesis argues that ethnographic research facilitates the exploration of particular gaps in knowledge by enabling the researcher to gain a distinct closeness to practice in a unique way which is not feasible with other qualitative methods. As the literature review revealed, surprisingly little is known about how social workers discuss SDS with others, or how practitioners make sense of and translate SDS policy. As far as can be ascertained, ethnography has not yet been utilised to explore SDS, or the wider area of adult social work in Scotland. This thesis therefore makes a unique contribution to knowledge through examining SDS and adult social work through the currently under-utilised and unseen lens of ethnography, consequently attaining a distinct intimacy to SDS practice and enhancing understanding of how workers translate the policy.

4.4.3 Doing ethnography

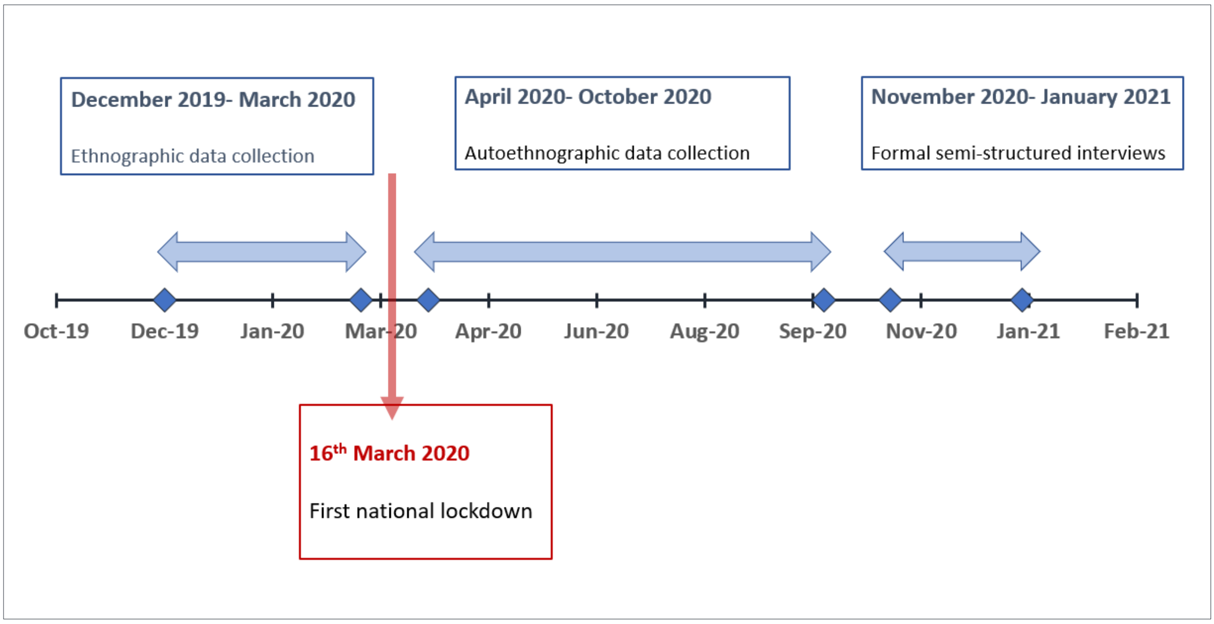
4.4.3.1 The research site

This ethnography was conducted in a large Scottish local authority adult team with an average of 24 social workers (18 female and 6 male), 5 team leaders (4 female and 1 male), and a service manager (female). However, it should be noted that staffing numbers fluctuated during the research period due to sickness and poor retention, and furthermore, a number of staff also held part-time positions. There were three main criteria for selecting this local authority, which is based on the outskirts of a large urban city in Scotland. Firstly, I was seeking a site which provided a sample of both urban and rural SDS implementation. The second criteria centred around ensuring that the local authority was invested in the research idea of advancing understanding of SDS, and thus was keen to work collaboratively, facilitating access. Finally, I had to consider the feasibility of my daily commute to the local authority offices.

The steps involved in gaining access combined with the linked ethical approval application are discussed later within this chapter, in section 4.5. For the purposes of the study the local authority became a microcosm of SDS translation and implementation; however, it is important to acknowledge that the site is not being presented in the study as the main national translation of the policy, but as one of many locations where SDS is generated, implemented and translated in a distinct manner. This research therefore explores one of many possible sites, yet this does not undermine the significance or power of the findings, as ethnographies 'select small sites that open windows onto larger processes of political transformation' (Shore & Wright, 2011: 12).

The ethnographic data was collected between December 2019 and January 2021 (see Figure 5). In the initial three months from late December 2019 to March 2020 I attended the office four days a week from 9:30am to 3:30pm to capture desk work, meetings, and informal interactions, and accompany workers on visits where they conducted informal interviews. Over this period of time I spent an estimated 280 hours observing the team, and captured detailed descriptions of events through keeping daily fieldnotes. All face-to-face research was suspended due to COVID-19 in March 2020, however as this chapter will later explore, I was able to maintain access and continue to gather data through formally gaining a full-time 6-month contract practising as a social worker within the same team. My positionality therefore changed from a *participant observer* to a *complete participant*, and 6-months of auto-ethnographic data was captured through a reflective log (Hammersley & Atkinson, 2019). Finally, from November 2020 to January 2021 I conducted ten semi-structured interviews with the team remotely online. Hence, my research design encompassed a multi-method approach, or as Nicolini (2009: 1403) describes, a 'toolkit logic'. My ethnographic toolkit comprised observation, formal and informal interviewing, and document analysis captured within my reflective log and fieldnotes. I will now explain each of these in detail to explain my evolving research design and fieldwork.

Figure 5: Timeline of data collection



4.4.3.2 Observation

Participant observation was a central tool within my research design which involved shadowing social workers as they completed their everyday SDS activities. Goffman (1989: 126) describes participant observation in the following way:

> *[…]subjecting yourself, your own body, your own personality, and your own social situation, to the set of contingencies that play upon a set of individuals, so that you can physically and ecologically penetrate their circle of response to their social situation, or their work situation […] you are in a position to note their gestural, visual, bodily response to what's going on around them and you're empathetic enough – because you've been taking the same crap they've been taking – to sense what it is they're responding to. To me, that's the core of observation.*

Although I initially entered the field with an observational focus on the practitioner, I was eager to capture what Geertz (1973: 10) describes as 'thick description'. To begin with everything I was observing was interesting, and I struggled to avoid the false idea and impossible task of a 'total ethnography', which is the pipedream of 'an in-the-round full ethnography of the whole social universe that you studied in' (Cerwonka & Malkki, 2007: 29). This process of paying attention to everything made it hard to fully make sense of anything, pushing me to reflect on my study's focus. I returned to Goffman's broad question 'What is it that's going on here?'. As I reflected on my research questions, sense-making and SDS policy translation were reconfirmed as the focus. My observational attention thus became centred, and I felt the ethnography had gained a clearer direction, rather than being overwhelmed by the entirety of the SDS phenomenon. I saw my task as exploring 'the largely tacit, mutual knowledge, the symbolic meanings, intentions and rituals, which provide orientations for their actions' (Blaikie, 2007: 90). Whilst in the field, although I was led by a combination of my research questions, my general curiosity, and responding to the evolving phenomenon, my observations were also guided by Spradley's observational framework. Spradley (1980) outlines the following nine focus areas to observations, including:

1. Space - what was the physical setting like?
2. Actors - who was present or absent?
3. Activities - what were the various activities completed?
4. Objects - what artefacts or objects were present?
5. Acts - what actions occurred?
6. Events - what occasion was this?
7. Time - what were the sequence of events?
8. Goals - what was the aim of this interaction or event?
9. Feelings - what emotions were present?

This framework provided me with a starting point for my observations, which would stimulate thoughts, reflections, and ideas, and lead to the development of ideas rather than a restrictive tool.

As I previously mentioned, from December 2019 to March 2020 I attended the office in person four days a week from 9:30am to 3:30pm, capturing an estimated total of 288 hours of practice. I sat with the social workers in an open plan hot-desk style office where I had the opportunity to regularly change seats to surround myself with different workers. I ate lunch with staff, we collected sandwiches from the shop for one another, we made each other cups of tea, and I sometimes caught the train with various workers. I therefore became enmeshed and entangled within the experiences of the field, gaining an understanding of 'how things hang together in a web of mutual influence or support or interdependence' (Becker, 1996: 56). My observational fieldnotes capture the mundane everyday activities, invisible work and tasks, and daily talk; for example, discussing a SDS case in the kitchen whilst making tea, or walking to a car park, or standing at the printer. It is difficult to quantify these rich but informal interactions which were captured within the fieldnotes. Nevertheless, other observational events and interactions are more measurable. During these three months I observed 52 resource allocation meetings, shadowed 20 visits to different supported people outside of the office, and sat individually with four different social workers as they wrote SDS assessment forms and care plans for a total of 15 supported people. I attempted to follow certain cases as they moved through the SDS journey of processes and procedures, but due to the unplanned, reactive nature of the work and the high staff turnover this was not possible. I therefore did not restrict myself to observing a selected number of cases, but dipped into a broad range of cases across the team which were at varying stages of the SDS journey.

I adopted the model of a ‘multi-sited ethnography’ whereby following the actor as they move through differing spaces generates rich data (Campbell, M. & Gregor, 2002; Marcus, 2012). This acknowledges that observations are rarely a single event in one place, but often ‘entail multiple observational areas within their geographic, organizational, or political settings; multiple interviews and chats; multiple events observed’ (Yanow, 2009: 294). This enabled me to capture how SDS manifests within the different spaces, for example a person’s living room, the open plan office, a manager’s office, a meeting, or during a drive with a social worker. Following the actors, or social workers, revealed different spaces as well as differing artefacts, systems, processes, procedures, conflicts, tensions, and talk.

4.4.3.3 Informal and formal interviews

Given the multi-sited nature of this ethnography, I had opportunities to informally inquire and question during daily activities in a range of locations, including the office, meetings, semi-public areas over lunch or on a train, or in the worker’s car whilst travelling to or from a visit. Consequently, my informal interviews varied greatly in style, length, location, and content. Importantly, the line of questioning coincided with an observation of practice, and therefore the interview felt more like conversational dialogue between myself and the practitioner. During these often fast-paced conversations it was not always possible to make notes or write down verbatim quotes, but these moments were captured in the day’s fieldnotes. My fieldnotes therefore include a web of observations and conversations from practice. Appendix 11 includes a typed extract from my fieldnotes and Appendix 12 includes a coded extract from my fieldnotes.

Although my experiences as captured in my written notes remained the core data, formal interviews complemented them by enabling me to specifically inquire about central ideas, explore meanings in more depth, and to seek clarification on certain matters (Miller & Glassner, 2016; Wagenaar, 2011). An interview also provides a space for a worker to state and share their view or understanding of experiences (Spradley, 1979). Following three months of ethnography and six months of auto-ethnography, I conducted ten formal semi-structured interviews remotely online with the team over the period of November 2020 to January 2021. I interviewed the service manager, two team leaders, six social workers and one community occupational therapist who co-worked on SDS cases with social workers. Appendix 8 includes the interview guide utilised for the interviews, Appendix 9 is an extract from a semi structured interview, and Appendix 10 is a coded extract from an interview. I organised interviews with practitioners whom I had directly observed, with the aim of enriching the data captured within the fieldnotes (Miller & Glassner, 2016). Nevertheless, I was systematic in ensuring that I captured the voice of frontline practitioners at the three different hierarchical levels within the area team structure. Although I designed an interview question guide (see Appendix 8), I did not feel the need to adhere strictly to this, instead allowing a more natural flow and exploration of topics. I was guided by the overarching open 'how?' question, which kept me situated with the dynamics of practice. Additionally, this question prompted the exploration of experience which supported me in answering the research questions. Interviews lasted between 60-90 minutes and were recorded and transcribed verbatim. The transcriptions captured the pauses, laughter, and repetitions, enabling the tone and context to be considered during analysis.

These online interviews took place once my fieldwork was completed, hence I had a strong rapport with the team. It was therefore easy to set up the interviews with workers who seemed keen to support my work. Given that I had co-worked cases with a number of these workers, they also had some insight into my views and opinions on SDS. This led to candid responses, but also a space for us to think together about SDS and our experiences. Heyl (2001: 396) suggests that conducting interviews at the end of the fieldwork elicits an open two-way conversation between the researcher and the interviewee, also described as a 'genuine exchange of views'. Hence, the positionality section later in this chapter acknowledges and explores my impact in co-constructing the data.

4.4.3.4 Objects, artefacts, and documents

The previous sections discussed ethnographic observations and interviews which emphasise the value of what social workers do and say. Nevertheless, the significance of the material world which exists alongside oral accounts and performances should not be overlooked. As Goffman's (1955; 1971) dramaturgical analysis indicates, actors utilise, value, distribute, make, and accumulate props or material objects within the performances which form part of the social phenomenon. Consequently, 'ethnographies need to *include* the analysis of materials and things, and to analyse how they are implicated in the production of orderly social conduct, social realities, and social identities' (Hammersley & Atkinson, 2019: 138). Including objects is not about negating the spoken word, but instead gaining a thick description of everything in combination. A clear connection can be made between objects and what Freeman and Sturdy's (2014) theoretical framework describe as inscribed knowledge. Assessment forms, care plans, policy documents, and meeting minutes are all examples of objects which contain inscribed knowledge, but are also examples of the material within the SDS social world.

My ethnographic research subsequently considered how objects shape and are woven through everyday SDS interactions, events, conversations, and doings. Acknowledging objects and the connections workers have with things within the field provides a thicker description of the SDS phenomenon. The central objects within this ethnography were documents, including assessment forms and care plans. I read a total of 60 assessments and the linked care plans from ten different social workers. Furthermore, during my six months of auto-ethnography I myself completed 18 assessments and care plans. On the one hand, the inscribed contents are of interest because they can reveal how a social worker has shaped, interpreted, constructed, and recorded information. On the other hand, Atkinson (2017) acknowledges that the technique involved when crafting an artefact draws upon an embodied and sensual way of knowing. Thus, it is important to pay attention to the assemblages of material objects, and ultimately to how social workers create documents. Often, the conversations surrounding the production of documents reveals how workers make sense of the forms, and also what information is included and left out of them. As Atkinson (2017) acknowledges, the crafting of objects such as documents can be guided and shaped by organisational culture and conventions, thus aiding understanding of the phenomenon (Atkinson, 2017).

4.4.3.5 Fieldnotes and reflective log

The main sources of data within this ethnography have been identified as observations, oral accounts from interviews, and objects. This section explains how these were captured and recorded via the long-established ethnographic method of keeping fieldnotes. There is an abundance of literature outlining guidance for ethnographers on crafting fieldnotes (Emerson *et al.*, 2001; Emerson, Fretz & Shaw, 2011; Hammersley & Atkinson, 2019; Murchison, 2010; Van Maanen, 2011). Crucially, the central focus of fieldnotes is capturing the detail, or what Atkinson (2017: 11) describes as 'the granular analysis' in order to reveal the complex layers of social order. As I previously noted, my focus was guided by my evolving research questions and Spradley's (1980) observational framework, which outlines the nine focus areas of space, actors, activities, objects, acts, events, time, goals, and feelings. Furthermore, woven through my research questions is Freeman and Sturdy's (2014) embodied-inscribed-enacted theoretical framework, which also guided my inquiry. This combination of tools steered me to consider and record aspects such as who was speaking and when; whether the language changed in different spaces; which routines, habits, and non-verbal communication occurred; or if anything different or unusual was happening (Emerson *et al.*, 2001; Emerson *et al.*, 2011; Hammersley & Atkinson, 2019; Murchison, 2010; Van Maanen, 2011).

My fieldnotes consist mainly of descriptions of events, with verbatim quotes when possible. Appendix 11 provides an extract from my fieldnotes and Appendix 12 a coded extract. Whilst in the field I made jotted notes during the day, and then each evening I typed up my fieldnotes at home in more depth and detail (Sanjek, 2019). Although fieldnotes should ideally be written during the observation, this was not always possible (Hammersley & Atkinson, 2019). For example, if I was observing a social worker discussing a case in the manager's office, followed by moving across the office to discuss the same case with another worker, it was not always practical or possible to spend time writing. I therefore recorded a rough description after the event, then captured further details when I got home. Although I tried to write and constantly record, at times I deliberately chose not to write in an attempt to draw less attention to my note-taking, so workers felt less watched and self-conscious of their actions. There were, however, some occasions when detailed fieldnotes were possible; for example, during a resource allocation meeting I wrote:

> *I feel like I can have a pen and paper in my hand and write when the social worker is also writing. They don't ask what I am writing about, not like in the office when I'm the only one taking notes whilst we chat.*

Fieldnotes are constructed by the researcher through a selective process which often depends on the evolving research questions, and how observational events potentially link to the predefined topic (Flora & Andersen, 2019). Given that fieldnotes are therefore a highly selective process, I had to think carefully about what I was recording, and I why paid attention to or omitted particular data. The interpretative nature of ethnography is addressed through reflexivity, involving a multi-layered self-awareness which considers the use of self within the research process (Madison, 2011). This involves being intentionally thoughtful regarding my own thoughts, understandings, values, preconceptions, and conclusions. The positionality section within this chapter aims to illustrate and evidence the continuous reflexive approach I adopted during this ethnography.

My construction of fieldnotes and what I identified as important evolved throughout the process, especially as issues emerged. This approach is echoed by Hammersley and Atkinson (2019), who describe the researcher's focus as continuously developing throughout data collection as a gradual understanding of what is or is not relevant forms. This extract from my fieldnotes marks a pivotal movement when a key theme begins to emerge, and thus my focus advances:

> *Amanda was talking me through an assessment form she was writing up at her desk. She had talked me through a couple of her forms before. Previously the conversation had centred around: the story of the service user, what the service user had requested, Amanda's views on the case, what information she was putting in each section, her views on co-production, and the next steps in the process. But this observation was different. I observed something that I hadn't noticed before, a disconnect between how Amanda spoke about the case to me, and then how she inscribed the case on the form. They were completely different. Although I am hearing and observing the same things, they sound and look so different today.*

This extract illustrates that once I had gained an initial understanding of how things functioned, I was able to move beyond a detailed description of processes to see things in a different light. Hence, new ideas surfaced and the research spotlight shifted.

My fieldnotes not only captured my observations of events, but also included my thoughts and analyses of objects. As previously noted, I read 60 assessments and care plans, and wrote 18 myself whilst employed as a social worker. Despite gaining consent to view these documents, due to the confidential nature of the content I was unable to take copies or remove documents from the building. I therefore recorded my observations about the material objects within my fieldnotes.

Throughout my three months of ethnographic research I recorded detailed fieldnotes; however, once I transitioned to auto-ethnography my fieldnotes stopped and I began a reflective log which resembles what Punch (2012) describes a field diary. This centred around my own experiences as a practitioner, capturing my thoughts, feelings, challenges, views, and relationships. My personal experience therefore became the data. Appendix 13 includes an extract from my reflective log and Appendix 14 includes a coded extract. The active process of engaging with reflexivity remained vital whilst exploring and documenting my own lived reality through auto-ethnography (Madison, 2011). Overall, my data was therefore captured in my fieldnotes, reflective log, and interview transcripts. It is important to note that all data used pseudonyms to maintain privacy and confidentiality, so no individuals or the local authority could be identifiable. Furthermore, I followed general data protection regulations and ensured that all data was stored appropriately on password-encrypted devices or in a locked cabinet.

4.5 Negotiating access and ethical approval

Once I had designed an outline of my ethnographic study, I applied for ethical approval from Glasgow Caledonian University's Ethics Committee. This proved unproblematic and my application was successfully accepted. Appendix 2 includes my ethics approval letter from the university. After gaining this approval, I began the process of identifying and gaining access to a potential research site through a mix of formal and informal channels. Initially, I approached Social Work Scotland and attended a meeting comprising the 32 SDS lead workers from each of the local authorities across Scotland. I pitched my research project and attempted to generate interest and recruit a local authority for the project. Although there was a supportive and encouraging response at the meeting, ultimately it produced minimal interest. I therefore had to take a different approach, so I considered the existing links between the university department and local authorities who provide placements for its social work programmes. Furthermore, various lecturers within the social work department at the university have historically worked within local authorities across Scotland and were able to recommend people for me to contact. Exploring these existing relationships proved advantageous (Hammersley & Atkinson, 2019) and led to a successful meeting with the Head of Health and Social Care within the local authority which later became my research site. After gaining informal approval from the Head of Health and Social Care, I then attended two separate meetings with the Locality Manager and Service Manager to gain their support. Next, I successfully completed the local authority's own ethical approval process. Appendix 3 includes my ethics approval letter from the local authority research site. A specific area team was chosen to provide a sample of both urban and rural SDS implementation. Furthermore, the local authority responded positively to the research idea and ethos, expressing an interest in participating and collaborating in order to advance understanding of SDS delivery.

Atkinson (2015) acknowledges that access is more than simply official and physical access to the research site, as 'It means that social actors grant the researcher access to their everyday lives: they grant licence to witness, participate in and converse about issues that might otherwise reach more restricted social circle' (Atkinson, 2015: 176). Although ethical approval and official access had been gained from both the university and local authority, I still had to gain the consent and trust of the team leaders, social workers, and supported people who would be involved in my research. I therefore held a meeting with the team leaders to discuss the research, and was able to answer questions and begin to build trust. Later, I met with the social workers to introduce the project and recruit participants; however, it is important to acknowledge that access to their daily practice was continuously negotiated throughout the ethnography. In order to access daily work I engaged in regular dialogue with the workers at the start of the week regarding their work plans, in order to explore any opportunities and tasks I could observe. Gradually, as I built up rapport with the workers I was invited to different events and encounters. Overall, my identity as a professional social worker supported me in steadily building rapport and access, as will be discussed further in sections 4.6 and 4.7.

Social workers and supported people were required to consent to participate in the study, which meant that access involved a number of ethical considerations. Although there is no universal set of ethical rules or procedures within ethnography, Hammersley and Atkinson (2019: 216) emphasise the importance of a 'contextualist position' towards judgements, actions, and responses which are grounded within the evolving context. Informed consent was gained from each of the social workers and supported people, which included: (1) providing a description of the study; (2) providing a full identification of the researcher; (3) highlighting that their participation was voluntary and that they had the right to withdraw from the research at any time with no impact on their job or service; (4) that the study was adopting pseudonyms and compliant with general data protection regulations and legislation promoting confidentiality; and (5) discussing the risks and benefits of participating (Padgett, 2017: 65). Information sheets, consent forms, and one-to-one discussions were utilised in an effort to cover all five areas. Appendices 4 and 5 include the participant information sheets provided to practitioners and supported people.

In relation to transparency, through providing the information sheets I had clearly identified myself as both a researcher and as a registered social worker, and provided space for any questions. Furthermore, Appendices 6 and 7 of this thesis include the participant consent forms utilised for the practitioners and supported people respectively. Verbal consent was also continuously sought throughout the data collection period. It was recognised to be essential that participants felt under no pressure to participate, thus informed consent was a crucial part of the process. In relation to confidentiality and anonymity, all the recorded data used pseudonyms to maintain privacy and confidentiality, so neither any individuals nor the local authority are identifiable. General data protection regulations were followed to ensure that all data were stored appropriately. Additionally, the local authority manager took on the role of gatekeeper to ensure that each case had been authorised and did not hinder any outcomes or increase risk to any parties prior to any research commencing. Finally, I completed a supplementary ethics application process for my reflective log when I transitioned from ethnography to auto-ethnography. My reflections were focussed on my experiences as a practitioner rather than on the supported person or the cases. As a qualified and registered social worker, I also complied with the SSSC codes of conduct and relevant safeguarding legislation. The following section outlines this change in roles from ethnography to auto-ethnography in response to COVID-19.

4.6 Shifting roles: auto-ethnography

Although an ethnographic research design was determined prior to entering the field, ethnography must remain adaptable and fluid to enable the researcher to respond to the field and to seize any relevant opportunities in relation to observations and interviews (Hammersley and Atkinson, 2007). This fluid approach proved advantageous when I was considering my response and research direction once the COVID-19 pandemic began in March 2020. My original plan was to immerse myself within an adult social work team for a period of six months in order to observe meetings, processes, and daily interactions, and to conduct interviews. Often, I was moving through care homes, hospitals, houses, and offices with frontline workers. After three months of ethnographic data collection as planned, the UK went into lockdown in response to the pandemic. The university paused data collection and the local authority was required to offer support in responding to the crisis. I felt drawn towards practice and was successfully able to gain a six-month full-time position as a social worker within the same local authority team. I therefore amended my university ethics application and shifted roles from an observer to a complete participant with the aim of capturing auto-ethnographic experiences of SDS as a social worker through a reflective log. This was not a complete shift into pure auto-ethnographic research, but I incorporated aspects of auto-ethnography into the research design as a means to continue the data collection which would complement the existing ethnography.

Auto-ethnography has been described 'as a form of ethnography' (Ellis, 2004: 31) which endeavours to 'systematically analyze (graphy) personal experience (auto) in order to understand cultural experience (ethnos)' (Ellis, Adams & Bochner, 2011: 273). The analytical gaze is turned inwards to self-reflection, to examine how the personal is influenced by the social, and how the social is influenced by the personal. It varies in form and can be 'research, writing, story, and method that connect autobiographical and personal to the cultural, social, and political' (Ellis, 2004: xix). Critics of auto-ethnography claim that the approach lacks rigour, objectivity, reliability, and validity, and that researchers are engaging in a self-indulgent task (Collinson & Hockey, 2005; Le Roux, 2017). However, those who endorse this approach, such as Lapadat (2017), argue that it gives the subject a direct voice rather than that voice being interpreted by the researcher, which can aid in balancing power dynamics. Furthermore, it is argued to offer a distinct gaze and insights into the phenomenon (Ellis *et al.*, 2011).

This change in role from a more passive observer to a complete active participant was not deliberately planned, but happened as an unforeseen consequence of the pandemic. On reflection, this alteration enhanced my observations and understanding. As Moeran (2009: 140) argues, a change in roles can result in a 'qualitative leap in understanding' because the researcher may learn 'things with their whole body and not just with their mind' which 'leads to a far more nuanced analysis'. I was therefore not simply observing SDS, but I began to personally enact the policy by engaging in the daily backstage activities. My fieldnotes recorded the moment I realised I could do more and enter the backstage:

> *It was coming towards the end of the day, and I was beginning to think about writing up my fieldnotes when I got home. Angela approached me and said she needed a second social worker on a home visit and asked if I was available. I attended the duty visit and assisted with organising emergency homecare. I am now seen as a legitimate second pair of hands, officially a second worker and a colleague, rather than a researcher or an observer.*

Although I was co-constructing reality during my three months of ethnography, I was not immersed in the same way with the personal lived experience of implementing SDS. In many ways I welcomed the inclusion of a reflective log and felt empowered to include my experiences and understandings, which complemented and enhanced the ethnography. This shift in role and position enabled me to gain a myriad of data, resulting in a rich, thick experience and description. Moeran (2009: 148) poignantly captures the potential for deeper, more holistic research and analysis through shifting roles:

> *Once you have crossed the invisible line separating front stage from back stage, things are never again the same as they were before. You, too, like your informants, can play both front and back stage games according to context and social role. Moreover, your informants may come to realize that you have learned the rules and know the difference between front and back stage games, and, as a result, they may stop pretending when in your presence and allow themselves to be seen as they are. […] But as you learn to play the game, you will be increasingly able, I think, to separate fact from fiction and gossip from information, while strategically using both to gain further data. The sheer wealth of information, criticism and commentary that can be made available by informants – who are now essentially colleagues – can lead to a further acceptance of the fieldworker as an insider who will then use his myriad data to create a holistic analysis.*

My reflective log captures the transition from observing backstage games to participating in them and learning the rules of practice. One of my reflections was as follows:

> *I began to do the maths when looking at my assignment. I had become fluent in understanding what risk ratings generated what budget, and how many hours of care could be purchased. I asked myself: does this assignment generate an adequate budget to meet needs? Should that even be a question a social worker asks? Was I now playing the game that I had so often observed, of engineering an assessment in order to get an adequate budget and care?*

Auto-ethnography shares ontological and epistemological commonalities with self-narrative, reflexive ethnography, and ethnographic autobiography (Collinson & Hockey, 2005). Nevertheless, not all personal experience writing is auto-ethnographic. Thus, my reflective log was guided by what Jones, Adams and Ellis (2013: 22) describe as the four traits which characterise auto-ethnographies, which are:

1. Commenting or critiquing cultural practices through drawing upon their own experiences and stories.
2. Contributing to existing research, knowledge, and scholarly conversation.
3. Becoming an intentionally vulnerable subject as a researcher by sharing personal experiences available for critique.
4. Creating a reciprocal relationship with audiences which actively seeks a response or action and encourages the reader to consider the topic in a distinct way.

Given the prominent role of self within ethnography and auto-ethnography, this chapter now moves on to consider and explore my positionality and reflexivity as researcher.

4.7 Reflections on positionality and reflexivity: ‘Oh, so you’re one of us then’

In ethnography, the researcher’s presence alters the generation of data and knowledge due to direct engagement with the phenomenon, so exploring my positionality was an essential part of the research process (Schatz, 2009), as: ‘Knowledge is co-produced in unique, often fleeting, power-laden, and deeply context-dependent relationships. It is more than subjective; it is intersubjective, co-constituted by a variety of subjects engaged in a thicket of multiple, overlapping forms of communication’ (Schatz, 2009: 15). Consequently, reflecting upon positionality shines a light on the ethnographer’s own sense-making processes, implicit assumptions, and operating principles (Shehata, 2015). Furthermore, as this section reveals, my positionality was tangled together with my identity, role, capacity to assemble relationships in the field, and ability to access field observations. To bring the concept of positionality to life here, I utilise extracts from my fieldnotes and reflective log to reflect on my evolving and complex stance. In doing so, I aim to be transparent about my engagement, effect, and influence within this research, thus acknowledging that neutrality and objectivity are an illusion (Pachirat, 2015).

Throughout my ethnography I was both unconsciously and consciously negotiating different positions through constructing my identity and role, and attempting to control how I was perceived. Goffman (1955) describes how our faces or identity construction changes depending on who we interact with during the process of impression management. Once I entered the local authority department, I quickly adopted the office language, including speaking in acronyms and abbreviations in an attempt to fit in and simulate the perceived common professional behaviour (Silverman, 2017). Furthermore, when describing who I was and my research project to practitioners in the office, my identity as a qualified social worker seemed to give me passage. This experience was captured in my fieldnotes:

> *After explaining who I was, my role, and the research project, I asked the worker if there were any bits of work I could observe or any visits I could possibly attend. The worker responded, "oh, so you're one of us then. You get it. You know what it's like. Sure, I am writing up an assessment at the moment. Have you seen the assessment form yet? I can talk you through it".*

My status as a social worker professional often resulted in my being positioned as 'one of them', rather than as an outside researcher, a benefit which enabled me to quickly build trust and rapport with staff, and to gain the swift acceptance of the team. Additionally, my identity of a younger woman who had never been a manager in any local authority aided in creating a more balanced power dynamic, as I was perceived to be at a similar level or status, as reflected in my fieldnotes:

> *One worker said to me, "you know… you look really like a social work student, rather than a researcher from the university". She smiled. I laughed, and asked what she meant. She responded, "like… I can't imagine you in university. Also, you're too practical".*

To maintain my position as 'one of them', I often concealed parts of my researcher identity; for example, I tended to write my fieldnotes up at home, out of sight. I found that by visibly being a researcher through writing fieldnotes in the office, I drew attention to the observation and potentially influenced behaviours. Furthermore, I wanted to avoid being a marginal member observing from a distance, and being seen as solely conducting an explicit research role. Atkinson and Hammersley

(2019: 218) state that in their view, there is some level of deception occurring within ethnography because there is ‘an element of not telling the whole truth’. They continue by highlighting that even ‘active deception, may be justifiable so long as it is not designed to harm the people researched, and so long as there is little chance that it will do this’. Although there was no need for active deception in my research, I did deliberately downplay and hide research activities such as fieldnote writing.

I initially negotiated and sought access to the local authority area team through the senior management. Accessing the site from this top-down position automatically enabled me to build relationships with managers who at times presumed I was a specialist in SDS and positioned me as a researcher rather than a social worker. The following extract from my fieldnotes acknowledges that others play an active role in creating parts of my identity and social status:

> *Whilst shadowing an informal case discussion between managers, I was caught off-guard as one manager turned to me and said: “Felicity will be able to help, you’re our resident SDS expert after all”. I noticed I was feeling uncomfortable. I thought I had always been mindful throughout my research project to position staff as the experts. Yet, my identity as a PhD researcher meant I was at times viewed as a specialist.*

My positionality is not only continuously evolving and multiple, but is also relational and contextual, and formed not only by me, but by others too.

Building rapport with frontline social workers enabled me to gain access to practice observations. Friendship building with colleagues therefore became part of the research process (Beech, Hibbert, MacIntosh & McInnes, 2009). As I transitioned from observer to complete participant during the auto-ethnography these friendships continued to grow. This inevitably impacted on what people told me, and how I responded and saw things. At the point when I was most immersed within the team, following three months of ethnography and six months of auto-ethnography, I conducted the semi-structured interviews. Often within these interviews there was a clear sense of rapport, where workers made comments such as “you know what it’s like” and “I think you probably know who I mean”, combined with informal language, jokes, and candid comments. Nevertheless, the informal atmosphere still generated a wealth of data which created a holistic picture of the phenomenon. Although at times I was shocked at the frank nature of some comments due to my position as a friend or colleague (as reflected in my findings), I felt that workers had a clear understanding and awareness of the research in order to make an informed decision regarding their participation.

Initially, during my first three months of ethnography I found myself in new surroundings and was attempting to make sense of what was happening. I was often seeking information and understanding encounters; therefore I adopted a position of naivety. During this period of data collection my views and opinions were not overtly discussed, and therefore remained hidden. When I changed roles from an observer to a complete participant, my views, assessments, opinions, and ideas then formed part of my daily practice, so I could no longer present as a neutral bystander, and consequently I felt vulnerable and anxious that my knowledge gaps as a practitioner would be apparent. I regularly had to discuss cases and seek advice from colleagues and managers. Nevertheless, through doing and embodying the policy, I reached new depths of understanding.

My position shifted again when I left the field, leaving my job as a frontline social worker and returning to my PhD researcher role. My reflective log captures some of my concluding thoughts as I left my job:

> *Leaving the office and the role as a social worker feels sudden, although I always knew it would be a six-month contract. My job took over in a way I never anticipated. The pace of work has never slowed, some of my cases are still open, ongoing, and transferred to other workers. Final goodbyes were not possible with everyone due to the restrictions. There seemed to be a feeling that I would see them all again soon. Practice during COVID was non-stop, so I do feel a sense of relief; however, I now have what feels like the impossible task of processing and analysing this mass of data. Will what I've found do justice to all the service users and workers?*

Throughout my research, I negotiated multiple faces as I interacted with different people in various settings. I considered what information to share and what not to disclose, at times consciously and at other times subconsciously. Furthermore, the research participants also contributed to my positionality and identity formation. I began as an observer keeping my views hidden, but later became more vulnerable and exposed during auto-ethnography. My complex and changing positionality has been described through drawing upon extracts from my fieldnotes in an attempt to be open and honest about how my presence altered the generation of data through direct engagement with the phenomenon.

Importantly my ongoing reflection on positionality and shifting roles raised a number of ethical challenges which I considered during my supplementary ethics application and throughout data collection. Once I began working in the department as an employed social worker, I had to carefully balance my duty of care and responsibility to the supported people, whilst also continuing to conduct research. As an employee I gained increased power through additional access to records, cases, documents, systems, and information. I was automatically included in more meetings, reviews, and conservations with other professionals, supported people and families. In some situations, I was working exclusively as a practitioner, whilst during other encounters I was also a researcher. Supervision with my Director of Studies, social work line manager, and gatekeeper provided a space to consider and manage these ethical concerns which arose from the shift in roles to auto-ethnography. Crucially, my role of a social worker always superseded my role as a researcher. My practice was underpinned by the SSSC codes of conduct and relevant safeguarding legislation, therefore, practice casework would come first above my research agenda. Working alongside my line manager and gatekeeper ensured I was engaging appropriately with cases, not misusing information for data, and therefore reducing the risk of the exploitation of practice situations for my own research objectives. Importantly, my reflective log focussed on my experiences as a practitioner rather than on the complexities and confidential information of supported people and their cases. Finally, as outlined in section 4.5, during my auto-ethnography I was transparent about my role as a researcher and I continued to gain informed written and verbal consent, provided information sheets, and offer one-to-one discussions, to empower workers and supported people to make an informed decision about whether they wished to be involved in the study.

4.8 Data analysis

Hammersley and Atkinson (2019) described analytical thinking as an ongoing iterative process which begins during the early stages of the research journey. Thus, data analysis is not a detached, standalone stage of the research process which occurs once a researcher leaves the field, but analysis remains in progress throughout data collection (Sarantakos, 2013). Consequently, there is free movement between the various stages of data collection, analysis, sampling, and study design (Sarantakos, 2013). It is argued that ethnographers engage in a process of ‘grounded theorizing’ (Hammersley & Atkinson, 2019: 167), which supports the simultaneous processes of data collection and analysis. This empowers the researcher to identify the issues and themes steering the direction of research, going ‘further and deeper into the research problem’ (Charmaz, 2008: 48). This process of grounded theorising is demonstrated within my fieldnotes, which include memos, questions, and thoughts on my observations, which indicated areas to follow-up and further explore. Additionally, whilst writing up my fieldnotes at the end of each day, where possible, I crudely grouped my data under early emerging themes which also helped to guide my research focus. This process of thematic progressive focussing informed my question themes and design for the formal semi-structured interviews.

As I have discussed, the research data are a mix of verbatim interview transcripts, electronic fieldnotes, and an electronic reflective log. Once I had left the field, this data were uploaded onto an NVivo software programme to organise and code the data. Kunda (2013: 17) explains that:

> *Coding means reading the notes, transcripts and documents carefully, over and over, understanding the terms the actors in the field use, sometimes thought of as "the native point of view," and asking oneself, repeatedly, of each event, saying, artifact, unit of meaning found in the notes, the crucial question […]: what is this an example of? To what analytic category, to what larger as yet unspecified set, to what meta-narrative, does this unit of meaning belong? What name can one give this set? And then asking further: How are these categories related to each other? Into what typologies and systems of classification do they fall?*

Although analytical thinking and coding occurred throughout the research process, this in-depth style of coding and data analysis described by Kunda (2013) became my sole focus once I left the field. I read and reread my data to become familiar with the content. NVivo provided storage and a quick visual aid which helped me to identify patterns, connections, and themes across my data sets. Lofland *et al.,* (2006) suggest that codes can begin under the specific categories of acts, activities, meanings, participation, relationships, and setting. To begin with, my themes were specific descriptive classifications, however gradually, through spending time with the data, broader overarching themes emerged which grouped many subthemes together. Throughout this process I continued to read the relevant literature, which also supported in guiding my themes and analysis. I began to share initial ideas in supervision and at talks or events, which generated discussions and further advanced my ideas. Given its close links to practice, the findings of this PhD were intended to support practitioners, so sharing initial findings with those in SDS practice circles aided with ongoing analysis, the development of ideas, and writing up. Researchers are encouraged to revisit data a number of times in order to reveal fresh layers of meaning which may not previously have been seen (Hammersley & Atkinson, 2019; Kunda, 2013). Gradually, my overarching themes and subthemes were then grouped under Freeman and Sturdy's (2014) embodied-inscribed-enacted theoretical framework (see Appendix 15).

Those critical of ethnography raise concerns regarding the small sample size, thus questioning the generalisability and representativeness of the resulting data and findings (Hammersley & Atkinson, 2019). It is important to emphasise that this study's findings are not intended to represent all the multiple realities of the complex SDS phenomenon, but instead they aim to shine a spotlight onto one of many distinct worlds where SDS is generated, implemented, and translated. Nevertheless, I do engage in some generalisation through drawing upon Nicolini's (2009) method of switching lenses, thus not only 'zooming in' on micro practice work, but also 'zooming out' on wider macro contextual issues. This process of shifting back and forth between these two lenses during data analysis ensured that the emerging themes related to the wider context of SDS practice. Ideas and experiences from the micro local data level are extended further than this small case study and link to the bigger picture. It is argued that these findings can provide a small piece of the jigsaw puzzle to complement the wider existing SDS knowledge.

4.9 Chapter conclusion

This chapter has presented a detailed discussion of the research process and relevant methodological considerations, evidencing the thorough and robust research design which underpins this thesis. I have explained the course of my decision-making and the evolving nature of the research project through Silverman's (2017: 476) 'natural history' approach. This approach specifically captured my shift from ethnography to auto-ethnography as a result of the COVID-19 pandemic. Through a comprehensive discussion, ethnography was evidenced as an effective form of inquiry which enables the researcher to see the inner workings or ecology of practice and experiences. It has been argued that ethnographic research facilitates the exploration of SDS practice and work by enabling the researcher to gain a distinct closeness to practice. The 'how?' question guides this thesis through keeping the focus situated within the dynamics of practice, the details of interactions, and the negotiation of meanings (Becker, 1998). The chosen multi-method design, or as Nicolini (2009: 1403) describes it, the 'toolkit logic' has been outlined, explaining the distinct combination of observation, formal and informal interviewing, and document analysis utilised within this project. Overall, this comprehensive discussion of my research design and processes aimed to evidence the validity and reliability of the chosen data collection methods and techniques.

Through this combination of theoretical frame and ethnographic method, this thesis aims to make the unseen everyday SDS work visible, thus providing a view into the black box of social work practice, or what has been described as the 'the invisible trade' (Pithouse, 1998). Ethnography, when fused together with the embodied-inscribed-enacted theorical framework (Freeman & Sturdy, 2014), provides a tool for the researcher to become immersed within the SDS phenomenon, capturing both frontstage and backstage activities, practices, narratives, and routines in an inductive manner. My effective use of ethnographic methods and the theoretical frame will now be evidenced in the three subsequent findings and discussion chapters, which are grouped under each of the following areas:

embodied, inscribed, and enacted, from Freeman and Sturdy's (2014) theoretical framework. Lastly, I will conclude the thesis with the final chapter which will summarise the discussion and provide implications for social work practice, policy, and research.

Chapter 5: Embodied SDS knowledge

5.1 Chapter introduction

This thesis's interpretative policy framework involves examining embodied, inscribed, and enacted SDS knowledge, as outlined in the theoretical frame in Chapter 3. This chapter, as the first of three chapters of research findings, specifically explores the significance and forms of embodied SDS knowledge amongst social workers. The findings examine social workers' deeply-embedded bodily experiences, emotions, and feelings on policy in order to understand how these shape their policy translations.

As a reminder, the body is where the individual, material, and social structures converge to form the lived experience of a frontline social worker. Social workers therefore experience and sense SDS policy through the medium of their body, which is the location of their feelings, values, views, thoughts, and desires. Habitus is a connected and helpful concept for considering the embodied knowledge of social workers. For Bourdieu, habitus refers to the internalised disposition of practitioners resulting from their conditioning by everyday practice experiences, often without a full understanding of how their disposition came into being and was formed (Bourdieu, 1990). It therefore describes the way in which social workers think, or a set of 'dispositions' unconsciously learnt during daily socialisation, also described as 'common sense' (Bourdieu, 1977: 80). Habitus is thus the conditioning by which an individual knows how to respond to a given situation, and includes skills, instincts, intuitions, values, attitudes, biases, feelings, emotions, judgements, thoughts, and tastes. This is not a fixed permanent state, but rather is evolving, continuously modified, and reinforced through daily experiences, encounters, and interactions.

During data collection it was evident that embodied knowledge played an important role in the translation of SDS. For example, workers returned from visits or meetings with 'feelings' about cases or discussed their intuition and senses by stating that 'something doesn't feel right', or saying 'I reckon they definitely meet the criteria for support', subsequently informing their judgments. The social workers' embodied emotions surrounding practice were particularly prominent, resulting in practitioners openly and frankly disclosing their emotions and feelings during daily translations of SDS. Understanding the embodied emotional aspects of practice supports an exploration of how social workers interpret, construct, and implement the policy. As Gould (2009: 17) states, 'emotion […] is […] a crucial means by which human beings come to know and understand themselves and their contexts'. Additionally, as was explored in the methods chapter in section 4.6, auto-ethnography requires that the body is utilised as a research tool engaging with subjective experiences and 'reflexive embodiment' (Crossley, 2006). My body therefore became a research tool and a site of inquiry. I engaged in self-analysis, paying attention to the everyday, habitual, embodied experiences that often remain non-verbalised or unwritten.

Embodied knowledge is commonly considered to comprise these tacit ways of knowing. Yet, as Chapter 3 highlighted, Freeman and Sturdy emphasise that embodied knowledge also encompasses explicit forms of knowledge, particularly embrained knowledge, a term which refers to fact-based or know-that explicit ways of knowing that are present in the mind and can then be expressed (Blackler, 1995). As I previously noted, the justification for including both tacit and explicit knowledge within this embodied definition is 'that it is impossible to draw any hard-and-fast distinction between "know-how" and "know-that" […] embrained knowledge is also always embodied' (Freeman & Sturdy, 2014: 9). During data collection, for example, knowledge was not always recorded or written down, but instead there were 'go-to' practitioners holding and embodying knowledge, and were thus 'the person to talk to' about a given issue, whether it was how best to navigate the database, or what third sector referral would be relevant. Furthermore, some workers were not simply valued for their practical knowledge, but also for their perspective on a given issue. Thus, the various forms of embodied knowledge held by different workers were relied upon to make sense of SDS.

This chapter's analysis of embodied SDS knowledge is divided into two main parts. The first part considers the emotions associated with SDS work which impact on practitioners' sense of professional identity. Frustration was often expressed regarding the high levels of bureaucracy and administration, often resulting in feelings of powerlessness and a reduced sense of autonomy. Workers often spoke of clashes between their values and the organisational systems and procedures in place, which resulted in ethical stress and dilemmas when implementing SDS. The constraints and boundaries imposed by SDS legislation and local authority policies and procedures resulted in embodied emotions of dissatisfaction and a sense that the professional role often did not meet expectations. Despite the ethical stress experienced by the practitioners, the findings suggest that workers have established ways to navigate the system.

The second part of this chapter moves away from the subject of embodied emotions to explore embrained fact-based knowledge or know-that explicit ways of knowing. These forms of knowledge are present in the mind and include the unconscious embodied case knowledge gained during daily socialisation which supports practitioners in navigating SDS. This chapter specifically explores social workers' embodied instincts regarding thresholds, ratings, and points when completing paperwork.

Overall, these non-verbal and embodied institutions were captured through ethnographic observation and being situated with the workers, exposing how they responded to cases through embodied instincts, intuitions, values, biases, feelings, and emotions.

5.2 Professional identity: 'this isn't what I signed up to, it's not *really* social work'

5.2.1 Financial work: 'it's not my work'

Social workers made a distinction between social work practice and administrative work. Workers often stated that they would rather be doing '*real social work*', 'face to face work', and '*working directly with people*', rather than administrative tasks such as writing case notes, minutes, assessments, closing summaries, emails, or calculating budgets. Often, these administrative tasks were viewed as hindering their practice and engagement with people. There was therefore a common belief that much of the daily work was not actually social work:

> *'I spend most of my time in front of my screen, and I get that some paperwork and recording is important… but it is too much, I'd rather be out doing real social work and talking with service users.'* (Ava, extract from fieldnotes)
>
> *'I thought social work was all about working with people, you know… building relationships and person-centred care. All that stuff you are told at uni… But I spend most of my time writing up my case notes, completing assessments, working out budgets and costs, chasing people up with emails. I thought there would be more time doing… social work… you know, sitting in someone's living room doing face-to-face work.'* (Oliver, extract from fieldnotes)
>
> *'Sometimes I just feel like an admin worker or a finance worker, rather than a social worker.'* (Dylan, extract from fieldnotes)

Workers thus voiced concerns specifically about the number of financial tasks associated with SDS which reduced the time they could spend with people. Similarly, Gibson's (2016: 165) research in a children and families setting illustrates that practitioners make a distinction between social work practice and administrative tasks, revealing that practitioners felt that 'much of what social workers were doing was not social work'.

Often, social workers' expectations of the job were not reflected in the reality of implementing SDS, which fuelled embodied feelings of disillusionment and frustration regarding the role and identity of a social worker amongst the team:

> *'Sometimes, I feel like I fill in paperwork, and record stuff on the system, and tick some boxes. I'm not really doing work with the service user; I just commission some care, but don't get to build a relationship up, or get to know them. Like social workers don't do interventions anymore. We record stuff, commission care, check-in, and close the case. I don't think the job is what it used to be. We used to get our hands dirty and do real work. […] It makes me wonder what good work we actually do.'* (Zoey, extract from fieldnotes)
>
> *'The level of paperwork and financial budget-focussed work we are expected to do on a daily basis makes it hard for, for the social worker to their job, and do it well.'* (Sally, extract from semi-structured interview)

When their work was not living up to their expectation, social workers began to question the meaning of their work and the difference it was making to lives of the people they support. Evidence suggests that workers felt constrained by the systems and organisational environment which impacted their ability to enact SDS in line with their values:

> Practitioner (Oliver): *'There is so much focus on the paperwork, the assessment, the points, the budget, calculating the how many hours care and all that. Everything is so process-led and I feel more like finance officer, rather than a social worker. […] Like, all this focus on the budget, I just don't get how our social work values link in with that. […] It can feel more like a business or a conveyor belt of cases.'*
>
> Interviewer (Felicity): *'[…] so how do you manage to integrate social work values into your practice, if you can?'*
>
> Practitioner (Oliver): *'I guess this is the job now… we all know we need to deal with budgets. I think it should be the finance team's job… but I guess we have to do what we can within the system.'*

There is a sense expressed here that SDS has introduced a focus on financial case management which is eroding the role and identity of the frontline worker. The New Public Management agenda which introduced neo-liberal policies and managerialism into public services, and which stresses the importance of measurable outputs, targets, cost effectiveness, and the free-market within the provision of public services, has dominated in recent decades (Banks, 2011). The care market and focus on budgets has resulted in a situation described by one worker where *'the service user has become a customer'*. Similarly, another worker commented that the local authority is *'run like a business'.* This focus on financial tasks undermines the philosophy of SDS, resulting in a process driven approach rather than a human-rights outcome-focussed narrative. Furthermore, it constrains practitioners, ultimately impacting their ability to enact SDS in line with their values.

5.2.2 Disappearing relationships

Social work literature positions the relationship with the supported person as central to the practice. Relationships have been portrayed as being at 'the heart of social work' (Collins, J. & Collins, 1981: 6), as 'an absolute precondition of effective social work practice' (O'leary, Tsui & Ruch, 2013: 137), and furthermore as crucial interventions (Fewster, 2004). Nevertheless, with the new public management approach which introduced business and market principles into practice and delivery, social work has taken a turn towards a 'technical/rational rather than an ethical relational', which is argued to have impacted relationships at the centre of practice (Ingram & Smith, 2018: 4). The SDS policy reform foregrounds co-produced an outcome-focussed social care, which moves away from the traditional care culture in which the professional was positioned as the expert holding power and control. Furthermore, the Act outlines a set of principles and values which explicitly link SDS delivery to a human rights approach. Building a relationship with the supported person is therefore essential to effectively delivery the four statutory principles specified in the SDS Act: (1) participation and dignity: (2) involvement; (3) informed choice; and (4) collaboration. However, the findings suggest that, relationships are hindered by the bureaucracy and processes involved in everyday work. This is echoed in the wider social work literature, which states that relationships 'have become secondary to forms of practice that, even when practitioners might claim to work in relational ways, are increasingly framed around following procedure and ensuring compliance' (Ingram & Smith, 2018: 4). When discussing relationship-based work, practitioners explained:

> *'You think when you train to be social worker that you will get to do all this relationship-based work, but actually you just need to get in there and get someone a service in place, you know, remove the risk and get them out of crisis.'*
> (Rose, extract from fieldnotes)

> *'I'm going to sound pretty doom and gloom here, but relationships are disappearing. It's about ticking boxes and getting the forms filled in.'* (Alex, extract from fieldnotes)

This theme links to section 7.2.4 of Chapter 7, which discusses how the building of relationships during practice enactments are restrained by time pressure to complete work quickly, which impacts the ability to build rapport and relationships during everyday work. Hingley-Jones and Ruch (2016: 243) link austerity and this technical/rational approach to practice to a progressively more 'austere' form of relationship based practice, which involves distancing or 'turning a blind eye' to the support person's experiences as a result of diminishing public services. Linked to these ideas, workers stated:

> *'I think we push way too many responsibilities back on the service user and their family. […] The local authority expects carers [informal family carers] to do a lot. Sometimes you think you are keeping someone independent and less reliant on services, but I think most of the time it comes down to the fact that there is no money. […] We put a lot of pressure of the family… and they sometimes… they break. […] It'd hard to build up rapport and trust with them when we have no resources.'* (Amanda, extract from semi-structured interview)

> *'There is definitely a lot of unmet need out there. We all know it, but it's not recorded. Don't get me wrong, we do the minimum to ensure people are safe, but I guess we only really fund critical risk stuff. […] So, we do the assessment, and give someone their budget, but half the time the budget just covers critical needs, so there are a lot of unmet needs, which [the local authority] doesn't see as their responsibility. So, we just have to move on to the next case. It's hard - because you feel like you are doing people a disservice.'* (Alex, extract from semi-structured interview)

High thresholds for support, limited funds, and diminishing public services all impact the ability to place the relationship at the heart of social work. The evidence suggests that relationships take a back seat, and instead procedural demands and expectations are placed upon practitioners. Each of the social worker's frustration was palpable, as they expressed concerns about the systems and processes which are changing the role of a social worker. Although SDS processes and procedures attempt to standardise work, the highly bureaucratic tasks involved in it seem to have encroached upon professional relations, depleting the time available to build rapport and relationships. As is further explored in section 5.3.2, the limited available resources and stringent eligibility criteria resulting from austerity influence the power of the practitioner and the burden placed on the supported person, further restricting effective relationship building. Consequently, these results are embodied as emotions of dissatisfaction, with the role not meeting expectations.

5.2.3 Autonomy and power(lessness)

White (2008) highlights that 60-80 percent of practitioners' time was spent on administrative tasks such as writing reports rather than engaging with the supported person and their family, which once more links to the challenges arising from a managerial-technicist reconstruction of the profession under the New Public Management paradigm (Clarke & Newman, 1997). Practice is embroiled in an 'audit culture' (Power, M., 1997), with a focus on budgets, targets, objectives, and administrative tasks, which some argue has deskilled practitioners who are increasingly subject to managerial control (Carey, 2009). Social work has therefore increasingly become organised around processes, procedures, and tools, resulting in concerns about a perceived weakening of professional discretion (Gilbert & Powell, 2010; Wastell *et al.*, 2010), as well as emphasising the paradox between organisational control and a practitioner's professional autonomy (Featherstone, Morris & White, 2014; Munro, 2011). Workers are thus required to balance their own values and ideas regarding social work practice against the wider local authority demands and agenda, as 'the spaces for professional judgement and autonomy become fewer and reduce the prospects of seeing beyond the enclosing technical framework itself' (Webb, 2006: 169). Managerialism consequently affects social workers' professional identity and autonomy, resulting in feelings of powerlessness (Carey, 2009; Featherstone *et al.*, 2014; Gilbert & Powell, 2010; Munro, 2011; Wastell *et al.*, 2010).

Although standard eight within the SDS Framework of Standards centres around worker autonomy, the following findings suggest that this is yet to be realised (Social Work Scotland, 2021). Consistent with the social work literature, SDS standardised processes, mechanisms, and procedures were described by social workers as *'prescriptive'* and *'rigid',* resulting in an inflexible and deterministic mode of practice, as is captured in the following quotes:

> *'The processes aren't very flexible, so you need to fit all your points into predefined boxes. […] So you're not free to write whatever […] The tool kinda forces you to squeeze people into a box, when really, they're more complex.'*
> (Tom, extract from semi-structured interview)

> *'The database is just so prescriptive, which means sometimes you can't include what you really want to say. Although I try and twist it so fits in somewhere.'*
> (Ruby, extract from semi-structured interview)

Here, practitioners describe having to *'squeeze people into a box'* which is *'predefined'*, and having to *'twist'* information so it *'fits'*, thus impacting their sense of freedom and ability to include what they would like to write whilst navigating the system. The evidence therefore suggests that the SDS processes have contributed to feelings of reduced discretion, autonomy, and freedom in day-to-day work. In addition to descriptions of rigid, prescriptive, and predetermined tools and processes, practitioners also described the implementation of SDS as *'too long',* with *'too many steps and phases',* thereby suggesting a fragmented and disjointed system:

> *'There are just so many steps from when you get the case allocated, to getting a budget, and then the commissioning of the care. It takes so long. […] You need to get every little thing signed off. I mean everything. […] You can't move to the next screen on the database, until a manager has authorised and signed stuff off. […] Sometimes I'm literally just waiting for other people to do stuff. […] I'm pretty sure the service user thinks we just aren't doing our job, but it's the way the system is designed.'* (Cora, extract from semi-structured interview)

There was a clear hierarchy with regard to the authorisation of budgets and decision-making. Section 7.4.1 in Chapter 7 highlights a practitioner's battle for a budget during a resource allocation meeting, which evidences a reduced sense of professional autonomy, control, and influence during these resource allocation procedures. On a daily basis, workers have to email managers to request that specific things are *'signed off'*, so they can progress cases further. There is a constant, multiple back-and-forth centred around the database and requesting authorisation from managers which results in practitioners feeling disempowered. Additionally, workers described the IT system as *'inadequate', 'really old technology', 'so dated', 'clunky',* and *'a complete hindrance',* clearly regarding it as inflexible and as paralysing practitioners until managers have authorised and signed pieces of work off.

Workers often stated that particular processes had to be completed or undertaken in a specific way '*because of headquarters'.* Schwalbe and colleagues (2000) state that a key form of identity work is the process of 'othering' whereby the worker identifies processes conducted by other groups and emphasises these differences, which maintains socially-constructed boundaries and blame. In this way, 'othering' headquarters maintains an 'us' and 'them' boundary and serves to highlight differences in identity between managers and social workers. The findings suggest that this othering supports social workers in reconciling with a role that they are uncomfortable with. Frontline staff held headquarters accountable for imposing bureaucratic tasks which they felt were out of their control, yet dramatically impact upon daily practice:

> *'We kinda just have to do what headquarters tell us. […] They don't actually get what it's like implementing all these things, and how much time it actually takes. They are too far removed from frontline work in headquarters. I don't think they really a clue, half of them aren't even social workers, they are finance workers.'* (Amira, extract from fieldnotes)

Workers felt heavily regulated by the processes outlined by headquarters, resulting in feelings of powerlessness and hindrance to autonomous working. Specifically, strict rules regarding how the SDS budget can or cannot be spent curtailed the potential to be creative with social care budgets. This will be further explored in the following section 5.2.4. As one worker described,

> *'We are bound by organisational red tape. Officially the SDS budget is meant to be super-flexible and allow lots of creativity, but the local authority don't really let you do anything unconventional with it. It's all about the day care and home care, to be honest.' (Ruby, extract from fieldnotes)*

The findings thus illustrate a visible tension between daily SDS processes and the workers' sense of autonomy and power. There is an ongoing dilemma for workers on negotiating both institutional goals and their responsibility to support someone as an autonomous worker. This sense of reduced professional autonomy is a theme which reappears throughout the subsequent thesis findings. For example, in Chapter 6, sections 6.7 and 6.8, social workers write and craft assessments with the managerial reader in mind, which ultimately influence how they frame the content and the narrative of their inscription.

5.2.4 Local authority constraints, not SDS legislation

Each of Scotland's 32 local authorities have interpreted the national SDS policy locally in their own way, resulting in various different assessment processes, care plans, service providers, eligibility criteria, resource allocation systems, review processes, and distinct guidelines regarding how individuals can spend their budgets (ALLIANCE & SDSS, 2020c; Morrow & Kettle, 2021; Rummery *et al.*, 2012). This has created a fragmented and uneven SDS landscape across Scotland, resulting in a 'postcode lottery' for those seeking social care provision (Slasberg & Beresford, 2016). The findings suggest there was a level of discomfort with the local interpretation of the national SDS legislation. As one worker stated when discussing her frustration with attempting to access equipment with a budget:

> *'You're meant to be able to be… creative, well… that's what you're told. But the rules [in this local authority] are so limiting. Like… you can't do much with the budget really. […] The service user has all these expectations about what they can do… and you kinda have to be like, "no", because of the local authority rules. […]. When I worked in [a different local authority] we were able to get equipment so easily with the budget and other random stuff, but there isn't the culture of doing that here. […] It's really frustrating 'cos the support is dead basic or generic […] It's rubbish.'* (Oliver, extract from semi-structured interview)

The practitioners in this study were thus observed to be struggling to reconcile their own views, values and personal feelings with their professional role as outlined by their local authority employer. This links to Fenton's (2014; 2016) description of the concept of ethical stress, meaning the stress which practitioners feel when they cannot base their practice upon their values. There are two categories of ethical stress resulting from practice situations. Firstly, Fenton (2016: 12) describes the 'disjuncture' which results when workers experience a feeling of conflict when their practice is inconsistent with social work values, often due to workplace restrictions and demands. Secondly, Fenton (2016: 12) describes 'ontological guilt' when practice cannot be based on what the practitioner deems to be right, and raises conflicts with their conscience. Similarly, Asquith *et al.,* (2005) argue that the challenge and crisis for the social work professional is rooted in the difficultly of maintaining and advocating for its values in the current economic and political climate.

As is later discussed in section 7.2.3, practitioners felt unable to offer all SDS four options outlined in the legislation, which hindered the choice and control experienced by the person in receipt of social care. Section 7.2.3 highlights the market and the complex local authority processes as barriers to fully enacting the four SDS options. When discussing the restricted availability of options, one worker explained:

> '*I know I'm not complying with the legislation. Well, nobody is - because we can't offer all the four options. […] Like, option 2 just doesn't exist here.[…] It's really difficult. […] We are definitely doing a disservice to the service user. […] It comes down to the commissioning of care and the [local authority's] approved providers list.'* (Alex, extract from semi-structured interview)

Additionally, workers also expressed feeling of powerlessness regarding the local authority rules on how and where budgets could be spent, describing them as '*strict*', '*inflexible*', and a '*hindrance*'. Workers recognised that the potential of budgets was not being maximised and the local authority was not encouraging creative social care, but only '*standard packages*' of '*home care or day care'.*

> Interviewer (Felicity): *'Can you think of any examples of you or people in the team being unconventional or more creative with the budget?'*
>
> Practitioner (Esther): *'Erm… sadly no! I know that sounds really bad… but the local authority just doesn't authorise things like equipment. You have to jump through so many hoops, then you're just told "no" anyway. It's more home care, day care, and personal assistants, just all the standard kind of everyday packages. […]. Even when you have the support from [the service manager], it's headquarters who have the final say.'*
>
> Interviewer (Felicity): *'hmmm, so how does that feel as a practitioner?'*
>
> Practitioner (Esther): *'It's hard, it seems like a bit of waste, you know, but that is how things are done here. […] I know in other councils the social worker has small budget that they manage, so effectively I could authorise small things, you know. […] Something like that would be great; then we could be a bit more creative.'*

The evidence suggest that social workers feel powerless and constrained by local authority framework and regulations which prevent them from being more creative with SDS budgets and practising in the manner they desire. Although this ethnography has a small sample size, during data collection there were two examples of practitioners attempting to buy equipment; however, after six months neither had been agreed or resolved by the end of the data collection.

Another commonly discussed form of ethical stress centred around the available budget for older adults (65 years and over). As was highlighted in the literature review in section 2.3.5, current practice is that an older adult's budget is often capped at a lower amount than that available to younger adults. This was a regular frustration discussed amongst the team, and as one worker stated: 'it's so arbitrary, why is someone's life worth less because of their age. I just don't get it. How can that not be ageism'. This was a reoccurring theme in many of the semi-structured interviews:

> Interviewer (Felicity): *'You mentioned the capped budget for those aged 65 and above, can you tell me a bit more about that?'*

> Practitioner (Amanda): *'Yeah, so basically, when someone turns 65 the budget available to them to capped at the cost of a residential care home placement. So… the local authority is basically saying, we'll only fund you in the community if it is cheaper than a residential placement. […] As soon as the cost of community care goes over that, either the person can top it up to stay at home, or the local authority basically says it isn't safe to keep them at home and the recommendation is made for a care home. [...] I think it is horrendous. Totally ageist. […] I get we can't just fund people indefinitely in the community, but what gets me is the difference between younger people and older people. […] How can that be right?'*

Local authority thresholds therefore constrain workers, resulting in frustration and ethical challenges when implementing a policy that they disagree with. In addition to thresholds around budgets and ages, local authorities solely provide support for those at critical or substantial risk. This acted as another point of ethical stress for practitioners, who felt that early intervention was not occurring.

5.2.5 Becoming a social worker and embodying self-directed support

I originally began my ethnographic data collection with a focus on participant observation and interviews; however, as I previously described in the methods chapter, sections 4.6 and 4.7, I adapted my research approach and methods to include auto-ethnographic experiences of SDS. This ensured the continuation of data collection during the COVID-19 pandemic. Consequently, I became a complete participant, capturing my day-to-day SDS experiences as a social worker within my reflective log. As this chapter and the subsequent findings chapters illustrate, practitioners hold rich embodied local knowledge which enables them to navigate through daily routines, tasks, and seemingly mundane situations. During the initial ethnographic participant observations, I documented practical competencies, esoteric tasks, and daily routines, illustrating the tacit knowledge held by the social workers as they made sense of the SDS world around them. Thus, whilst immersed as an employed social worker and a complete participant, I too became sufficiently adept at these embodied competences while undertaking everyday activities. I developed a working knowledge of, for example, the processes, procedures, team dynamics, navigation of uncertain situations, and gauging thresholds of risk, thus illustrating my own evolving embodied SDS knowledge. Many of these skills were bodily routinised activities, also known as 'body-work' within the ethnographic literature (Atkinson, 2015: 125). I moved from considering 'how *do they* do that task, and how *do they* feel?' to 'how to *do I* do this task and how *do I* feel?', thus untangling my own embodied experiences. I transitioned from *knowing that and knowing about SDS,* to knowing specifically *how I* translate and interpret SDS. I reflected on my evolving embodied knowledge in my reflective log as follows:

> *Following the home visit, I made my way back to the office. In my head, I was piecing together what I had seen and heard during the visit. I felt confident that the individual was at substantial risk in a number of areas, and therefore I would be able to justify their eligibility for some sort of SDS budget within their assessment. On reflection, I seem to have developed a sense or a feeling about whether somebody meets the risk threshold for support. I seem to now know what evidence equates to certain risk levels, budgets, and points. I had observed social workers confidentially assess cases and make judgements following visits, with a seemingly innate instinct about thresholds and risk levels. My instincts and confidence in assessing this case seems to stem from the fact that it is similar to a case I had seen before* (Extract from reflective log).

Ingold (2007: 174) describes 'wayfinding' or finding one's way as experiential embodied knowledge whereby we know as we go, and not before we go, stating that, 'what matters is not the final destination, but all the interesting things that occur along the way. For wherever you are, there is somewhere further you can go'. I therefore developed my knowledge of SDS as I gradually practiced and stored experiences and interactions which would inform subsequent encounters. Similarly, Mauss (2007) discusses the 'techniques of the body' in a prominent anthropological discussion, highlighting that the physical body is saturated and infused with local culture. I wrote in my reflective log that: *'Zoey and I just knew it when we saw it. It was definitely critical risk',* highlighting our embodied tacit knowledge of thresholds. Connections can be made to notions of socialisation or enculturation, whereby I began to internalise the cultural norms within the social work office and developed embodied local knowledge to support me in navigating through daily routines. The analytical gaze turns inwards to self-reflection, thus examining how the personal is influenced by the social, and how the social is influenced by the personal. I draw upon my embodied auto-ethnographic data capturing my lived experience of SDS throughout these findings chapters, specifically in sections 5.2.7, 5.3.3, 6.7, 6.8, 7.2.1, and 7.3.4.

5.3 Embodied case knowledge

This second part of this chapter explores the embrained fact-based knowledge present in the minds of practitioners supporting their navigation of SDS. The following sections illustrate the embodied habitual activities and knowing when making sense of thresholds, ratings, and points.

5.3.1 Sense making: the unwritten embodied knowledge

As highlighted in section 3.6.1 of the theoretical frame chapter, embodied knowledge corresponds to the concept of sense-making. During the process of sense-making, practitioners' knowledge is not explicitly stated but is often tacit, consisting of embodied habitual activities which are practiced rather than explicitly accounted for. 'In the mundane work of observation and dialogue… the social worker shares the sights, scents, and tastes of life that transcend narrative and talk to reveal the realities of a client's life' (de Montigny, cited in Cook & Gregory, 2020: 184). In part, sense-making is therefore a process in which practitioners attribute meaning to the embodied sensations of what they see, hear, and feel during their work (Cook, 2016). During home visit observations, practitioners gathered information for the assessment form through listening to verbal narratives and observing non-verbal evidence such as body language and sights in the house. Upon leaving these home visits, practitioners discussed and shared some observations of what they had heard and seen:

> *'She said that she was coping with meal prep, but she really seemed to struggle to walk into the kitchen. […] She couldn't stand for long… and was really unsteady on her feet.'* (Alex, extract from fieldnotes)
>
> *'She could chat for Scotland! But, she seemed pretty confused when talking about what she had done this morning […]. She couldn't really sequence making a brew. [..] She's definitely not showered for weeks either […]. I really think she is struggling with her personal care… although she seems to think she showered this morning… which makes me question her cognition.'* (Zoey, extract from fieldnotes)

Often following these statements of observations in which a social worker is considering what they had seen and heard, practitioners then consider whether the information is consistent, coherent, and believable. Workers drew upon embodied feelings and senses to aid in forming judgements:

> *'Something doesn't add up. I don't feel like she has insight into how unwell she is.'* (Zoey, extract from fieldnotes)

> *'I think what they were saying made sense, and matches with what I saw in the home.'* (Tom, extract from fieldnotes)

> *'From what I've seen and then what they are saying. Something isn't right. I just have a feeling they are minimising things.'* (Esther, extract from fieldnotes)

The social workers reflected on their initial impressions and considered the coherence of what they had seen and heard to make a judgement on how credible the situation seemed. Following the home visit, they described how they would mentally *'replay'* the visit and their experiences in their head to further enhance their understanding of the situation. Workers therefore engaged in an embodied sense-making process whereby they would *'think through'* (Roesch-Marsh, 2018: 413) evidence in an internal embodied dialogue which enabled them to make sense of their experience through returning to the visit. Workers described this process in the following ways:

> *'After the home visit, I kinda replay it my head and think about all the things that were said and what I saw.'* (Esther, extract from fieldnotes)

> *'My head is always buzzing after an assessment. It's filled with lots of stuff that I need to process, you know.'* (Tom, extract from fieldnotes)

> *'I think about everything that happened during the visit, because you can miss stuff, or not pick up on stuff at the time. Then after, when you're thinking and running through it again, you start to work out what you need to do.'* (Ava, extract from fieldnotes)

Social workers thus use their bodies during the visit to see and sense things which are often referred to as gut feelings or intuition. Their bodies are also sites of sense-making when they replay the visit in their head and process their judgements. The process of arriving at a judgement involves considering the embodied feelings and engaging in embodied reflection. Cook and Gregory (2020) highlight the dangers of intuition and gut feelings which can lead to biases and compromise effective judgements when making sense of situations, noting the importance of reflexive practice.

5.3.2 Embodied knowledge of ratings and points

The financial crisis of 2008 resulted in unprecedented cuts to public services and years of austerity measures (Pollitt & Bouckaert, 2017; Prowle, Murphy & Prowle, 2014), restricting local authorities' access to resources. Individuals requiring social care were therefore required to meet high thresholds of risk and need in order to gain access to formal support under their local authority's eligibility criteria framework (Pearson & Ridley, 2017). In line with the national eligibility framework, a social worker assesses and classifies risk as: critical risk; substantial risk; moderate risk; or low risk within the co-produced assessment. The Independent Review of Adult Social Care found that people felt that the threshold for accessing support is too high, and that support is often only available at a point of crisis (Feeley, 2021). Furthermore, 'eligibility criteria were described as one of the main barriers to accessing support' (Feeley, 2021: 10). Decades of reduced resources and public spending have therefore resulted in 'cost pressures' adding 'to a sense that SDS is, *per se*, "too expensive"' (Dalrymple *et al.*, 2017: 20). This sentiment was echoed by social workers during the ethnographic data collection.

Workers frequently discussed the limited available provision and a pressure to keep costs minimal which, in turn, affected the delivery and quality of services. Common statements captured within the ethnographic fieldnotes included: *'there isn't enough money for that', 'the local authority just doesn't have enough resources', 'the resources and services just aren't there anymore', 'you used to be able to get money for social support, but they have clamped down on that', 'there just isn't enough to go around',* and *'there isn't enough money to fund SDS properly'*. This pressure to keep costs low through high thresholds of eligibility criteria resulted in the focus becoming centred on crisis management rather than early intervention. As one worker stated:

> *'There is a high demand for support, but we don't have enough resources to support everyone, so we only really work with people at critical risk in crisis… well, they're our priority. The local authority just doesn't have enough money to support everyone. […] Things are really stretched. […] It really changes the job, it's too expensive to support everyone, so we just end up doing statutory crisis work only. Often, service users only get the bare minimum. It's brutal, to be fair. […] The low and moderate risk stuff is low tariff, so that sits with the third sector. So, we just signpost that stuff. […] Then, once it gets to a critical level it will be referred back in again.'* (Sally, extract from semi-structured interview)

This practitioner felt that the high thresholds have contributed to fundamentally changing the remit of a social worker, reducing their work to crisis intervention underpinned by statutory legal responsibilities. Services are described as *'stretched',* and it is felt that the local authority '*doesn't have enough money to support everyone'* resulting in individuals getting *'the bare minimum'*. Furthermore, this worker highlighted that the third sector are often seen as providing services for those who don't meet the criteria for statutory intervention. Similarly, another worker stated:

> *'It's a joke. We [social workers] are meant to promote the wellbeing of all adults. But… really with the eligibility criteria, we are only supporting those where we have a statutory duty. […] It undermines the whole ethos of SDS and the person-centred empowering approach. […] Our role is reduced to crisis intervention, rather than proper social work with people.'* (Amanda, extract from semi-structured interview)

High eligibility thresholds were repeatedly cited as contradicting and undermining the philosophy of SDS and the practitioner's ability to practice '*proper social work'.* Correspondingly, the Independent Review of Adult Social Care makes the recommendation that all eligibility criteria and charging regimes need to be fundamentally reformed and removed, highlighting that social workers should be focussed on the rights of the supported person, rather than hampered by considerations of eligibility (Feeley, 2021). The national macro-austerity policies therefore filter down to the micro-level casework, resulting in social workers and their department making difficult decisions regarding who receives support and in what circumstances. Resources are spread carefully and thinly across groups due to high thresholds combined with a culture amongst the team that there are limited resources, with not enough to go around. I spoke to one worker at her desk regarding her case and recent home visit:

> Practitioner (Amira): *'It's a real shame… this guy is struggling, but to be honest he isn't struggling enough, so I guess… well… he doesn't really meet the criteria or threshold for any support. […] If we supported this kind of case, we'd end up supporting everyone, and we all know there isn't enough money to do that. So, we need to think about who is getting what. […]. I'd rather the money went to people who really need it.'*
>
> Interviewer (Felicity): *'Yeah. Hmmm, and why does he not meet the criteria?'*
>
> Practitioner (Amira): *'Well… I guess daily tasks are hard for him, but he is still managing independently… at the moment. He definitely needs an OT referral. He could do with some equipment like handrails, or a shower seat, and a raised toilet seat, and walking aids maybe. […] But at the minute he can still do most things*

> *himself. I'll put a referral into the befriending service too. […] It can be really hard to explain to service users, and other professionals, you know, that even though someone is struggling there is no way we could get resources put in place for them. He just isn't high enough risk for us. […]'*
>
> Interviewer (Felicity): *'Yeah, yeah, okay…'*
>
> Practitioner (Amira): *'So, I think the referral for him came in from the district nurse, but they think things are high risk when they're not. […] If I brought this to my manager and said it was substantial risk she'd be having none of it. […] There'd need be a pattern of more falls… or pattern of... like, physically unable to get up out of bed and dressed. […] I didn't see any of these things that'd increase the risk.'*

This practitioner has embodied the local authority criteria and normalised these thresholds to the point that they are now accepted rather than challenged. She is focussed on keeping expenditure to a minimum, stating that *'there isn't enough money'* to support each case, so workers need to *'think about who is getting what'* and ensure the money goes *'to people who really need it'*. The practitioner's approach and focus is therefore not centred around person-centred outcomes, but influenced and impeded by considerations of eligibility and limited resources. Furthermore, for this individual to meet the threshold, the practitioner describes the need to evidence patterns of commonly agreed risks, such as falls or struggling to get washed and dressed. Social workers therefore have embodied senses and intuition surrounding thresholds. The process of arriving at a judgement involves consideration of the embodied feelings regarding the evidence, and engaging in embodied reflection. Schutz (1967) describes how actors have a stock of shared typifications or common-sense knowledge that support them in making sense of the world. Schutz (1967) calls this 'recipe knowledge', which is a recipe we tend to follow without thinking too much. For example, double yellow lines mean we cannot park a car there; however, this is only true because there is shared common agreement amongst the population. Consequently, social workers' embodied understanding of thresholds and eligibility criteria is intersubjective and only exists when we share the same meanings. My auto-ethnographic log reflects how I became socialised into various threshold typifications during my own practice:

> *'As I wrote the assessment, I knew I could evidence substantial risk due to poor medication management due to reduced cognition. Support around medication management was required to keep him safe. Some of the sections were more*

> *borderline and could perhaps be argued either way. However, having now completed a number of assessments, I knew what evidence to gather and explore in the assessment which would likely sway the assessment from moderate to substantial. On reflection, I am moving away from the human rights-based empowering approach outlined in the national guidance and begin to interpret SDS at a local level.'* (Extract from reflective log)

When completing assessments, I pieced together effective tried, tested, and trusted recipes or formulas learnt from other workers and previous experiences when navigating thresholds and the eligibility framework. I would therefore tap into my embodied and embrained knowledge of thresholds and, as highlighted in the quote, considerations of eligibility criteria and thresholds influenced my approach to practice and pushed me away from the human-rights approach.

5.3.3 Illegitimate SDS cases: 'that's not SDS'

The introduction of the SDS Act marked a mandatory shift to provide social care in line with the legislation. Nevertheless, as was highlighted in the literature review chapter in section 2.3.2, there are ongoing concerns regarding the extent to which SDS is the mainstream approach, and is thus available to all (ALLIANCE & SDSS, 2020c; Audit Scotland, 2017; Dalrymple *et al.*, 2017). Concerns have been raised regarding specific groups facing barriers when accessing support, or in some cases, about reports that individuals have been denied access to SDS because the local authority has deemed SDS to be unavailable for that group. Similarly, during data collection when discussing referrals there was a culture of considering some cases as legitimate or illegitimate SDS referrals. The evidence suggests that a practitioner's body acts as a container for knowledge of the thresholds and eligibility criteria which are non-textual parts of the policy. This section builds on this further and evidences that social workers draw upon embodied, experiential feelings and senses when assessing whether something should go down '*an SDS route',* or when considering whether a case is '*stable and ongoing'.* Practitioners are shown to hold embrained knowledge which influences their sensemaking regarding SDS cases. Importantly, this dominant team culture facilitates some groups to gain access to SDS, whilst inhibiting others. Consequently, the unwritten but embodied team culture surrounding access to SDS has the power to distort or promote effective access to SDS and must be critically considered. Practitioners made the following statements in this regard:

> *'I think this one feels like a referral to the home care team, rather than SDS assessment.'* (Cora, extract from fieldnotes)

> *‘That’s not SDS. That’s probably a home care one.’* (Amira, extract from fieldnotes)

> *‘This referral is a bit borderline… but I reckon it feels more of a home care one. […] I’ll send it up to home care for an assessment, but… but they’re probably going to send it back down to us.’* (Alex, extract from fieldnotes)

These quotes highlight that SDS and home care services operate separately, resulting in individuals being sent down different ‘*routes*’ or *‘paths’* when attempting to access social care provision. People receive a *‘pre-SDS assessment’* which assesses their need for local authority-organised home care visits. This group therefore by-pass the *‘full co-produced SDS assessment’*, and are thus inhibited from accessing the allocated budget and the four SDS options outlined within the SDS legislation. Consequently, those sent down *‘the home care route’* have restricted choice and control over their social care, which is automatically commissioned and organised by the local authority. Commonly, the home care team refers cases to the social work team if there are concerns that the case has become high risk, too complex for home care to manage, or they require an SDS budget to access respite services. When I asked why home care had referred a case for an SDS assessment, the local authority social worker responded:

> *‘This service user has had home care in for years, but their condition has deteriorated, and I think they are looking for respite. […] So, you need an SDS budget in order to access respite, so the home care team has referred this down to us now.’* (Tom, extract from fieldnotes)

Workers commonly expressed concerns regarding the disparity between the allocated resources within the routes. One explained that:

> *‘Sometimes people are better off with home care, rather than an SDS budget. The maximum amount of home care is actually more than you can get through the SDS budget, […] so I’m reluctant to take people off home care sometimes. Although if they need respite or something like that, then you need to take them down the SDS route. […] I’m pretty upfront with people and tell them straight that if they request an SDS budget they could end up with less.’* (Amanda, extract from fieldnotes)

Workers often stated that if an individual was receiving the maximum amount of home care, in some circumstances this could represent more hours of support than the maximum provision through the

'*SDS route'.* Nevertheless, when this topic was discussed, practitioners regularly mentioned that this would soon be changing so that the maximum provision in both systems would be the same.

Similarly, during data collection there was an unwritten but embodied understanding that hospital cases were considered *'not an SDS case'*. Whilst on duty, I received a referral from a hospital health worker regarding a planned discharge. Within my reflective log I captured a discussion with my colleague, Ava, who stated:

> Practitioner (Ava): *'That's a hospital discharge case. That shouldn't have come into this inbox…That doesn't sit with us. It needs to go to the hub team for discharge planning, and maybe a hospital discharge social worker, it will probably get some home care, rather than SDS.'*
>
> Interviewer (Felicity): *'Okay […] Do hospital discharge cases all get an SDS assessment or access to one?'*
>
> Practitioner (Ava): *'No, hospital discharge cases go down a different route, so they tend to get a pre-SDS assessment, basically home care. They sometimes land on our desk if they have really complex needs that can't be met with home care, then they get access to a SDS budget. […] But normally, the standard hospital discharge cases aren't considered to be stable and ongoing, so they don't go down the SDS path.'*

Consequently, hospital discharge cases often received home care packages to support them to return home; this would then be reviewed, and the care could be reduced, maintained, or increased depending on the assessed need. Workers often used the phrase *'stable and ongoing'* when discussing whether an individual could access an SDS assessment. As one worker stated, 'they can't go down the SDS route. They aren't stable and ongoing'. When asked to define stable and ongoing, one worker replied:

> *'So, the case needs to be viewed as stable and ongoing to be eligible for SDS. It sounds a bit like Theresa May's line "strong and stable" doesn't it [laughs]. So basically, if somebody is going to get an SDS assessment the case needs to be pretty stable with no anticipated big changes.[…] So, for example, a hospital discharge case, it just needs short-term temporary support a lot of the time, to get people back on their feet. So the case isn't stable and ongoing because their condition will change once they are back home in their house. The case is pretty*

> *changeable, so they don't meet the criteria for SDS.'* (Alex, extract from semi-structured interview).

Cases which were subjectively deemed to be unstable and ongoing therefore bypassed the SDS co-produced assessment. However, this criterion is a local authority-specific interpretation regarding who is eligible for SDS rather than a condition outlined in the national legislative framework. This led to a form of ethical stress for some workers, one of whom stated:

> *'The most vulnerable service users often lead very chaotic lifestyles… you know… addictions and homelessness and stuff like that. […] So they aren't deemed stable and ongoing, so they definitely slip through the cracks. Their chaotic lifestyles are their form of stable and ongoing, so they probably don't get enough support. […] They'll never be able reach our threshold of stable and ongoing, you know. I don't really think that's right.'* (Zoey, extract from semi-structured interview).

Social workers use their bodies in sensing and feeling to draw upon their team culture to make sense of whether cases are or are not SDS. This section highlights a concerning culture that SDS is yet to be established as the mainstream approach to social care delivery in Scotland. An embodied attitude persists with some practitioners that SDS will not work for particular individuals, cases, or situations. Embodied ideas and the influence of local authority thresholds result in dangerous biases and assumptions and lead to practitioners buying into the idea that some cases are not SDS. Workers have therefore embodied the local authority's criteria and normalised these thresholds to the point that they are now accepted rather than challenged.

5.3.4 Lost embodied knowledge: staff turnover

Stress, burnout, high staff turnover, and poor retention are well-documented pressing concerns within the social work literature (Healy, Meagher & Cullin, 2009; Middleton & Potter, 2015; Siebert, 2005; Turley *et al.*, 2021). On average, social workers practice for under eight years, compared to an average of 16 years for nursing staff and 25 years for doctors (Bowyer & Roe, 2015; Curtis, Moriarty & Netten, 2010; Turley *et al.*, 2021). Many reasons have been suggested for this poor retention within the social work profession, including 'high work demands, ineffective bureaucratic structures, and little opportunity for advancement. The role also occurs within an environment of rapidly changing policy and subsequent role uncertainty' (Turley *et al.*, 2021: 4). Furthermore, the *Changing Lives* report (Scottish Executive, 2006: 8) concluded that 'the crisis' in social work is mainly a matter of professional identity that impacts on recruitment, retention, and the understanding of the profession's basic aims'.

Correspondingly, the findings presented in the first part of this chapter evidence feelings of disillusionment and frustration regarding the role and identity of a social worker amongst the team.

These ethnographic findings illustrate that high staff turnover was a prevailing factor and influence within the team. Whilst I conducted the ethnography there was a constantly changing team, which included new staff and temporary agency staff. Throughout my time in the office there had been a constant flow of jokes, with members of the team typically stating, '*we will have nobody left next month, at this rate', 'people are dropping like flies, they mustn't be able to hack it',* and *'I don't think I could name the folk in my team. No idea who half the folk are in the office'*. Workers regularly discussed their intention to leave and openly talked about applications to different social work posts. Furthermore, practitioners often expressed a desire for a career change; however, it is difficult to assess the level of intention behind these statements. Nevertheless, a culture of dissatisfaction with the role was present, along with an acknowledgment that their professional lifespan had a time limit for many members of the workforce. One worker commented on the fluctuating nature of the team, stating:

> *'We constantly have people off on long term sick, and so many workers come and go. I think I have had six different team leaders over the last couple of years. […] There're a few staff who have stuck it out. I have been here a while, and people don't last long. […] When I look around the office it is a completely different team to what it was six months ago. […] The turnover is so high.'* (Zoey, extract from fieldnotes)

Similarly, another worker shared her observations regarding high staff turnover and offered possible reasons for the poor retention:

> *'I've been here just over a year and half… And all the people I started with are long gone [laughs]. […] Now the new staff come and ask me stuff! So I'm now treated like an experienced team member… which is weird […]. I guess people leave because our caseloads are high, and also, probably more to do with our systems and procedures. They are so bureaucratic. It drives everyone mad. Like, the job isn't satisfying anymore. [...] So, people just burn themselves out and would rather work in a different local authority. [...] Also, recently [another neighbouring local authority] has been recruiting and poaching our staff and they offer a higher salary for the same job. So a lot of folk have jumped ship.'* (Rose, extract from fieldnotes)

Practitioners value their colleagues for their embodied knowledge, which is not inscribed or recorded elsewhere. This embodied knowledge includes distinct ways of thinking about certain issues. Particular staff were seen as the 'go-to person' for information regarding particular topics. Practitioners regularly drew upon their embodied knowledge to discuss cases and assessments together, sharing opinions and values, seeking and giving advice, and sharing experiences. As is further explored in explored in sections 7.3.1 and 7.3.2 of Chapter 7, social workers engage in collective sense-making to create a coherent understanding of the situation (Helm, 2017). Whilst this embodied knowledge was often relied upon and valued, as Freeman and Sturdy (2014: 10) identify, 'embodied knowledge is, by definition, coexistent with the body of the person or persons who embody it' therefore 'shares in the limitations, the frailty and the fallibility of the human body itself'. High staff turnover results in the team losing embodied knowledge because when a staff member leaves, so do their embodied ways of thinking. Zoey described this issue in the following way:

> *'I picked up a case recently that had had four different social workers in the last eight months. It really impacts the service user, but I totally get why practitioners want to move on. […] It's hard to pick up a case like that, because the service user is sick of the turnover of staff and doesn't want to have to start at the beginning again. […] Also, there aren't proper detailed handovers, so often it takes a while to get your head around the case, and work out what has been done. […] And when the old worker has moved local authorities, you can't ask them about it all, and work out what is really happening.'* (Amanda, extract from fieldnotes)

Often the inscribed handover notes were incomplete, rushed, or inadequate compared to a direct conversation with the previous worker who had held the case. The high staff turnover result in a loss of knowledge about cases, but also a loss of knowledge about navigating the specific systems and procedures in place within the local authority. These findings echo the wider concerns found within the social work literature about poor retention, stress, and burnout, all of which impact on the service provided to the supported person.

5.4 Chapter conclusion

This chapter has provided an analysis of the embodied knowledge associated with SDS work. The social worker's body is a site where emotions and feelings manifest in relation to the policy, and also a space where SDS understandings and typifications are stored. This chapter attempted to open the black box and make visible practitioners' often unheard embodied feelings and taken-for-granted everyday embodied understandings of SDS. When exploring professionals' emotions towards the policy, themes of marketisation, consumerism, and managerialism all emerged, which were linked to obstructing relationship-based practice, whilst hindering practitioners' sense of autonomy. Frustration was commonly expressed by the practitioners who participated in this study, who often spoke of conflict between their own professional values and organisational procedures, which resulted in ethical stress when attempting to implement SDS legislation. Furthermore, the local authority interpretation of SDS resulted in embodied emotions of dissatisfaction regarding the professional role, which often did not meet expectations.

In addition to these tacit embodied experiences, a practitioner's body is also a site of 'know-that' embrained knowledge which stores case knowledge, which supports workers to assemble and translate the policy. Social workers had gut feelings about cases, and embodied understandings of thresholds and risk ratings. The practitioner's body therefore acts as a container for knowledge surrounding the non-textual parts of the policy. Social workers have been unconsciously socialised and conditioned to respond to various instincts and intuitions when translating SDS. Embodied knowledge can prove problematic with the possibility of including biases and prejudices. Furthermore, embodied knowledge can easily be lost due to the high turnover of staff, and thus lacks longevity.

Nevertheless, although embodied knowledge was relied upon by practitioners, it 'must be enacted to be realised' (Freeman & Sturdy, 2014). Hence, disembodied knowledge in the form of inscription and enactment will be examined in the subsequent chapters to explore how practitioners spend their time reassembling the policy within documents and translating it during encounters. Embodied knowledge works in combination within inscribed and enacted knowledge as the SDS policy continues to move through practice and is it is continuously assembled and translated. The following chapter presents a detailed discussion exploring the findings linked to inscribed SDS knowledge.

Chapter 6: Inscribed SDS knowledge

6.1 Chapter introduction

From day one of data collection the centrality of the inscribed documents within social work practice was evident. Discussions revolved around emails, meeting minutes, assessments, care plans, financial assessments, personal assistant contracts, guidance documents, spreadsheets, and the various screens within the database program. This chapter examines the forms of inscribed SDS knowledge which illustrate how social workers translate SDS through the process of writing and reading. As the theoretical frame in Chapter 3 outlined, embodied and enacted knowledge becomes visible once it is translated into an inscribed tangible artefact, such as a document (Freeman & Sturdy, 2014). Knowledge is 'inscribed in objects and artefacts whose purpose is to mediate and inform our interactions with the world rather than represent it' (Freeman & Sturdy, 2014: 10). The act of inscription and the pressure to inscribe was often openly discussed in the office. The following quotes give examples of the reoccurring conversations:

> *'Social work has turned into recording everything we do. We spend way too much time in front of a screen and not enough time actually with the service user. […] There is always so much paperwork now, whether it is case notes, emails, assessments, care plans, or the financial assessment forms… It's a lot.'* (Esther, extract from semi-structured interview)

> *'Make sure you record that. Remember if it isn't recorded, it never happened. Get it wrote [sic].'* (Zoey, extract from fieldnotes)

> *'Sometimes I feel our work is just assessment after assessment. It really is assessment, assessment, assessment. Nothing can happen without an assessment.'* (Amanda, extract from semi-structured interview)

During the ethnographic data collection practitioners were captured moving through different practice spaces, revealing a range of inscription activities. Social workers gradually collated information by completing forms and care plans. Jottings were made during the home visits which were later translated into the assessment document. Furthermore, social workers recorded their case notes on the database, and crafted emails to other professionals, supported people and families. Ethnography provided a means by which to capture inscription including the edits and alterations to documents following management recommendations. Later, during the auto-ethnography, I developed know-how understanding and participated in the process of inscription during my daily work. The concept of know-how refers to the skills and practical capabilities I learnt through being situated in the office (Freeman & Sturdy, 2014). I became fluent in writing assessments, care plans, case notes, and emails as my SDS inscribed knowledge grew.

When considering these links between people and inscribed objects, the sociological concept of ‘boundary objects’ facilitated in conceptualising and understanding the connection between a social worker and documents within a practice setting. Star and Griesemer (1989: 393) state that boundary objects:

> *[…]both inhabit several intersecting social worlds and satisfy the informational requirements of each. Boundary objects are both plastic enough to adapt to local needs and constraints of the several parties employing them, yet robust enough to maintain a common identity across sites. They are weakly structured in common use, and become strongly structured in individual-site use. They may be abstract or concrete. They have different meanings in different social worlds but their structure is common enough to more than one world to make them recognizable, a means of translation. The creation and management of boundary objects is key in developing and maintaining coherence across intersecting social worlds.*

This definition thus offers a frame for understanding the key documents prevalent in daily practice. The SDS assessment document and the SDS care plan can be considered as boundary objects because whilst they maintain a constant structure, they transcend the different social worlds of the home visits, the office, and a resource allocation meeting. These documents acquire slightly different meanings within these distinct spaces. This ethnographic research moved with the workers through practice spaces, observing their actions and interactions as the documents were crafted and utilised. Freeman and Maybin (2011: 162) highlight the importance of examining the practices and interactions surrounding the acts of creating, writing, and reading of documents, rather than exclusively focussing on the content of a finalised artefact:

> *To understand implementation, then, which we might think of as the realisation of documents in practice, we need to understand what happens in the spaces between them. How is one document translated into another, by whom and what for? How is one document articulated with and in another? Even to begin to answer such questions, we need to know how documents are written and read, produced and received.*

Although the content of a document can be examined through the use of research methods such as content analysis or document analysis, this chapter is concerned with the series of interactions involved in the crafting of documents. Despite the ubiquitous presence of written documents, they are often overlooked, as research tends to focus on the content or information contained within a given document instead of positioning a document as a material object. This focus on the practice of crafting aims to render the processes of inscription visible, revealing how assessments and care plans are put together, produced, and assembled. Documents leave material traces and marks of actions, but can also trigger and ignite actions too (Freeman & Maybin, 2011). This chapter therefore aims to explore the black box of writing and reading by considering the social life of documents (Appadurai, 1986; Atkinson, 2017).

The chapter opens by exploring the familiar theme of bureaucracy (see sections 2.3.4 and 5.2.1), followed by the defensive practice of leaving a paper trail. Next, it zooms in on the backstage work of writing an SDS assessment through utilising a case study from the collated ethnographic fieldnotes. This case study captures the conversation between a social worker and the researcher as the practitioner actively writes an assessment in the office. This exemplar of practice renders the backstage process of inscription observable, and throws into relief many of the themes captured within this chapter. Next, writing is considered as part of a practitioner’s sense-making, aiding them in piecing together the case narrative and generating new understandings. This chapter therefore positions the social worker as a translator who refines and distils gathered information. Then, it is acknowledged that if writing is crucial in practice, so is the process of reading. The findings suggest that practitioners are acutely aware of the manager reading their assessment, which impacts the inscribed content. Although a social worker is writing documents, the evidence suggest that they are not always the sole author due to managers’ contributions. Next, the fieldwork reveals what has *not* been inscribed, suggesting limited record keeping of good conversations. Furthermore, the evidence indicates that both the care plan and the review paperwork were process-led and lacked the desired outcome-focussed approach.

6.2 Bureaucracy: time to tick-boxes and complete forms

Recording, documenting, and completing paperwork was a fundamental part of daily work within the adult social work team. As was previously described, workers were observed completing daily case notes, assessments, care plans, and financial assessments, and regularly updating key screens on the database. Furthermore, workers frequently received and responded to emails from families, supported people, professionals, and colleagues. Recording was a labour-intensive activity, with some workers putting a day aside in order to *'catch up on case notes and admin'*. As previously highlighted within the literature review chapter, high levels of bureaucracy within local authorities have hindered social workers' implementation of SDS (Care Inspectorate, 2019). Section 5.2.2 highlighted that 60-80 percent of practitioners' time was spent on administrative tasks (White, 2008), and evidenced that workers felt that bureaucratic tasks had encroached on the time available to them to build rapport and relationships with the supported person. Building upon this, these inscribed findings suggest that practice continues to be overwhelmed by bureaucratic procedures, which persistently act as a barrier to implementing SDS. Social workers expressed daily frustration at the lengthy assessment process, and the months needed to gain a finalised budget. Practitioners spoke of having to *'jump through too many hoops*' and navigate around *'red tape'*. The following accounts portray some of the typical views expressed by the practitioners:

> *'There're just so many unnecessary steps… from when you get allocated the case to finally closing it. So many long forms, and it feels like they're always changing. […] Then [the database] is a complete nightmare. When I wanted to start a new service for someone, the guidance for doing [the care plan] was, no joke, about 30 or more steps of how to input stuff, like five A4 pages of instructions of where to click, what screens to complete. […] The guidance wasn't about the content of the care plan, but how to work the database. […] Then, obviously, you just lose the person in the middle of all that.'* (Tom, extract from semi-structured interview)

> *'I spend all my time in front of a screen and not actually with people.'* (Oliver, extract from semi-structured interview)

> *'[The database] is so prescriptive in so many ways, but it's also got too many steps to it. So, people then devise their own short-cuts, do you know what I mean, everyone uses it slightly differently, and whole localities interpret it slightly differently. So, things just get lost in translation. The more steps you've got in a process, the more mistakes you can make.'* (Ruby, extract from semi-structured interview)

Furthermore, section 7.3 in the following chapter explores the practitioners' enactment and offering of limited SDS options due to lengthy administrative processes. The findings suggest that option 3 becomes the default selection of social care because support can be accessed more quickly, whereas option 1 is viewed as involving a very lengthy bureaucratic procedure. Section 7.3 also evidences that some supported people who originally opted for option 1 changed to option 3 due to the long processes involved, representing a reduction of choice.

The pressure to get through caseloads and produce assessments emerged quickly and strongly as a theme. Practitioners expressed frustration and long bureaucratic processes, and spoke candidly about the temptation to provide *'generic'* or *'bog-standard'* answers within the assessment:

> *'It is more about getting down the main points, so you can get the care in place. […] It sounds bad, but I don't always have time to build that rapport. […] So assessments can get a bit samey… I guess a bit generic.'* (Ava, extract from semi-structured interview)

> *'I've got into a rhythm with my assessments. I know what needs to be included in the bog-standard assessments. They get pretty repetitive when you have been here as long as I have.' (Zoey, extract from fieldnotes)*

> *'The assessment form is long and repetitive. It asks the same stuff again and again, you end up repeating yourself just so you're ticking the boxes. […] If I'm being honest, I do copy and paste things from other assessments. Like, I adapt and adjust it of course. […] Everyone does. It's not great practice, but… you know.'* (Alex, extract from semi-structured interview)

The long bureaucratic processes and the pressurised nature of their work result in practitioners producing routine, standard, and narrow accounts within the assessment documents, calling into question the personalised and person-centred nature of assessments. High caseloads and bureaucracy are therefore contributing to practitioners capturing a potentially distorted and shallow account of individuals, which contradicts the overarching philosophy of SDS. SDS practice is entangled with the dominant 'audit culture' (Power, M., 1997), with a focus on getting through the administrative tasks. Once again, SDS work has therefore become increasingly organised around processes, procedures, and tools, resulting in concerns regarding the weakening of professional discretion.

6.3 Paper trail: risk and defensive practice

Workers had distinct styles of recording, with varied focusses. Some practitioners wrote in the first person, while others wrote in the third. Some included verbatim quotes from the supported person, whilst others focussed on the supported person's strengths and weaknesses. At times, some practitioners noted their own feelings, whilst others stated that they '*document the facts*'. Although workers were frustrated with the high levels of administration tasks, they also spoke of leaving a '*paper trail*' to evidence their work, interventions, meetings, concerns, and conversations. Furthermore, practitioners stated:

> *'I always have a paper trail, then if things get tricky I copy my manager into emails and things.'* (Ava, extract from fieldnotes)
>
> *'I generally discuss stuff with my team leader or run it by them quickly. Then, I always type that conversation up and put it on [the database]. Just to cover my own back.'* (Amanda, extract from fieldnotes)

Inscription therefore serves as a defensive function, with some workers recording in order to protect themselves from perceived risk and accountability. Whittaker and Havard (2016: 1160) describe defensive practice as social work's 'open secret'. Social workers are increasingly held accountable for their judgments, with a blame culture in place, and therefore practitioners are often forced to consider the potential risk to themselves (Webb, 2006). The growing pressure in our modern-day risk-averse society leads to reduced professional discretion and instead to a focus on explicit forensic judgement (Beck, 1992; Webb, 2006). The findings suggest that daily practice, including the work surrounding SDS, includes the use of defensive team cultures as a coping strategy. This defensive narrative contributes to diminishing or threatening the positive risk-taking approach and philosophy which underpins SDS. During an interview with a practitioner, I discussed using the SDS budget for equipment or a more creative option to meet the supported person's needs, rather than utilising the budget to employ a Personal Assistant. The worker highlighted the local authority's organisational risk-averse approach as impacting frontline implementation:

> *'I think it comes down to what risks the local authority are willing to take. I don't think folk at headquarters are willing to take many risks. […] They just want straightforward packages with home care, respite, and day care. […] This attitude filters down to us in the office. […] So creative options aren't really an option, or even if they say they are, it's impossible to get it authorised. […] I don't think they think it's a risk worth taking. […] People get really stuck in their ways and scared to do something different in case it all goes wrong and comes back on them.'*
> *(Sally, extract from semi-structured interview)*

Risk-taking and defensive practice at an individual and organisational level continue to hinder SDS implementation. The former deficit and risk-averse models of social care assessment, which quantify need in terms of hours of support and types of care rather than the co-production of desired outcomes, continue to dominate. The evidence suggests that preoccupation with the risk to the social worker and to the organisation diverts attention away from the positive risk-taking needed to empower the supported person.

6.4 Case study: inscribing an assessment

The literature review in Chapter 2 revealed the frustrations of both supported people and practitioners with the paperwork and assessment processes they faced (see section 2.3.4). Building on this theme, the method of ethnography provides a tool for the researcher to observe the active inscription of SDS assessments, thus capturing the writing process from an unseen and previously unexplored position. Four different social workers were observed at their desks during data collection completing assessment forms and care plans for 15 supported people. The intention was to examine the everyday situated inscription process in a detailed manner, in order to develop what Geertz (1973: 10) famously described as a 'thick description' of the layered writing activity.

This section presents an extended extract from the ethnographic fieldnotes, as a case study example of inscribing an assessment. The extract is deliberately lengthy in order to capture the details and thick description. This case study renders the backstage process of inscription observable through capturing the conversation between the social worker and I during the act of crafting the assessment document. The conversation offers a more performative insight into SDS work, illustrating the worker's thinking aloud, thus giving a sense of what a social worker actually does during implementation. Commonly, practitioners draw upon information they have gathered from a range of sources, including notes from home visits, meetings, phone calls, health reports, police reports, and care plans. When writing, social workers translate their views and experiences, which became embodied within the text. This particular observation and extended extract was selected because it offers an echo of other themes which emerge within the three findings chapters. Below is the encounter with Ava:

> *I pulled up my chair to sit alongside Ava at her desk as she opened the database screen and launched a new assessment form. Two weeks prior to this I had attended the linked home visit with Ava and met the supported person. Ava turned to me and began with a verbal overview of the case which included the supported person's health diagnosis, previous hospital admissions, housing situation, and family support. She also explained how the individual became known to the social work department. She finished the summary by stating 'so, a pretty standard case. Nothing particularly complex with this one.' Ava began to*

discuss the timescales of the work surrounding the paperwork, stating, 'a worker has about four weeks to get an assessment submitted from when you do your first visit. So I am still well within this timeframe. Although the service user was on the waiting list for months before I got the allocation… so it will feel a lot longer for them.'

I asked who contributed to the assessment following the visit. Ava said she had contacted the linked health professionals and that she was also using a recent respite plan to inform the assessment. Ava: 'So I rang around the linked health professionals and got their views. […] They've been working with him longer than me, so they have a good idea about his abilities and what kinda support he'll need.' I asked how many home visits she tends to do when gathering information for the case, and Ava explained 'it depends on the case and how complex it is. […] During that visit we were able to get through all the questions. So, I got all the information I needed.'

Ava moved on to explain the format of the assessment and the various sections which need completed. She passed me her notes from the home visit and stated, 'so I tend to print a blank assessment and bring it with me to the home visit to guide the conversation. […] I make lots of notes […] I don't always follow the order of the assessment, but it means I don't forget to ask certain things.'

Ava clicked on the first section of the assessment form and pointed to the screen, 'at the top of each section there is box for the service user views and the service users risk rating.' She continued, 'their ratings can be way off, but you record their views anyway.' I asked if she feels their voice is heard during the process and she stated, 'to an extent, but my team leader wants to know my professional view of the case mostly.'

She moved through the various parts of the assessment and populated it with information from her notes. There was a section which included information about medication management. Ava began looking at her notes and typing in the box, using first person and quotation marks to emphasise the direct speech of the supported person. She typed into the box 'I sometimes forget to take my medication and my wife supports me with this.' She added in other content and then clicked 'moderate risk' under the service users views. She turned to me and *explained 'although he gets constant support from his wife, it's only a moderate risk because support arrangements are in place to safeguard him. It probably could be low risk, to be fair.'*

She moved onto another section and said, 'so we need to be careful here. So this assessment tool actually generates the carers budget too. […] So there is an overall amount a service user and their carer can get, which is capped. […] So, if the carer is getting money, it kinda means there is less money available for the supported person. Although the carer would be spending that money on the supported person, like respite, so it's all the same really.' I nodded and then asked how that impacts the way she completes the assessment. Ava pointed to the screen 'so how I fill out this section impacts how the money is allocated to the carer and the supported person. It's a bit complicated. So here, for example, I need to be careful, I have said it is substantial risk, but requires constant support and currently gets all his help from the carer. This means that the carer gains points and it generate a carer's budget. Ultimately, if the carer wasn't there it would be high risk. Whereas I have another case where it's moderate risk, and he is independent, and gets no support, so that won't generate a budget because the service user is managing fine. Whereas for example, the combination of critical risk with the need of frequent support and no help, will generate a budget for the service user because there is high risk and no support in place. […] Sorry, I feel like I'm making it more confusing! Does any of that make sense? It's all about getting a balance of risk levels, current support arrangements, and what support might be needed.'

Ava continued to into the information into the assessment form, picking risk ratings and considering the impact this would have on the supported person's budget. She turned to me and stated, 'he has had a few falls, but I don't think, I mean he doesn't need four visits a day. His wife is happy to provide medication… hmmm… lets aim for enough, for three visits a day and a carers budget.'

Ava stated that Alex taught her the ratings and smiled over to him. She then asked him, 'is there any difference between substantial and critical, they generate the same budget, right?' They discussed the evidence that Ava had and decided what they felt was an appropriate rating. The conversation then moved onto whether workers share the assessment document with the supported person. One *social worker stated 'I don't give them the assessment, it is very negative, but you need to write it like that to get the budget. So, I tend not to give them it.' Ana looked back at her screen and was considering the number of falls and the number of hospital admissions, and said to me, 'it might be worth putting an OT referral.'*

Ava decided she was going to ring the nurse for an update about the supported person. They spoke for about 15 minutes. Ava asked the nurse, 'How do you feel he could manage at home? In terms of home care, do you think three visits a day or four a day?' She continued, 'I know his wife still wants to do meals, but I'm not sure how sustainable that is in the long term.' She listened and made notes and stated 'I don't want to overload them with support, I think they are looking for twice a day.' Ava ended the conversation and thanked the nurse for the information. She turned to me and said 'okay, I've got a better idea about what budget I need to generate now, so we can meet his needs.'

She continued to type and stated, 'you have probably noted how repetitive the assessment is. It's really task focussed, I don't think it is great tool for capturing people with learning disabilities, or mental health needs. Because it's so task focussed and you can't really capture things like mental health in box […] On a good day someone might be able to do something, but then on a really bad day with poor mental health they can't get washed and dressed. Like, how do you fit that in such rigid boxes?'

Throughout this observation Ava, was approached five different times about different cases, whilst also answering her phone. I sat with Ava for three hours until the end of the day. She said she would continue to work on the assessment the following afternoon after a couple of home visits in the morning.

The following afternoon Ava waved me over to her desk. She printed out a copy of the assessment and handed it to me. 'Thought you might want a copy to have a look through.' She explained she was going to ask the team leader what budget the assessment was currently generating. Ava said 'social workers don't have access to the budget screen. They obviously don't trust us with that information [laughing].' I went with Ava to the team leader's office. The team leader looked up the supported person and budget which the assessment form was generating.

> *Ava responded, 'so I need to change one rating, I reckon.' She had done the calculations and realised the current budget wasn't enough to cover three visits a day. Ava and I went back to her desk and she altered a few ratings. She went back and forth to the team leader's office and stated 'third time is a charm.' Ava submitted the assessment to the service manager and requested a resource allocation meeting where the final budget would be decided.*

This case study encounter with Ava highlights how social work practice is negotiated through the assessment artefact, illustrating the social life of the document. Initially, Ava developed her understanding and view of the case whilst writing and through speaking to another professional, thus the inscription process supported her sense-making. She cast doubt on the impact and importance of the supported person's views, illustrating how views can be muffled and lost in translation with practice becoming process-led. Additionally, she considered the combination of the ratings selected and the impact on the carers budget. It is evident that the ratings are engineered with a focus on process and budget, rather than an outcome co-produced assessment in collaboration with the supported person. Ava engaged in meetings about meetings with her team leader in order to prepare for the resource allocation meeting. The process of inscribing was thus observed to be a calculated, considered, and consequential part of daily work. The case study emphasises that although the social worker is writing the assessment, it is being written for management, which calls into question the purpose of the assessment itself. Rather than focussing on the content of the document, Ava's interactions surrounding the crafting of the assessment were centred, thus the case study partly opens the black box of writing. Overall, this case study highlights the power of documents, illustrating how they influence, steer, and create daily work within the office. Finally, the section sets the scene for the broad range of themes explored throughout these three findings chapters.

6.5 Inscribing as sense-making

During the observed home visits, social workers made written notes, gathering evidence regarding what they saw and heard, and jotted down important observations and points, moving through the standard questions from the assessment form, often from memory, and steering the conversation in order to gain the information required. When questioned about the notes made following a visit, Zoey responded:

> *'We [social workers] meet so many people all the time, so I would forget if I didn't make notes. […] I don't need to bring the assessment form with me anymore. I know it by heart now [laughing]. […] It's just the key points I guess… and then I*

> *will flesh them out later when I put the assessment together.'* (Zoey, extract from fieldnotes)

Similarly, when Tom momentarily could not locate the correct notebook and was searching around his desk, he commented:

> *'I can't remember what notebook I used. […] I really need those notes to jog my memory.'* (Tom, extract from fieldnotes)

Notes from the home visit supported workers with their recall when they began to assemble or *'put the assessment together'* potentially days or even weeks later. When describing her notes, one worker explained that she will '*flesh them out'*, therefore expanding and building on the jottings. Yet, the process of writing represented more than recounting the evidence from the original notes. Writing is thereby a method which facilitates enhanced or new understandings of the case. The extracts below illustrate the practitioners' thought processes when completing an assessment form.

Ava commented:

> *'When I get everything written down together, I can connect the dots. […]. Then I can begin to work out the risk ratings. I can see the full picture and what's really happening […], then I know how I am going to argue my case.'* (Ava, extract from fieldnotes)

Similarly, Tom stated:

> *'Sometimes when I am writing it all up… it kinda hits you and you get it. […] It kinda clicks and then I know what community resource, or service, I'm going link in with.'* (Tom, extract from fieldnotes)

Social workers thus utilise writing as a process of social storytelling whereby a coherent narrative can be constructed. As Weick (2012) highlights, sensemaking is centred around creating order through a narrative, bringing different pieces of information together and rendering them explicable. Sensemaking is therefore the process of creating a story from fragmented information so that meaning can be conveyed to others (Weick *et al.*, 2005). Writing provides a space for social workers to translate and make sense of multiple gathered pieces of information in order to form a holistic *'full picture'* of *'what's really happening'.* Through writing, intelligible narratives can be produced from messy jottings and notes.

6.6 Backstage inscription: translation, refining, and distilling

Sally vividly described how the social worker has to *'translate' embodied feeling of* what they see, hear, and even smell into an inscribed assessment, stating:

> *'The manager has to sign it [the assessment] off, from what they've got in front of them. They haven't met the person, they don't know anything about them, they don't know what their family situation is, or how they or their house looks, and how it smells, or heard them speak. They haven't knocked on the door, sat in the living room, walked around the house, and all the rest of it. They don't have the joy of, you know, of knowing that. All they have is the assessment that's in front of them, and they've got to make a judgement on that. So, the social worker has to translate all that information across in the assessment and put forward their case.'* (Sally, extract from semi-structured interview)

Consequently, social workers are translators who bring information from one social world to another via the boundary object of the assessment (Star & Griesemer, 1989). The assessment is thus a powerful tool for the social worker, in which specific pieces of evidence are purposefully threaded together to translate a particular narrative. Goffman's (1974) concept of framing can be applied to describe the way in which practitioners construct and place emphasis on specific pieces of information to communicate particular understandings and meanings. This process was described by Amanda:

> *'I'm selective about what I put in [the assessment]. That's what actually makes a good assessment. It's that ability to be more concise… I think when you first start [as a social worker], you write everything down because you don't know what's important, but now I guess I know what things are important and what to leave out.'* (Amanda, extract from semi-structured interview)

Translation therefore involves making conscious and unconscious choices about what to include within inscriptions through filtering, refining, and distilling the collated evidence. This raises questions around the representation of individuals within assessments; furthermore, it confirms the importance and significance of co-produced assessments in collaboration with the supported person. This backstage-inscribed frame of the case can influence subsequent encounters and enactments and result in action or inaction depending on the reader's response to the content. How an individual is assembled in an assessment is crucial, because an enduring and pervasive image is conjured in the reader's mind, which influences decision-making forums. Thus, an assessment impacts the type of immediate intervention, but also future approaches when the case is revisited and assessed. As Toch *et al.,* (2003: 157) state, 'the importance of the written records, reports and files are crucial to the way 'cases' are constructed. After a while a file takes on a life of its own, and it can be very difficult to question what it appears to represent'. Thus, inscription impacts and crafts future interaction orders, as is explored in the following enacted chapter.

6.7 The reading of a document

The social work team are immersed in documents and consequently not only engage in writing, but also in the process of reading documents. Workers have become increasingly dependent on texts to aid with understanding and navigating the practice world. Social workers often read the work of colleagues when developing their own knowledge of the paperwork. Example assessments, care plans, or emails are circulated, read, discussed, saved, and reviewed. As one social worker stated:

> *'I learnt how to write assessments from reading loads of Zoey's. She's a good assessment writer. […] Or, if I have a complex case, I ask around the team and see if anyone else has had a similar kind of case, and then give that a read… to help me with mine.'* (Rose, extract from fieldnotes)

The process of reading therefore enables the social worker to develop what they think, thus supporting practitioners to make sense of their case and writing. Similarly, when I began practicing in the team, I noted the following in my reflective log:

> *'As part of my induction I have been sent through a range of different assessments to read. They capture a variety of individuals with different diagnoses and needs. […] My team leader said they were examples of good well written assessments. […] She explained they are often shared with new starts, so they can see what the assessment looks like in [this local authority].'* (Extract from reflective log)

Although the evidence suggests that reading is a form of sense making, a separate theme emerged here linked to reading, which was that social workers were conscious of who was going to read their assessments, and therefore engineered documents for the reader. Freeman (2006: 53) states that:

> *[…]text links its authors not only to each other but also to a specific readership. Readers are selected when writers choose a certain format, method of publication, or means of dissemination for their work. In turn, it becomes a source of authority, a means by which influence is established and exerted, such that the*

> *production of the document may be thought of as a process of underwriting as much as writing.*

The evidence suggests that workers were concerned with how the reader would interpret their assessment form, and what budget would consequently be allocated. As one worker stated:

> *'You kind of learn after a while what gets you points. Like, I know the buzz-words now. So I write my assessment with that in mind.'* (Amira, extract from fieldnotes)

Furthermore, when I asked a social worker who they were writing the assessment for, they responded:

> Interviewer: *'So when you are writing the assessment, who is the audience? I guess I mean, who do you have in your head as you are writing?'*
>
> *Esther: 'Probably the service user, right? I want to get them the support in place. But I guess also [the service manager]. I need [the service manager] to sign it off.'*
> (Esther, extract from fieldnotes)

In sections 7.3.1 in the following chapter, the findings suggest that writing an assessment was not simply about capturing the supported person, as there was also a preoccupation about what budget it would generate. Furthermore, section 7.3.4 captures the informal meetings between the social worker and team leader where the assessment would be *'checked over'* prior to the resource allocation meeting. Social workers are therefore inscribing and crafting texts with both the reader and the budget in mind, which ultimately influences how they frame the content. The assessment document forms the basis of the narrative of the resource allocation meeting, thus the practitioner can influence the discourse through their inscription. Nevertheless, the content of the text is debated, which may result in edits and alterations to the document. Freeman and Maybin state: 'Like writing, then, reading is a function of power relations. Just as it matters who writes what, so it matters who reads' (2011: 164).

6.8 Authorship: writing and rewriting

Although a social worker writes the assessment, they also engage in a series of informal and formal interactions with managers which result in edits prior to final agreed draft. Workers would engage in a series of informal encounters to discuss the unfinalised written assessment in preparation for the resource allocation meeting (see section 7.3.4). Following discussions with their team leader, at times alterations are sometimes made to the inscribed assessment document. Additionally, the present findings suggest that cases were re-storied during the resource allocation enactment, resulting in various changes to the content before the assessment could be agreed and signed off (see section 7.3.5). Through observing the life of the document, various drafts and inscribed edits and alterations revealed how the assessment was crafted (Appadurai, 1986). Based on observations of the resource allocation meetings, the social worker was often relieved or frustrated at the amount of changes required:

> *'I just need to make a few changes before it can be signed off.'* (Dylan, extract from fieldnotes)

> *'My team leader asked me to make some changes, which I did. Now [the service manager] is asking me to change them back, which I will do now. Such a waste of time. I just want it signed off.'* (Cora, extract from fieldnotes)

I reflected upon my own experience of producing a written assessment within my reflective log:

> *'I had an online call with my team leader to discuss any required edits to my latest assessment, prior to the resource allocation meeting with the service manager. I needed my team leader to sign-off and authorise the assessment before I could move onto the next meeting with the service manager. The team leader quizzed me on a few parts, asking me "what do you mean here?", and recommending "well, make sure you include that". She also advised, "you perhaps need a bit more information in this section" and asked "where are the GP's views? I think we need more of that." She concluded "this is a really complex one. We are going to need a very large budget, so the assessment has to be solid." I came away from the online call with some scribbled notes of the various amendments. I made the changes later that day, which included expanding on some points and changing the ordering of the written content. It feels more like a collective authorship when I include the alterations recommended from my team leader and service manager. It makes me question who really is the author of my assessments and to what extent is the service user co-producing this assessment?'* (Extract from reflective log)

Although the social worker is the author of the assessment, their written words are scrutinised by managers and the final version often includes alterations and modifications by supervisors. It was evident that managers held the ultimate control over the final content of the document, as they held the power when signing it off. It is important to note that management's role is to guide and supervise frontline workers, which means they play an important role in monitoring and checking content and thresholds. Nevertheless, at times a tension existed between the social worker's stance and the manager's views, which could deplete the social worker's sense of autonomy. During an interview with Amanda, her loss of voice when crafting the assessment was apparent:

> *'The assessment has my name on it as the social worker, so appears like I wrote it, and I did write it, but sometimes [the service manager and team leader] want you to make some changes, and you have to. […] They are more experienced, and in charge, so they get final say. […] You need them to sign it off to get the budget. […] There was one assessment a while ago where we had completely different views, you can argue your case, but you have to go with what management say… But you know my name is still on it. […] If there are major changes I don't agree with… I always put a case note on [the database], just to cover my back. You know, so my professional opinion is documented somewhere.'* (Amanda, extract from semi-structured interview)

The social worker's voice is therefore diluted, and the assessment becomes an inscribed document which is assembled by multiple contributors and authors. Yet, although the policy promotes a co-produced assessment in collaboration with the supported person, the voice of the supported person remains weak, and instead the dominant voice is that of practitioners.

6.9 Not inscribed and unrecorded

6.9.1 Unrecorded: good conversations

Following a home visit, workers recorded their case notes on the database and utilised them at a later date when writing the assessment and care plan. From critically reading the inscribed documents and case notes there was often limited description explaining the conversation between the supported person and the social worker. This links to the findings in the following chapter which suggest that the enactment of 'good conversations' was partly hindered by the crisis-reactionary nature of social work practice, which reduced the ability to have preventative long-term conversations (see section 7.2.2). Furthermore, the findings highlight that the process-led practice of utilising tools which are deficit-focussed created a barrier to fully implementing personal outcome empowering conversations. Nevertheless, during data collection good conversations were observed, however limited recording detailing the content of the conversation occurred. Below are two extracts from case notes and care plans which reference the enactment of a good conversation:

> *‘[redacted name of the supported person] has stated their preferred option is option 3. They have expressed that they would prefer the budget to be managed by the local authority and do not wish to manage the finances.’*
>
> *‘Option 1 was chosen because the family feels it is important for [redacted name of the supported person] to build a relationship with carers and work with many people who have supported him for years, and know his needs. A direct payment will enable the family to employ workers who [redacted name of the supported person] is comfortable with and will respond well to.’*

These limited recorded explanations lack the detail needed to evidence informed choice and control surrounding the four options. Although this is a small sample, limited and inconsistent inscribed records describing good conversations were evident. This echoes the findings within the thematic review:

> *There was often little recorded evidence that people had discussed the four options available to deliver their support. There was also a lack of written evidence in case records that people had made an informed choice about which option was the best for them or of people agreeing to their final assessment or support plan. This made it impossible to determine the extent to which choice and control was being offered and delivered through self-directed support. (Care Inspectorate, 2019: 9)*

6.9.2 Unrecorded: care plan

Workers are advised during the local authority SDS training to initially complete an assessment of need and submit this to a resource allocation meeting. Only once the resource allocation meeting is complete and a budget has been allocated can the worker begin care planning conversations and complete the care plan document. During training it was deemed premature to discuss outcomes and potential support until a budget had been formally authorised. Officially, social workers therefore attend the first meeting, explain the process of SDS, and begin gathering the information needed for the assessment. Nevertheless, despite the local authority’s linear approach, often initial assessment home visits result in discussions of the options and how to spend potential future budgets. Care planning conversations therefore happened on an *ad hoc* basis throughout the SDS journey, often during home visits, meetings, emails, and phone conversations. Similarly, social workers informally fed back to their manager after a visit and speculated regarding the potential need for care and an estimated required budget. Many of these conversations went undocumented and unrecorded.

Following the resource allocation meeting, once the official care planning stage was reached, social workers contacted the supported individual via phone and email to discuss the allocated budget. Some workers recapped on previous care planning conversations and completed the care plan on the database in the moment, whilst others conducted a home visit. The care plan document is an important financial tool which links to the assessment document. For example, if money was allocated due to a risk identified with the individual's washing and dressing capability within the assessment, the funds would need to be specifically linked to an outcome in this same area. Whilst completing the care plan, social workers spent time calculating how much money had been generated for personal care or for non-personal care. Overall, the money had to be spent on the areas deemed to be critical and substantial risks within the assessment. As Amira completed a care plan on the database, she stated:

> Practitioner (Amira): *'So I don't know why it's called a care plan… it is pretty much a financial tool. […] It's mainly used by the finance team to work out how the budget is being spent on all the different outcomes… and whether the outcomes reflect the needs determined in the assessment.'*
>
> Interviewer (Felicity): *'Okay, I see… what do you see as the main purpose or point of the care plan then?'*
>
> Practitioner (Amira): *'Well it's definitely for the finance team. Have you seen one? It's not exactly a service user friendly document.'*
>
> Interviewer (Felicity): *'Hmmm… so, have you already discussed the outcomes with [redacted name of the supported person]?'*
>
> Practitioner (Amira): *'Yeah, so it's a pretty standard package. They need the maximum amount of care, four visits a day. It's all personal care. […] If I don't get this in and start tomorrow, it would be a respite admission. […]'*
>
> Interviewer (Felicity): *'So what is [redacted name of the supported person] looking for?'*
>
> Practitioner (Amira): *'It's going to be local authority managed.'*
>
> Interviewer (Felicity): *'So an option 3?'*

> Practitioner (Amira): *'Yeah, so it's four calls a day, to get him up and dressed in the morning, food, medication prompts, his meals and a tuck visit. So the full works.'*
>
> Interviewer (Felicity): *'So what are the outcomes?'*
>
> Practitioner (Amira): *'Hmmm… I have this word document here with lots of outcomes saved on it. [Amira opened up a word document saved on her desktop, and copied and pasted an outcome stating "To have a varied balanced diet with nourishing meals"]. […] So, that means any money linked to this outcome can be spent on personal care meal provision. […] [Amira copied and pasted another outcome "to have good personal hygiene routine to prevent risk of illnesses, and effective management of my medication"]. And this one means that money can be spent on personal care, washing, dressing, and medication prompts and that.'*

Amira had a list of prewritten generic outcomes which could be copied and pasted into the care plan. This use of generic statements calls into question the authenticity of providing personalised, person-centred care which is at the heart of the SDS philosophy. Amira felt that the form is primarily for the finance team, and showed little evidence of including co-produced outcomes designed in collaboration with the supported people. The supported person in this example was also at a point of crisis, which produced a sense of urgency to get the care in place in order to keep the individual safe and avoid a respite admission. An outcome-focussed approach aspires to shift service delivery away from processes and task-centred thinking, yet this observation reveals that Amira was pushed to keep outcomes open and broad to facilitate a financial tool. As Alex stated to me whilst completing a care plan:

> *'You don't actually want to be too specific in your outcomes because you are limiting where the money can be spent. […] It is better to be broad, so that the money can be spent generally in that area.[…] This way, you are actually giving the service user more choice and control. What a contradiction! But that's the way we roll.'* (Alex, extract from fieldnotes)

Alex further evidenced the process-led approach when completing the care plan, in direct conflict with the philosophy of SDS. Finally, if outcomes are broad and generic, it will be challenging to measure the extent to which SDS budgets are supporting people to achieve their outcomes, and ultimately to understand how effective SDS can be.

6.9.3 Unrecorded: review process

Once an SDS budget and support services had been put in place, a final home visit would be conducted six weeks later *'to review the care package and check in'*. If the case was deemed stable by the social worker and there were no ongoing concerns, it was closed. The practitioner then updated the database with a case note and a closing summary. These actions were supervised and authorised by the team leader, who then allocated a new case from the waiting list. Given that there was no formal review team, cases were not regularly revisited. Cases were allocated for a review on an *ad hoc* basis; for example, if concerns were brought to the social work duty team. The findings highlight frustration among practitioners regarding the lack of specific review paperwork, which resulted in a requirement to complete a new assessment. These frustrations are captured in Esther's comment below:

> *'Well, I was quite surprised when I first learned that you're basically just doing a whole brand new assessment and everything for the person. Because you're not really gonna be able to just do a review or an update as such, because there isn't a separate review form. Like, in other local authorities I've experienced a separate review form. […] I'm not sure why it's called a review, because you're basically just going and doing a whole new assessment for the person.'* (Esther, extract from semi-structured interview)

When conducting a review, the focus of the practitioners therefore centred around gathering a broad range of information to populate the assessment form, rather than specifically reviewing the care package in place. Furthermore, practitioners brought their assessment back to the resource allocation meeting and requested that a new budget be authorised. Thus, a review of a budget was the same process as a new assessment. During an interview, Alex explained:

> *'It's a whole new assessment when something needs reviewed. […] It generally gets allocated because the person's support package doesn't seem right for their needs. […] Sometimes it gets picked up on duty, then it gets allocated for a review. […] The purpose of it is to see whether the support level needs decreased and increased.' (Alex,* extract from semi-structured interview*)*

Alex explained that cases were allocated for review because there was a suggestion the care package was not at the correct level, therefore considering '*whether the support level needs decrease or increased',* rather than whether personal outcomes were being met. Furthermore, Tom also highlighted that during a review the paperwork does not enable practitioners to easily revisit the care package, personal outcomes, and support and results options in a broad assessment, rather than an update:

> *'I get [that] in some cases time has passed, so the situation is different, but there should be a way of doing a review or an update of some sort. To start from the very beginning makes life harder than it needs to be. Maybe in some cases a brand new assessment is needed, if a lot of time has passed, but not always. […] Sometimes you need to just focus on discussing how the care package is actually going and what needs changed, rather than such a broad assessment.'* (Tom, extract from semi-structured interview)

As was noted in the thematic review, 'reviews are important in evaluating the impact of care and support and ensuring people have ongoing choice and control over the support they receive and the option through which it is delivered' (Care Inspectorate, 2019: 20). A review should also provide a space for supported people to challenge decisions and raise concerns or preferences regarding how their support is delivered and planned. This evidence raises concerns about the review paperwork, and thus the focus of the reviews, which tend to be process-led.

6.10 Chapter conclusion

In this chapter I have explored the various backstage writing and reading practices of inscribed documents, rendering these often-unnoticed pieces of daily work visible. As I indicated in the introduction, recording, documenting, and completing paperwork is a fundamental part of day-to-day work in the adult social work team. Looking at the data through the lens of inscription reveals how social work practice is negotiated through documents. Inscribed artefacts are therefore powerful objects which influence, steer, and create daily work within the office.

Bureaucratic procedures persist, acting as barriers to implementing SDS. Social workers expressed daily frustration at the lengthy processes and having to '*jump through too many hoops'* and navigate around '*red tape'.* Assessment documents, care planning tools, and review processes were all regarded as laborious to use, and the evidence suggests that they are yet to fully embed outcome-focussed approaches. Practitioners are obliged to be process-led rather than person-centred, which reduces the potential to implement the principles of participation, choice, and control. A cultural change to fully embed SDS, including a shift to personal outcomes rooted in a human-rights based approach, needs to be supported by processes and procedures which also reflect this philosophy.

Although the process of inscription aids workers in their sense-making of a case as they translate their experiences into a written narrative, the findings suggest that practitioners are acutely aware of the manager who will be reading their assessment, which impacts the inscribed content. When producing an assessment or care plan, the focus remains on the generated budget and the linked number of hours of care, rather than on a person-centred outcome-focussed approach. Although a social worker is writing documents, the evidence suggests that there are really multiple authors due to the manager's contributions and recommendations, which affect practitioners' sense of autonomy.

Towards the end of the chapter I explored the absence of inscription, and specifically the lack of documentation evidencing good conversations between the social worker and the supported person. This exploration suggests that supported people have limited input in the crafting of the co-produced assessment and care plans; however, the impact of the assessment on the individual is significant as they await what budget will be allocated for their social care support. Furthermore, a closer look at the care planning and review paperwork reveals that these activities are constrained by documents which fail to embed an outcome-focussed approach in their delivery. This lack of focus on considering outcomes, and failure to inscribe good conversations, makes it difficult to evaluate levels of choice, control, and co-production throughout SDS delivery. Overall, this analysis has aimed to partly open the black box of producing assessments and care plans through revealing some of the steps taken before delivering the final document. The next chapter is the final of the three findings chapters, and examines social workers' daily practice enactments to reveal their collective interactions, performances, and negotiation of SDS policy.

Chapter 7: Enacted SDS knowledge

7.1 Chapter introduction

This chapter examines forms of enacted SDS knowledge which illustrate the way in which social workers translate and construct SDS through their daily encounters and interactions. As a reminder, enacted knowledge is what we do with inscribed and embodied knowledge; it is knowledge in action. Freeman and Sturdy (2014: 12) state that:

> *In the absence of action, knowledge remains latent: thoughts unspoken, skills not exercised, texts unread and instruments unused are indistinguishable from ignorance or nonsense. It is only when they are enacted that embodied and inscribed knowledge acquire meaning and significance - that their status as knowledge becomes apparent. By the same token, action in the absence of knowledge can scarcely be thought of as action.*

SDS therefore comes alive when actors translate their embodied knowledge or inscribed knowledge into actions. The embodied and inscribed ways of knowing discussed in Chapters 5 and 6 are considered the precursors which inform practitioners' enactments of SDS. Nonetheless, enacted knowledge is not simply reproducing existing embodied and inscribed ways of knowing, but crucially interactions provide a space for new knowledge to emerge which goes beyond what already exists. Enactments and performances during, for example, home visits, office case discussions, phone calls and meetings, only survive for the duration of the act itself (Freeman & Sturdy, 2014). As a result, they are often momentary and can vary from one encounter to the next. Doing SDS is therefore not a single phenomenon; there is no single way to perform the policy. Instead, SDS is continuously translated, developed, and constructed through the myriad of enactments occurring in different spaces between various actors. Furthermore, the production of new embodied or inscribed knowledge following action can endure longer than the enactment itself.

This chapter examines data from the refined frontstage interactions with supported people during home visits, and from the backstage office encounters where uncertainties are expressed and understandings are forming. The pivotal question of 'how' is considered through examining daily practice which exposes the collective interaction, performances, and negotiation of SDS policy. These daily evolving actions are crucial in revealing that practitioners are not implementing a finalised version of policy, but that their daily work and doings are where the policy is continuously produced (Shore & Wright, 2011).

This chapter is structured around the daily encounters of practitioners which illustrate the contested nature of SDS. Particular attention is given to the patterning of interaction and performances, in terms of the interactional order, which reveals shared conventions and understandings (Goffman, 1983). The focus is not the individual social worker, but instead on the micro-level situation, the event, or the encounter. The chapter is divided into three sections which focus on different practice spaces. Firstly, the encounters with the supported person will be examined. Secondly, the daily office talk with colleagues is explored, and thirdly, the chapter turns to scrutinise the resource allocation meetings. The resource allocation meetings are the formal meetings between social workers and management where assessment content and cases are discussed, and individual budgets are calculated using a points-based system centred around risk ratings.

7.2 Enactments with the supported person

7.2.1 The contested meaning of co-production

Co-production appears as a central transformative feature in the national SDS government strategy, which makes great promise regarding the involvement and participation of those receiving social care services. It has been described as ‘support that is designed and delivered in equal partnership between people and professionals’ (Scottish Government, 2010: 7). As is highlighted in the practitioner guidance, it is anticipated that an ‘assessment through co-production recognises the capacity, capability, strengths and personal assets people possess, which in turn informs risk assessment and, where appropriate, risk enablement’ (Scottish Government, 2014a: 30). The four legally-binding statutory principles which underpin practice specified in the SDS Act are: (1) participation and dignity; (2) involvement; (3) informed choice; and (4) collaboration. A co-productive approach through partnership working appears to form the foundations of SDS interactions, performances, and encounters. Consequently, it is a pertinent starting place for this chapter, which is centred around face-to-face enactments.

Despite the suggested transformative change outlined in the national strategy, the research findings reveal a contested understanding surrounding the definition and practical delivery of co-production. The implementation of co-production arose as a complex process which was continuously changing, questioned, negotiated, defined, and performed in a multitude of manners. A diverse range of understandings emerged from the daily talk in the office captured in the ethnographic fieldnotes. Some practitioners described it in the following terms: *'a waste of time', 'a sham', 'a box ticking exercise', 'tokenistic', 'an idea that doesn't work in practice', 'empty talk', 'a nice idea',* and '*not possible with these processes and procedures'*. These findings cast doubt over the true inclusion of the support person's voice and the level of influence they hold in the decision-making forums through relocating power and control. For others it meant: *'working together', 'collaborating', 'giving the supported person a voice', 'capturing their words', 'hearing the supported person', 'empowering the person to have a seat the table',* and '*listening to the person and what is important to them'.* Yet, Ruby was dismissive of the 'co-production thing', stating:

> *'Our work is already meant to be collaborative, and empower people, so this co-production thing isn't anything new. We were already doing it.'* (Ruby, extract from fieldnotes)

Furthermore, Sally summed it up as:

> *'I guess co-production means so many things… Hmmm… it depends who you ask, you know. So, for me, well, I can't get to the bottom of what it really is or what I am meant to do, so it doesn't really mean anything. I just do what I always did. I think it's a sham… meaningless. People want to believe that we co-produce everything, but we don't, I don't think.'* (Sally, extract from fieldnotes).

The definition of co-production was dependent on the respondent, so conflicting definitions emerged with no clear pattern other than the evident lack of shared agreement on the characterisation and implementation of co-production. The ambiguity surrounding the approach was a positive and a negative which enabled some workers to be creative and establish powerful spaces to empower and collaborate with individuals. Equally, due to the ambiguity there was a lack of co-production present within practice. Following an observation of a home visit I discussed the case with the social worker, Ava, in the car whilst driving back to the office. Our conversation was as follows:

> Practitioner (Ava): *'So, the service user thinks they need support with […] and it's kinda like well… no, the local authority don't support with that. And you know he thinks somethings are really low risk, or high risk, when it's not. […] So, I will put his views down on the assessment form, even though they are way off the mark … because we have to co-produce the assessment. But… so… I've ticked that box, got the views, you know.'*

> Interviewer (Felicity): *'Yeah, hmmm… and do you think his views will influence the process or decision?'*
>
> Practitioner (Ava): *'No, not really… It's more my views that are the focus I guess… […] He doesn't want an option 1, so it will probably be some day care and some home care through option 3. So, you know, a pretty standard package. […] His views would probably matter more if we were going down an option 1 route… but even then, hmm… the local authority are pretty strict with where you can spend your budget.'* (Ava, social worker, extract from fieldnotes)

Ava thus cast doubt on the strength and validity of the supported person's views and demonstrated a paternalistic attitude in adopting the role of the expert, which hindered her ability to establish a legitimately equal partnership with the supported person. Co-production was reduced to simply recording views on the form and ticking a box. Although a space was created during the home visit for the supported person's voice to be heard, it became muffled and was described as having little influence within the future decision-making processes. This indicates an uneven partnership and power dynamic between the professional and individual. This finding illustrates little evidence of co-production being truly embedded into daily processes and procedures, with the voice getting lost once it has been captured on the form. Capturing views on an assessment form can therefore give an illusion of co-production, but should not be used as the measure of success. Co-production seems centred around encouraging compliance with paperwork rather than transforming services through relocating power and control. The social worker in the example had also already determined the type of care package prior to care planning discussions with the supported person, again demonstrating little evidence of co-production and highlighting the power to silence certain narratives. Social workers are not simply managing the assessment process and the content, but choosing and defining the narrative within the constraints of practice.

Within my auto-ethnographic reflective log, I considered the power imbalance when attempting to advocate on behalf of the supported person in the resource allocation meeting:

> *'In preparation for the meeting, I printed off the assessment form and underlined the key points I wanted to stress. I selected the evidence and the views which I thought would have the most impact and potentially generate the budget required. I had previously observed other workers doing the same. I therefore chose the narrative and held the power. I am ultimately privileging and valuing certain pieces of information over others. I and other workers therefore have the*

> *discretional power to create certain opportunities, or not.'* (Extract from auto-ethnographic reflective log)

Here, the invisible operations of power held by the social worker are made visible, combined with highlighting the complexity of promoting their views and working in partnership. The supported person's narratives can make a significant contribution to the SDS process if they are allowed to do so; however, this is dependent on the actions of the practitioner. Thus, the seemingly straightforward definition of co-production as 'support that is designed and delivered in equal partnership between people and professionals' (Scottish Government, 2010: 7) is highly contested. Chapter 6 reveals the bureaucratic tick-box nature of the processes and procedures, whilst also highlighting that whilst the policy promotes a co-produced assessment in collaboration with the supported person, the voice of the support person remains weak during the inscription process, and instead the dominant voice is that of practitioners. Social workers are captured inscribing and crafting texts with the reader and the budget in mind, with the supported person's voice getting lost in the process. The largely uncritical adoption of the broad definition of co-production has resulted in inconsistent practice which has the potential to disempower or empower individuals depending on its interpretation. Furthermore, the processes and procedures do not fully embed a co-productive philosophy or facilitate a reliable and consistent practice. The evidence suggests that co-production is yet to be achieved, and that co-production is, in fact, an unrealistic task within the confines of the current processes. Consideration must therefore be given to designing processes and procedures which can facilitate co-production.

7.2.2 Good conversations: how good can they be?

As was highlighted in the literature review, the SDS policy endorses the practice of 'good conversations', emphasising the importance of outcome-focussed dialogue between the professional and supported person as a method for ensuring the co-production of personal outcomes (Scottish Government & COSLA, 2019). This focus on social care outcomes represents a theoretical departure from considering the number of hours and types of tasks which an individual requires in their social care. Nevertheless, as has been observed above in this thesis, the former deficit models of delivery have proved hard to shift (Care Inspectorate, 2019; Rummery *et al.*, 2012). This has resulted in a clash of old and new approaches, causing practitioners to converse in 'two different languages' (Care Inspectorate, 2019: 10). Staff adopt empowering outcome-focussed language when supporting an individual, however workers are forced to engage in a risk deficit language when writing an assessment and requesting a budget (Care Inspectorate, 2019: 10).

The evidence presented in this section is consistent with that found in the Care Inspectorate's thematic review in emphasising that practitioners converse in two languages. These ethnographic findings further illustrate that practitioners are yet to fully adopt the new outcome-focussed language and implement good conversations, with processes drawing dialogue back to a language of time and tasks. Social workers commonly expressed frustrations at the conflicting demands of the job, and reported feeling limited and restricted by the local authority processes which they thought contradicted the outcome-focussed philosophy of SDS, reducing their sense of professional autonomy. Amanda described being pulled in different directions:

> *"I feel like we're really put in the middle because the legislation is telling us to practice in an empowering way, in a person-centred way, and to hand over that choice and control. But you're not able to write an empowering assessment. It's horrible, kind of thing [laughing]. I tend to, like, see when I go out and do a visit and do the assessment, that's my time to empower the service user, by doing it vocally, rather than in the written assessment. So yeah, I do all the empowering stuff during the home visit, because everything else is really negative and focusses on what they can't do."* (Amanda, extract from semi-structured interview)

Amanda thus described the home visit and the verbal conversation with the supported person as the limited space where she is able to engage with empowering language in line with SDS policy, because elsewhere within the SDS process the focus becomes a deficit-oriented language. Good conversations between the supported person and staff surrounding personal outcomes can therefore occur; however, without the supported person's preferences and rights being embedded throughout the SDS processes, these good conversations get lost in translation as the narrative moves towards a deficit focus outside the home visit.

> *'I do try to have a positive conversation with the service user, but at the end of the day, you need to get in the information for the assessment form, so conversation ends up being focussed on what they struggle with, so I can work out how many hours they need.'* (Esther, extract from semi-structured interview)

The team leader allocates cases to each social worker on a priority needs basis; however, due to long waiting lists, high caseloads, and understaffing cases have often reached crisis level before being assigned to a worker. Upon allocation of a new case, the social worker contacts the individual to organise the initial visit and begins the SDS assessment process. There are high variations in assessment timeframes, with some workers conducting an assessment in one visit, whilst others complete a series of visits to gather information to populate the assessment form. Given the high levels of crisis associated with these cases, workers often expressed that they felt the focus becomes the speed at which the assessment form can be submitted so that support can commence, rather than an emphasis on co-produced empowering conversations. The following account portrays the concerns which were typically voiced by social workers:

> *'It's about the speed, really, that you can do that assessment, get that service in place, and move onto the next one, for somebody else who's in the same crisis situation. So, you're trying to alleviate the stress and the crisis of a lot more people, but then that leads us to quantity, rather than quality. It doesn't really create space for a meaningful or long conversations about what they want.'*
> (Cora, extract from semi-structured interview)

Similarly, Zoey stated that:

> *'Most of the time the service user is at breaking point, you know. So often they're in need of support as soon as possible… really to avoid a respite admission. We offer more of a… like, a reactive crisis response I guess. We don't have time for the long-term outcome-focussed stuff really, and they just want some support as soon as possible.'* (Zoey, extract from fieldnotes)

Likewise, Amanda highlighted that a social worker has to focus on other issues, and questioned whether the idea of a good conversation really captures the complex nature of social work practice:

> *'I think the focus on having a good conversation… well… it's nice, but it oversimplifies what we do. We need to think about how to evidence risk, or manage the crisis, you know.'* (Amanda, extract from semi-structured interview)

This sense of crisis and the urgency of obtaining formal support often reduced the ability to fully engage in what the policy describes as the practice of 'good conversations' (Scottish Government & COSLA, 2019), ultimately impacting the choice and control experienced by the supported person. Although practitioners were aware of the empowering policy philosophy, they often highlighted a tension between their practice aspirations and what they felt they could feasibly deliver and do. Thus, the deficit-focussed processes and the crisis nature of the work impact upon practitioners' ability to fully adopt the new SDS culture, resulting in a tendency to rush conversations which are often centred around tasks and hours, rather than outcomes and creativity. If good conversations are not embedded throughout the SDS systems and processes, then good conversations will only happen in isolation and not at every stage of the process. Finally, Amanda questioned whether the idea of 'good conversations' oversimplifies the complex role of a social worker, who has to balance on a tightrope between care-control and evidence-feelings.

7.2.3 What options are really available?

The proposed four options theoretically enable the supported person to choose to mix traditional services with personalised approach with the aim of offering them greater flexibility, choice, and control over care arrangements (Rummery et al., 2012). As was highlighted within the literature review, practitioners failing to discuss and offer all four options is a common issue, which appears elsewhere within the SDS research (Mitchell, 2015; Flemig and Osborne, 2019; ALLIANCE & SDSS, 2020c). A prominent finding within this and prior research was the view that the care market and the available commissioned services fail to facilitate the delivery of the intended four SDS options outlined in the legislation. There is a legal obligation for social workers to offer each of the options, but in the present study the workers said this was not possible given the limitations of the market. Practice will vary nationally depending on the local commissioning and market landscape of care providers within each local authority area, but it is nevertheless a striking finding that option 2 was commonly described as '*unavailable*' and that '*the dominant route remains option 3'*. During the 20 observed home visits, although workers did engage with some empowering outcome-focussed language, their ability to co-produce assessments and to have authentic, good conversations was hindered and restricted by the availability of the commissioned services. This lack of diversity in the available services from the market therefore had a significant impact on what outcomes were feasibly possible, and ultimately constrained how outcomes could be met.

The below extract captures Dylan, a social worker, explaining the options during an observed home visit:

> *'So, did you have the chance to read the information? So, I guess officially there are four options [the social worker smiled towards me, the researcher], but as I mentioned before, we only really do option 1 and 3. So, it's either a direct payment, you know, when you become an employer and manage the budget. Or option 3, when we manage your budget and commission the care on your behalf. Then I guess, if you were interested in the combination of option 1 and day care that would be an option 4, a mix.'* (Dylan, extract from fieldnotes)

This captures a typical translation of the SDS options, which reduces the supported person's choice to either option 1 or option 3. Furthermore, option 4 was commonly understood and presented as the local authority organising day care to accompany a direct payment. During two of my observations, the supported person asked for clarification on what option 2 was, and the allocated worker stated *'I'm sorry, but we don't offer that service at this local authority.'* Similarly, another worker stated, '*we don't have any providers who offer that kind of package here.'* In other words, there was a shared understanding amongst practitioners that option 2 was unavailable and could not be delivered. This lack of true availability of options was also openly discussed in the office, illustrating a lack of direction, awareness, and understanding amongst practitioners regarding option 2. When I asked how option 2 was provided within the local authority, social workers responded:

> *'Option 2… it's not really a thing here, I have never heard of anyone getting it.'* (Alex, extract from fieldnotes)
>
> *'Nobody really knows what option 2 is, so we all just kinda ignore it, you know. I know that sounds bad, but I don't really know what is looks like, or what that care plan would look like… like what care provider or who would support with that. So… option 2 is a bit of a mystery.'* (Sally, extract from semi-structured interview)
>
> *'That's a good question. What is option 2; nobody seems to use it. We're definitely not complying with the legislation there… but I blame the commissioning of service. We just don't really have a provider to support with delivery option 2, so it puts us as workers in a crap situation, you know. Then we get blamed for not offering the option.'* (Amira, extract from fieldnotes)

Amanda highlighted that due to the limited availability of options, practitioners restrict the options presented to the supported person, a path which ultimately hinders the choice and control felt by the supported person:

> *'I don't think SDS is very effective at providing choice and control, because… I think we are basically saying, look, these are really your options, we're kind of telling them what their options are.'* (Amanda, extract from semi-structured interview)

These findings further illustrate an absence of strategic level direction and commissioning in relation to the implementation of option 2, causing challenges for frontline workers' delivery of the policy. Practitioners are currently unable to enact the policy in line with the legislation, raising questions regarding the levels of meaningful empowerment, choice, and control being offered to supported people. Beresford (2012: 40) critiques the market-based system, stating that:

> *[…] we have moved to what is essentially an under-funded voucher system. From a replacement for a traditional and inadequate set of services, we have moved to an exchange relationship, which casts the service user as a consumer, not a citizen with rights – to a model that is market based and market driven rather than liberatory in intent.*

Supposedly option 2 should provide an opportunity for the supported person to direct the local authority or a third party on how the budget will be spent, reducing their personal risk whilst offering choice and control (Kettle, 2015; Dalrymple *et al.,* 2017). Nevertheless, the findings illustrate a failure to effectively deliver this option. Consequently, option 2 remains underutilised and the potential flexibility, choice, and control contained within this option remains unrealised.

A separate finding associated with the availability and enactment of options was present within the data. Social workers often referred to the long, unwieldly process and the hoops they needed to jump through in order to access and deliver option 1. Practitioners discussed that when individuals and families were at a point of crisis, option 1 was seen as impractical due to the long bureaucratic process, resulting in option 3 becoming the default selection of social care. One worker summed it up, stating:

> *'Option 1 is great, if you have a lot of time and the service user can cope in the interim and wait for the paperwork to be processed. There are just so many different forms, so many steps, [the database] is so confusing, it takes forever. It's a minefield to navigate to be honest. Once it is in place, it is fine… but it feels like an absolute mission. Option 3 is definitely more straightforward… and quicker.'*
> (Alex, extract from fieldnotes)

Another worker candidly expressed his frustration at enacting the long process and the impact that the delays can have on the supported person:

> *'I mean, from start to finish option 1, um, it can take months. [laughs] Um, you know, from meeting a service user, doing… completing their assessment, getting their assessment and their budget approved, signed off, then starting the self-directed support paperwork, um, getting that approved, signed off by all the participants, having input from finance, you know, sending forms here, there and everywhere to get signed, it's… it's so much longer than it… than it really needs to be, in my view. It's debilitating, um, for… for me as a social worker, because obviously, you know, you've got so many cases to deal with, so time is precious for*

> *everybody, so the time-consuming nature of the processes has an impact not only on the service user you're working with, but all the other ones that you're working with. Um, and during the time it takes to get anything in place, you know, they've not got any support during that whole period of time, you know, it's the service user that's inevitably suffering.'* (Oliver, extract from semi-structured interview)

The processes have not only been described as frustratingly long, but also as unclear and confusing. This is illustrated below, where a worker describes her experience of attempting to enact option 1 through purchasing equipment for the supported person (something which was rarely done), rather than arranging hourly care:

> *I felt like I was just getting shipped around different people for somebody to try and give me an answer. And then, you would think you were there and then it was, no, that's not right, this is what we should be doing. Umm… it… [sigh] yeah. And I think the idea of buying equipment was the… the best solution for him. It's going to meet his needs and his outcomes. It's also maintaining his independence, instead of dependence on a personal assistant and hourly care. I think because it isn't homecare and it's something a bit different, the local authority are really resistant. I would like to be able to feel confident to offer a creative outcome like equipment to somebody else if that… arose and I was doing an assessment and thought, oh actually you would benefit from equipment rather than homecare. But, this whole experience has probably put me off looking at buying equipment with option 1 a wee bit. It's just been like six months of back and forth between headquarters, finance, and everyone, with no answers. Whereas if you knew… okay, so this is how I did it the last time, this is how we're going to do it this time… I mean, I will still go for it, if the person was going to… benefit from it, but I would be aware that it's going to probably be a very long process [laugh] and because, what, that's… six months and we're still not there… we're still not completed.'* (Roisin, extract from semi-structured interview)

Option 1 is therefore viewed as '*too long*', '*confusing*', '*bureaucratic*', *'debilitating',* and *'unclear',* which results in it becoming less accessible and manageable both for the social worker and the support person. Option 3 is then framed as the faster default method by which to gain support:

> *'There are really only two real options, an option 1 or an option 3. You can get option 3 reasonably quickly, but still longer than I would like to be honest. I think*

> *it's down to the processes at this local authority. I worked in another local authority where it is easier to navigate the options and the processes aren't so much of a barrier.'* (Amanda, extract from semi-structured interview)

One worker even highlighted that some supported people who originally opted for option 1 changed to option 3 due to the long processes involved:

> *'There has been a few of my cases where to begin with the person really wanted a direct payment, um, but then, you know, you're a month or two down the line, and it's still not in place because of the processes and systems we're using. So they come back to you and say they need support straightaway, so they want to change it to an option 3. So it's not really choice and control, is it?'* (Oliver, extract from semi-structured interview)

This echoes and links to the embodied findings in Chapter 5 which emphasise the practitioners' emotions of frustration, powerlessness, and lack of autonomy resulting from the deficient care market and long and confusing processes. The lack of availability of options has also been identified by the wider SDS literature, which has suggested that the traditional care culture has been difficult to shift, and that little has changed with regard to the type of services people are receiving (Pearson and Ridley; 2017, Pearson *et al.,* 2018). SDS processes and systems have been repeatedly criticised for long waiting lists and multiple layers of decision-making resulting in slow, drawn-out procedures, often when an individual is at a point of crisis (ALLIANCE & SDSS, 2020c; Care Inspectorate, 2019; Manthorpe *et al.*, 2015; Mitchell, 2015). The present ethnographic findings suggest that option 3 remains the dominant SDS provision and that although option 1 is possible, option 3 tends to be less complicated and most easily available. Furthermore, limited access to option 2 and 4 was observed within this small sample. Whilst attempts were made by workers to practice 'good conversations' and explain all the options, communication was often unclear, with the market and complex processes creating barriers against fully enacting SDS. Not all options were practically available, fully communicated, or understood by the workers, reducing their ability to offer flexible care, creative alternatives, choice, and control to the individual. Finally, supporting people at a point of crisis often resulted in a sense of urgency to gain support, rather than considered and rich conversations.

7.2.4 Time limited enactments

The research data revealed high variations in the frequency and lengths of home visits once a social worker was allocated to a case. Some workers conducted an assessment in one visit, whilst others completed a series of visits. Nevertheless, workers felt that time was limited, and that there was a pressure to complete work quickly due to high caseloads and slow bureaucratic processes. One worker stated:

> *'It really depends on the case and how straightforward it is. Ultimately, we don't have much time, so I tend to meet the person and collect all the information for the assessment, then get back to the office and get it written and submitted. […] Mostly I try and keep it to one visit for the assessment, then a few phone calls with other professionals who know them.'* (Ava, extract from fieldnotes)

Similarly, another social worker described the rushed nature of the assessment process which impacts on their ability to have co-produced deep conversations regarding options and outcomes:

> Interviewer (Felicity): *'Can you tell me a bit about how you co-produce assessments?'*
>
> Practitioner (Amanda): *'Uh-huh. [Pause]. I don't think there's enough time. Do you know, there isn't, when we get the cases, I mean, they're already at substantial or critical risk. So they're already at a stage that they just want things, now. So it's, I want my assessment done, I want this in place. So, everything's rushed. Like, I don't think there's that chance to, like, go, go and do numerous visits, like we're writing this together. Or, and like, including, even like other professionals. It's a quick phone call, isn't it, it's not like the professional would go out and then speak with the service user, like all the time, do you know what I mean, for everyone to be kind of part of it, and co-produce, kind of thing. Erm, it just doesn't happen, there's not the time for it. It's almost a, bish-bash-bosh, just, get the assessment done, get it out, get it closed, next.'* (Amanda, extract from semi-structured interview)

This 'bish-bash-bosh' nature of the work and the pressure to get through your caseload and continuously produce assessments was identified by some workers as impacting their ability to build relationships with the supported people. One worker stated that:

> *'Ideally you want to build a relationship with the person, but we don't really have time for that anymore.'* (Amira, extract from fieldnotes)

Likewise, another explained:

> *‘You think when you train to be a social worker that you will get to do all this relationship-based work, but actually you just need to get in there and get someone a service in place, you know, remove the risk and get them out of crisis. […] I wish there was more time to work with people and build that relationship… I preferred my support worker job… If only it paid more (laughing)… anyway, the thing is, we don’t do early intervention, even though we should, it’s more crisis management by the time you get the allocation.’* (Rose, extract from fieldnotes)

The evidence thus highlights that home visit enactments have become process-driven and restrained by forms, which often dictate the structure of the interaction, potentially de-skilling practitioners and reducing their sense of autonomy and power. Furthermore, the findings suggest that home visit enactments are further restrained by time limitations. Nevertheless, it is important to acknowledge the variations in practice and that some workers in the team did conduct numerous visits to build a rapport with the family and supported person. This is captured below, as one worker described his slower pace of work:

> *‘So, I guess I am a bit of an old-school worker. I tend to do a lot of visits and take my time really get to know the person and situation, so you know, so I can really advocate for them. But, I’d say that’s rare. The rest of the team have probably said I take too long, or that I’m slow. But it is just the way I roll. Most workers go out and gather all the information for the assessment in one visit, some only stay an hour and write a generic assessment. But, that’s not really social work. But there is a lot of pressure to get through the cases and onto the next one. There’s a big waiting list.*’ (Tom, extract from fieldnotes)

Tom described his slow relationship-based approach as ‘old school’ social work, inferring that the changes generated by SDS have produced a culture of fast bureaucratic social work which moves away from a relationship-based approach. SDS was meant to establish a transformational shift or change in practice, but the systems-led fast paced approach does not seem to adequately reflect the philosophy outlined within the proposed policy document.

7.3 Office enactments between colleagues

7.3.1 Playing the game: group sense-making tactics

This research captures the backstage, mundane, often unnoticed everyday office activities, talk and work which takes place across desks, around computers, in the kitchen, on the stairs, or standing by the photocopier. These observed conversations in the office were where uncertainties were discussed, and where understandings and judgements were forming. Practitioners discussed cases and assessments together, sharing their opinions, modelling values, bouncing ideas around, seeking and giving advice, and sharing experiences. These findings specifically focus on the sense-making surrounding the assessment form and the navigation of the connected processes. The following extract from the ethnographic fieldnotes captures a typical conversation within the office:

> *'There are three social workers huddled around the computer discussing the risk ratings and associated points on the assessment form. One worker told the other: "you need to bump both those sections up to substantial risk if you want to have any chance of getting a big enough budget for three visits a day, seven days a week." He continued, "does anyone in the family provide care? If they don't, you have a better chance of getting a budget. You know, if they don't have any informal care, you will be able to get more of a budget." The three workers tweaked the assessment form, altering risk ratings and taking into account that some ratings may be lowered or changed by the manager during the resource allocation meeting. They looked up at me and said, "you have to know how to work the system. It it's about making sure we can argue the case and get the budget. You've got to play the game, you know."'* (Tom, Ava, and Alex, extract from fieldnotes)

Discussing cases with peers in the office creates a space for collective sense-making or group sense-making to create a coherent understanding of the situation (Helm, 2017). Similarly, Roesch-Marsh (2018: 412) describes this peer process as 'thinking it through' with others, which supports in connecting the various pieces of evidence together in a dialectic exchange to render information comprehensible. The discussions in the office observed here revolved around risk ratings and the subsequent budget that the assessment would therefore generate. After conducting the home visit and gathering information from a range of sources, workers carefully populated the assessment form by selecting the evidence and risk rating for each section. Although accurate and true information was included within the assessment form, workers debated and tweaked the associated risk ratings in order to gain the budget they felt the individual required. The following accounts further evidence these commonplace happenings:

> *'So I would put that information in that section, so it evidences higher risk there.'*
> (Zoey, extract from fieldnotes)
>
> *'I would emphasise that more, that's definitely high risk, so you'll get more of a budget.'* (Alex, extract from fieldnotes)

Workers also discussed the type of information which was not favourable to include together:

> *'I'd take that bit out […] it makes them sound more able that they actually are, so you might not get a budget.'* (Amira, extract from fieldnotes)
>
> *'Don't include that.'* (Amanda, extract from fieldnotes)

These group discussions enabled workers to share their experiences and perspectives, making sense of the assessment systems through a dialogic process. Writing an assessment form was not simply capturing who the supported person is, but a process-led task centred around engineering the ratings to ensure that the recipient received the desired budget. The assessment inscriptions and the narrative surrounding these documents centred around the individual's deficits, budgets, risk ratings, hours, and care tasks. The systems and procedures provided little space for workers to engage with the policy agenda of co-produced assessments informed by good conversations with empowering language. The office is therefore a site of constructing risk in order to navigate bureaucratic systems. Consequently, workers are not simply managing risk, but they are transmitters and definers of risk across practice boundaries.

7.3.2 Storytelling: making sense of the case

Social workers engage in sensemaking through forming ordered narratives and stories which render fragmented pieces of evidence intelligible (Weick, 2011; Weick *et al.,* 2015; Cook and Gregory, 2020). Field observations captured this sensemaking storytelling activity in action during daily team talk. Workers returning from a visit often '*offloaded*', '*vented*', or '*unpicked*' a particular case, situation, or event with a colleague. Co-workers responded by providing thoughts, questions, and ideas which advanced understandings surrounding the situation. Additionally, colleagues replied by adding and drawing upon their own related experiences, resulting in collective story-building narratives which created coherent dialogue. Often, these conversations concluded with an outline of the potential next steps or actions. An extract from the ethnographic fieldnotes captures a typical conversation between two workers in the office:

> Practitioner (Tom): *'[…] my head's bursting after that visit… not really sure what just happened. […] I've no idea what to do with this one. I thought I'd seen it all, but this one's new to me! Emmm… I don't even know where to start. […] One of those off-the-wall cases, you know. […] It's way too complex to squeeze into an assessment form. […]'*
>
> Practitioner (Zoey): *'You look shattered […] you alright?'*
>
> Practitioner (Tom): *'It's just a complicated one… what would you do? So this might take a while [laughing]… I think I just need to vent… so let me start at the beginning. So I went out to the house for the first time about a month ago. [redacted]'*
>
> Practitioner (Zoey): *'[…] That's a bit of a messy situation to be fair. […] You definitely need to get some services in there. Who else is involved in the case? Are health involved, or the police?'* (Tom and Zoey, social workers, extract from fieldnotes)

This conversation continued for 41 minutes, with both workers drawing on their past experiences to support them in making sense of the situation. Additionally, community resources and potential actions were discussed. The conversation was reaching a conclusion when both workers had to leave the office for an emergency duty visit.

The following accounts further evidence storytelling happenings in the office:

> *'Do you have a second? I just need to run this case by you. Unpick it a bit… just make sure I'm not missing something… [redacted].'* (Amira, extract from fieldnotes)
>
> *'Oh my god. I've got an absolute cracker to tell you. You aren't going to believe what happened this morning. […] Maybe you'll know what to do next with this one. So, wait to you hear this… [redacted].'* (Ava, extract from fieldnotes)

These findings highlight the importance of informal peer support and discussions in the office which provide a space for workers to develop understandings, judgements, and actions. Co-workers did not simply listen, but probed and explored the case in depth, supporting in constructing meaning whilst working towards possible actions. As a result of conversing with colleagues, practitioners' views at times changed and evolved. Following a conversation, workers stated:

> *'I'd not thought about that. That's really good point.'* (Esther, extract from fieldnotes)

> *'I didn't know about that community resource. […] I'll give them a call now.'* (Oliver, extract from fieldnotes)

These everyday sensemaking enactments through storytelling influence the trajectory of SDS policy translation. The evidence suggests that through sharing stories and experiences, colleagues play a key role in supporting practitioners to arrive at a judgement.

7.3.3 Office narratives of deservedness: deserving and undeserving cases

As was previously discussed, building stories to make sense of cases is a social process whereby practitioners collaborate and draw upon experiences to form a narrative (Cook and Gregory, 2020). These collaborative narrative-building conversations with colleagues have been termed by Avby (2015: 95) as a process of 'social rationalization' and described by Roesch-Marsh (2018: 410) as 'thinking it through'. Importantly, 'dominant societal narratives can influence how stories are told. This, in turn, has the potential to negatively influence sensemaking. […] Social work teams can either facilitate or inhibit the sensemaking process' (Cook and Gregory, 2020: 188). Consequently, a team culture has the power to distort or promote effective sensemaking and subsequent professional judgements (Helm, 2017). Observations revealed that cautionary stories existed and circulated within the team. They often emerged in order to remind colleagues to be vigilant and maintain a level of scepticism or curiosity regarding those who they were supporting. The following statements evidence the reoccurring cautionary tale that some people may deliberately attempt to cheat the system:

> *'Watch they aren't just taking you for a ride. They may be out to try and get everything they can. […] More than they need.'* (Ruby, extract from fieldnotes)

> *'People don't understand that our resources are finite. Resources are allocated on an assessed needs basis, not just because they request them. There are always people who will exploit the system.'* (Sioned, extract from fieldnotes)

> *‘People think because they’ve paid their taxes all their life they are entitled to free care, but it doesn’t work like that.’* (Ruby, extract from fieldnotes)
>
> *‘I know he said that he struggles with [redacted], but do you actually believe him? Or do reckon he’s gaming the system?’* (Cora, extract from fieldnotes)

Whilst social workers were engaged in enacting the SDS policy, some individuals were storied and constructed as attempting to deceive or cheat the system in order to gain ‘more than they need’, or an undeserved budget. Equally, observations revealed stories of seemingly deserving cases where the social worker highlighted that individuals and their families were making what were constructed as legitimate claims and requests:

> *‘I really felt for them, you know. You can tell they are really struggling to cope. It was just chaos… they really need some services in there… like, yesterday.’* (Ava, extract from fieldnotes)
>
> *‘I thought he was exaggerating on the phone. […] But he definitely does need support. It’s way worse than I thought.’* (Tom, extract from fieldnotes)
>
> *‘You know when you go out and you just see what people are dealing with… and your like… you definitely need services. No doubt about it.’* (Zoey, extract from fieldnotes)

Narratives of deserving and undeserving people often coincided with ideas of limited resources and funds available in the local authority. Workers were influenced and pulled in different directions by contradictory narratives when enacting SDS. The tales of limited resources creates this idea of burden on practitioners whereby they are required to make judgements about levels of needs, and who has greater levels of need. Storytelling can thus inhibit and facilitate understandings of cases. It is important to recognise the common biases which can be highly influential and unhelpful, contradicting not only the philosophy SDS, but also wider social work values. The storied enactments of cases can therefore both inhibit and facilitate understandings of cases.

7.3.4 Meetings about meetings

To progress to a resource allocation meeting between the social worker, team leader, and service manager, the team leader is required to ‘*check over and sign off*’ the assessment first. Consequently, the ethnography revealed a noticeable number of informal meetings between the social worker and their team leader with the objective of preparing for the resource allocation meeting. This backstage SDS work is thrown into relief here, highlighting uncertainties and questions surrounding the assessment evidence, points, and budgets, providing a fleeting glance into the black box of social work practice (Goffman, 1978). These meetings about meetings took different forms, including popping into the team leader's office, tagging on a quick conversation at the end of a phone call, organising a formal sit-down or zoom call, or communicating through a series of emails. These pre-meetings or planning meetings provided a space for case discussion, focussing on the generated budget and whether the written evidence warranted the selected risk rating. The database screen which displayed the correlating generated budget was only available to management staff members, thus the social worker had to request this information from the team leader. Once the budget was known, workers could begin to calculate how many hours of care could potentially be purchased, and whether they felt this would reduce the levels of risk and meet the supported person's needs. The following views were common:

> *'Everyone does it. You have to check what budget the assessment has generated. […] It's so frustrating that we don't have access to that screen… like… that privilege is just for managers. […] They just don't trust us with budgets. But how are we meant to do our jobs, you know? […] Such a waste of time, all this back and forth with the team leader.'* (Oliver, extract from fieldnotes)

> *'I do the assessment, then ask the team leader what the budget is coming out as, but if my professional opinion is that it isn't providing enough money to keep that person safe… of course, I will alter the ratings… so you know… it reflects that person's needs. […] And I don't think there is anything wrong with that. We're here to write an assessment that reflects that person, and that is what I am doing.'* (Ava, extract from fieldnotes)

Furthermore, an extract from my reflective log captures my experience of pre-meeting conversations:

> *'Once I had finished writing the assessment form, I did what I watched so many other social workers do. I got in touch with my team leader to find out what budget all my ratings were generating. Once I was informed of the figure, I began to calculate how many hours of care could be bought with an option 1 personal assistant. I then calculated how many hours of care could get if they went with an option 3. I also considered if they used day care, how this would impact the budget. I didn't know what the service user was going to do with budget, but I felt*

> *the need to know whether the generated budget matched the needs I saw on the home visit. I had become very process-led, but I didn't want to walk into a resource allocation meeting and not really know what budget I was advocating for.'*

In some circumstances during these backstage planning meetings, the team leader would question whether sections were credible, if more evidence was needed, or whether parts should be altered. Furthermore, talk would revolve around whether there was any room for movement of ratings given the evidence, or if ratings needed to be increased or decreased. As one team leader explained:

> *'You want to get it sorted and right before the real meeting, so there's less room for error and potential changes. So, I try and pre-empt what might be seen as problematic, you know. Sometimes workers put the wrong bits of information in the wrong section, so it doesn't add up.'* ([redacted name], extract from semi-structured interview)

Dialogue between the team leader and social worker was candid within these informal settings, often with the worker idea-testing and brainstorming during these verbal exchanges:

> Practitioner (Dylan): *'I put in the recent hospital admission and the falls there. Then I included the views of the doctor and OT there. But do you reckon that's enough?'*
>
> Team leader [redacted name]: *'I don't think it would hurt to highlight those points again here. Have you managed to speak to the carers? […] I'd really want to know what they're thinking. […] Maybe check to see if the diary in the house is up to date […] That'll probably have some information in it. […]'*
>
> Practitioner (Dylan): *'Okay, okay. I just don't know whether that budget will be enough. […]'*
>
> Team leader [redacted name]: *'[…] If you can get a bit more information about […]. Then update that assessment and send it back through. I'll give it a quick scan, we can see what the budget is coming out as, then we can take to [the resource allocation meeting].'*

Often these recommendations and subsequent alterations were undocumented negotiations between the social worker and team leader. This once again highlights a lack of co-production with the supported person, combined with a reduction of the social worker's autonomy. Given that these exchanges are unrecorded, the dialogue is direct and candid. These pre-meetings were viewed as a space to enable any issues within the assessment form to be 'ironed out' in preparation for the 'real' meeting, or the resource allocation meeting. In many ways they were rehearsals enabling the worker to test out their assessment and prepare a certain argument or agenda. These backstage pre-meetings would then give rise to a next meeting; thus, meetings generated more meetings.

7.4 Resource allocation meetings

7.4.1 Getting a result: a battle for a budget

Once a social worker has completed the SDS assessment form, they are required to present it to the team leader and service manager at a resource allocation meeting. The discussion is guided by the format of the assessment form, with the content of each section unpicked to explore the justification for each of the assigned risk ratings. Ratings are regularly debated, maintained, and changed. When describing the resource allocation meetings, practitioners said the following:

> *'I'll already have a pre-planned argument in my head [laughing]… of what I'm gonna say […] so I'm not kind of caught off-guard. Because you know, you do want to try and get as much as you possibly can for someone, erm, obviously with, within the assessed needs, you know.'* (Alex, extract from semi-structured interview)

> *'The resource allocation meeting can be a bit of a battle. As long as I have… kinda like a solicitor or a lawyer, I have, my defence, and my assessment information or evidence to back up what I'm arguing, they tend to go okay, but you really have to be prepared to justify and argue the case or you wouldn't get anything.'* (Esther, extract from semi-structured interview)

> *'it's frustrating when you know that, essentially, there may be a, a battle, a discussion, having to fight a case. It's frustrating. […] I suppose, for the service user, it's, I suppose it's a kind of luck of the draw, then, to an extent, isn't it, about who, who you get.'* (Oliver, extract from semi-structured interview)

This scrutiny resulted in social workers generally feeling that they had to battle for a budget with 'pre-planned arguments' or having their 'defence' organised so they were ready for 'a battle' or 'to fight' in order to justify the written assessment. It became apparent that the resource allocation meetings were a site for deliberating and conceptualising risk. This process of arguing for a budget impacted practitioners' sense of professional autonomy, with workers feeling a lack of control and influence, and disempowered by the resource allocation procedures. Furthermore, the resource allocation meetings also become a practice space where risk was re-defined:

> *'So I don't really see how this is critical risk here. Tell me a bit more about your thinking.'* ([redacted name], extract from fieldnotes)
>
> *'I'll take you down a level of risk here, and I will bump you up in the next section. I think that will make more sense given what you've just told me.'* ([redacted name], extract from fieldnotes)
>
> *'Right, let's forget the assessment form for a moment and just tell me about the person. What are your thoughts on how they are managing?'* ([redacted name], extract from fieldnotes)

The service manager and team leaders often requested further information in order to understand the justification for the level of risk. To rationalise their risk assessment and to render the gathered information intelligible, social workers told the supported person's story (Weick *et al.*, 2005), which acted as a frame for making sense of the world (Cook, 2020; Czarniawska, 2010). The meetings were thus a space for in-depth discussion, moving beyond what was inscribed in the assessment form. Practitioners often described the assessment form as acting as 'a barrier' to capturing the person, and often felt it necessary to deviate from the prescribed assessment form in order to present the case effectively. Practitioners explored and made sense of risk through dialogue, anecdotal stories from the home visits, and informal conversation during the meeting, which provided a space to enact SDS knowledge which was not formally recorded elsewhere. Given that all these conversations and decisions take place at a distance from the supported person, this calls into question whether the processes and procedures fully support a legitimately co-produced assessment.

7.4.2 Breaching the script: storytelling beyond the assessment form

As was highlighted in the inscription chapter, social workers engage in strategies and tactics when crafting the assessment form, often selecting or omitting evidence to frame the case discussion for the subsequent resource allocation meeting. The resource allocation meeting structure is guided by the assessment form layout, and therefore, this document is the central focus of the meeting, acting as a script which guides the interaction. Without the enacted meeting, the knowledge from the assessment form remains 'latent', 'unspoken', 'unexercised' and 'unused'; therefore, it is only through action informed by embodied and inscribed knowledge that the document develops meaning and significance (Freeman & Sturdy, 2014: 12). Assembling this script or interaction order in preparation for the resource allocation meeting can be a powerful intervention for the social worker because the former preparation work can dictate the latter performances. Tactical anticipating and framing performances were described by Amanda in the following comment:

> *'I guess I'm thinking about… what information will win [the service manager] over… to my way of thinking. Like, what's a convincing argument.'* (Amanda, extract from semi-structured interview)

Nevertheless, the planned and scripted performance does not always go as anticipated, nor does it guarantee the expected result. Observations revealed that practitioners would breach the script and engaged in impromptu narratives during the meeting, often expanding on points or disclosing additional information which was not included on the assessment form. Specifically, practitioners recounted stories from home visits which had a powerful influence in creating shared understanding of the case. The examples below are of social workers building upon the content in the assessment form and further elaborating on evidence using stories from home visits:

> *'I was in there for hours and hours, she can talk for Scotland. […] She is in a really bad way. […] Very isolated […] I couldn't believe what she has been through. […] So she doesn't have the best relationship with her family […] She's had a tough life. […] And because of all that shit, she basically said she can't trust anyone in her family now.'* (Zoey, extract from fieldnotes)
>
> *'I sat with her for a while, and she showed me all her handmade cards, and arts and crafts stuff. She is really into it.'* (Alex, extract from fieldnotes)
>
> *'[…] He was so confused when I was at the house, not making any sense. He definitely thought I was his daughter at times [laughing] […] Then on the way out, I managed to catch the neighbour […] She basically seen him… like lots recently… wandering about in the garden at strange times during the night, or just sitting in his car in the driveway, or talking to people that aren't there […]. [the neighbour] seems to keep an eye on him, but from what she was saying his dementia seems to have got worse recently.'* (Amanda, extract from fieldnotes)

Social workers extended and relayed first-hand embodied experiences and stories about what they had seen and heard. These personal stories have an emotional impact which brings the case to life. Enacted knowledge is ‘transient’, ‘fleeting’, and ‘variable’, only surviving for the duration of the enactment itself (Freeman & Sturdy, 2014: 12). The unofficial rule seemed to be that these stories were appropriate in the verbal discussion to generate understandings; however, this level of detail and informal narratives were not included within the inscribed document. Resource allocation meeting enactments were therefore not simply a transfer or reproduction of the inscribed assessment knowledge, but a space where workers breached this script and shared embodied knowledge. Practitioners thus deviated or strayed from the official line, creating a space for potential creativity beyond the assessment form. These enactments could potentially produce new embodied or inscribed knowledge which would endure longer than the enactment itself.

7.4.3 Collective thinking meetings: re-storied cases

As highlighted, the resource allocation meetings featured significant moments where workers breached the script to enhance understandings and deepen discussions (see 7.4.2). In order for management to form a professional judgment and work towards a decision, the document was questioned, discussed, and tested for robustness. Furthermore, the resource allocation meeting was a space where practitioners could join together in collective thinking to unpick a case, work through conflicting evidence, and further develop insights. Management probed workers for further evidence to understand their thought processes. These enactments were therefore a form of group sense making whereby discussions of the case create a space for collective sense-making in order to create a coherent understanding of the situation (Helm, 2017). Nevertheless, a theme of managerialism also emerged, which at times hindered the practitioners’ sense of autonomy (Banks, 2011). Meetings resulted in crucial changes and adjustments to assessment document and the subsequent budgets.

> *‘Okay, so from what I’m hearing from you…I don’t think this section is high risk. Can you lower that to substantial risk please. […] I see where you’re coming from, but I think with that level of family support it isn’t high risk.’* ([redacted name], extract from fieldnotes)

> *‘Your ratings don’t really add up in these sections. Can you tell me a bit more? […] Why is this only low risk […] Yet that is high?’* ([redacted name], extract from fieldnotes)

> *'You have described [redacted], but why does that make it high risk?'* ([redacted name], extract from fieldnotes)

The workers' professional judgments were tested with questions such as those in the examples above, and sometimes the social work manager reframed the evidence, drawing upon their experience to reach a different conclusion. Cases were at times re-storied and re-defined. As highlighted in 7.4.1, there could be a power struggle between the practitioners and management which resulted in a battle to gain the budget for the supported person. Although this was the social workers' professional assessment, they would often be required to make various edits before the assessment was agreed and signed off. The social workers' voices were therefore diluted, and the assessment became an inscribed document assembled by multiple contributors and authors (see section 6.8). This process therefore impacts upon social workers' sense of autonomy, whilst calling into question the authorship of the assessment document. The following accounts further evidence feelings of powerlessness and lack of control and agency in relation to crafting the assessment as a social work professional:

> *'Well what we've always been taught, through your degree […] you're taught to be an autonomous social worker. Erm, and to a certain degree, we are. Because you go out there, and you're the one that's there, you're the one that's seeing the person, you're getting all the information from all the other agencies, so you're case managing that […] which does feel satisfying. But in reality, it's all taken away from you until you've got the approval from management. Like in this council, we can't even make a decision on a small thing. Anything we need a budget for, we have to ask management. So at times, we feel like we have autonomy, but we don't, not really.'* (Oliver, extract from semi-structured interview)

Similarly, Esther stated:

> *'Sometimes, certain bits of information aren't in the assessment form. So that when we get into the discussion part of the meeting, and then it all starts coming out. You get told to add bits in there and take parts out. […] Hopefully you can give a clear picture and explain your way of thinking… or justify something. […] They [management] haven't met the person so they don't know anything about them, they only have the assessment form, whereas I know the case. Sometimes they see things differently, then you have to change the assessment form, which is a bit annoying, because it is meant to be my professional assessment. Like my*

> *name is on it, kinda thing [laughing].' (*Esther, extract from semi-structured interview)

Through following the life of the assessment document (Appadurai, 1986) and observing the linked enactments surrounding the artefact, the findings suggest that the narratives were not centred around the supported person, but instead were focussed on risk and the potential budget the document would generate. The evidence suggests that managers hold considerable agency and power which influences the assessment frame and content. Many of these backstage edits and conversations remain undocumented, resulting in the decision making process remaining distanced from the supported person. As the literature review highlighted, there is a lack of transparency regarding SDS decision-making and distribution of budgets, which results in supported people having concerns about the 'fair allocation' of support (Slasberg, 2013). Supported people therefore feel detached and distanced from decision-making fora and processes, which obstructs their choice and control (Care Inspectorate, 2019; Audit Scotland, 2017; SDSS and ALLIANCE, 2020; Young, 2020; Dalrymple *et al.,* 2017). The findings from this thesis further evidence the backstage decision making processes which fail to fully include the supported person.

7.4.4 Decisions restrained by resources

As section 5.3.2 highlighted, practitioners have embodied the local authority's eligibility criteria and normalised the high thresholds. Practitioners maintain a focus on keeping expenditure to a minimum, commonly stating that *'there isn't enough money'* to support each case, and that money must go *'to people who really need it'*. Years of reduced resources and cuts to public spending have therefore resulted in 'cost pressures' adding 'to a sense that SDS is, per se, "too expensive"' (Dalrymple *et al.*, 2017: 20). Furthermore, 'eligibility criteria were described as one of the main barriers to accessing support' (Feeley, 2021: 10). These embodied feelings around high threshold have attributed to fundamentally changing the remit of a social worker, reducing their work to crisis intervention underpinned by statutory legal responsibilities (see section 5.3.2). Linked to this, within the resource allocation meetings the enacted case discussions and decisions are often hampered by considerations of eligibility and restrained resources, rather than focussing on the supported person and a human-rights based approach. During these meetings, managers made the following statements:

> *'You are going to have to keep this case on your radar. He doesn't meet the criteria at the moment, but I think he is going to need support soon. Definitely one to keep an eye on, maybe don't close it just yet.'* ([Redacted name], extract from fieldnotes)

> *'He is struggling, but not enough to warrant a support package. Unfortunately, he just doesn't meet the criteria. If we supported him, we'd be supporting everyone. The budget needs to go to those who aren't coping.'* ([Redacted name], extract from fieldnotes)

Individuals requiring social care are required to meet high thresholds of risk to gain access to support under the local authority eligibility criteria framework (Pearson & Ridley, 2017). Within the decision-making forum, although practitioners are aware that someone is struggling, the budget is recognised as limited and only to be allotted to those '*who aren't coping*'. Services were described as *'stretched',* resulting in crisis intervention rather than preventative early intervention. Similarly, the Independent Review of Adult Social Care found that supported people felt that the threshold for accessing support is too high, and that support is often only available at a point of crisis (Feeley, 2021). Decisions to intervene were thus restrained by limited resources. During another resource allocation meeting, a reoccurring theme was discussed between the manager and the social worker, the manager stating:

> *'He has got the maximum amount, but I just don't know if that is going to be enough. Make sure you keep this under review. It could end up being residential care shortly.'* ([Redacted name], extract from fieldnotes)

Thus, there was an awareness that even assigning the maximum amount of support could still leave a recipient inadequately supported, which could then signal the recommendation for residential care. Section 2.3.5 in the literature review and section 5.2.4 in the embodied chapter each highlighted the ethical stress felt by the practitioner when an older adult's budget is often capped at the cost of residential care, which is a lower amount compared to what younger adults can receive. Once the cost of supporting someone in the community exceeds the cost of residential care, often a recommendation for residential care is made. This further evidences that enacted decisions are restrained by limited resources. Moving forward, the Independent Review of Adult Social Care makes the recommendation that all eligibility criteria and charging regimes need to be fundamentally reformed and removed, highlighting that social workers should be focussed on the rights of the supported person, rather than hampered by considerations of eligibility (Feeley, 2021).

7.4.5 Lost in translation: the voice of the supported person

Within the SDS policy and legislation guidance, the views of the supported person are of central importance to practice, which should centre around good conversations and co-production to enable a human rights-based approach (Feeley, 2021; Scottish Government, 2010; Scottish Government, 2014a; Scottish Government, 2014b) (see section 1.2.3). Nevertheless, the evidence within this thesis suggests that in reality, the enactment of good conversations is constrained, and that co-production is contested and inconsistent (see sections 5.2.2, 7.2.1, 7.2.2). There are therefore concerns regarding the meaningful inclusion of the supported person's views and voice within SDS translation. The findings in this section continue to demonstrate that the supported person's voice gets lost in translation during the SDS process. Although this echoes across the wider literature (ALLIANCE & SDSS, 2020c; Care Inspectorate, 2019; Morrow & Kettle, 2021), the direct observation of resource allocation meetings described here offers a distinct closeness to practice which provides new insights into the ways in which this theme is practically manifested during everyday enactments.

From observing resource allocation meetings, the extent to which the views of the supported person's views were enacted and present within the decision making forum was limited. As was explained above, these meetings centred around the format of the assessment form. As Chapter 6 highlights, although the supported person's views are inscribed on the form, the dominant voice is that of that practitioner. Social workers were captured inscribing and crafting texts with the reader and the budget in mind, rather than the voice of the supported person. Similarly, despite the supported person's views being present on the written assessment form, there was limited verbal enactment or representation of these views during the meeting. Furthermore, there were multiple instances where the views were not explicitly discussed, and instead the views of the social worker were dominant. Following the observation of a resource allocation meeting, Zoey explained that:

> *'The service user's voice is important, and I hear it and advocate for them, but really… hmmm… well… there are limited resources available in the community, so everyone tends to just get the generic type of home care, you know an option 3, especially when they're at breaking point, in crisis. I mean, option 1 does provide some more choice and control, but it's a long process. And they needed support, like, weeks ago. So in some ways… the decision is kinda already made.'* (Zoey, extract from fieldnotes)

Similarly, Esther stated:

> *'The service user is physically far removed from the resource allocation discussion […]. Their views are captured in the assessment, um, you know, at the top of each section […] but unless I get that across in the discussion, I don't really feel as if it's picked up too much or really considered by, um, managers. It is more the worker's*

> *opinion and the budget which are the focus of the discussion, rather than any views of the service user.'* (Esther, extract from semi-structured interview)

Based on examining the assessments, care plans, and resource allocation meetings, it seemed that what was considered 'a view' varied depending on the social worker. Some included depth and gave a long answer, whilst others recorded a brief statement. Overall, there was an inconsistent approach, and a range of understandings of what could be deemed a sufficient view. Yet, the process of co-production should support in gaining an authentic view of the supported person which is not heavily filtered by the social worker.

Further evidence of poor co-production and the omission of the supported person's views was apparent when workers regularly discussed how the budget would be spent at the end of the resource allocation meeting. Theoretically, once workers knew the budget outcome at the end of the resource allocation meeting, they were required to begin care planning with the supported person. Nonetheless, the practitioners frequently ended the meeting with fully formed opinions and ideas about how the personalised budget should be spent. For example, staff commonly made the following types of statements:

> Practitioner (Zoey): *'So, what sort of package are we looking at for them?'*
>
> Practitioner (Ava): *'Well… I reckon it will be just an option 3 with two visits a day. I think I know who has availability to deliver the package. I will just double-check with the service user what times they would prefer the visits and I will see if I can get it started.'*

As was highlighted in section 6.9.2, care planning was process-led, with limited co-produced discussion informing the inscription – a practice which directly contradicts the philosophy of SDS. Whilst completing the care plan, social workers spent time making calculations and working out how much money had been generated for personal care or for non-personal care. Overall, this section has emphasised the concerns which arise regarding the meaningful inclusion of the supported person's views and voice within SDS translation. The evidence suggests that the practitioner's voice remains dominant, and that there is limited co-production, good conversations and partnership working with the supported person.

7.5 Chapter conclusion

This chapter has explored a range of backstage enactments of SDS connected to home visits, the office, and resource allocation meetings, rendering these often-unnoticed and unrecorded interactions and pieces of daily work visible. Looking at the data through the lens of enactment, SDS is seen to be continuously translated and constructed through a multitude of interactions occurring in different spaces between various actors.

There was little evidence of meaningful co-production having been truly embedded into daily enactments during the interactions with the supported person or with co-workers. Co-produced conversations were particularly hindered by the crisis nature of the work, which was often time limited. This resulted in the supported person's voice getting lost during SDS implementation, and ultimately reduced the supported person's choice and control. Significantly, one worker critically questioned the concept of good conversations, suggesting that they oversimplify the complex role of a social worker. Practitioners are required to carefully balance the care-control dynamic whilst assessing supported people, and therefore are often pulled in different and contradictory directions in balancing their values whilst adhering to local authority's guidelines and procedures. Good conversations do not occur in isolation, but against the complex and multifaceted backdrop of practice. Emphasis on good conversations is crucial, but the wider context of SDS, including the backstage process and conversations, require equal consideration in order to ensure that the entire SDS journey is underpinned by the philosophy of SDS.

The wider SDS literature raises concerns surrounding the limited availability of all four options (see section 2.3.1). These enacted findings confirm that option 3 remains the most dominant provision, which demonstrates that the traditional care culture has been difficult to shift in terms of the type of services people are receiving. Although practitioners are aware of the empowering policy philosophy, they highlighted a tension between their practice aspirations and what they felt they could feasibly enact and achieve. Limited care provider provision in the marker hinders practitioners' power to commission all options. Additionally, long bureaucratic processes negatively impacted their ability to effectively enact and deliver the full range of options, with some supported people selecting the quickest option.

Overall, the office narratives centred around the deficits of an individual, budgets, risk ratings, hours, and tasks. Although the enacted discussions between workers support their sense-making of a cases and process, the findings suggest that practitioners are acutely aware of the impact of limited resources in the local authority on decision making and sense making. Practitioners engineer and manipulate ratings on assessment forms in an attempt to receive the desired budget, evidencing a process-led rather than person-centred approach, and regularly conduct a noticeable number of informal meetings with team leaders to discuss ratings and budgets in preparation for the resource allocation meetings. These pre-meetings result in further changes and alterations to the assessment and rating in an attempt to generate a specific budget. The backstage office enactments were thus bureaucratic process-led encounters, rather than outcome-focussed conversations.

Practitioners viewed the resource allocation meetings as a battle, and a site where they had to argue their case, reducing their sense of power and autonomy. These meetings involved in-depth discussion which often moved beyond what was inscribed within the assessment form, whereby workers went on to disclose additional information and recount stories from home visits which had a powerful influence in creating a shared understanding of the case. Resource allocation meetings were therefore not simply a site of transfer of the inscribed assessment knowledge, but a space where workers could breach the script and share embodied knowledge. Managers held considerable agency and power to influence enactments and assessment content, while practitioners often edited their assessments following meetings which reduced the social workers' sense of agency and autonomy. These backstage edits remained undocumented, creating an unclear and ambiguous decision-making process.

Overall, the evidence presented across the three findings chapters indicates that SDS values and principles are yet to be fully woven through the daily processes, procedures, and practice enactments. A clear gap is therefore apparent between policy and practice. Next, the final chapter outlines the overarching discussions and conclusions.

Chapter 8: Discussion and Conclusions

8.1 Chapter introduction

This longitudinal research project, which involved 12 months of data collection with staff members in one local authority social work team, set out to explore how practitioners translate and assemble SDS work through their everyday activities. In the first section of this thesis, Chapters 1 to 4 explained the wider context of the research, outlined the pertinent SDS literature, described Freeman and Sturdy's (2014) overarching embodied-inscribed-enacted theoretical frame, and gave an account of the methodological research approach. In the second section of the thesis, Chapters 5 to 7 presented the research findings through the lens of the embodied-inscribed-enacted framework. In this concluding chapter, the overarching research questions will be revisited and considered. The main findings are presented, and their implications discussed in relations to SDS practice and research. This discussion chapter contributes to the current conversations regarding the condition and future direction of SDS, given the ongoing shifting national landscape surrounding the National Care Service. Additionally, the chapter considers the originality of this research and its contribution to the knowledge in the field, before outlining the limitations of the study. Although it is ontologically contradictory to impose objective strict criteria with which to appraise this ethnographic research, Richardson (2000) outlines five criteria for evaluating ethnographic work which align with a constructivist research philosophy. These criteria focus on levels of insight, narratives, and creativity within the study, rather than on the scientific rigour of the evidence and questions of truth. The following sections within this chapter evidence the effective realisation of these criteria. Richardson's (2000: 254) five criteria are:

1. Making a substantive contribution to our understanding of social life;
2. Aesthetic merit, in terms of whether the work uses creative analytical practices to open up the text and invite interpretive responses;
3. Reflexivity,
4. Impact, in terms of whether the research affects the reader emotionally and intellectually, and generates new questions; and
5. Expression of reality, proposing that the research must 'seem "true"- by giving a credible account of a cultural, social, individual, or communal sense of the "real"'.

8.2 Revisiting the research questions

The analysis of the relevant SDS literature in Chapter 2 resulted in the identification of key research gaps. Through understanding these knowledge gaps and areas of concern, the direction of the project and the subsequent research questions came to fruition. In response to the research gaps, the focus of the thesis centred around the absence of understanding of the day-to-day SDS work of social workers, specifically in terms of how they make sense and translate the policy. A series of questions were developed and specified in section 4.3 through utilising the overarching 'how?' question (Becker, 1998: 58). As was previously stated, the central research question which guided this thesis was:

- *How* do practitioners translate SDS?

Furthermore, the subsidiary research questions were:

- What are the daily micro SDS interactions and encounters in practice, and therefore what forms does SDS work take?
- What people, objects, and spaces are involved in SDS translation work?
- How do practitioners make sense of SDS? Thus, how is SDS embodied, inscribed, and enacted?
- When SDS moves, what parts are successfully reassembled and translated, and what parts are invisible and missing?
- Finally, how does this understanding of SDS influence future practice and implementation?

The how-focussed inquiry, rather than explicitly concentrating on the question of 'why', drew out rich descriptions of the phenomenon and the inner ecology of practice experiences (Becker, 1998: 58). This line of questioning during data collection centred inquiries on how things worked, capturing the unfolding dynamics of the practice processes and interactions. As illustrated in the findings chapters, this approach rendered visible both how practitioners shape SDS and how SDS shapes practitioners. Consequently, a complex, evolving, and contested SDS phenomenon was presented, with practitioners positioned in the ambiguous interface between practice and legislation.

To answer the research questions restated above, the method of ethnography (see section 4.4.3) supported the how-focussed inquiry through enabling the researcher to interact with the phenomenon in various forms and spaces with differing people (Delamont, 2004). Crucially, these questions sought to achieve depth rather breadth during data collection. Nevertheless, the data analysis strategy did not solely 'zoom in' on practice work to reveal the micro picture, but also 'zoomed out' to consider the macro wider contextual issues (Nicolini, 2009). The findings chapters shift back and forth between these two lenses through considering the micro-practice of practitioners, whilst also linking to the wider literature in order to contextualise daily individual performances within the broader SDS landscape. Furthermore, this chapter continues to move between these two lenses in discussing the implications of the research findings for wider practice and future research. The key findings outlined in the following section combined with the subsequent sections on practice and research implications will evidence how each of the questions has been answered.

8.3 Core findings: what has research revealed about the implementation of SDS?

This section outlines the core findings of this doctoral research, grouped under thirteen main themed headings. These overarching themes unite the separate findings revealed through the earlier application of the embodied-inscribed-enacted framework, resulting in the following key messages:

8.3.1 Constrained choice and control

Within the broader SDS literature, constrained choice and control have been widely identified as a matter of concern, which highlights that not all options are nationally available and being offered to supported people (ALLIANCE & SDSS, 2020c; Care Inspectorate, 2019; Kettle, 2015; Pearson *et al.*, 2018). This study builds upon this macro national-level literature through characterising the manifestation of choice and control during a practitioner's local day to day work.

All the frontline workers in this study grappled with offering the promised choice and control to individuals requiring social care, and many frequently stated that the crisis nature of practice had a concerning influence over their everyday actions. Social workers felt it reduced their ability to enact good conversations and form enduring relationships with individuals and their families, thus impacting the time people had to consider their SDS options. This thesis further contextualises the delivery of choice and control, demonstrating that these practitioners felt powerless and constrained by the local authority framework and regulations which prevented them from having the time to build relationships and be more creative with SDS budgets, and thus practising in the manner they desired. This research specifically captures how the inscribed process-led approach and tick-box procedures often push workers towards reducing choice to a transaction of providing a service for money which directly contradicts the outcome-focussed coproduced philosophy of SDS. Within these findings, practitioners specifically provided examples of supported people selecting option 3 simply because it was viewed as the quickest way to gain social care support at a point of crisis. The crisis time pressured nature of the work resulted in option 3 becoming the dominant default option for people in need of support, thereby hindering meaningful, informed, and considered choices regarding support.

Additionally, this thesis broadens understanding surrounding practitioners' delivery of choice, through revealing that all four options were not available for practitioners to present and commission to individuals. Social workers described a lack of provision available in the community, specifically highlighting that no providers were available locally to offer option 2 or specialist services. Finally, it is important to acknowledge the role of risk aversion and defensive practice which, as the evidence indicates, limit individuals' choice and control experiences. Overall, the findings demonstrate that meaningful choice, supported decision making, and adequate support involving all four options is yet to be effectively delivered.

8.3.2 Contested understandings of co-production

The wider SDS research captures the concerns of supported people surrounding the practical receipt of coproduction (ALLIANCE & SDSS, 2020c; Flemig & Osborne, 2019). Furthermore, at a national level, the extent to which co-produced good conversations have been embedded into practice has been queried, however due to the lack of recording of such conversations, it has been impossible to evaluate and measure this. The present thesis expands and builds upon these existing studies, and due to the ethnographic nature of the study, the findings home in on the micro daily practices of social workers' implementation of co-production. This research reveals a highly contested understanding of the definition and practical delivery of co-production, which results in considerable ambiguity and a lack of shared agreement surrounding the concept. The findings specifically demonstrate that practitioners cast doubt over the true inclusion of the support person's voice, which was described as getting lost in the process, and which has little influence within the decision-making forums. This study further indicates that co-production was seen as being centred around encouraging compliance with paperwork, rather than transforming services through relocating power and control. Furthermore, practitioners felt that the processes and procedures they were obliged to follow do not fully embed a co-productive philosophy or facilitate a reliable consistent practice. Practitioners therefore indicated that co-production is an unrealistic task within the confines of the current processes.

Social services have existing structures in place within other settings which could inform changes and different directions in the practical delivery of co-production; for example, advance statements, family group decision making models, the Children's Hearing Panel structure, and the Looked After Child review. Although each of these approaches contain particular challenges, they provide examples of different methods of putting the supported person's voice at the heart of the process. Overall, the evidence demonstrates that co-production is yet to be consistently understood, practiced, and achieved by practitioners within the research site. Additionally, consideration must be given to designing processes and procedures to ensure they facilitate co-production.

8.3.3 Outcome-focussed implementation frustrated by processes

Existing research notes the tendency of systems to tie thinking and language to hours and tasks (Critchley & Gillies, 2018); however, this study advances these ideas and understandings through actively observing and capturing the frustrated bureaucratic daily practice of SDS implementation. This work can therefore be differentiated from the existing SDS research due to the micro level observation and focus on practices, which revealed a complex relationship between the practitioner and local authority processes throughout the three findings chapters. Specifically, these chapters noted the power which processes hold in directing, steering, and influencing the focus of the practitioner away from the outcome-focussed philosophy and towards procedural tasks. The research demonstrates that in order to complete the necessary SDS paperwork, the priority of the practitioner was pushed away from personal outcomes and towards the language of hours, budgets, time, and tasks, especially in backstage office spaces. Despite the claimed shift towards personalised outcome-focussed practice outlined in SDS legislation, this thesis highlights that practitioners deliberately kept outcomes broad and generic to give the supported person some flexibility regarding how the budget could then be utilised, rather than tying the money into a specific service.

The local authority systems support a very limited amount of recording about how outcomes were decided, or achieved, and whether unmet needs exist. The data thus revealed that there were limited discussions, recording, and reviews of personal outcomes, making it a challenge for the local authority to review the specific outcomes SDS has supported people to achieve. Currently, it therefore does not appear possible to extrapolate in what way SDS budgets are helping to tackle the inequalities faced by supported people. Instead, the evidence conveys that outcome-focussed approaches are yet to be embedded within the process and procedures to facilitate a true cultural shift in SDS implementation.

8.3.4 Heavily bureaucratised process-led work

There are a considerable amount of studies highlight how social work practice is heavily hindered by bureaucratic processes (Banks, 2011; Care Inspectorate, 2019; Gibson, 2016; Ingram & Smith, 2018; Manthorpe *et al.*, 2015; Webb, 2006). This research demonstrates that bureaucracy also affects SDS practice by disproportionately influencing and burdening practitioners with heavy bureaucratic procedures, resulting in a system-led approach which focuses on administrative activities rather than a practice centred around empowering relationships. The findings illustrate how daily work has become increasingly organised around paperwork, processes, budgets, and tools, shifting the focus away from the promised person-centred approach.

Social workers often discussed the layers of management they were required to navigate to gain authorisation for an SDS budget. The present ethnographic research captured the lengthy and slow process which burdens practitioners through physically moving with social workers as they went back and forth between staff and held numerous meetings, resulting in frequent edits to assessments. Workers felt heavily regulated by the standardised processes which were described as prescriptive and inflexible, and which resulted in a deterministic mode of practice.

This thesis captures how social workers drew a distinction between social work practice and administrative work, often voicing concerns about the number of financial tasks associated with SDS, which reduced the time they could spend with supported people. The findings specifically demonstrate that long bureaucratic processes and the pressurised nature of work result in practitioners producing what they described as routine or standard accounts within the assessment documents. Bureaucracy is steering practitioners towards routinised and narrow descriptions, calling into question the personalised and person-centred nature of assessments, and fundamentally contradicting the person-centred approach of the Act. Furthermore, specific options are considered to be more bureaucratic and slower routes than others to arrange, therefore hindering choice and control. For example, practitioners often suggested that option 3 is the fastest route to gain social care support. Overall, the heavily bureaucratised nature of social work resulted in some practitioners questioning whether their work can really be defined as social work, because it is so far removed from their expectations of the job.

8.3.5 Multiple languages of SDS

The thematic review indicates that social workers speak two different languages, one with the supported person and another with professionals (Care Inspectorate, 2019). This thesis builds upon that finding, revealing that practitioners speak multiple languages and were seen to tailor their SDS language within the home visit, the office, the written document, and in formal meetings. Through examining the micro daily practices, the findings highlight that although good conversations can occur with the supported person during a home visit, multiple other narratives also occur backstage which are not in line with the policy philosophy. The research further contextualises the language use surrounding SDS through exploring the backstage spaces including office conversations and assessment inscriptions, which were found to be dominated by the bureaucratic language of hours, risk, points, and budgets, and centred around the deficits of an individual. The findings demonstrate that these systems and procedures provided little space for workers to engage with the policy agenda of co-produced assessments informed by good conversations with empowering language. Empowering conversations seem to be restricted to the home visit, and although these good conversations are essential, this research illustrates that they are only valid if accompanied by backstage processes and procedures which also support this philosophy. Overall, the findings highlight that the philosophy of SDS yet to be embedded into processes and procedures throughout the SDS journey, and that the processes hindered rather than supported practitioners to have empowering outcome-focussed conversations.

8.3.6 Complexity surrounding the availability of SDS

A concern surrounding the accessibility of SDS for specific groups has already been expressed within the broader SDS literature (Dalrymple *et al.*, 2017). This thesis's findings further deepen understanding of this issue by indicating that within this particular local authority, a tension exists between SDS and home care delivery. SDS and home care operate separately, resulting in some individuals going down different routes and paths when attempting to access social care provision. Consequently, those sent down 'the home care route' have restricted choice and control over their support, and bypass the SDS co-produced assessment. The findings specifically highlight that hospital discharge cases were classified as 'not an SDS case', but a home care case. This study therefore raises concerns regarding the extent to which SDS is the mainstream approach to social care, and highlights the persistent attitude that SDS will not work for particular individuals, cases, or situations. Overall, it demonstrates that SDS is not routinely accessible to all those requiring support.

8.3.7 Limited resources and austerity measures

In the wider SDS literature, those critical of SDS claim that it acts as a mechanism to facilitate budget cuts and austerity which have restricted the potential to deliver transformational change (Manji, 2018; Pearson & Ridley, 2017). Furthermore, it has been said that the policy has created a market for care and 'backdoor privatisation' (Pearson, 2004: 10). This thesis draws upon these ideas, and due to the ethnographic nature of this research, the findings focus in on the impact of limited resources during the micro daily practices involved in SDS implementation co-production. The findings reveal that individuals requiring social care were required to meet high thresholds of risk in order to gain access to formal support under the strict local authority eligibility criteria framework. This thesis further characterises the impact of limited resources by highlighting the limited provision available to practitioners and the ongoing pressure to minimise costs, which in turn affects the delivery and quality of services. The research demonstrates that some workers felt that these high thresholds have contributed to fundamentally changing the remit of a social worker, reducing their work to crisis intervention underpinned by statutory legal responsibilities. Overall, the findings indicate that high eligibility thresholds undermine the philosophy of SDS, resulting in practice becoming disproportionately influenced and impeded by considerations of eligibility and limited resources, with a lack of focus on person-centred outcomes.

8.3.8 Crisis-dominated work

Crisis-oriented practice was a major theme which dominated daily work within the local authority team. The findings highlight that practitioners felt pressure to complete assessments and gain SDS budgets quickly, often in order to reduce the chance of a respite admission. The local authority supported those deemed at substantial and critical risk, and therefore, the focus of the social work was centred around crisis intervention rather than early intervention in low and moderate risk cases. The wellbeing of the supported person was often of great concern to the social workers, who sought to gain support as soon as possible. This pattern of crisis-dominated work was also clearly identified and criticised in the national macro-level Independent Review of Adult Social Care, which suggests the need for a change in approach towards early invention and increased amounts of prevention work (Feeley, 2021). The present thesis builds upon this national literature through specifically observing the manifestation of crisis during a practitioner’s local daily work. The findings highlight that SDS option 3 is promoted by practitioners as the quickest method by which to gain support with the least bureaucracy. This study acknowledges the challenging space occupied by the practitioner who is required to strike a balance between offering choice and control to the supported person whilst also safeguarding them at a point of crisis. The findings reveal the wider practice contextual factors of high caseloads, understaffing, and underfunded local authorities, all of which contribute to a reactive crisis response service which can have a dehumanising impact on the supported person. Overall, crisis-oriented practice fails to create an environment conducive to outcome-focussed conversations, thus hindering social workers’ ability to enact SDS as imagined.

8.3.9 Reduced sense of worker autonomy and power inequalities

Under the New Public Management paradigm, practice has become entangled in an audit paperwork culture with a focus on budgets, targets, objectives, and administrative tasks (Banks, 2011; Clarke & Newman, 1997; Power, M., 1997; White, 2008). This thesis draws upon these ideas and specifically illustrates how daily work has become increasingly organised around processes, procedures, and tools, resulting in concerns about the weakening of professional discretion and autonomy. This thesis further characterises SDS processes as standardised, prescriptive, and inflexible, resulting in a deterministic mode of practice. The evidence indicates that social workers do retain a certain level of discretion when crafting assessments and conducting home visits; however, the findings demonstrate that documents are often created with the managerial reader in mind, which influences the final written content. Through moving with the social worker through practice settings, the present research reveals that workers felt heavily regulated by processes and were required to navigate through multiple layers of management to gain authorisation and move forward with cases. The theme of a depleted sense of autonomy and power equality was particularly prominent throughout the resource allocation process, which was described as ‘disempowering’ and a ‘battle to gain funding’. Although the SDS Framework of Standards highlights the importance of worker autonomy, it is yet to be realised (Social Work Scotland, 2021). Overall, the findings illustrate a visible tension between daily managerial SDS processes and social workers’ sense of autonomy and power. This thesis reveals an ongoing dilemma for workers caught between SDS institutional goals and their responsibility to support someone as an autonomous worker.

8.3.10 Frustrated sense of professional identity

The ethnographic research approach adopted in this study facilitated a distinct closeness to practice, which revealed social workers’ emotions and feelings regarding their own professional identity. The findings demonstrate that the social work role often failed to match expectations, with a detrimental impact on professional identity. Although workers enacted their person-centred empowering values at an interpersonal one-to-one level, the neoliberal, heavily bureaucratised systems they had to work within made increasingly it difficult for each step of the SDS journey to move away from an overly deficit-focussed system. Workers were often frustrated and deflated by the processes within the local authority, querying whether much of the work they were completing was actually social work. This thesis reveals that relationships take a back seat as instead, procedural demands and expectations are placed upon practitioners. Practitioners thus struggled to reconcile their own views, values, and personal feelings with their professional role as outlined by the local authority.

8.3.11 Variable workforce practice

The research findings demonstrate that most members of the social work team had a clear understanding of SDS, including of the principles and values which underpin this policy. Nevertheless, this ethnographic findings captured inconsistent and variable approaches to SDS amongst staff. This inconsistency seemed to develop in response to long unwieldy processes and procedures which acted as a barrier to effective implementation. Practitioners developed tactics to navigate and *'work the system'* or '*play the game'*. Overall, this study illustrates that although practitioners were informed about and generally understood SDS, local authority interpretations and internal policies often contradict the wider national policy, leading to conflicting implementation.

8.3.12 Sensemaking in SDS

Although the process of sensemaking is gaining momentum within the wider social worker literature, as far as can be ascertained, SDS has not yet been framed through this lens. The present study thus characterises and captures the sensemaking occurring within the context of SDS to contribute to the wider sensemaking literature. This thesis highlights that practitioners piece together a case narrative and generate new understandings through writing notes during a home visit and inscribing the assessment. The research reveals that social workers also engage in an embodied form of sensemaking through mentally replaying the visit and their experiences in their minds to further enhance their understanding of the situation. The findings indicate that through an internal embodied dialogue, the social worker makes sense of their experiences through returning to the visit in their mind. This thesis further characterises sensemaking through the activity of sharing stories and experiences with colleagues to support in forming ordered narrative and stories, thereby rendering fragmented evidence intelligible. The findings reveal how colleagues support each other to arrive at a judgement; however, as the wider literature suggests, a team culture has the power to distort or promote effective sensemaking and subsequent professional judgements (Helm, 2017). This thesis specifically reveals narratives where supported people were storied and constructed as attempting to deceive or cheat the system, highlighting seemingly deserving and undeserving SDS cases. Importantly, the role of reflexivity, supervision, and effective management supports improved and enhanced sensemaking (Cook & Gregory, 2020; Helm, 2017).

8.3.13 The policy and practice gap

The final core finding presented in this thesis relates to the disconnect and gap between practice and policy. As illustrated in a number of the preceding twelve core findings, the values, principles, and philosophy of SDS are yet to be fully embedded throughout processes, procedures, approaches, and practice. It is, however, important to highlight that during this study's data collection the needs of supported people were met and social care was provided, even though at times SDS was not delivered in the spirit of the legislation. A considerable amount of national large-scale studies have reached the similar conclusion that although social care support is provided, there is a gap in that the underlying spirit and philosophy of SDS is yet to be universally embedded into practice (ALLIANCE & SDSS, 2020c; Audit Scotland, 2019; Care Inspectorate, 2019; Feeley, 2021). As was highlighted in the previous twelve core findings, this thesis builds on the contemporary literature through characterising and discussing the specific disconnects within the daily practice of frontline workers.

8.4 Connections to the current literature, research, and debates

The findings from this study address many of the central questions and difficulties associated with the implementation of SDS which were set out in the thesis's opening literature review. Through capturing the lived experience of social workers who occupy a challenging space whilst delivering SDS, significant gaps have been revealed between SDS legislation and practice. These findings relate and build upon many of the themes presented in the literature review chapter; however, as this thesis offers a distinct in-depth ethnographic practitioner lens, it is able to develop and complement the existing national surveys, reports, literature, and research. Concerning and saddening as these findings may appear, there are very live national conversations regarding future changes and improvements to social care delivery. Amid this global pandemic the importance of social care has never been more apparent, which has sparked an overdue, but much-needed discussion regarding the state of health and social care.

In February 2021, following the completion of this project's ethnographic data collection, the Independent Review of Adult Social Care Report was published (Feeley, 2021). Amongst its 53 recommendations is the creation of a National Care Service on an equal footing to the existing National Health Service (Feeley, 2021). Subsequently, the Scottish Government conducted a National Care Service consultation which began in August 2021 and closed in November 2021, which sought views on proposals to improve social care delivery. The proposed future National Care Service combined with other recommendations from the Feeley review could result in significant reforms to social care delivery, and could therefore specifically impact SDS implementation. Whilst the exact National Care Service structure remains undecided at the time of writing, there has been acknowledgment that change is required and improvements are needed. Nevertheless, with the limited information presented, concerns have been raised about potential restructuring which would reduce the power, control, and influence of local authorities, and instead empower Scottish Ministers with new responsibilities and oversight of care delivery and commissioning. Some observers are supportive of national accountability and local implementation, whilst others are apprehensive about this centralised structure, arguing that local authorities remain the best-placed organisations to respond to local social care needs. Whichever path is ultimately taken, what is important is that the current system does not just continue with superficial rebranding, which would make very little difference to those receiving social care and those implementing it.

As has been mentioned, how SDS is effectively integrated into this undecided structure is an unknown factor, yet consideration surrounding SDS progression continues and in March 2021, Social Work Scotland published the SDS Framework of Standards (Social Work Scotland, 2021). This document outlines up-to-date standards which complement practitioner guidance for local authorities to consider and follow with the aim of the further integration of SDS principles into daily practice. The Feeley review, the National Care Consultation, and the SDS Framework Standards all highlight the inadequacies of the current care system and importantly prioritise a human rights-based approach. This thesis joins in advocating for a system truly based on a human rights-based approach; however, it also recognises that what this means in terms of the practicalities of daily social work activities and how it is enacted requires further exploration. Additionally, consideration of how systems and processes can be designed to embed a human rights-based approach also requires further research. Given that the practical enactment of a human rights-based approach is unclear, caution is therefore needed around this term, which is threaded through all recent social care and SDS documents. Yet, this thesis acknowledges that a human rights-based approach is what supported people require, and it is also what the social workers who I worked alongside support.

Finally, the findings from this study also relate to a complex and concerning picture surrounding the social work identity. Practitioners are pulled in different directions due to competing functions in their daily work. Identities and expectations of the job have been impacted by neoliberalism and managerialism manifested in the marketisation of care, risk management, and bureaucratisation. Whilst attempting to practice in line with their values at the same time as adhering to the local authority's policies and national legislation, practitioners continue to walk a tightrope between care-control, technical-moral, and evidence-feelings.

8.5 Implications and recommendations for social work practice

The purpose and aim of this research was not to evaluate the specific practice of the team who participated in this study, nor to identify forms of SDS best practice in order to produce a blueprint for delivery. Nevertheless, given that the research explored the lived experience of practitioners and was embedded in practice, it is well placed to highlight some potential opportunities for SDS practice development. Many of these areas of development have echoed within the wider SDS literature.

The design of local authority systems, processes, tools, and procedures must not be overlooked. The findings evidence that their design has a direct impact on daily practice, which can ultimately hinder or enhance practitioners' ability to enact SDS in line with the stated philosophy. Such systems must be flexible in nature to easily enable a change of SDS options and allow appropriate freedom regarding when and where to spend a budget. The design of the systems, processes, tools, and procedures partly orchestrates and pushes practitioners down particular practice avenues. It is therefore essential that key SDS concepts of choice, control, co-production, and outcome-focussed approaches are effectively integrated throughout each step of the system, thus promoting effective SDS translation. Crucially, the support person's voice continues to get lost in the system and co-production remains a contested concept. The applied implementation of co-production therefore needs to be revisited and reshaped to ensure that the supported person's voice takes centre stage at each step of the SDS journey, crucially including the decision-making forum of resource allocation and reviews.

The high levels and numerous layers of bureaucracy found within the local authority processes impact the systematic recording of data surrounding SDS. Developing clear and consistent national recording datasets surrounding, for example, choices and personal outcomes, will enable disaggregated intersectional analysis which can be used to monitor and report on the extent to which people's personal outcomes are being met. Thus, it will be possible to establish how effectively SDS policy is supporting those accessing social care. This recorded information supports resource planning for the future of services.

The care market and the services being commissioned had a direct impact on what service provisions and options a practitioner could offer. An ethical long-term commissioning and procurement plan to support practitioners with the correct community resources is needed to offer all four SDS options promised in the legislation. Additionally, a cultural shift is required to promote creativity and innovation when commissioning care providers and provision.

The findings of this thesis indicate that practitioners are heavily reliant upon, and affected by, local authority resources, budgets, eligibility criteria, and thresholds. Consequently, as many previous studies have illustrated, working conditions are burdened by managerialism, high caseloads, long waiting lists, underfunding, and high thresholds, none of which promote and enable the key social work values which underpin the philosophy of SDS. In light of these findings, there is much to be considered regarding a change of culture in society, whereby we view social care as an investment, rather than a burden (Feeley, 2021). Practitioners responding and supporting people at the point where their cases reach crisis point was a reoccurring and dominant experience within the research. As I noted, this impacted the ability to build relationships and have meaningful conversations about support. To enable practitioners to move away from crisis intervention work, and towards earlier intervention, the national eligibility framework and intervention thresholds which suggest that those entitled to support must be at critical or substantial risk need to be revisited, so that guidance promotes early intervention. These broad discussions should form part of conversations and research into the proposed National Care Service.

Overall, this thesis presents a concerning gap between social work practice and policy expectations based on shining a light on the complex position of social workers who are often pulled in multiple competing directions. The key message from this research is that SDS is not a fully-formed and finalised piece of policy, but instead is continuously assembled and translated through daily practice. Consequently, through rendering the frontstage and backstage work visible, the centrality of social workers, local authorities, and local processes are apparent. The research has attempted to foreground the agency of the worker and of the local authority, thus highlighting that given the malleable and evolving nature of SDS, there is a possibility of negotiating an alternative SDS future.

8.6 Future avenues for research

The opening literature review indicated gaps in the knowledge and understanding of SDS, suggesting a range of potential research areas. SDS is a vast topic with multiple stakeholders from distinct groups of supported people (for example, those with lived experience of mental health diagnosis, addictions, learning disability, dementia, and physical disability), various professionals and third sector organisations (for example, occupational therapists, hospital discharge staff, advocacy workers, and personal assistants), as well as informal carers. Nevertheless, this section does not aim to list every possible research avenue, but instead highlights several lines of enquiry which have arisen from this thesis. Given the aforementioned core findings, the following areas warrant future research in order to build upon the work presented in this thesis:

- ➢ The heavily bureaucratised nature of SDS burdens practitioners, resulting in a system-led approach which focuses on administrative activities. Further research is required to explore how SDS tools and paperwork can be designed to support and equip practitioners to enable more flexible and creative practice. This includes enhancing understanding of how tools can successfully embed and promote concepts of co-production, choice, control, a human rights-based approach, and personal outcomes, thus supporting practitioners to adopt a human rights-based approach.

- A particular challenge highlighted here relates to the contested understanding and practical implementation of co-production. It would be valuable to further explore how co-production is actively translated into practice, and which processes support social workers with effective implementation. It may be beneficial to explore existing alternative collaborative protocols and systems within other social work and health care settings in order to inform potential future avenues; these include, for example, advance statements, family group decision making models, the Children's Hearing Panel, and the Looked After Child (LAC) review.

- As was highlighted in the literature review, the prior research focusses on those already in the SDS, rather than those who have been unable to gain access. Furthermore, this thesis reveals that some groups (for example, hospital discharge cases) or individuals by-pass SDS. It would be advantageous to explore the experiences of different groups in attempting to access SDS.

- Local authorities currently respond to critical and substantial risk, resulting in social work practice dominated by crisis responses rather than early intervention and prevention. Although the recent Independent Review of Adult Social Care promotes a new narrative of early intervention, further research is required to explore how preventative work can be effectively delivered within the SDS system, and what forms these interventions will take.

- Not all of the promised four options outlined in the legislation are currently available for social workers to commission from local providers. As highlighted in the Independent Review of Adult Social Care and the thematic review, a reform of commissioning is required. Further research into an ethical commission processes and the impact of the care market is crucial.

- Younger and older adults are eligible for different maximum budgets based on their age. This merits further investigation to understand its influence on decision-making regarding residential care once an older person exceeds their capped budget. This is especially pertinent given that the Independent Review of Adult Social Care emphasises the importance of frontline workers focussing on the human rights of the individual, rather than on considerations of eligibility.

- Finally, the proposed National Care Service design and delivery is as yet undecided, and therefore how SDS will be integrated into this new national model is unclear. Consequently, further research and consideration are needed to ensure that the current issues do not continue within a new system.

8.7 Originality and contribution to knowledge

There are two main areas of originality in this research which represent important contributions to the knowledge in the field. First is its unique application of an ethnographic methodology to explore SDS and the wider area of adult social work in Scotland. As described in section 4.4.2, there is a rich history and a proven track record of social work researchers successfully utilising ethnography to get close to practice, however it was yet to be applied to SDS in Scotland. The adopted ethnographic and auto-ethnographic lenses thus enabled a distinct and intimate exploration of SDS practice which resulted in an in-depth understanding of how social workers translate the policy. It is argued above that this closeness to SDS practice through observation would not be feasible via other qualitative methods (see section 4.4). Crucially, through the ethnographic tool of observation, this research captured how SDS is embodied, inscribed, and enacted in multiple spaces, gaining what Geertz (1973: 10) describes as ‘thick description’. As was noted in Chapter 2, there is limited literature on how social workers implement SDS, and therefore gaps in research exist. This ethnographic study facilitated a sustained focus on the actions and perspectives of practitioners, in a way which contributes towards addressing this gap in knowledge by providing the necessary insights into the role and actions of social workers during SDS translation.

Secondly, SDS Freeman and Sturdy’s (2014) embodied-inscribed-enacted theoretical framework enabled a focussed theorisation of social work practice grounded in everyday work, specifically framing *policy* as *practice.* This interpretative approach challenges the assumption that SDS is a fixed policy with a static meaning, and instead recognises that SDS is continuously translated and assembled through daily activities. This theoretical framework characterises practitioners’ SDS knowledge as embodied, inscribed, and enacted, offering a powerful tool with which to identify and frame social workers’ policy translation. It is argued that viewing SDS through this particular lens offers a distinct way to capture the policy which sheds light on unseen manifestations of the phenomenon. As such, this lens frames SDS from a previously unobserved angle, offering a unique contribution to knowledge.

Whilst not wishing to overclaim based on the findings of this thesis, it can be argued that the findings have potential implications for Scottish practice and highlight opportunities for future research, thus making a valuable contribution to the field (see sections 8.4 and 8.5). Finally, through presenting an in depth study of the Scottish SDS context, this study also offers an important contribution to wider debates surrounding the global shift towards personalisation policies, as adopted by a host of countries over the past two decades (Dickinson *et al.*, 2020).

8.8 An unexpected journey: research reflections

This research journey took some interesting diversions, and as discussed in Chapter 4 an unexpected auto-ethnographic element was integrated into the methodology as a consequence of the COVID-19 pandemic in order to continue data collection. This had a significant impact on my positionality, which changed from that of a *participant observer* to a *complete participant,* resulting in six months of auto-ethnographic data collection (Hammersley & Atkinson, 2019). Nicolini (2009: 1403) describes the ethnographer as responding to the evolving phenomenon through utilising their ethnographic 'toolkit logic', which consist of a variety of tools including: observation, participation, formal and informal interviewing, and document analysis. The flexibility offered by this interpretivist methodology enabled me to amend my 'toolkit' to include an auto-ethnographic element in response to the COVID-19 pandemic. My initial decision to utilise ethnography was underpinned by the firm belief that to understand SDS it was essential not just to simply hear practitioners talk about the policy during an interview, but to become immersed in their daily activities, and thus experience SDS in action (Hammersley & Atkinson, 2019). Auto-ethnography enabled me to gain a level of access and involvement with the social work team that has supported the PhD process and greatly enhanced my understanding of SDS. This is explored in greater detail above in section 4.6, which argues that the deployment of auto-ethnography complimented and facilitated a deeper immersion, resulting in more holistic research and analysis (Ellis *et al.*, 2011; Moeran, 2009).

Auto-ethnography grants the researcher a heightened level of immersion; however, it is important to acknowledge that due to the unexpected alteration to my research plans, I became more personally involved in the research process than I had originally anticipated. Commencing a full-time job as a social worker for six months during my PhD journey during a global pandemic was an all-consuming, powerful, and influential experience. Throughout these six months of practice, although I attempted to strike a balance, my responsibilities to my caseload as a social worker took precedence over my research and data collection. Overall, the present thesis argues that this unexpected journey impacted the research in a positive way. Additionally, my own wider professional development and knowledge as a practitioner progressed. I therefore gained broader learning and realisations during this journey which cannot be captured within this thesis. I am certain that this final thesis and its findings would have looked very different without the auto-ethnographic element, and consequently I believe that practicing as a social worker within the team significantly altered the research as a whole, in an overwhelming positive way. Finally, whilst practising, I carefully reflected on the role of a social worker and their complex position in translating legislation and policy whilst subject to organisational constraints. In doing so, I have a renewed respect and appreciation for social workers in practice settings.

8.9 Study limitations

Wolcott (1990) notes the importance of being clear and upfront regarding the limitations of research, whilst acknowledging what has been achieved and learnt during the journey. This study set out to explore the daily experiences of practitioners in translating SDS. It was designed to gather deep and rich narratives about their lived experiences of policy translation by exploring one specific team experience at a particular time. Some consider the low generalisability of the findings a key limitation of ethnographic research due to the small nature of the sample size (Bryman, 2004). Nevertheless, the findings complement existing SDS literature through telling another piece of the policy story, which was yet to be reported. Hammersley and Atkinson (2019) argue that the in-depth nature of ethnographic investigations enable researchers to discover meaningful findings regarding the context of study, which may be less possible using alternative research methods. Hence, many of the key findings and themes presented within this thesis are linked to the wider national SDS literature such as the thematic review (Care Inspectorate, 2019), Audit Scotland report (2017), the Independent Review of Adult Social Care (Feeley, 2021), and the research project MSMC (ALLIANCE & SDSS, 2020c). These nationwide studies illustrate similar tensions and conflicts between the philosophy of SDS and its practical delivery or receipt of support. Furthermore, they mirror several themes found within this thesis including, high levels of bureaucracy, complex systems, and constrained levels of choice, control, flexibility, and co-production. Given that many of the themes from this thesis link to the national SDS narratives, it is argued that as far as it can be determined, this thesis offers a typical account of SDS practice in Scotland through the lens of a frontline worker. This thesis therefore harmonises with and supports a national holistic understanding of SDS.

For those who position themselves as positivists on the philosophical research spectrum, the seemingly more subjective nature of ethnography may also be considered a limitation. This study acknowledges the subjective nature of the project, and in fact, openly draws upon my co-construction of reality which was inherent in all phases of the research process to support in making sense of the phenomenon. I do not seek to deny or conceal my impact on the data; instead, I have sought to actively incorporate it, especially through utilising my reflective log. Importantly, it is argued that this does not compromise the rigour of the study, but that reliability and rigour are maintained due to the application of an appropriate theoretical frame, sampling techniques, and analysis processes as outlined in Chapter 4. Furthermore, through the mode of supervision and a reflective log, I engaged in continuous reflexivity in order to acknowledge and constantly consider my own impact on the project. Importantly, reflexivity does not guarantee more valid and reliable research, but it does support the researcher in working towards this (Pillow, 2003).

Although every effort was made to engage with all the workers in the team it was, of course, only possible to be in one place at any one time. Undoubtedly, whilst I was working with one worker, multiple other workers were conducting SDS in other spaces. Furthermore, I spent less time with members of the team who did not have relevant cases. The practical limitations of time and the nature of working as a sole researcher did limit and constrain my data collection; however, as I outlined in Chapter 4, an appropriate sampling technique was followed to facilitate rigorous sampling. Generally, the local authority was extremely open and facilitated access to the information, data, and cases I requested. That said, it is important to acknowledge that the gatekeeper made the decision on two occasions not to grant access due to the perceived risk to all parties involved. Additionally, some data has been excluded from this thesis because it would not have been possible to include this information and maintain confidentiality. For example, personal details regarding a supported person's circumstances.

As I have highlighted throughout this thesis, COVID-19 had a large impact on the research journey. The pandemic could potentially have caused major limitations and ultimately stopped the research prematurely after only three months of ethnographic data collection. Nevertheless, although COVID-19 was disruptive and impacted the entire project, I argue that the auto-ethnographic amendment ultimately enhanced the project, rather than constraining and limiting it (see section 4.6).

Overall, although there are limitations to using ethnography as a research method, this thesis still makes a unique contribution to knowledge and enabled the researcher to specifically explore how SDS is being translated in practice. The findings from this study have been presented to both academics and practitioners at seminars and workshops across the academic, policy, and practice fields, which could be considered a measure of validation.

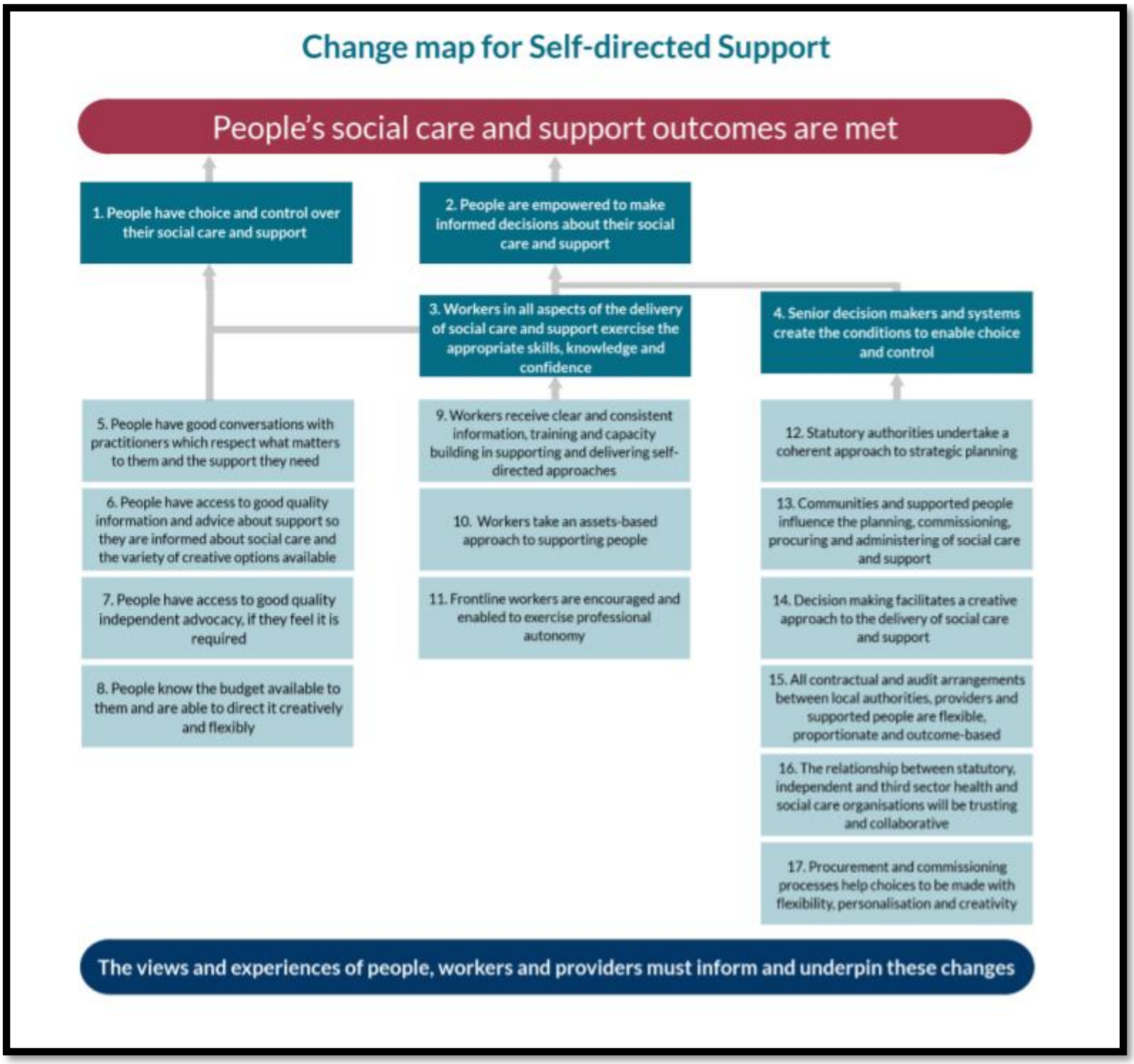
8.10 Final remarks

Every day across Scotland, social workers conduct a range of SDS activities including home visits, paperwork, meetings and interactions with individuals, families, colleagues, and professionals, assessments of levels of required support, all whilst navigating SDS processes and procedures. SDS is the key policy and mechanism by which some of the most vulnerable in society gain their required social care support. Despite the centrality of SDS to social work practice, there has been limited empirical research. The findings from this study work towards addressing this gap and offer insights into daily SDS social work practice. Listening to social workers' accounts of their work and observing the social workers' everyday practice has provided this research with vital pieces of information in conceptualising SDS. At first glance, SDS policy and legislation may be considered as something which is presented in formal documents; however, as this study reveals, SDS policy comprises the everyday processes of assemblage and translation work conducted by frontline workers. SDS implementation is a messy process, in which the policy philosophy does not currently fit comfortably together with the practice.

It is not possible to neatly tie up and conclude this research given that SDS implementation is dynamic and evolving. This final chapter has looked back at the research questions and the main findings, whilst also looking forward to the potential implications for future practice and research. A vast gap between SDS legislation and practice is apparent, and the transformational change promised by the SDS Act is yet to be achieved. The evidence suggests that processes, procedures, resource limitations, and tools which do not reflect the philosophy of SDS reduce practitioners' ability to base their practice on the co-produced outcome-focussed principles rooted in a human right based approach. The barriers faced by practitioners when attempting to embed SDS values and principles must be addressed to drive and promote a culture change, working towards bridging the gap between policy and practice. The specific service design and delivery of the proposed National Care Service remain undecided, with multiple potential directions moving forward. Scotland is thus at an important crossroads in deciding the future of social care, and consequently, these findings merit consideration when considering and planning how SDS will fit into this new national care model.

Appendices

Appendix 1: Change map



Change map for Self-directed Support

People's social care and support outcomes are met

1. People have choice and control over their social care and support

2. People are empowered to make informed decisions about their social care and support

3. Workers in all aspects of the delivery of social care and support exercise the appropriate skills, knowledge and confidence

4. Senior decision makers and systems create the conditions to enable choice and control

5. People have good conversations with practitioners which respect what matters to them and the support they need

6. People have access to good quality information and advice about support so they are informed about social care and the variety of creative options available

7. People have access to good quality independent advocacy, if they feel it is required

8. People know the budget available to them and are able to direct it creatively and flexibly

9. Workers receive clear and consistent information, training and capacity building in supporting and delivering self-directed approaches

10. Workers take an assets-based approach to supporting people

11. Frontline workers are encouraged and enabled to exercise professional autonomy

12. Statutory authorities undertake a coherent approach to strategic planning

13. Communities and supported people influence the planning, commissioning, procuring and administering of social care and support

14. Decision making facilitates a creative approach to the delivery of social care and support

15. All contractual and audit arrangements between local authorities, providers and supported people are flexible, proportionate and outcome-based

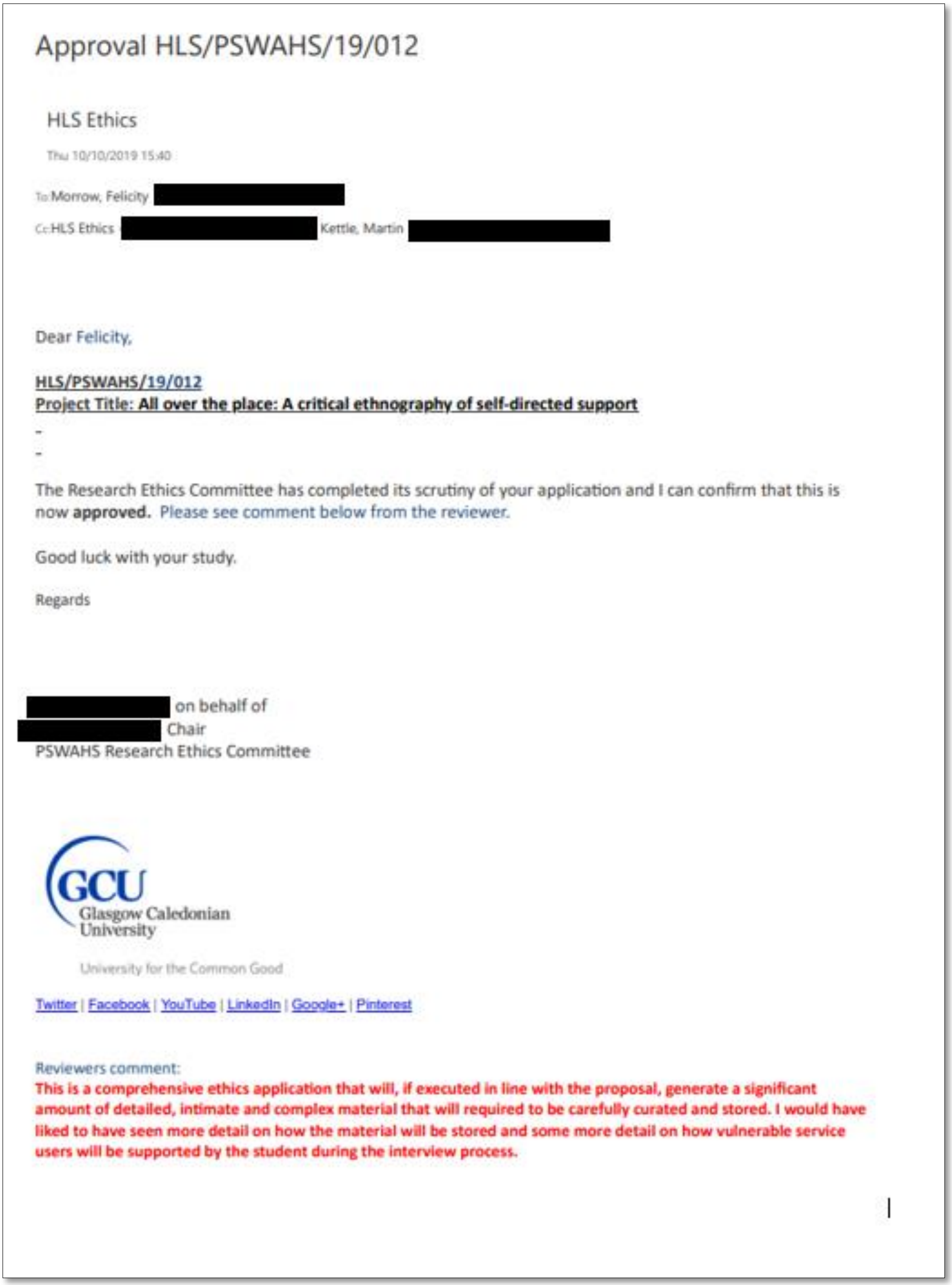
16. The relationship between statutory, independent and third sector health and social care organisations will be trusting and collaborative

17. Procurement and commissioning processes help choices to be made with flexibility, personalisation and creativity

The views and experiences of people, workers and providers must inform and underpin these changes

Appendix 1 illustrates the SDS change map from the SDS Implementation Study 2018 report, which was authored by independent researchers at the APS Group Scotland for the Scottish Government .

Appendix 2: Ethics approval from Glasgow Caledonian University



Approval HLS/PSWAHS/19/012

HLS Ethics

Thu 10/10/2019 15:40

To: Morrow, Felicity [redacted]

Cc: HLS Ethics [redacted] Kettle, Martin [redacted]

Dear Felicity,

HLS/PSWAHS/19/012
Project Title: All over the place: A critical ethnography of self-directed support

-

-

The Research Ethics Committee has completed its scrutiny of your application and I can confirm that this is now **approved.** Please see comment below from the reviewer.

Good luck with your study.

Regards

[redacted] on behalf of
[redacted] Chair
PSWAHS Research Ethics Committee

GCU
Glasgow Caledonian
University

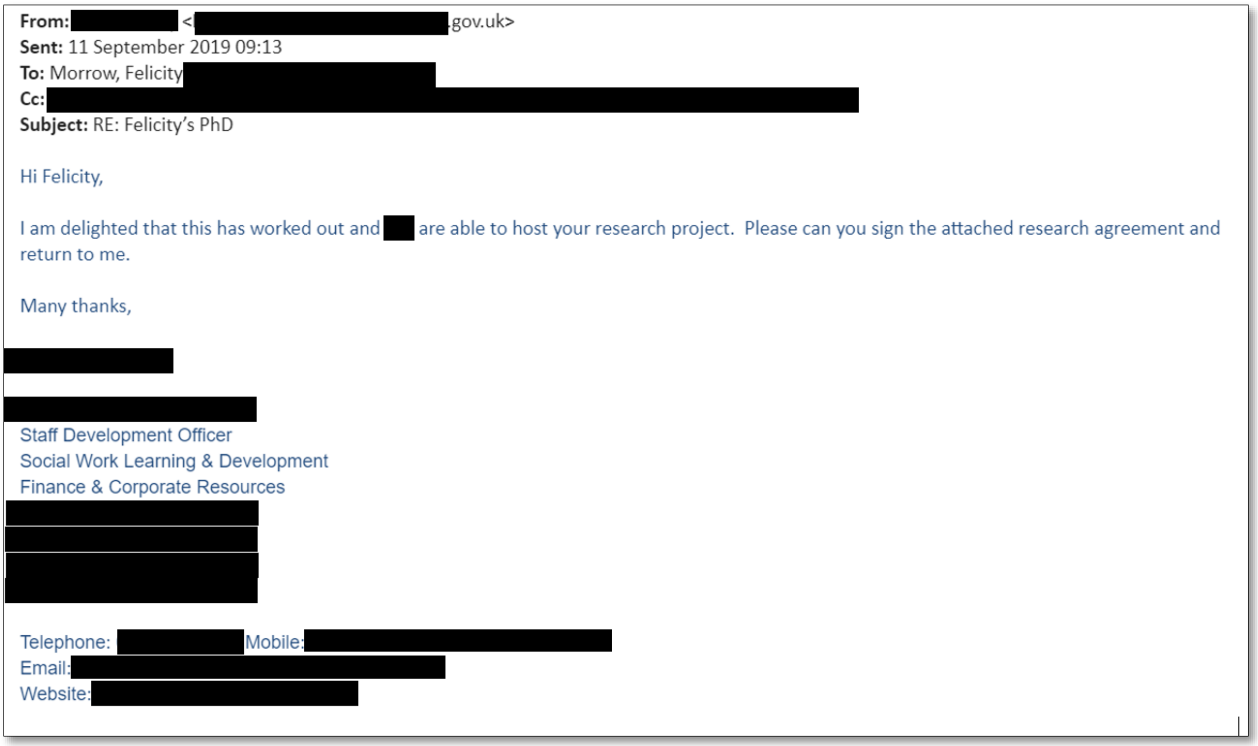
University for the Common Good

Twitter | Facebook | YouTube | LinkedIn | Google+ | Pinterest

Reviewers comment:

This is a comprehensive ethics application that will, if executed in line with the proposal, generate a significant amount of detailed, intimate and complex material that will required to be carefully curated and stored. I would have liked to have seen more detail on how the material will be stored and some more detail on how vulnerable service users will be supported by the student during the interview process.

Appendix 3: Ethics approval for local authority research site



From: [redacted] <[redacted].gov.uk>
Sent: 11 September 2019 09:13
To: Morrow, Felicity [redacted]
Cc: [redacted]
Subject: RE: Felicity's PhD

Hi Felicity,

I am delighted that this has worked out and [redacted] are able to host your research project. Please can you sign the attached research agreement and return to me.

Many thanks,

[redacted]

[redacted]
Staff Development Officer
Social Work Learning & Development
Finance & Corporate Resources
[redacted]

Telephone: [redacted] Mobile: [redacted]
Email: [redacted]
Website: [redacted]

Appendix 4: Participant information sheet for practitioners

Participant Information sheet for practitioners

Title of PhD project: A critical ethnography of self-directed support in Scotland

What is the purpose of the research?

This research aims to explore how SDS is understood in adult social work teams. I hope to follow and move with the SDS policy to observe how differing practitioners interpret and translate SDS when they come into contact with the policy. Within this study the social workers are positioned as the experts. I am seeking to better understand how practitioners make sense of SDS; what are practitioners experiences of SDS; in what ways does SDS impact practice; what challenges exist with SDS; and finally are there any examples of innovative work surrounding SDS. The fundamental question is not whether SDS works, but rather how it works, what forms of work does it take, and what kind of work gets done.

Importantly, the study is not focussed on evaluating and critiquing the local authority or working practices of individual social work teams. Instead, this research aims to create an in-depth description of how SDS gets done within the context of Scottish adult community care.

Methodology of research: what should the participating local authority expect?

This research takes an ethnographic approach which requires me to locate myself within the setting for a prolonged period of time to gain an in-depth holistic understanding of the phenomenon through interviews, observations and document analysis. This extended period of time enables me to immerse myself in the day to day SDS work of the local authority. This could involve following cases through various processes including: observing duty, case conferences, assessments, meetings, resource allocation meetings, attending home visits, and informal and formal interviews with key staff members.

I would collect this data in the form of written fieldnotes and recorded interviews where consent has been granted.

Your role in the study:

I am seeking to explore what you think about SDS and how you understand SDS. I am interested in how it affects you practice and day to day work. This is a deliberately open-ended research question, guided by what you tell me and what I observe. This research is not about evaluating your practice, but to create a detailed in depth description of how SDS works and what SDS work actually is.

I plan to conduct interviews between with professionals as cases evolve. These will be semi-structured conversational interviews to discuss experiences surrounding SDS. I plan to be based in the local office where I will conduct observations to understand the culture and practices of the team. Observations are likely to include day to day activities, meetings, home visits, resource allocation meetings, duty calls. I plan to conduct documentary analysis and will be asking permission to read how SDS assessment forms have been completed and to read how an SDS meeting or home visit has been recorded in case notes. You are able to ask that I do not observe certain things at any time and you are able to withdraw consent and data provided at any time.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form and provide some basic information about yourself. You are free to withdraw at any time and without giving a reason.

Consent and confidentiality

After reading this information sheet and asking me any questions regarding the research, I will ask you to sign the attached consent form. If you change your mind, you may withdraw from the study at any time. Please inform me of this in writing.

Importantly, the research will always be anonymised so that any data, including individuals and the local authority location, will not be identifiable. All data will be stored in a password encrypted device or in a locked cabinet. Transcripts and notes will be linked to a pseudonym, so individuals are not associated with any quotes, experiences or information.

What happens to the findings and outcomes of this research?

A PhD thesis will be produced at Glasgow Caledonian University. Presentations will be provided at conferences and if requested at the local authority. Additionally, articles may be published in academic journals to disseminate findings.

Who is the researcher?

My name is Felicity Morrow and I am a research PhD candidate at Glasgow Caledonian University (GCU). I am a qualified and registered social worker with the SSSC. The Director of Studies for this research project is Dr Martin Kettle, who is currently the Programme Lead for the MSc in Social Work and the Postgraduate Award Chief Social Work Officer at GCU. Martin is a qualified social worker with over thirty years' experience in practice.

If you have any questions or wish to contact me regarding this study my details are as follows:

Name: Felicity Morrow

Email: [redacted]

Appendix 5: Participant information sheet for supported people

Glasgow Caledonian University

Participant Information sheet for supported people

Title of PhD research project: A study of how self-directed support (SDS) works in practice

What is the purpose of the research and how will it be carried out?

This research aims to explore how SDS works in practice for social workers and those who receive services. The researcher aims to observe the whole process of SDS including the day to day work in the office, meetings with those who receive services, home visits, reviews and assessments. The aim is to create an in-depth description of how SDS gets done in Scotland and work towards improving services.

Do I have to take part?

No, it is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep and be asked to sign a consent form and provide some basic information about yourself. You are free to withdraw at any time and without giving a reason.

Your role in the study:

I am seeking to explore your experiences of SDS and to understand what you think about the SDS process. I will do this through shadowing how your social worker supports you during home visits, meetings and assessments. I may also request to speak to you and ask you some questions about your experiences.

You are able to ask that I do not observe certain things at any time and can change your mind about taking part in this study at any time.

Who is the researcher?

My name is Felicity Morrow and I am a research PhD candidate at Glasgow Caledonian University (GCU). I am a qualified and registered social worker with the SSSC. The Director of Studies for this research project is Dr Martin Kettle.

Consent and confidentiality

After reading this information sheet and asking me any questions regarding the research, I will ask you to sign the attached consent form.

Importantly, the research will always be anonymised so that any data, including individuals and the local authority location, will not be identifiable. All data will be stored in a password encrypted device or in a locked cabinet.

What happens to the findings and outcomes of this research?

A PhD thesis will be produced at Glasgow Caledonian University. Presentations will be provided at conferences. Additionally, articles may be published in academic journals to disseminate findings.

If you have any questions or wish to contact me regarding this study my details are as follows:

Name: Felicity Morrow Email: [redacted]

Appendix 6: Participant consent form for practitioners

Glasgow Caledonian University

Participant consent form for practitioners

Please tick the boxes below to indicate you have read and agree to the statements below. Please print, sign and date the form to consent to participating in this study.

Please tick the box

☐ I confirm I have read and understood the attached information sheet for this study. I have had the opportunity to think about the information and was able to ask the researcher more details if I wished.

☐ I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, combined with retracting any data I provided.

☐ I understand that the researcher is observing social work practice within the office environment and that the researcher will take fieldnotes regarding observations of practice.

☐ I understand I can request for observations not to occur at any time.

☐ I understand the research involves informal and formal discussions and interviews between the researcher and participants, which may be recorded through fieldnotes or using an audio device (with my permission).

☐ I understand that information or quotations I provide may be used within the PhD thesis and publications, but that neither myself nor the local authority will be identifiable. Thus, I understand that the details of the local authority and individuals will be anonymised and not revealed.

☐ I agree to take part in the study.

Print your name: Signature: Date:

Appendix 7: Participant consent forms for supported people

GCU
Glasgow Caledonian
University

Participant consent form for supported people

Please tick the boxes below to indicate you have read and agree to the statements below. Please print, sign and date the form to consent to participating in this study.

Please tick the box

☐ I confirm I have read and understood the attached information sheet for this study. I have had the opportunity to think about the information and was able to ask the researcher more details if I wished.

☐ I understand that the researcher is focussed on learning more about how self-directed support (SDS) works in practice and that the researcher will take notes when shadowing the social work staff during meetings. With my permission the researcher may read assessments and other paperwork associated with my SDS budget.

☐ As well as attending the meetings between the social worker and myself, I understand the researcher may ask for a further discussion with me to explore my experiences of SDS.. This may be recorded through written notes or using an audio device (with my permission).

☐ I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, combined with retracting any data I provided.

☐ I understand that information or quotations I provide may be used within the PhD thesis and publications, but that neither myself nor the local authority will be identifiable or revealed.

☐ I agree to take part in the study

Print your name: Signature: Date:

Appendix 8: Interview guide

Interview topic guide

Introduction: thank you for taking the time to talk to me today. (Action- confirm a consent form has been received and answer any questions regarding the consent form and interview). The recorded conversation will last around an hour and you don’t need to answer a question if you would prefer not to. Please remember everything discussed will remain anonymous and pseudonyms will be used.

1. Can you begin by reminding me how long you have been a social worker for and what roles you have had?

2. Can you describe your experience of the SDS assessment form?

Potential prompts:

- Do you feel that all supported people can be captured in the assessment form?
- Can you tell me about the different ratings and how you decide on these?
- Can you describe to the language in your assessment form?

3. Can you describe your experience of support planning?

Potential prompts:

- To what extent are people able to obtain non-conventional forms of social care?
- How does SDS increase choice and control of people?
- How do supported people decide on the four options?

4. Can you describe your experience of the processes and procedures surrounding SDS?

Potential prompts:

- How do you find navigating the journey of SDS including all the processes?
- Can you explain to me what a resource allocation meeting is like? – how do you feel? What is the focus?
- Can you tell me about the process of sourcing care?

5. Given that health and social care are now integrated, how would you describe the role of health professionals when delivering SDS?

Appendix 9: Extract from a semi-structured interview

Interviewer: And I was wondering, can you expand on that and tell me how do you feel as a practitioner, when you're sitting in a resource allocation meeting, how does it feel, that environment?

Respondent: Erm, I think it can feel, sometimes it's quite a challenge. Because before you go into [resource allocation meeting] you'll have had the discussion with the worker, or you've seen the assessment, you've gone through it. You've had the view, and the views of the social worker, on why they're justifying something in a certain way. I meet with my workers before. You want to get it sorted and right before the real meeting, so there's less room for error and potential changes. So, I try and pre-empt what might be seen as problematic, you know. Sometimes workers put the wrong bits of information in the wrong section, so it doesn't add up.

Interviewer: Uh-huh.

Respondent: Erm, when we go to [resource allocation meeting], then you might have, then, erm, your fieldwork manager having a different view on that. But that could be because we've had certain discussions about it regularly. And sometimes that information is not in the assessment. So what they're reading can come over differently to them. And then, we just get into, then, a discussion about that part of it, and then it all starts coming out. And it's, well, you've not got that in there. So if you put that in there, then that would give a clearer picture, and then you can say, yeah, now I see why you're justifying it that way.

Interviewer: Yeah.

Respondent: The manager has to sign it [the assessment] off, from what they've got in front of them. They haven't met the person, they don't know anything about them, they don't know what their family situation is, or how they or their house looks, and how it smells, or heard them speak. They haven't knocked on the door, sat in the living room, walked around the house, and all the rest of it. They don't have the joy of, you know, of knowing that. All they have is the assessment that’s in front of them, and they’ve got to make a judgement on that. So the social worker has to translate all that information across in the assessment and put forward their case

Interviewer: Right.

Respondent: …and usually then, the social worker will know that case inside out. So they'll be able to justify exactly why they're putting it forward in that way.

Interviewer: Yeah. And is that something that social workers have to do in a [resource allocation meeting], justify things?

Respondent: Sometimes. A lot of the time, if they’ve got, if they’ve got the assessment, they’ve got enough detail in it, and they’ve got all the views of all the agencies that needed to be in it, sometimes it's just clear-cut. The risk is so high, yes this person needs this, erm, and it's signed off there and then.

Interviewer: Yeah.

Respondent: Erm, but other times, when it's kind of debateable, are they able to stay in the community, are they not, have we tried this, have we looked at that. Then that’s when you get the discussion going. And that’s a good thing, because you're reflecting on what you’ve, you’ve written, aye. I guess you know which workers will go in there and be able to give over a really good account. The same thing happens at a meeting…

Interviewer: Uh-huh.

Respondent: …you know if you have confidence that worker to present that case, to know why that person needs, erm, adults with incapacity, say. Then, that, you would say to them, right, over to you to, to give that account. They'll do that, erm, sometimes in the middle of it you'll find some workers will struggle. Erm, and then it's just about the wee prompts that you need to get, to remind them of the conversation you’ve already had with them about it.

Interviewer: Yeah.

Respondent: And, and that comes back out again. But that’s just all down to experience, and the nerves of somebody going into it. It can be quite daunting.

Interviewer: Uh-huh.

Respondent: It’s a better system now… we used to go in there, and there was, everybody was there, home care was there, district, district nurses were there, day care was there. And it's very daunting to be a worker coming in, with your assessment, in front of this whole panel of people, which sometimes could be a dozen people…

Interviewer: Yeah.

Respondent: …to then go in and, and justify what you want a medication prompting, you know [laughs].

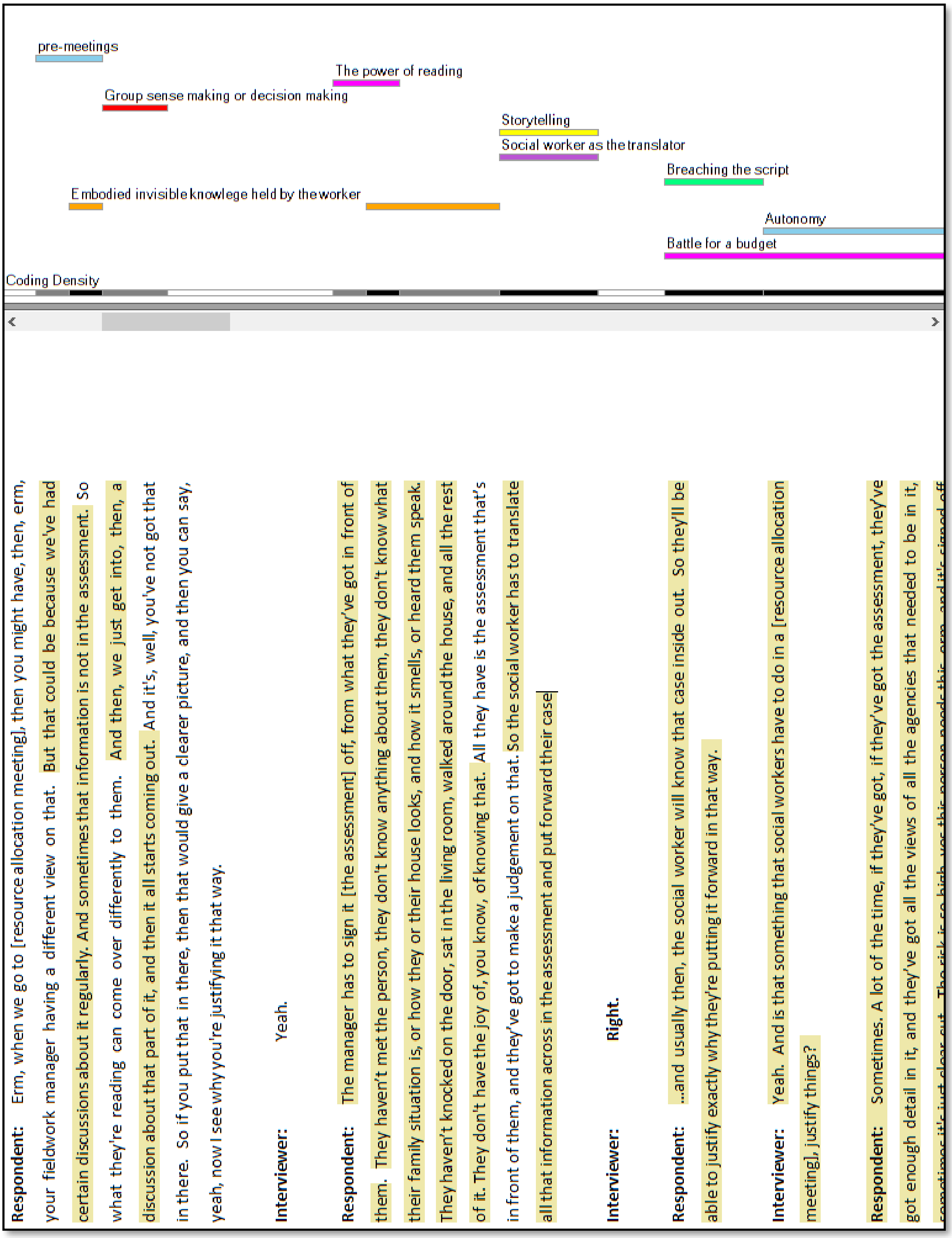
Interviewer: Yeah, yeah.

Respondent: But I still find the [resource allocation meeting] a challenging situation and sometimes very difficult, you know. Erm, it's a bit the same as when you, I suppose you say that, when you're in a class and you're learning, it's one thing, you can write about it ‘till the cows come home. But you sit in an exam room, and it all goes, it's completely out your head, and you can't get passed, you know. And that’s where it can then happen, when you're in, erm, when you're going into one of these meetings. If I was taking in an assessment, I would highlight my main points, on my assessment. So when it was in front of me, those were the points I talked to. So that I was able to emphasise, to get the service that I needed [laughs].

Interviewer: Yeah.

Respondent: And I, and I passed that knowledge on, because I think that helps, you know. If you're going in with a, an adult protection meeting and you've got, erm, the risk assessment in front of you, highlight it in yellow, the bits that you want to stress.

Appendix 10: Coded extract of a semi-structured interview on Nvivo



Respondent: Erm, when we go to [resource allocation meeting], then you might have, then, erm, your fieldwork manager having a different view on that. But that could be because we've had certain discussions about it regularly. And sometimes that information is not in the assessment. So what they're reading can come over differently to them. And then, we just get into, then, a discussion about that part of it, and then it all starts coming out. And it's, well, you've not got that in there. So if you put that in there, then that would give a clearer picture, and then you can say, yeah, now I see why you're justifying it that way.

Interviewer: Yeah.

Respondent: The manager has to sign it [the assessment] off, from what they've got in front of them. They haven't met the person, they don't know anything about them, they don't know what their family situation is, or how they or their house looks, and how it smells, or heard them speak. They haven't knocked on the door, sat in the living room, walked around the house, and all the rest of it. They don't have the joy of, you know, of knowing that. All they have is the assessment that's in front of them, and they've got to make a judgement on that. So the social worker has to translate all that information across in the assessment and put forward their case

Interviewer: **Right.**

Respondent: ...and usually then, the social worker will know that case inside out. So they'll be able to justify exactly why they're putting it forward in that way.

Interviewer: Yeah. And is that something that social workers have to do in a [resource allocation meeting], justify things?

Respondent: Sometimes. A lot of the time, if they've got, if they've got the assessment, they've got enough detail in it, and they've got all the views of all the agencies that needed to be in it, sometimes it's just clear cut. The risk is so high, yes this person needs this, erm, and it's signed off

Appendix 11: Typed extract from fieldnotes

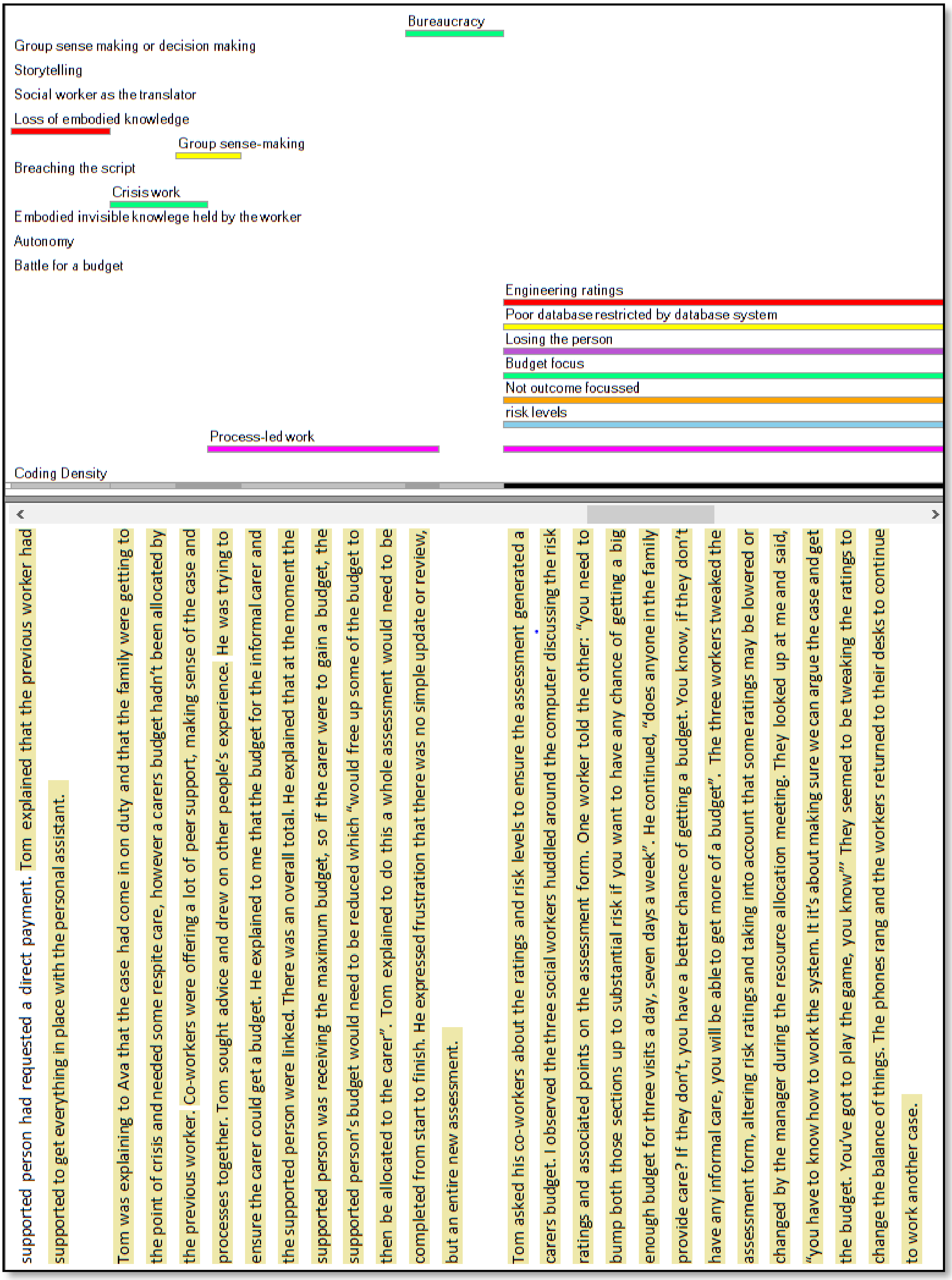
Date of events: Monday 13th January, Location: observation in the office

As I sat in the open plan office with the social work team. Tom was discussing a case which came in on duty. He had since been allocated the case yesterday. He was explaining to Ava that another worker had been managing the case before and organised the SDS budget. He was explaining that the previous worker had since left. The case had been assessed and a budget allocated. The supported person had requested a direct payment. Tom explained that the previous worker had supported to get everything in place with the personal assistant.

Tom was explaining to Ava that the case had come in on duty and that the family were getting to the point of crisis and needed some respite care, however a carers budget hadn't been allocated by the previous worker. Co-workers were offering a lot of peer support, making sense of the case and processes together. Tom sought advice and drew on other people's experience. He was trying to ensure the carer could get a budget. He explained to me that the budget for the informal carer and the supported person were linked. There was an overall total. He explained that at the moment the supported person was receiving the maximum budget, so if the carer were to gain a budget, the supported person's budget would need to be reduced which "would free up some of the budget to then be allocated to the carer". Tom explained to do this a whole assessment would need to be completed from start to finish. He expressed frustration that there was no simple update or review, but an entire new assessment.

Tom asked his co-workers about the ratings and risk levels to ensure the assessment generated a carers budget. I observed the three social workers huddled around the computer discussing the risk ratings and associated points on the assessment form. One worker told the other: "you need to bump both those sections up to substantial risk if you want to have any chance of getting a big enough budget for three visits a day, seven days a week". He continued, "does anyone in the family provide care? If they don't, you have a better chance of getting a budget. You know, if they don't have any informal care, you will be able to get more of a budget". The three workers tweaked the assessment form, altering risk ratings and taking into account that some ratings may be lowered or changed by the manager during the resource allocation meeting. They looked up at me and said, "you have to know how to work the system. It it's about making sure we can argue the case and get the budget. You've got to play the game, you know"' They seemed to be tweaking the ratings to change the balance of things. The phones rang and the workers returned to their desks to continue to work another case.

Appendix 12: Coded extract from fieldnotes on Nvivo



supported person had requested a direct payment. Tom explained that the previous worker had supported to get everything in place with the personal assistant.

Tom was explaining to Ava that the case had come in on duty and that the family were getting to the point of crisis and needed some respite care, however a carers budget hadn't been allocated by the previous worker. Co-workers were offering a lot of peer support, making sense of the case and processes together. Tom sought advice and drew on other people's experience. He was trying to ensure the carer could get a budget. He explained to me that the budget for the informal carer and the supported person were linked. There was an overall total. He explained that at the moment the supported person was receiving the maximum budget, so if the carer were to gain a budget, the supported person's budget would need to be reduced which "would free up some of the budget to then be allocated to the carer". Tom explained to do this a whole assessment would need to be completed from start to finish. He expressed frustration that there was no simple update or review, but an entire new assessment.

Tom asked his co-workers about the ratings and risk levels to ensure the assessment generated a carers budget. I observed the three social workers huddled around the computer discussing the risk ratings and associated points on the assessment form. One worker told the other: "you need to bump both those sections up to substantial risk if you want to have any chance of getting a big enough budget for three visits a day, seven days a week". He continued, "does anyone in the family provide care? If they don't, you have a better chance of getting a budget. You know, if they don't have any informal care, you will be able to get more of a budget". The three workers tweaked the assessment form, altering risk ratings and taking into account that some ratings may be lowered or changed by the manager during the resource allocation meeting. They looked up at me and said, "you have to know how to work the system. It it's about making sure we can argue the case and get the budget. You've got to play the game, you know'" They seemed to be tweaking the ratings to change the balance of things. The phones rang and the workers returned to their desks to continue to work another case.

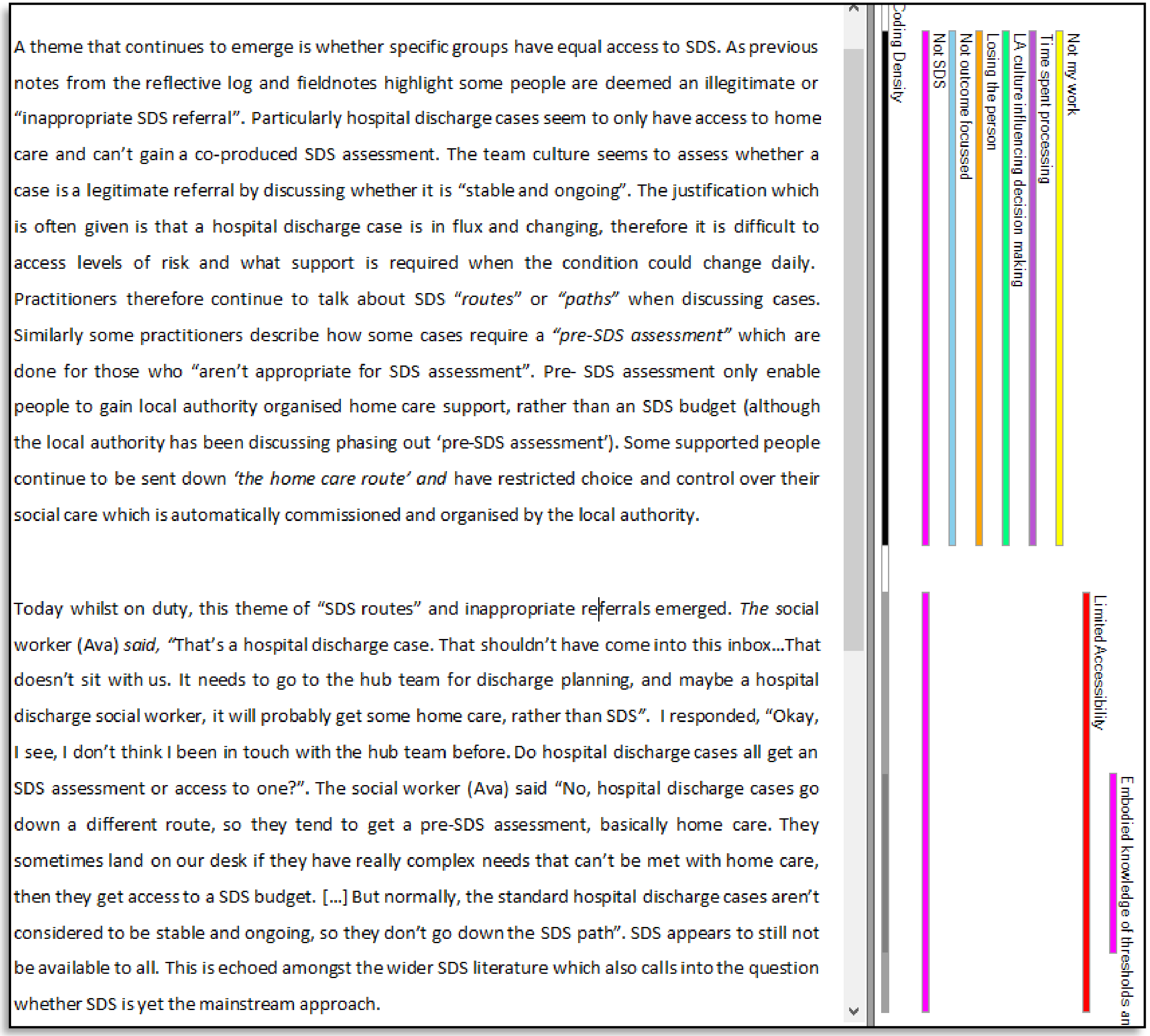
Appendix 13: Typed extract from reflective log

Date of event: July **Location: In the office during duty**

A theme that continues to emerge is whether specific groups have equal access to SDS. As previous notes from the reflective log and fieldnotes highlight some people are deemed an illegitimate or "inappropriate SDS referral". Particularly hospital discharge cases seem to only have access to home care and can't gain a co-produced SDS assessment. The team culture seems to assess whether a case is a legitimate referral by discussing whether it is "stable and ongoing". The justification which is often given is that a hospital discharge case is in flux and changing, therefore it is difficult to access levels of risk and what support is required when the condition could change daily. Practitioners therefore continue to talk about SDS "*routes*" or *"paths"* when discussing cases. Similarly some practitioners describe how some cases require a *"pre-SDS assessment"* which are done for those who "aren't appropriate for SDS assessment". Pre- SDS assessment only enable people to gain local authority organised home care support, rather than an SDS budget (although the local authority has been discussing phasing out 'pre-SDS assessment'). Some supported people continue to be sent down *'the home care route' and* have restricted choice and control over their social care which is automatically commissioned and organised by the local authority.

Today whilst on duty, this theme of "SDS routes" and inappropriate referrals emerged. *The s*ocial worker (Ava) *said, "*That's a hospital discharge case. That shouldn't have come into this inbox…That doesn't sit with us. It needs to go to the hub team for discharge planning, and maybe a hospital discharge social worker, it will probably get some home care, rather than SDS*"*. I responded, "Okay, I see, I don't think I been in touch with the hub team before. Do hospital discharge cases all get an SDS assessment or access to one?". The social worker (Ava) said "No, hospital discharge cases go down a different route, so they tend to get a pre-SDS assessment, basically home care. They sometimes land on our desk if they have really complex needs that can't be met with home care, then they get access to a SDS budget. […] But normally, the standard hospital discharge cases aren't considered to be stable and ongoing, so they don't go down the SDS path". SDS appears to still not be available to all. This is echoed amongst the wider SDS literature which also calls into the question whether SDS is yet the mainstream approach.

Appendix 14: Coded extract from the reflective log on Nvivo



A theme that continues to emerge is whether specific groups have equal access to SDS. As previous notes from the reflective log and fieldnotes highlight some people are deemed an illegitimate or "inappropriate SDS referral". Particularly hospital discharge cases seem to only have access to home care and can't gain a co-produced SDS assessment. The team culture seems to assess whether a case is a legitimate referral by discussing whether it is "stable and ongoing". The justification which is often given is that a hospital discharge case is in flux and changing, therefore it is difficult to access levels of risk and what support is required when the condition could change daily. Practitioners therefore continue to talk about SDS *"routes"* or *"paths"* when discussing cases. Similarly some practitioners describe how some cases require a *"pre-SDS assessment"* which are done for those who "aren't appropriate for SDS assessment". Pre- SDS assessment only enable people to gain local authority organised home care support, rather than an SDS budget (although the local authority has been discussing phasing out 'pre-SDS assessment'). Some supported people continue to be sent down *'the home care route' and* have restricted choice and control over their social care which is automatically commissioned and organised by the local authority.

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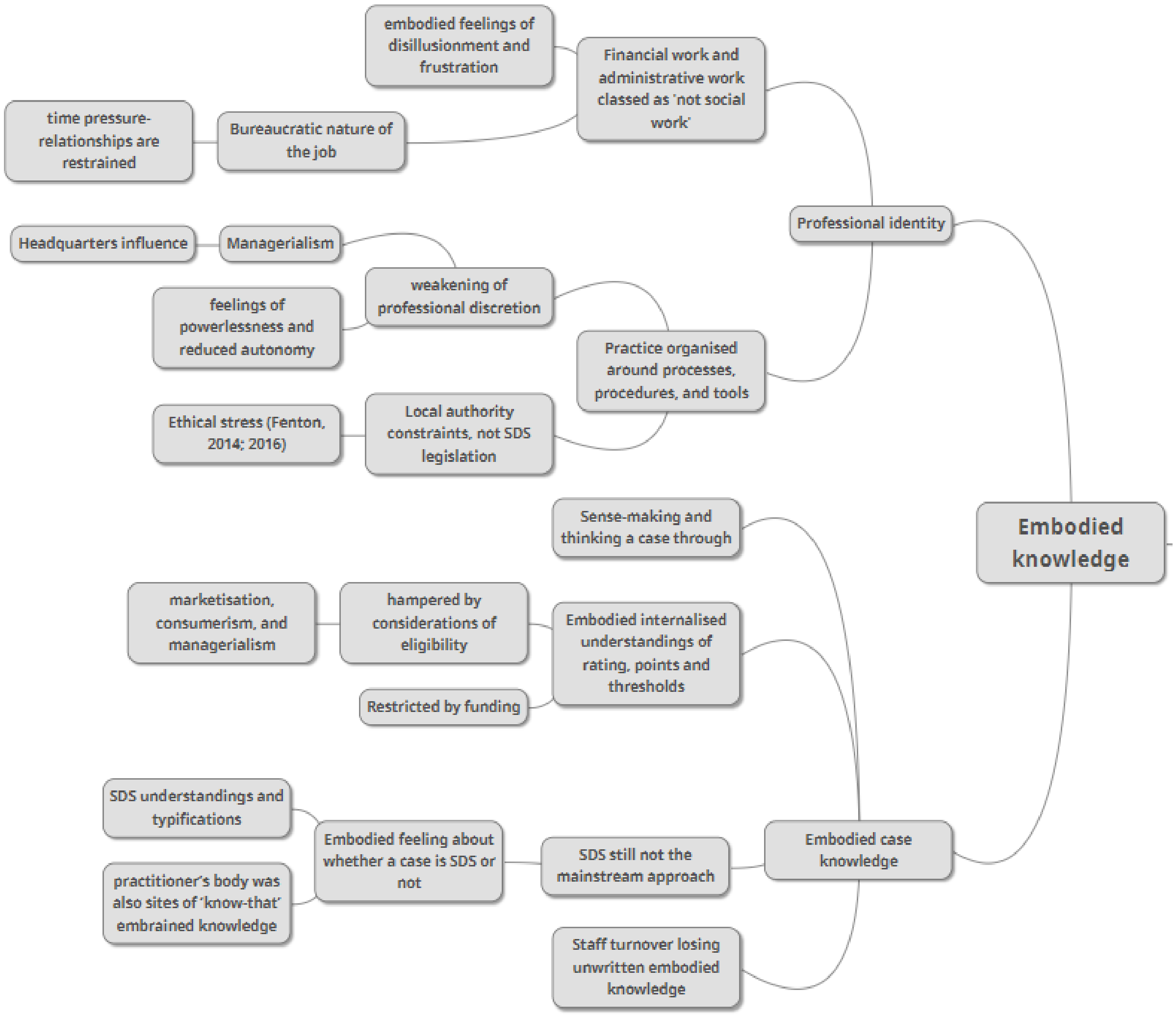
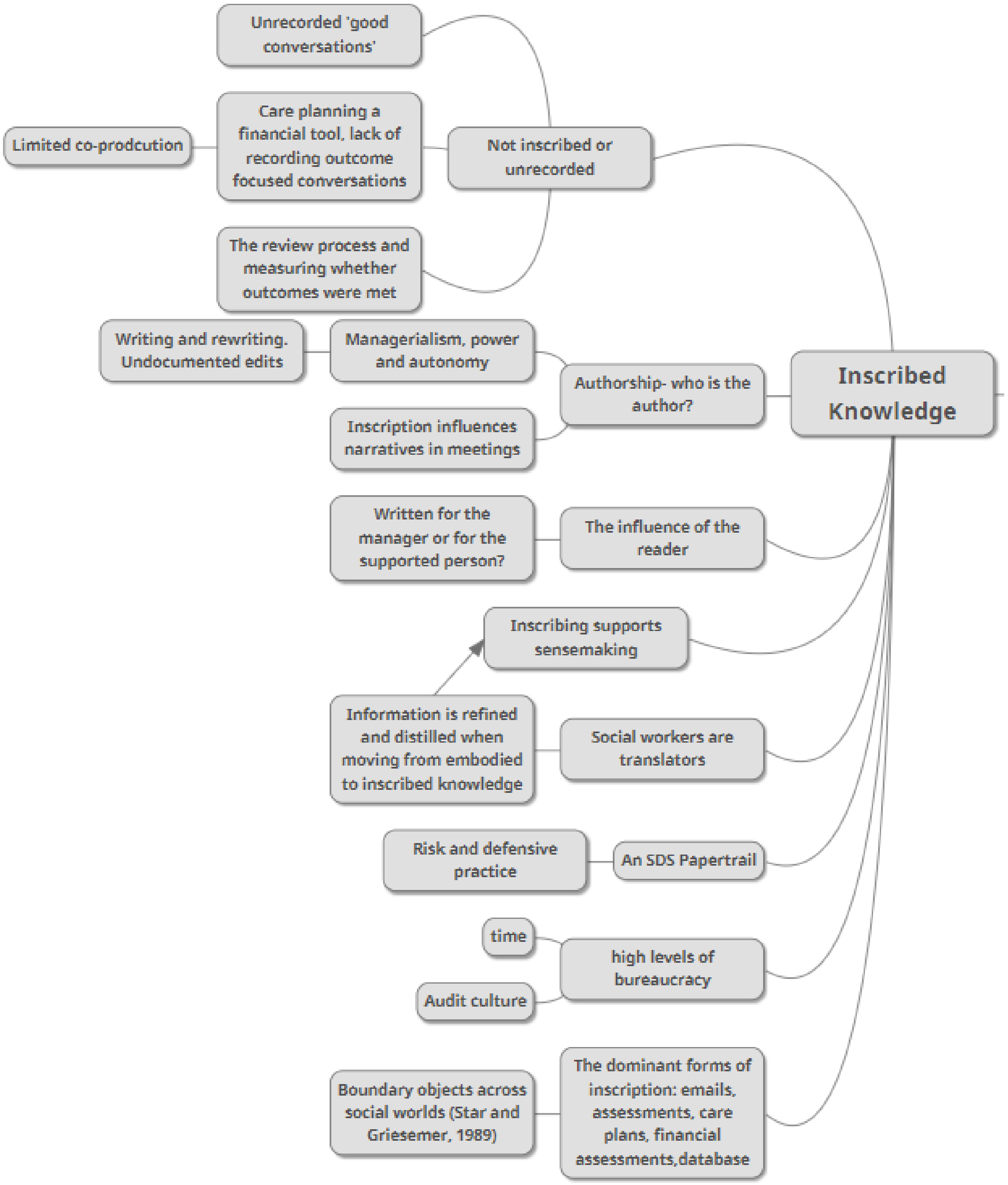
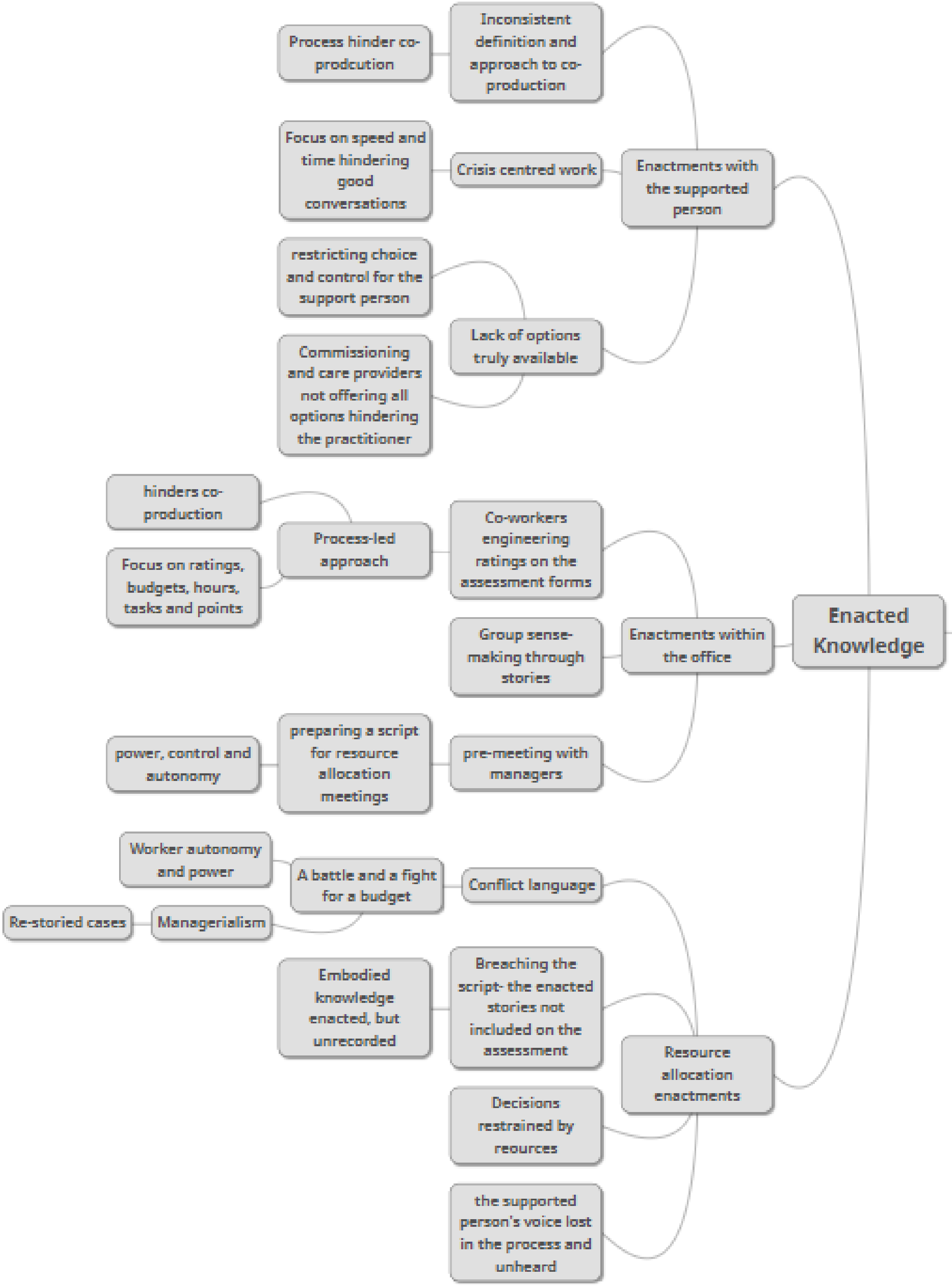
Appendix 15: Analysis and coding mind-maps




Inscribed Knowledge
Not inscribed or unrecorded
Unrecorded 'good conversations'
Care planning a financial tool, lack of recording outcome focused conversations
Limited co-prodcution
The review process and measuring whether outcomes were met
Authorship- who is the author?
Managerialism, power and autonomy
Writing and rewriting. Undocumented edits
Inscription influences narratives in meetings
The influence of the reader
Written for the manager or for the supported person?
Inscribing supports sensemaking
Social workers are translators
Information is refined and distilled when moving from embodied to inscribed knowledge
An SDS Papertrail
Risk and defensive practice
high levels of bureaucracy
time
Audit culture
The dominant forms of inscription: emails, assessments, care plans, financial assessments,database
Boundary objects across social worlds (Star and Griesemer, 1989)


Enacted Knowledge
Enactments with the supported person
Inconsistent definition and approach to co-production
Process hinder co-prodcution
Crisis centred work
Focus on speed and time hindering good conversations
Lack of options truly available
restricting choice and control for the support person
Commissioning and care providers not offering all options hindering the practitioner
Enactments within the office
Co-workers engineering ratings on the assessment forms
Process-led approach
hinders co-production
Focus on ratings, budgets, hours, tasks and points
Group sense-making through stories
pre-meeting with managers
preparing a script for resource allocation meetings
power, control and autonomy
Resource allocation enactments
Conflict language
A battle and a fight for a budget
Worker autonomy and power
Managerialism
Re-storied cases
Breaching the script- the enacted stories not included on the assessment
Embodied knowledge enacted, but unrecorded
Decisions restrained by reources
the supported person's voice lost in the process and unheard

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