UNIVERSITY OF SOUTHAMPTON

AN EXAMINATION OF THE PROCESS OF THE REORGANISATION OF AREA CENTRES OF A SOCIAL SERVICES DEPARTMENT

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ABSTRACT

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The aim of the research is to examine the process of the reorganisation of three area centres of the Social Services Department of Hampshire County Council.

When an area centre is considering reorganising, it has to examine how certain functions will be carried out, priorities set and decisions made about how services will be provided and by whom. This will include how an area centre receives requests for services, how these will be provided and the quality control over these services. The research sought to find out how each area centre dealt with these matters. Of particular interest were the processes used in setting objectives and decision making. The method of research used was case studies of three area centres based on the information obtained by depth interviews of staff. A cross section of key informants was interviewed in each area centre. An interview guide was used for the interviews.

The research came to the following conclusions. The Area Centres gave inadequate attention to the objectives they were trying to achieve. The Area Managers used the reorganisations as a cloak to make changes in personnel, practices and the organisation of services. Area Managers confused their management responsibilities with their social worker roles. Little consideration was given to the needs of others except those of the staff involved. The views of the consumers were not represented directly. The prioritisation of the services to the public was largely based on the immediate urgency of need. The changes involved in the reorganisations increased the stress on some staff, particularly with the break up of informal supportive peer groups. While the Area Centres recognised the importance of maintaining an efficient work intake system and improving services to adults, they had difficulty in achieving either.

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CHAPTER ONE

INTRODUCTION

Prior to the Local Authority Social Services Act of 1970, and its implementation in 1971, the services provided by the Social Services Departments (SSD) were the responsibility of different Local Authority Departments. Sainsbury (1977, p. 73) shows that the services were "provided by three local authority departments: the Public Health Department carried responsibility for mental disorder, physical disability, the care of discharged patients, Home Help Services and, in some areas, meals-on-wheels; the Children's Department as its name implies, carried general responsibility for the child care provisions, though this was shared in respect of some legislation with probation and aftercare officers and educational welfare officers; the Welfare Services Department was responsible for the welfare of the elderly, the homeless and in some areas, had established family advice centres". Some authorities linked the health and welfare services into one department.

Requests for these different services from individuals and families often caused an overlap in their provision with various officials from different departments visiting those requesting help. Sainsbury (1977, p. 73) says "The structural disfunctions of services inevitably led to difficulties for consumers - clients needed to be referred from one agency to another, and some problems and needs seemed to be artificially divided between departments." All Three Departments employed social workers, although they were given different titles such as child care officers and welfare officers. Webb and Wistow (1987, p. 41) state that although the term social worker was used many, probably the majority, were unqualified except by experience. They also point out that it was partly because these departments all used social workers that there was overlap in the work done. They add "That these distinct services and policy worlds of child care and health and welfare touched one another was due in part to the fact that both involved the use of social workers. But

there was also an undoubted degree of overlap in that some families were clients of both services."

In 1965 The Seebohm Committee was appointed. The committee (p. 11) was "to review the organisations and responsibilities of the Local Authority personal Social Service in England and Wales, and consider what changes are desirable to secure an effective family service." The Seebohm Committee reported in 1968 and recommended "a new Authority Department, providing a community based and family oriented service, which will be available to all." This new Local Authority Department was the Social Services Department. Their recommendations were largely included in the Personal Social Services Act 1970. Webb and Wistow (1987, p. 56) point out that "The government had accepted the Seebohm argument that the appointment of a Social Services Committee and a Director of Social Services should be a legislative requirement and that the Minister should have some control over the kinds of people short-listed for the new (Director) posts." It seems that most of the directors appointed had had some form of social work training or experience. These new departments as Webb and Wistow (1987 p. 50) state, "Consisted largely of the old Child Care and Welfare Services plus the important transfer from Local Authority health services of the Home Help service." Furthermore, in 1974 there was also a reorganisation of the National Health Service resulting in the transfer of responsibility for hospital social work to the social services departments. This included the social workers in general hospitals and the psychiatric social workers working in mental health situations.

The social services departments set up following the 1970 Social Services Act were established mainly in two forms: those on a geographical basis and those on a functional basis. Those departments that chose a geographical basis, usually divided the geographical area they covered into divisions with the responsibility for the provision of the services delegated to the manager of the division often called the divisional director. The functional model comprised managers at headquarters level responsible for particular service provisions. These were often in the form of fieldwork services, residential and day-care services. Managers headed these up with titles such as 'assistant director'. The area centres or area teams were geographical subdivisions of either model.

At the time of the area centre reorganisations and the research, Hampshire Social Services Department was organised on a functional service basis. It was administratively divided into Services for Children and Services for Adults at Headquarters. Residential and Day Care Services for all client groups were managed by Departmental Headquarters staff. The overall management of the fieldwork services were the responsibility a senior assistant director at the Headquarters. The fieldwork services were provided from 17 area centres and four hospital-based social work teams. The area centres provided services to geographical areas, usually with boundaries coterminous with those of the district councils. The cities were covered by more than one area centre. The area centres were each managed by an area manager (AM). The services provided from area centres were to people in their homes or to other agencies. They included social work services, home help services, adoption and foster parent services and occupational therapy. Access to the residential and day care services were also through the area centre staff who made the assessments and applications for these services.

In Hampshire, the Social Services Department gave considerable independence to area managers about how they organised their area centres. Generally there were area centres in which a number of professional staff and ancillary workers whom were grouped together into teams working to team leaders who were part of a management hierarchy. The area centre was supported by an administrative and clerical team structure. It was these teams that carry out the fieldwork functions by which the public and other agencies were provided with the services available. Area centres were the main operational units from which fieldwork services, including social work, were provided. The role of social workers in these area centres varied. In 1982 the Barclay Committee Report was published. This Committee had been charged by the Secretary of State for Social Services to enquire into the role and tasks of social workers. Bamford (1982, p. 179) states, "The (Barclay) report saw social workers as having two areas of responsibility. First, they have a continuing responsibility for social casework- the counselling of individuals and families with difficulties. Second, they have the responsibility for what the Committee termed social care planning - the development of strategies to provide effective community support including community development and the necessary social and political action." Challis (1990, pp. 12,13) sees the "Fieldwork staff were the eyes and ears of the SSDs, experts on their Area who had

information which was not available to the rest of the SSD. They were also the most highly qualified staff of the departments and, perhaps most important of all, they controlled the flow of people from the community into the residential and day care sections of the SSDs. She saw that "The result was that the areas began to grow in terms of the number of staff, the range of tasks to be undertaken, and the range of responsibilities they had." She suggests that "Such developments might not have occurred had it not been for the second fixture of the post Seebohm SSDs namely the willingness and the and the capacity to provide new services and develop new specialisms." She adds "There was also a massive amount of work to be undertaken as the result of legislation passed at the end of the 1960's which was awaiting implementation by the new SSDs; immediate treatment, therapeutic intervention for young offenders, aids and adaptations for people with disabilities." In Hampshire there was an agreement that additional staff could be appointed in the SSD where they were needed to meets the additional responsibilities brought about by new legislation. This resulted in a growth of specialist social workers. It was partly this that caused AMs to reconsider the structure of their area centre teams.

In addition to pressures mentioned by Challis, there were other factors that might have made an AM consider reorganising. They include: new organisational ideas and styles; trying to maintain a balance of specialist knowledge and wide profile experience of staff; AMs thinking that the teams were stale and needed stimulus; reoganisation being imposed by senior management; demographic changes; AMs using reorganisations as a means to make changes already considered. I will tease out what they were in the organisations researched in Hampshire.

When reorganising, AMs must examine what they are trying to achieve and how decisions will be made. In making plans, consideration must be given to the certain responsibilities that must be carried out that may place constraints on the extent of change. These relate to service provision and include the methods of receiving requests for services from the public, the means of allocating the work that results from these requests and the quality control of the services provided. AMs need to establish how certain roles will be carried out, priorities set and what form of team structure will provide the services. Although, there is a tendency with each reorganisation to attempt to start afresh, many ideas that have proved to be successful elsewhere are absorbed into reorganisational plans or adapted for this purpose.

Fieldwork staff were the main providers of services to the public and the gatekeepers to the other services of the Department. They had considerable knowledge as to what resources were needed. AMs therefore considered it important to involve them in the decision making and them seeing the reorganisation as a cooperative exercise. Cockburn (1990, p.66) when describing the roles of team leaders says, "There was surprising consistency in the terminology team leaders used to describe their teams. The words collective, sharing and working together were used repeatedly." However, Glastonbury, Cooper and Hawkins (1982, p. 79) maintain, "In reality the area officer is accountable for running a social setting (the local office) which enables others to be responsible for the actual work with clients." This may be easier for the staff to accept when the majority generally agrees the decisions. The research examines if the non-management staff knew of the preferences of their AMs regarding the reoganisations and to what extent the AMs were open about the degree they would allow staff to be involved in the decision making process. Of particular interest was the proposition that the AMs used the reorganisations as a cloak to make changes in personnel, practices and the organisation of services.

It was decided to undertake in depth case studies in areas centres that had relatively recently reorganised. I thought this form of research would be most appropriate to obtain the information I was seeking regarding the causes and affects and processes used relating to the reorganisations. My involvement in the research as an AM of one of the area centres examined is discussed in the chapter on methodology.

The definitions of the terms used in the research are in Appendix 1.

CHAPTER TWO

LITERATURE REVIEW

In reviewing the literature relevant to the research project, I examined that relating to current and past changes in the provision and management of social work. I also considered the associated developments of social services departments. This included examination of the structure, organisation and management of area centres. I have restricted my review of management theory mainly to literature relating to the operation of social services departments. I have concentrated on the literature of the 1970s and 1980s, as this is most relevant to the circumstances prevalent at the time of the reorganisations and the development of social services departments at that time.

THE DEVELOPMENT OF SOCIAL SERVICES DEPARTMENTS

The Seebohm Report (1968) became the blue print for the social services departments. The Local Authorities Social Services Act 1970, which implemented many of the recommendations of the Seebohm Report, brought about major changes in and the development of social services. Glastonbury, Cooper and Hawkins (1982, p. 36) point out, "The arguments of the Seebohm Report were overwhelming. There were important flaws in the fragmented system and social service departments would give a better service to more people - easier access, a broad span of services to be obtained with greater convenience and efficiency than before, and a more coherent relationship between people's needs and the organisation of the service." However, Bamford (1982, P. 10) claimed that the "lack of guidance in the report led to the adoption of some confused and complicated structures which subsequently had to be unscrambled." I think that it is possible that this also led to confusion about structures at area team level.

Glastonbury, Cooper and Hawkins (1982, p. 77) found that in practice they suspect that managers have tended to oscillate erratically between what one could consider a conventional management role and that of a sympathetic case advisor or supervisor.

The new social services departments were organised in two basic forms. These were identified by Rowbottom, Hey and Billis (1974, p. 70) as the Functional and Geographical models. The functional model was where the divisions of the Department are activities described as "fieldwork," "domiciliary care and daycare" and "residential care." Usually there was an assistant director in charge of each of these fields of work. The geographical model created "geographical areas and divisions that deal with all work with any one client." Regarding this model, they point out this creates a number of mini-developments within the main SSD - at least as far as the delivery of services is concerned. In this model the "Divisional Officer" or "Divisional Director" is concerned with all operational work of all kinds. Payne (1979, p. 36) suggests that in addition to functionally and geographically organised departments, there is a third type of underlying structure, which he calls specialist. "In a specialist structure, there are divisions for major client groups, such as child care, mental health and the elderly and physically handicapped."

Within both major models there are further divisions into smaller operational units. Those that related to fieldwork were usually referred to as area teams. Following the implementation of the Local Authority Social Services Act 1970, the managers of social services departments were mainly social workers. The area centre or area team concept developed in line with Seebohm's recommendations that services should be community based. Bamford (1982, P. 92) says, "Seebohm argued for a community-based social services administered from area offices serving a population of 50 -100,000. Together with the team concept, the report advocated the delegation of maximum authority for decisions to area offices." The area centre or team became the focal point and the gatekeeper for the provision of services. Generally it was through the area centre that the public obtained the services provided by the Department. Although the area centres mainly comprised social workers; they also brought together other staff of very diverse skills, experience and training. As Parsloe (1981, p. 18) states "The social services teams established in 1970 were largely made up of one discipline. They always consisted of social workers, whether trained or untrained, and a team leader who was also a social

worker." She goes on to say that some included social work assistants and occupational therapists. In looking at how area centres reorganise, it was necessary to consider the composition of teams and their functions and how these were considered in the process of the reorganisations of the area centres. Following what was considered to be in the spirit of the Seebohm Report, social workers were brought together into new teams with an expectation of them carrying generic caseloads. Such changes caused anxiety and uncertainty. Sainsbury (1977) suggested that specialist social workers from the earlier departments found it difficult to widen the scope of their interests and methods of work and to undertake 'generalist' functions. He thought that the Seebohm Committee was concerned that specialisation should not lead to a denial of service. However, Sainsbury (1977 p. 77) says, what happened was that "By a misuse of the word 'generic' however, a concept properly applied to the education of social workers has been inappropriately applied to their practice; staff have been appointed as 'generic social workers' with 'generic caseloads'. What this has meant in practice is a partial loss of specialized skills and an unrealistic expectation that all social workers should be professionally competent in dealing with every kind of human problem and need." Sainsbury later (1980, p. 66) indicated that he had more sympathy with the generic team concept. He saw this as a situation where there is a team caseload in which "although one worker would continue to orchestrate the inputs of work for each case and would provide continuity of experience for clients, all workers would be encouraged to develop personal areas of expertise. " Challis (1990, p. 40) maintains "Genercism has been taken to be the guiding principle underlying the creation of SSDs in the early 1970's, but from the very beginning there was controversy as to what the term really meant and what form its application in priorities might take." Challis (1990, p. 42) goes on to point out that "The legislation which places duties and powers upon LSSAs is predominantly client group specific."

I think the substantial growth in client group specific legislation encouraged the appointment of specialists and the creation of teams relevant to such legislation. Initially, there gradually developed a trend to specialisation of individuals within teams and then towards team specialisation. Parsloe (1981, p. 18) says, "From the middle of the 1970's there was evidence that suggested some diversification of team membership towards a social services team." Such teams included staff other than social workers who carried out specialist functions.

It was necessary in the research to examine the causes of change in team composition and what alternative possibilities were available. Stevenson (1981, p. 84) indicates that the size of the team greatly affects the possibilities for specialisation. She also says, (p. 95) that among other factors that affected the development of specialisation has been "the felt need" for certain specialisms either because of skills required, or (more commonly) because of the need to develop certain skills or resources. She adds that there had already developed informal specialisms or "concentrations of interests" as the Seebohm committee described them. The research examines how the choices of team structure were considered in the team reorganisations and how the issues of generic or specialist team operation were dealt with.

REORGANISATION AND CHANGE

The above factors particularly the growth in size of teams, the increase in client group specific legislation were further reasons for AMs to have to consider the appropriateness of the existing area centre organisation.

The reorganisation of an area centre entails changes in the way resources are allocated to provide services to the public. It involves looking at the structure of teams, the responsibilities of teams, and other staff in the area centre. It affects all staff to a greater or lesser extent. Consideration has to be given to what is to be achieved and the means of doing so, who will be involved in the decision making and how decisions will be made. It would be important to consider changes affecting how work is received at the centre (duty and intake work), how assessments of client need will be made, what priority will be given to these needs and what resources will be provided to meet them (allocation of work).

When planning a reorganisation, AMs must start by considering the extent of the proposed changes and whom they will affect. As Watzlawick et al. (1974, p. 10) suggest we must consider what degree of change will be necessary. They state that "There are two different types of change, one that occurs within a given system which itself remains unchanged and one whose occurrence changes the system itself." They describe these changes as first and second order changes respectively. Ross and Bilson (1989, p. 120), when considering the systems

approach to social work and change, comment that "Watzlawick makes the point that real change in social systems has to be of a higher logical type than merely rearranging the way variables relate to each other." They go on to say "In social systems, therefore, introducing a new provision, a new policy, a new law, or a combination of all three, will not necessarily make a difference. The rules of the system have not changed and any new elements introduced have to ensure that the system cannot adapt without a change of state. Changing social work services thus means changing the rules of the system, creating new systems, policies, laws or resources which challenge the operation of the system so that it cannot merely accommodate to the new developments." The degree to which change takes place may be influenced by the frequency of change. Smale and Tulson (1988, p. 52) see social services as "evolving all the time." Although they were looking at departments as a whole, their comments are also relevant to the sub-systems within them. They maintain that the major changes in social work agencies and social work departments at that time may be best understood as symptomatic of the failure organisations to evolve adequately. However, major changes in area centres may take place as adjustments to changes in demography, the law or public expectation. Challis (1990, p.3) says, referring to departments but it also applies to area centres, "The growth in the numbers of old people, the rise in the incidence of child abuse, the increase in the divorce rate the increased awareness of discrimination and the disadvantaged, the increases in unemployment and poverty all have direct relevance to social services. The arrival of information technology, the growth of consumerism and the emphasis on regulation all represent new tricks which have to be learned." The research examines the causes of change, to what extent change was brought about by external pressures and the effect of change on those involved and the operational systems. This will include an assessment of who made the changes and who gained advantages and who lost out in the reorganisations.

DECISION MAKING AND MANAGEMENT STYLE

The research examines how managers gained the co-operation of staff and extent to which staff collaborated with managers who adopted a participative approach to the reorganisation. This involvement was partly based on the common team membership and social work training. Cockburn (1990, p. 68) says, "Closely aligned

to the collective approach was the recognition of the need for consensus and compromise. The reasons for this are complex, and include the respect for the work of professional social workers, the sense of partnership that grows up as team norms develop, and the difficulties inherent in social workers to carry out actions with which they do not agree." Bamford (1982, p. 88), when talking about collaboration for team changes, points out that "Not all teams have the skills among team members to create a genuine collaboration. Not all teams will respond in the ways sought by the Area Officer, who then faces the ultimate dilemma of the participation-orientated manager - who takes the final decision when the Area Officer is out of step with the team? And not all teams have the basic harmony of approach from which collaborative working can flow." However, he goes on to say, "Yet without a participative approach, it is virtually impossible for the organisational structure to reflect the shared values and shared professional identity which characterize social work." However, without adequate training managers may be unclear about how to involve staff.

Glastonbury, Cooper and Hawkins (1982, p. 79) state, "If it is the task of a manager to create the setting for work, this also implies laying down guidelines, and marking boundaries. Managers have not found this task easy; partly this is understandable given the lack of training, the great expansion of social work and the uncertainty of the public about what tasks they desire social services departments to undertake. It is observed in social work that much personal freedom is sought by individual practitioners, but they also want clear guidance from above - a point noted in the National Institute for Social Work study of Southampton Social Services Department Neil et al., Social Work Today Vol 8 No 5 (2nd November 1976)." At the time of the research most managerial positions were occupied by qualified social workers. This training may influence their management style. Whether one can easily combine the role of social worker with that of manager has been considered by others. Glastonbury, Cooper and Hawkins (1982), compare K. Brill interviewed in Community Care (4 September 1974 pp 37-9), who was about to become a director, saying "I doubt if social workers would have much time for a manager who turns his back on the profession" with Bamford (1978, p. 77) who argues "The truth, I suspect is that the very qualities which make a good social worker are often the antithesis of those required in management. Talking things through patiently and determinedly is an admirable quality applied to work with clients. Applied indiscriminately to management decisions great and small it is a recipe for administrative paralysis."

The concern of Challis (1990, p.63) regarding the reorganising of departments might equally apply to area centres. She warns, "To put it crudely, it seems as if departments switch from one form to another as soon as difficulties are encountered, such switches seem rarely to be based on an analysis of the tasks, but rather upon the current fashion in organisation. This casting around for a better way of organising departments is doomed to failure unless it is underpinned by careful analysis, not careful analysis of organisational issues but analysis of the purposes which organisational forms are supposed to serve." Bamford (1982, p. 89) queries "Within the hierarchical structure of many social work agencies, how possible is it to make a true sharing of decision making? The emphasis on securing objectives has ceased to be the exclusive prerogative of management. As the responsibility is a shared one, group support and group censure have to supplement the authority of the team leader as the means to achieve the collectively agreed goals."

Changes in an area centre can be considered desirable but not carried out until triggered by other factors such as an opportunity to reorganise. AMs may see reorganising as a means of bringing together changes they have been considering. The degree to which they were open about this are examined. Bamford (1982, p. 106) highlights this when talking about residential establishments and changing roles. He says "one characteristic of bureaucracies is that it is far easier to innovate and break free from the mould of long established practices when setting up a new establishment but exceptionally difficult to do so when a change of policy is being applied to an existing establishment where precedents can be cited as resistance to change." The research examines what caused the reorganisations and associated changes in the three area centres and how the decisions were made regarding these changes. This will include the degree to which AMs used the reorganisations as a cloak to make changes they already had in mind.

OBJECTIVES AND PRIORITIES

When considering reorganising, AMs must decide what are their objectives including what priorities to give to the various operations of the area centre. When these have been established, it is important that all staff know what they are. Peters and Waterman (1982, p. 65) say, "The focus on a few key values lets

everyone know what is important." Several writers have mentioned the use by social services of management theory. Parsloe shows (1981, p. 55) that teams have developed processes to help them in making a series of decisions to help carry out their tasks of service provision. They must decide who is to be served, in what way and by whom and when the service is to end. Each of these decisions involves consideration of agency policy and resources, team capacity and client need. She (p. 61) gives examples of the processes that may help managers under the following headings:

1. Operational Priority systems.
2. General statements about the priority to be accorded to various types of work.
3. Weighting Case and Workloads.
4. Case Review Systems.
5. Task and/or role analysis.

The research explores the extent to which management tools were used. Miller and Scott (1984, p. 3) cover many aspects that need to be considered in a reorganisation. They state that "A common theme (in literature) is that a prime task of management (of social services) is the allocation of scarce resources." They attempt to show how this can be achieved. They view the team, as a system into that are fed needs and resources. When considering the goals of Social Services they point out (p. 13) "Closer investigation is likely to reveal that there is no written record of any objectives or that those that exist are far from being clear or specific enough to help in any appraisal of progress." The research examines the extent to which this was true in the area centre reorganisations examined and in particular how their objectives were arrived at. An approach mentioned in literature that was commonly used in social services departments was that of management by objectives (MBO). This is defined by Humble (1972, p. 31) as "a dynamic system which seeks to integrate the company's need to clarify and achieve its profits and growth goals with the manager's need to contribute and develop himself." Bamford (1982, p. 42)) states, when considering MBO, that "it means that every manager from the director down to the individual social worker - who has the responsibility for managing time - must set objectives for himself, and set objectives where performance can be measured or observed." Miller and Scott (1984) have reservations about MBO. They point out that the Management by Objectives theory

tends to have dangers in that "MBO, although participative, gives the final say on objectives to Senior Management." They see this as relegating social workers "to the realm of doers only capable of commenting on the minutiae of agency work." This was referring to the agency as a whole but also applies at area centre level. The extent to which staff were involved in decision making was examined in the research.

Algie (1975, p. 9) posed several questions, for example "what are the significant social values and objectives of present-day communities? How do they interconnect? How are they to be realized in practical action?" He continued by describing a range of managerial practices that would assist managers to resolve these issues. He places emphasis on the devising of management structures such as client problem dictionaries to help in setting priorities. These are a means of grading priorities across client groups. Such systems are useful, but the research examines how helpful they are in practice. A number of systems have been developed to help determine priorities. Parsloe (1981, p. 63) describes various priority systems used by social services to decide how much of what service a team should provide. It is pointed out that direct service by teams is only one aspect of the total services available in the community. She says that there is a range of what she refers to as "operational priority systems." She described these as attempts to bring together three big factors described by Hall in Policy Making: More Judgement than Luck (Community Care 6th August) as "The intrinsic merits of each problem, the response of the agency workers to each problem, the incidence of problems." The first she states "is usually managed by a client problems or needs dictionary and the second by a service response inventory." However, Bamford (1982, p. 18) states "The thinking of the Association (British Association of Social Workers) had moved on from when it produced a detailed paper on priorities (Bamford 1976). While stressing that any attempt at a definition and ranking inevitably led to invidious distinctions, the policy statement accepted that the gravity of the need presented by the client should be the major factor in weighing whether to intervene. An individual assessment on the basis of need was regarded as more equitable than rigid adherence to defined categories. It was on that basis that teams have worked to refine their own priority system." But, the grading of priorities can be a managerial tool. Miller and Scott (1984, p. 26) propose the use of a "client problem dictionary" for use in setting priorities. They differentiate client priorities from

objectives as follow "Objectives give the overall rationale for action. Priorities decide the order and extent of actions."

In order to provide services to specific client groups, the Department at the time of the research created specialist social work posts. Such specialist workers can influence the resources directed by area centres to particular client groups. As Miller and Scott (1984, p. 43) state "regardless of the internal priority policy of each group its very existence dictates priorities. Intake teams, for example, influence area centre and departmental priorities by acting as gatekeepers. Where they concentrate on short term casework, the selection of appropriate clients influences the work of the other sub-groups (teams) in the area."

It was important to find out how area centres set their priorities and how closely they kept to them. The research considers how the priorities of social services may be subjected to outside influences such as public opinion. Bamford (1989) recognised that Child Care tragedies, such as that in the Maria Colwell report of 1974, influenced the priorities given to any case or client group. This, in turn will affect the resources available to other client groups. Hayes et al. (1989. P. 49) conclude, "The priority given to child protection work leaves all other clients receiving a reduced service whether they are handicapped, elderly, mentally ill, or even young people leaving local authority care." Cockburn (1990, p. 54) found " In general team leaders did not have specific 'priority criteria'. Where they existed at all, the client groups were joined together under such headings as 'high', 'medium', and low risk." He goes on to say (p.54) "In reality the people most likely to receive service quickest were non-accidental injury cases, regardless of risk, and the elderly at the extreme end of risk."

Commitment to consumer participation in the planning of services was given more recognition about the time of the research. Glastonbury, Cooper and Hawkins (1982, p. 25) state, "Some attention might also be given to customers of the service and their views about the proper functions of social services departments. In reality, however, they are of very little influence. Except in the therapeutic context, social workers have a poor record for consulting with the public." The research considers the degree to which consumers were involved in the planning of the reorganisations.

TEAMS AND THEIR FUNCTIONS

A major part of the reorganisation of the area centres was the restructuring of the teams. AMs usually considered it necessary to retain some forms of teams, although they can vary in size, composition and responsibilities. Parsloe (1981, p. 27), when considering definitions of teams, quoted Kane (1978 pg.3 Kane - Multi-disciplinary team work in the United States), who saw teams as having three components:

1. A common team purpose.
2. Distinct roles for team members in achieving the purpose
3. A method of communication among team members.

Parsloe adds (1981, p. 54) that teams are set up to perform functions determined by the managers. She describes the functions as activities. She says, "The work of a team is to provide certain social services to some of the citizens who live in a particular geographical area." She describes this as the "purpose" of a team. She follows on from this to say "The activities of teams, while all, at least in theory, contributing to this overall purpose, seem to fall into three categories." My summary of her three categories is as follows:

1. Those concerned with the relationships of the team to the people in the area it serves, which is usually called the community. For example, the assessment of client need and developing community involvement.

2. Those concerned with the relationship of the team to the Department.

3. Those concerned with the internal organisation of the team and its work. When considering a reorganisation, managers have to bear in mind how these critical activities of the teams will be performed for the area centre to operate.

Following the setting up of the social services area centres most of the teams in Hampshire were largely composed of generic social workers located in area centres/offices. Parsloe states that "These offices were to provide co-ordinated services and community ideas." She adds that this seemed, at the time, to be the

logical way to move from the separate specialist services to a unified department. Also "it was largely considered desirable that each social worker would carry a mixed case load. It was considered that in a team each social worker would share his knowledge with others" (1981, p. 16). Therefore, at that time mutual support among social workers, which included sharing experience and knowledge, was encouraged. This was relevant with the reorganisations researched that broke up such supportive groups.

Teams and their team leaders can become isolated in their particular area of work. This may be especially so with specialist teams. Parsloe (1981, p.102) when looking at inter team relationships says, "Our general impression was that team members were ignorant about other teams and had little reason to find out about them." She adds, "Probably groups cannot communicate unless individuals can and do on behalf of these groups." The research reviews how managers decided on their future team formats and how these decisions affected the operation of the area centres and the staff involved.

Parsloe (1981, p. 26) found the term "team" to mean different things to different people. It can describe a grouping of social workers and social work assistants supervised by a team leader or the whole area centre. In the area centres researched, a team can include non social work specialist staff but still working in social services setting. There can also be teams within teams. For example the home help managers and occupational therapists saw themselves as working groups. It can be difficult for a team that is created as a matter of supervisory convenience to have a common purpose except in the most general way. In the end it may depend on a feature of a team recognised by Parsloe as "a feeling amongst staff that they belong to it."

Teams have become the prime means of providing services to the public. Parsloe (1981, p 52) states, "Summing up the advantages of the kinds of teams most often found in the Social Services, we find that they may give easier access to clients, they do provide support, and can offer an enriching environment to staff and they provide a means for agency control and unions to influence staff." It is for these reasons that the examination of the reorganisations of the area centres will concentrate on the team structure, composition and function aspects.

THE RECEPTION AND ALLOCATION OF WORK.

AMs in providing a service will need to construct adequate duty/intake systems. These means of access to the services are important to the public and may be the only contact the client has with the area centre. It is vital that they are correctly established. Webb and Wistow (1987, p. 31) state, "one feature of social work which has gradually been recognised to be endemic is that of 'gatekeeping', or the rationing of services between clients." They point out that the Barclay Committee (1982) identified it as a central feature of the social work task. In Hampshire, as Parsloe (1981, p. 21) says was the case elsewhere, intake teams, were often established initially to protect long term work. But gradually intake work was given higher status. She added that intake teams tended to be disbanded for 'patch' teams or specialist teams. This was not always the case in Hampshire where in some area centres duty/intake systems continued to operate alongside specialist teams.

Parsloe (1981, p. 58) says that 'duty' usually refers to the responsibility for dealing with referrals which reach the office either by telephone or personal calls." She adds that it is concerned with situations that require immediate attention: intake with planned assessment and short term work. Duty work and assessment together are often called intake. She describes assessment as the gateway to social services as well as social work. It is at the duty/assessment stage that major decisions can be made regarding whom will or will not receive a service. She states that intake decisions regarding referrals are as follows:

1. To end contact at once either because the duty considers that they have had the help they need or because the need should be met by another agency whom they may be advised to visit or to whom they may be referred. Some clients may be refused service because their problems do not place them in a sufficiently high category.

2. To seek further information.

3. To allocate as a case.

4. To put on the team case load for occasional visiting.

Parsloe adds that generally workers are allowed greater discretion to refuse a service or end contact than give service or prolong contact that requires a commitment of resources.

Another major consideration for an AM reorganising an area centre concerns the allocation of the work received through the intake system. Parsloe indicates (1981, p. 59) some allocation methods used. These are either by direct or group allocation. She says that ideally one should consider:

1. Whether there is sufficient information to make a decision
2. Whether the case needed further work.
3. The nature of that work.
4. Whether there were other cases with similar problems and therefore some community development and/or group programme were required
5. Which worker has the skill the case needed.
6. Which worker might be able to meet the client's needs if supported by the team?
7. Whether the case was of sufficient priority to be allocated.

The priority given to various areas of work relies on good assessments. Consequently, the duty and assessment arrangements require careful planning in reorganisations.

TEAM LEADERS

Assistant area managers who primarily acted as team leaders are likely to be under pressure from more senior managers and from the staff they supervise. It is an important role that is examined in the research. The responsibilities of the role are extensive. It could include the allocation of work to staff, the quality control of the work and the support of the staff. They are the essential links between management and the fieldwork staff. As Parsloe (1981, p. 51) states another advantage of teams for a manager is that "Policies and required procedures can be fed through the team leaders whose job it is to enforce them. Some kind of

uniformity can be achieved at least amongst members of the same team." But as she points out "Teams can offer coalitions between workers which could counteract the forces tending towards control" This latter aspect can add to the stresses on team leaders who can find themselves in dispute situations between more senior staff and the staff they supervise.

The team leader must try to keep a balance between the needs of the individuals and the team as a whole. Parsloe (1981, p. 139) says "The individual growth and development of social workers may be valued in its own right, but within the team the importance lies in ensuring that the service to clients is better provided. It is a means to a collective end and not, as in social group work, the reason for the groups existence."

For efficiency of operation and to reduce the stresses involved by spreading the load, AMs may aim to get the balance of team leader to staff ratio as low as possible. The Hayes et al. (1989, p. 55) study found "With regard to supervision, our interviews with staff confirmed the general findings of the survey, that it is a high priority for staff, and yet is at best irregular, and often infrequent and sometimes non-existent." Supervisors also need time to be more than inspectors of work. The report states that a recurring theme seems to be management's inability or unwillingness to give praise where staff felt it was their due. They quote an interviewee as saying "no one ever tells you that you have done a good piece of work."

CHANGE AND STRESS

Changes in team structures in a reorganisation and the movement of staff that breaks up groups, changes responsibilities and work patterns can create stress and undermine sources of support. Whether or not this happened was examined with the reorganisations researched. Parsloe (1981, p. 50) writing on the roles of teams indicates that the Rowntree Report (1969) "stressed the way team members could learn from each other." She adds that her own research "suggests that social workers place high value on this support and, when they discuss how they managed pressures of the job, they almost always mentioned the help colleagues provide, usually on an informal basis." This informal support was also mentioned by

Bamford (1982, p. 74) when talking about the way a team evolves in its thinking. He says, "The team leader will need to be alert to both formal and informal relationships within the group. Sometimes for instance, while formal responsibility for aspects of child care practices may be vested in a senior social worker, the team may operate by identifying another worker as an unofficial consultant in this area to whose opinion others defer."

With the creation of new teams, there is likely to be resistance to change and stresses associated with the process of change. This is particularly so when the teams are first set up. Changes in team composition can affect support networks. These can be found in the form of informal work support and social support networks among colleagues. They can be significant factors in working conditions. When discussing the development of teams Parsloe (1981, p. 140) says "Most people will recognise the stage of forming when members figuratively sniff around to find out what kinds of other people they are working with and who can be relied upon for support and who should be avoided and who can be influenced to one's own way of thinking." She adds, "gradually the process of forming gives way to a conflict ridden time when disagreements come to the fore and norms of behaviour and values which were previously agreed are now subject to dispute. It is during the process of storming that some members may leave or get pushed out of the group, and the responsibilities of the leader are greatest."

Stress may be exacerbated by the work itself. In the study commissioned by NALGO, Hayes et al (1989, p. 27) found, "more than 9 in every 10 people in the survey considered their job to contain high risk work. About 1 in 5 consider that they sometimes do high risk jobs, but the vast majority think that the job is always risky." It was reported (p. 42), "the relationship between stress and supervision is pronounced. Far from those in greatest stress being given more supervision in consequence, fewer than 1 in 3 get the frequency of supervision they want. While a high proportion of those whose stress is such that it spills over into domestic life (42.8%) get irregular, infrequent or no supervision."

Stress is related to many factors including the responsibilities of the work involved, the anxieties associated with it and time scale available to complete the work. Bamford (1981, pp. 24,25). When discussing the accountability of social workers refers to the Second Report of the Joint Steering Group on Accreditation in Social

Work (B.A.S.W. 1980 b). This report identifies five different but related forms of accountability:

1. Personal accountability

2. Accountability to employer

3. Professional accountability

4. Accountability to other agencies for who work is done

5. Public accountability

Although, these areas of accountability are not constantly in the minds of social workers they are there and may be shown to contribute to the stress of their work.

The research checked to see if there was a connection between stress and team structure. The area centres examined had to consider the types of teams with which to provide services and the formal support of the staff involved. There has been a growth of specialist teams. Despite the suggested advantages of specialisation, this way of working does not necessarily reduce stress related to the work involved. Hayes et al (1989, p. 28) found that "specialist social workers appear to experience more persistent stress than their generic colleagues." The level of stress among specialist social workers could be partly the effect of having constantly to deal with emotionally demanding and sensitive areas of work such as the child protection work as opposed to that provided by generic work. But even in the child protection field stress can be reduced by the provision of more resources particularly staff. However, the report of Hayes et al. (1989, p. 47) add, "There is little doubt in our minds, however, that much of the stress felt by the staff in these six authorities (that they studied) was due not so much to the intense nature of the task itself but to the increasing and largely uncontrolled level of demand and the inability of local management to do anything about it, due to inadequate resourcing."

WORK SATISFACTION

It is probable that most fieldwork staff in area centres want to provide services to the public and find the work satisfying. They may also have a preference to what client group they would like to work with. Decisions such as the allocation of staff to teams would, therefore, be critical ones for the staff involved. As Parsloe (1981, p. 138) states, "Different types of teams make different kinds of demands, and offer different rewards, and workers should be able to chose the type of work group from which they can offer their best service to clients." The research looks at if staff had the opportunity to choose the team in which they were placed and how the managers organised this.

Friederick Herzberg (1966, p. 176) states that "The events that led to job satisfaction were of a quite different kind from those that led to dissatisfaction. Five factors stood out as strong determinants of job satisfaction: achievement, recognition, the attraction of the work itself, responsibility and advancement." But lack of these five factors was mentioned very infrequently in regard to job dissatisfaction. When the reasons for job dissatisfaction were analysed Herzberg found them to be concerned with a different range of factors: company policy and administration, supervision, salary, interpersonal relations and working conditions. Herzberg concluded that these two sets of feelings "are not opposites to one another, rather they are concerned with two different ranges of human needs. He refers to the first range as job hygiene or maintenance factors, lack of which will cause job dissatisfaction but, " their presence will not of themselves cause satisfaction." Satisfaction is provided through the second set of factors that are concerned with the job content of the work itself. These are the motivator or growth factors and "their absence will not cause dissatisfaction (if the job hygiene factors are adequate) but will lead to an absence of positive satisfactions." An AM would have to bear Herzberg's findings in mind when contemplating a reorganisation. Consideration might need to be given to the outcome of making changes that affect both sets of Herzberg's conditions. Work satisfaction may be affected by change and was examined in the research.

WORKING CONDITIONS

Working conditions can be a source of discontentment among staff. Hayes, et al. (1989, p. 50) show that "Almost half those surveyed gave working conditions as a cause of stress." The environmental conditions of an area centre can be a source of discontentment and may not be within the complete control of managers. In their report they found (p. 51) "open plan offices which were 'open' but showed little signs of 'plan'." And "little understanding of the impact of the office location on staff and clients." It also reported "no quiet place for thinking, writing, or 'phoning or doing those tasks which are hindered by bustle and noise"--- "lack of privacy and inadequate rooms for interviewing clients"--- "commonly no staff room, primitive or no tea/coffee facilities, nowhere for a moment of peace, and only a lavatory to hide in or be upset." These matters can be a major source of discontent, and need to be addressed when reorganising an area centre. These factors are involved in a reorganisation do not operate in isolation. Some will have a greater effect on the success or failure of a reorganisation to reach its objectives than others will. The research examines the interplay of the various aspects of the reorganisations and tries to establish cause and effect relationships.

CHAPTER THREE

METHODOLOGY

INTRODUCTION

In Hampshire the Social Services Department gave considerable independence to how area centres were organised. Generally in area centres there were a number of professional staff and ancillary workers grouped together in teams and working to team leaders. Team leaders were usually, part of a management hierarchy. The area centre was supported by an administrative and clerical structure. These teams carried out the functions whereby the public and other agencies were provided with the services that came through the area centre.

The research aims examines how area centres were reorganised, and particularly the processes used to reorganise their teams' structures, and the effect of this on their service provision. The research examines what were the reasons or causes of the reorganisations, how decisions were made, and the impact of these on those involved and the outcome of the reorganisations. Also considered were the objectives of reorganisation and how the area centres dealt with the needs of the public, the Department, those of other agencies, and the staff, including those of the managers.

THE QUALITATIVE AND QUANTITATIVE APPROACH TO RESEARCH

A quantitative approach was considered in the form of an analysis of the service outcomes following the reorganisation of area centres, compared with what had existed before. However, analysis of such outcomes would say little about many significant aspects of the reorganisations such as the processes involved or how decisions were made. Quantitative analysis might show that one area centre team

format was more efficient than another, given the same resources was, but it would only be right for that area centre at that time. No area centre is an exact copy of another as Stevenson (1981, p. 131) suggests, "There can be no blueprint or model which is generally applicable. Demographic characteristics, organisational and professional constraints and personal idiosyncrasies have to be taken into account."

A survey of participants that could be subjected to statistical analysis was also considered. The reservation with this was that the information I was researching was about the processes involved in planning and decisions making. This would include examining the personal plans, objectives, and views of those involved. I thought that a survey designed for statistical analyses rather than in-depth analysis would be too restrictive. I thought this could be better obtained by in depth interviewing.

I had considered the possibility of doing both a survey and interviews, but I did not think that that would lead to any useful conclusions. Patton (1980, p. 329) when considering this states that given "the kind of questions that particularly lend themselves to qualitative methods, it is highly likely that quantitative methods and qualitative methods will eventually answer different questions that do not easily come together to provide a single, well-integrated picture of the situation." Consideration was given to sending out interview schedules but this did not seem to be likely to provide the depth of information that would be useful and lacked the opportunity for immediate clarification of questions and follow up to answers. However, I saw the danger of having unstructured interviews that might develop into informal discussions, particularly with those person with those persons known to me. I therefore decided that when examining such processes that a qualitative approached based on case studies with depth interviewing had more to offer than a quantitative approach.

CASE STUDIES

Yin (1989, p. 13) says, "In general, case studies are the preferred strategy when "how" and "why" questions are posed, when the investigator has little or no control over events, and when the focus is on a contemporary phenomenon within some real-life context." He adds (P. 18) that "such questions deal with operational links

needing to be traced over time, rather than mere frequency or incidence." It appeared that the case study approach provided the basis to examine the how and why the reorganisations took place and the processes involved.

My choice of case studies as the basis of the research was supported by Yin's (1989, p. 24) discussion about the suitability of case studies for various uses. He holds that there are at least four different applications for case studies and says "The most important is to *explain* the causal links in real-life situations that are too complex for the survey or experimental strategies. A second application is to *describe* the real-life context in which an intervention has occurred. Third, an evaluation can benefit again in a descriptive mode, from an illustrative case study - even a journalistic account-of the intervention itself. Finally, the case study strategy may be used to *explore* those situations in which the intervention being evaluated has no clear, single set of outcomes." I think that my examination of how area centres reorganise, including the processes used and decision making, fits clearly into Yin's descriptions of possible applications for using case studies for research.

CHOICE OF AREA CENTRES FOR CASE STUDIES

Consideration was given to studying only one area centre reorganisation in depth but I decided that I was likely to get a more balanced view if different area centres were researched. Hadley and McGrath (1984, p. 5) recognised there could be problems in studying only one team. In their research, they say "We are very aware of the difficulty in the study of any one team of distinguishing the effects of a particular form of organisation and a particular philosophy of work from other factors such as the character of the background and views of its own staff." They examined two social services areas, one of which was operating as a patch system, the other in a more traditional form and compared the effects of the two on service provision to the public.

I decided to do case studies of area centres that had relatively recently reorganised as this form of in-depth research would be most appropriate to obtain the information I was seeking. The case studies comprise information from those involved in the reorganisations, including managers, and those who might be more on the periphery and might see themselves more as the reorganised.

I identified five area centres in Hampshire that had recently reorganised. I approached the AMs and explained what I was proposing to do. I asked them to consider allowing me to carry out research in their area centres. I arranged to contact them later for their decisions. I thought that those interested in helping me would need time to discuss my proposals with area centre colleagues. I telephoned or met all five managers within three weeks. Two of the AMs agreed to their area centre being involved in the research. These AMs managed area centres were geographically close to mine but were different in team structure, departmental resources and demography. The other three AMs said that they could not help because of the pressures of work on their staff.

I recognised that in my research major departmental changes may cause area structures to be restricted or controlled by policy decisions. Therefore, although AMs had considerable autonomy, as Hadley and McGraph (1984, p. 33) suggest, staff may also be influenced by the ideology of the employing authority and their professional ideologies through training and previous experience. I had, therefore, to acknowledge that these will influence views or restrict choices, when reorganisation is considered. In addition, I think that the way an area centre attempts to meet the needs of the public, and the personal and professional needs of its staff, determines the culture of the centre as an organisation. I aimed to research how these needs were met in each area centre examined. As Van Maanen (1983, p. 13) says "People have a form of life; a culture that is their own and if we wish to understand the behaviour of these people and groups and organizations of which they are part, we must first be able to appreciate and describe their culture." The research aims at examining the motives, aspirations and the anxieties of those involved in the reorganisations.

I included the reorganisation of the Area Centre of which I was AM in the research because It had been suggested that I would have a particular insight into what were the dynamics, motivation and concerns involved. Lofland (1984, p. 2) says, "Qualitative social research encourages you to start where you are - to use your current situation or past involvement as a topic of research." I agree with this although it also placed on me a particularly important responsibility of taking an objective view. It was also important to balance my views by those of others who

have also gone through a re-organisation process and may have taken different paths and faced different problems.

My knowledge of what was involved in reorganisation of my area centre helped me understand what happened in other area centres. There were also advantages of my seniority. As I knew the Managers involved and some of the staff, it was possibly easier for me to make the arrangements for researching at the area centres than otherwise. Lofland (1984, p. 24) states "The principle of 'starting where you are' as we have seen, leads many naturalistic investigators to do research in their own 'nests' as it were. If they decide to conduct that research openly, they have the task (as do outside researchers) of making their attentions known, gaining the co-operation from the setting participants, and, depending on the character of the setting, perhaps seek formal permission. The participant researcher, however, has the advantage of already knowing the 'caste of characters'. The outside researcher must discover whom to ask or tell, whom to ask or tell *first,* whether formal permission is required, whether a letter is necessary, and so forth." They add that to the participant researcher, such knowledge is part of the badge of membership.

I was aware of the risk of me influencing the responses of those I interviewed. As Cockburn (1990, p. 31) says when referring to depth interviewing, " The main problem of such an approach was one of interviewer bias. It is difficult to judge how much my seniority did affected the responses. Those interviewed did so voluntarily. However, I found it surprising that people were able to be open about the positive and negative aspects of the reorganisations and the Department. I was particularly concerned about the affect of interviewing staff at my own area centre. I tried to avoid any bias resulting from choosing people by asking the team leaders to make the arrangements as to which staff I would interview without my involvement. I also had to be objective about what was said to me by the area managers and not to be too sympathetic about problems which I might also have. As indicated by Hakel et al. (1982, p. 61), "The researcher must be concerned about the motivation of the client or research subjects to provide valid data and to act on the conclusions of the research." I also had to avoid a blinkered approach of only examining what I was interested in.

DATA GATHERING

The Interview schedule

An interview schedule (see Appendix 2) was constructed for the case studies, comprising questions that were considered relevant to the processes of a reorganisation. These questions followed a probable sequence of events in a reorganisation. They referred to matters before the reorganisations, the reorganisation process and the consequences. Consideration was given to asking different questions to different levels of staff but it was anticipated that all staff would have a view on all aspects of the reorganisation and how they were affected.

The interview schedule was primarily a guide for my own benefit, to give consistency to the questions asked in each area centre and to ensure that the ground was adequately covered. It allowed flexibility of response. Yin (1989, pp. 76-77) says," The heart of the protocol of case studies is a set of substantive questions reflecting the actual enquiry. Two characteristics distinguish this question from those of a survey interview. First, the questions are posed *to the investigator*, not a respondent. The questions in essence, are reminders to the investigator regarding the information that needs to be collected, and why. In some instances, the specific questions may also serve as prompts in answering questions during a case study interview; however, the main purpose of these questions is to keep the interviewer on track as data collection proceeds. Second, each question should be accompanied by a list of probable sources of evidence. Such sources may include interviewees, documents, or observations." Regarding the second characteristic, there was little documentary evidence available in the research that was useful. That which was available was only useful to check dates. Most of the documentary evidence had been disposed of between the reorganisations and the research period.

I interviewed 27 key informants. I also answered the interview schedule myself. Of those interviewed there were:

Area managers	2
Deputy area managers	2

Assistant area managers	3
Social workers	8
Area administrative officers	3
Social services officers	3
Home help organisers	3
Occupational therapists	2
Day care officer	1

The main subject headings of the interview schedule asked of all key informants in interviewed were as follows:

- The previous structure of the department and the area centre.
- The causes of the reorganisation of the area centre.
- The objectives of the reorganisation.
- The influences on the area centre when making changes. These could be from within the area centre or external.
- The timing of the reorganisation including the sequence of events.
- Data sources including demographic data.
- Decision making processes including how the decisions were made and who was involved.
- The changes in roles of teams and how the changes were brought about.
- Staff changes and how staff were allocated to teams and the affect of the changes on those involved.
- What had happened since the reorganisation. If any reviews had taken place. Also, their recommendations to others.
- Personal matters relating to their work.

THE SELECTION OF KEY INFORMANTS

It was decided to concentrate the interviews on a spread of key informants. Yin (1989, p. 89) says, "Key informants are often critical to the success of a case study. Such persons not only provide the case study investigator with insights into the matter but also can suggest sources of corroboratory evidence- and initiate the access to such sources." The criteria for the selection of key informants were that they would be people who had been in post at the time of the reorganisation and

would be still working at the area centre at the time of the interviews. To get a spread of views, key informants would include at least one of each of the following: the area manager, the deputy area manager (if the area centre had one), an assistant area manager, one or more social workers (as these were a majority of the staff), a home help organiser, an occupational therapist, an area administrative officer and an unqualified member of staff. I intended by this selection to get views regarding the reorganisation from both management and the other staff.

The selection of key informants was discussed with the Area Managers when I met them. I asked them to encourage their staff to participate. I thought that I would get a better response in this way than by a direct approach myself. I particularly wanted to get a cross section of staff committed to the research. In doing this, I had to rely on the managers taking an objective approach and not excluding people whom they thought might be critical of their management. The managers later sent me a list of names of people who met the criteria for selection. The Deputy Area Manager in my Area Centre was asked to make the selection. I thought it would help to avoid possible bias if I were not involved in making the selection myself.

INTERVIEW ARRANGEMENTS

I wrote to the two managers and indicated that I would like to arrange to come to their area centres and outlined how I would like to proceed (see the letter in Appendix 3). I offered to come to the centre and explain to their staff what I was proposing to do. This offer was not taken up. They indicated later that they had enough information. I proposed that if they did not reply to the contrary, it would be assumed that they were in agreement with what was suggested. I did this to avoid any delay in setting up my visits to their area centres by them having to write and reply to my letter. It was also proposed that I would telephone to arrange to visit them and discuss the selection of the key informants for interviewing. I stressed that I would try to avoid any disruption in their area centre.

I telephoned the AMs and arranged to visit them within a month. I explained in more detail what I was proposing to do. I indicated the basis of the choice of key informants and how I intended to carry out the interviews. I asked them to let me have the names of the key informants that I could interview.

Different numbers of key informant social workers were given by the AMs. The variation in numbers was because some staff had left the area centres, or, because of pressures of work, the managers could not commit them to the work involved in the research, or they did not want to participate. As I was seeking to obtain information about the processes of the reorganisations and not a quantitative approach, and as there was key informant staff in each staff category, I decided I could accept a variation in the number of staff that I would interview in each area centre. I wrote to the proposed key informants to introduce myself, to explain how they were identified as a key informant and to ask for their help with the research. I indicated that I would telephone them shortly to arrange interview dates. (See the letter in Appendix 3)

To make good use of my time in each area centre, and hopefully to be less disturbing, I tried to carry out more than one interview on the same day. The interviews lasted approximately one hour to one and a half-hour. All the interviews were carried out by me recording the answers to the interview schedule in writing. Tape recording significant statements supplemented this. The use of the tape recorder had only limited success. I found the acoustics in most of the rooms I used for interviewing very poor and the recordings consequently distorted.

I aimed to keep the responses to the interviews confidential and gave this commitment to those who participated. To do this I used fictitious names for the area centres and letters or titles for the interviewees. When interviewing my own staff, I gave them a commitment that the information would be confidential and only used for the purposes of the research.

The process of the interviewing was as follows. I asked each person to be interviewed to arrange a place in his or her office for us to meet. This was easier to achieve by the more senior members of staff, who had their own offices and more control over the use of space. I stressed the need for us not to be disturbed and for a power point for the tape recorder. At the start of each interview I indicated my intention to keep what they said as confidential as possible and discussed how I would do this.

I was aware of the dangers of my management position and its possible influence on the responses and my reporting of them. However, there were advantages in having knowledge of the organisation of the Social Services Department and the professional expertise of those interviewed. Hakim (1987, pp. 73-4), when writing about the practical considerations of case studies, says, that when interviewing informants who are professionals, the interviewer is often required "to demonstrate prior knowledge of the subject, to treat the interviewee as an informant as well as a respondent, to display sensitivity to the fact that the views offered by organisational and other role-holders may not be coterminous with their private opinions, and the discussion takes place on a basis of equality (or even of the of researcher inferiority)."

The interview responses where written down in long hand in note form and then written up by me fully as soon as possible afterwards. With the previous agreement of the interviewees, I had recorded on audiotapes parts of the interviews that I thought it would be useful to have in detail. I listened to these recordings afterwards with the notes of the interviews to clarify any details of what I had written or to record useful verbatim quotes. The interview responses were grouped together according to the each interview schedule question, under the interview schedule sub-headings. This was done for each of the three area centres.

The responses were not recorded verbatim. I thought to do so would provide a very fragmented and repetitive report. Consequently, I reported selective responses that are important and relevant to the reorganisation process being considered. If there were a number of responses of the same nature, I did not record them all. This approach seems to be supported by Hakim (1987, p. 74) Who says, " another practical problem is that analysis and presentation of case study data requires more skill than reports based on a single type of evidence. Two common errors are to present an indigestible mass of detailed evidence in the report, or to report only the researchers conclusions, instead of presenting carefully selected robust and central items of data in combination with the various questions and issues addressed by the study."

DATA ANALYSIS AND PRESENTATION

Yin (1989, p. 29) says that for case studies there are five components of a research design that are especially important. These are:

1 a study's questions;
2 its propositions, if any;
3 its unit(s) of analysis;
4 the logic linking the data to the propositions; and
5 the criteria for interpreting the findings.

I think that this research meets Yin's criteria. The following are my comments on his above components as they relate to the research:

1 The study question - this relates to the examination of the process of the reorganisation of area centres of a social services department.
2 The propositions - I see the sections of the interview schedule relating to propositions that, as Yin says, direct attention to something that should be examined.
3 The units of analysis are the area centres.
4 The logic linking the data to the propositions are the responses of the key informants to the interview schedule.
5 The criteria for interpreting findings is by comparison of findings between key informants, between areas centres and the findings found by others in literature.

Because of the time span between the reorganisations and the interviews, there was a danger of interviewees not remembering, or not remembering correctly, aspects of the reorganisations. Yin says (1989, p. 91), " Interviews should always be considered *verbal reports* only. As such they are subject to problems of bias, poor recall, and poor or inaccurate articulation" However, with the number of interviews involved in the research, I was able to cross check responses, if they were substantially different to others. Also, as I was involved in one of the reorganisations, I was likely to be aware of possible anomalous responses.

The research findings of each area centre are reported separately in the following three chapters. A thematic approach is used based on what was judged to be the probable processes involved in a reorganisation. The themes are the sub-headings in the interview schedule. Under these are the responses of the key informants to the questions of the of the interview schedule. At the end of each chapter examining the area centres, I have included my reflections on the reorganisation of the area centre. A chapter entitled "Summary and Conclusions" follows these chapters. This draws together the research findings of the three area centre reorganisations. It compares and contrasts the reorganisations and examines the outcomes. This includes the advantages and disadvantage of the various processes used in the reorganisations and the affects on those involved.

CHAPTER FOUR

TOWNHAM AREA CENTRE

I managed the Area Centre at the time of the reorganisation and at the time of the research interviews. All the members of the area management team (AMT) were interviewed, as they fulfilled the criteria for selection as key informants. I also asked them to negotiate for interviewing other key informants from their team members. I asked the Assistant Area Administrative Officer (AAAO) to participate as the Area Administrative Officer (AAO) had left. In reporting on the results of the interviews, I have tended to report the responses of the management and non-management staff separately. I think that this will show differences in emphasis, opinion or experience relating to the reorganisation.

BACKGROUND INFORMATION

This Area Centre covered an area between two cities. It had a population of 106,000. The area was divided geographically between the old industrialised and densely populated North and the more rural South. The Northern part had been an old railway town and included the main shopping area, the commercial area and that of the local authority administrative offices. Also located in it were the main offices of the voluntary and statutory offices including the Area Centre researched. A third of the population lived in the southern part of the area. This mainly comprised agricultural land and rapidly developing housing estates, primarily for first time buyers. Residents in the South tended to use the shops in the local city rather than those in the northern part of the District. The Social Services demand from the public was fairly well spread geographically in terms of client referral type. However, a predominance of the work time was concentrated on statutory child care work. Two health authorities again reinforcing the North/South divide covered the

area. This was one reason why the possibility of operating on a large, two patch system was seriously considered

PREVIOUS STRUCTURES

Before the reorganisation, the Townham Area Centre team structure was that of a long-term generic team, an intake team and an administrative support team. There were two assistant area managers (AAMs) working to me as the Area Manager (AM). There was no Deputy Area Manager (DAM). The two AAMs were primarily team leaders. One led a generic team of social workers: the other an Intake Team, which did the duty/assessment work. The occupational therapists (OTs) were supervised by the intake Team Leader. I supervised the home help organisers (HHOs). Both these latter groups also had the support of advisory staff at the Headquarters of the Department. The Administrative/ Clerical Team was headed by the (AAO). The Long Term Team, although theoretically generic, was largely child care work biased. The Intake Team did the duty and assessment work, the short-term work and much of the work with adult clients, including long-term work with them.

The reorganisation discussions were started in January 1986, and the reorganisation planning finished in July 1986 and was partially implemented. It was completed following the appointment of the new AAM in October 1986. The interviews of the key informants were carried out during May and June of 1989. The team structure following the reorganisation was two generic teams and a duty/ assessment team.

THE KEY INFORMANTS

The key informants involved in the research in the Townham Area Centre were as follows:

Area Manager (myself)

Deputy Area Manager

Assistant Area Manager

Assistant Area Administrative Officer

Social Workers A, B, C.

Occupational Therapist

Home Help Organiser

Social Services Officer

ORIGINS OF THE REORGANISATION

This section looks at why the Area Centre was reorganised and how people were involved, before going on to consider these in more detail in other sections. It was maintained by most of those interviewed, that the opportunity to reorganise was brought about by the provision of an additional management post. This was a position of DAM that had not previously existed in this Area Centre.

In the Townham Area Centre the members of the AMT were aware of changes in the roles of teams that were taking place nationally and within the County. We had discussed the need of a review of how we were providing services. But the catalyst of the reorganisation was the provision of an additional post of DAM to the AMT. This gave us the opportunity to decide how to use this additional post in relation to the others. There were two main choices. One was that the DAM should not lead a team but perform other specialist functions supplementary to those of the AM. Alternatively, the DAM could be a team leader as well as deputy to the AM. Both ideas had advantages. It was considered that a DAM, without team commitments, would be able to fully deputise for the AM and have much more flexibility of operation. Consideration was also given to the DAM not having a main team but supervising the HHOs and OTs. However, it was considered that there were too many staff at the Area Centre requiring supervision for it to continue to be provided by two team leaders. It was, therefore, decided to move into having three teams and the DAM would lead one of them. This would spread the staff supervision over

three rather than two team leaders. Supervision of staff work was not seen solely as a management quality control tool. Most staff welcomed it as an opportunity to seek advice and share anxieties.

The DAM was promoted from within the Area Centre, following the usual processes of advertising and interviewing for the vacancy. An AAM was appointed to the position and this released a post to be filled by replacement AAM. We did consider delaying the reorganisation until after the appointment of the additional Team Leader. This would provide him/her with the opportunity of involvement in the planning of the reorganisation. However, to avoid any loss of time associated with the appointment, it was decided to proceed with the reorganisation process with the knowledge that the post would be filled after the reorganisation of the structure of the teams. This had the advantage that once the team structure had been decided upon, there would be a clearer idea of the type of experience that should be looked for in the new appointment.

As AM, I saw no external changes that affected the reorganisation, except the provision of an additional management post. However, the Intake team/ long-term system that we operated was generally becoming less favoured at the time. Most of the additional specialist staff appointments that might have influenced the outcome were not made until after the reorganisation of the Area Centre. It was a period of no growth for staffing in the Department.

When interviewed, the DAM acknowledged the provision of a third team leader as having provided the opportunity to change the team structure of the Area Centre. She had previously led the Duty/ Assessment Team as one of the two AAMs. She said that that team had taken on referrals of all client groups, other than those of long term child care. These went predominantly to the long term/generic team. She was involved as a member of the AMT in the planning and decision making process that took place in the reorganisation. She thought that the reorganisation was "structurally determined rather than client determined, although that is not to say that the needs of clients were not considered." She said, "We did not have problems that prompted the reorganisation. With the reorganisation we were trying to create an environment that could make best use of another team leader. This enabled us to concentrate on improving client services." She added, "These were positive reasons for changing. As the changes were not seen as threatening, it was

easy to involve staff. We were looking towards the future, to an improvement in services and with smaller teams there would be greater support to the staff themselves." She said that the reorganisation of the Area Centre took most of a year to complete. This was from the time it was made known that we were to get a DAM, until the appointment of the new AAM.

The AAM also thought that the prime cause of the reorganisation was the provision of a DAM who could become a further team leader. This was an additional resource to the area. He pointed out that staff wanted a review of the services, particularly the long term /generic team structure. They saw child care work as becoming increasingly more dominant in their caseloads. He thought that we wished to respond to the expectations from the public that we should offer an increased comprehensive service to client groups other than children and families. This was encouraged by the new legislation regarding disabled people. He said that there was an AMT agreement that there should be three teams. He led the working party that looked at the model based on specialist groups. He added that very early on, it was made clear to staff that, although this was a consultation exercise, the final decision would be made by the AMT.

I interviewed three social workers. Social Worker A, as did most other members of staff interviewed, thought that the provision of the DAM as an additional management post provided the opportunity to reorganise. He thought that there had developed an increasing awareness in the informal discussions of staff of the need to review the team structure, as the result of the proposed appointment of a DAM. The involvement of staff in the planning process was mainly through their involvement in the three working groups that looked at the possible team formats. He had a preference for the creation of an adult services team. Social Worker B also saw the appointment of an additional manager as a prime factor in the reorganisation. There was also recognition of the stress on the Team Leader of the Intake Team from the work involved. He also saw a need to review the duty system, too much child care bias in the work of the long-term generic team and a desire for a truly generic way of working. He described it as "an oldish structure that needed revamping." Social Worker C, who had been in social work for many years, indicated that he had seen it all before. However, he was willing to contribute to the research, although he usually had less to say than the others.

OBJECTIVES

The objectives of the reorganisation were not clear to some of those interviewed. Nor how these objectives were established. There was a general view that the reorganisation was an attempt to try to provide a better service to the public. There was also an acknowledgement by those interviewed, that they had also been concerned about how the reorganisation would affect them personally.

I saw the appointment of a DAM as giving us the opportunity to review the structure of the Area Centre and the way we provided services to the public. The objectives of the reorganisation were to make changes to the way we operated to improve these services. Initially there was a need to define the role of the DAM and spread the supervisory work of the team leaders out more equitably. I hoped to find a more suitable team structure as a vehicle for providing better services. In trying to achieve this, I aimed to involve staff in the decision making. Departmental policies and statements regarding service provision were kept in mind but these allowed us considerable flexibility. I had an open mind about what the team format should. I saw the advantages of specialist teams and patch systems. I also recognised that the choice of a generic team structure would mean the fewest changes. The DAM also saw that "our primary aim had been to assimilate a third team leader into the structure without affecting the services deleteriously." She thought that the needs of management, staff and clients were all considered and the additional post had given us the opportunity to reorganise. She said "We wanted to use this opportunity creatively and to rationalise the service provision and give better service to the public." She added "Each individual staff member had their own interests, but we also had to give our perception about what would be beneficial to clients." The AAM was more specific about what he saw were the objectives of the reorganisation. He said that we had tried to create three effective working teams and to establish more adult work in the teams and maintain a clear commitment to an adequate duty system. As to how these aims were achieved, he thought that we responded to what staff were saying through the working groups. When considering the reorganisation, the needs of the public were uppermost but he also said that it was a "chicken and egg" situation as "It was also important to achieve happy staff

working situations and relationships." He added, "One needs to keep staff to get the work done. Therefore, we didn't totally respond to public needs." The AAM also thought that the needs of other agencies were given only minor consideration depending on their importance. For example good-working practices with the Health Authorities was considered important because of a substantial overlap of services. He considered that a reasonable attempt had been made to balance the needs of all groups and agencies but with staff and client needs uppermost in the consideration.

Social Worker A saw the reorganisation aim as at meeting the needs of the Area Centre. By moving into three teams and relieving staff from some of the stresses they had suffered with the two teams operation. He thought that the needs of the public were not considered except in the patch team's discussions. In his discussion group, which looked at specialist team formats, priority was given to the needs of the staff and the Area Centre. Other agencies were not consulted. He had a preference for the creation of an adult services team. He thought that the needs of the public were considered at the next stage, when the decisions were made about how the teams would operate. Social Worker B thought the objectives of the reorganisation were to relieve the stress on the Intake Team and its Team Leader, to review the duty system, to change from the child care emphasis in the long term work and generally to review the team structures. He thought that the objectives were decided by the AMT after a consultative exercise with staff. Following this, the specific terms of reference were given to the study groups. All staff were involved. If there was any priority, it was given to the needs of the staff. Social Worker C thought that the aims were to provide a better service. The Social Services Officer (SSO) saw the needs of the public as considered but acknowledged that she was concerned about her own needs. These had been met by her obtaining a permanent place in one of the new teams. She thought that most people were involved in deciding the aims of the reorganisation. She saw these as to provide a more efficient service with the creation of a third team. The OT added that all staff had the opportunity to put their own specialist interests forward. The HHO said that they wanted to be involved in the work of an Area Centre team not just to be attached to it.

INFLUENCES

This section considered the internal and external influences regarding objective setting and decision making. These were affected by the personal, self interest and sectional influences mentioned above. The following matters were considered and they influenced us in differing degrees:

1. The geographical spread of the population. In particular, the problems relating to the needs of the southern part of the area. This was isolated from the main resources, which were located in the town centre in the northern part of the area, for example, the Area Centre was in the town centre.
2. We had a high proportion of young children and new families in new housing developments. These families were often isolated from the help of extended families and support services.
3. Homelessness was mainly associated with single parent families.
4. Juvenile crime rates were considered and influenced the child care aspects of the reorganisation.
5. We were influenced in our thinking by the geographical North/South population divide. The southern part of the area tended to identify with the adjacent City rather than the local District Council that had responsibility for it.
6. We had to consider that the area we covered was served by two different Health Districts and how we should work with them.
7. The ideology that predominated among staff was a major commitment to generic social work, although specialist workers, who mainly worked with adults, had a preference for specialist teams. Patch systems were in vogue at the time and their theory of operation was also influential in the discussions.

There were different opinions about what influenced us. For example, the DAM said that she was not aware of using social need indicators specifically, but had been concerned about the importance of the high incidence of single parents and associated housing problems. She also pointed out the problems associated with the NSPCC not providing a service in the area, and we had to consider how to cover this gap in the child care support network. She thought that there had been a very strong opinion that we should not lessen the level of our commitment to the

public. There was also a child care lobby committed to maintaining child care standards in the reorganisation. She said, "People were worried about a reduction in this service to families. However, because there was an agreement that the composition of caseloads would take into consideration experience and personal Interests as well as the Area Centre's allocation priorities, this did not happen." The AAM thought that the AMT and the staff had a good knowledge of the demographic factors. He said the "facts and figures" were collected and given to the teams and working parties. He added that the reorganisation was influenced by the absence of agencies rather than their presence. This relates to the absence of residential child care facilities and of the NSPCC, as mentioned by the DAM. He thought that the patch system theory and the knowledge that other offices were considering a move into specialist team operations was also influential.

Social Worker A saw it as an "internal reorganisation and uninfluenced by external factors." He personally wanted to see a retention of the duty/assessment system that provided a good service. He thought those who also believed this were influential. Social Worker B thought that the Area Centre had demographic, referral and caseload figures, but he was uncertain how they were used. He felt that we relied too much on the general working knowledge and impressions of staff. He added, "To some extent the aim of the exercise was to enable a large group of people to come to a consensus, rather than respond to the needs thrown up by the statistical information." He said that the Area Centre had been influenced by the presence of very active voluntary agencies. He also thought that the members of the previous long term team, with their child care commitment, were influential and that the Intake Team's views had an effect on the outcome of the reorganisation. He was one of the more politically active members of the Area Centre. He said that the staff of the Area Centre were mainly politically left of centre. He added "The social philosophies of the Tories did not get too much of a look in nor did the socialist preference for patchwork/community work have much influence on the outcome of the reorganisation." He thought that the social work methods of the office were based on the classical casework model with crisis intervention as the second most important model. Social Worker C thought, like the DAM, that the large number of single parent families and the numbers of children in care had influenced us. The SSO, OT and HHO were not aware of any influences affecting the outcome of the reorganisation. The AAAO also thought that there had been little outside or ideological influences.

TIMING OF THE REORGANISATION

This section looked at the length of time the reorganisation took and the sequence and timing of the different aspects in relation to each other and the whole.

The reorganisation discussions started in early 1986. We were vague about the length of time the reorganisation would take, but we generally thought that it would take about six months. The sequence was as follows:

1. The Area Management Team considered why it wanted to reorganise.
2. AMT decided what we wanted to achieve and what problems we wanted to overcome in the present structure.
3. This was explained to staff and their commitment sought to a review of the operation of the Area Centre.
4. Involving staff in the process of examining structural alternatives.
5. Obtaining the views of others outside the area.
6. Discussing the working parties reports with staff.
7. Making decisions.
8. Advising staff of these decisions.
9. Implementing these decisions

To a major extent we kept to this sequence, although sometimes several events were happening simultaneously. For example working party discussions took place within the Area Centre, at the same time as discussions with others outside the area, regarding the value of various team structures. I had looked at the project planning theories and the possible use of critical path analysis. I did not study these in depth. However, my timing of the reorganisation was more structured than it would have been without this knowledge. On reflection it would have been very useful if all members of AMT had looked at how to use project management theories before we started the reorganisation. The DAM saw the reorganisation in phases. From January to April '86 was a phase of discussion and consultation in groups. This was followed by a phase devoted to analysis of the information gathered and decision making. The AMT was then involved in July with appointing the third Team Leader who started in September. The new structure was put fully into operation in October of 1986. The AAM had a similar view of the length and

sequence of the reorganisation, planning and implementation. He thought that it could have been shorter but for the delay due to the need to appoint the new AAM.

Social Worker A thought, "The timing had been psychologically appropriate in that the reorganisation developed during the spring, the holidays intervened and the reorganisation was implemented following these." He also saw the process in phases of consultation, discussion and decision making. Social Workers B and C and the OT thought that the length and sequence of the reorganisation had been satisfactory. The HHO said that although, the meetings of staff regarding the reorganisation were held regularly and were informative, towards the end people were mainly interested to know what team they would be in.

DATA SOURCES

Data sources included those obtained within the Area Centre regarding referrals, government demographic information, and statistical/ demographic information obtainable from the statistical section of the Department. Such data was mentioned in the interviews. However, although such information was available, there was general uncertainty about the extent to which it was used as basis for setting objectives and decision making. This section also asked questions about the Area Centre's policy regarding service priorities.

We obtained statistics from the Department relating to the area including demographic data, caseload breakdown, referral data and a document relating to Team Leader/staff ratios. Further help came from my discussions with other AMs. This was part of the planned sequence of information collecting. My discussions with other AMs were informal. They were asked about the present team structure of their Area Centres and any associated problems. Other sources of information were our knowledge of the operation and structures of other agencies such as the Probation and Health services. Written material dealing with patch systems operating elsewhere at that time was examined. We also read articles relating to matters of a more general nature such as studies of the roles of teams and team members. When it came to the use made of the data obtained opinions varied. The DAM was in the working group that considered the patch system of operation. To get further information, they looked at the way patch systems operated

elsewhere. She pointed out that the Area Centre had largely to rely for its statistical information on the Headquarters' information system. It had little means of collating it on a local basis. She added that we had to use what was available, which was not always the most useful. This was particularly so when examining geographical patches, as there was a need for information on demographic and demand data covering relatively small areas. The AAM also mentioned that the statistical information we obtained from the Headquarters' statistician was used in the group he was in.

Social Worker A thought that apart from referral and population statistics, little information had been. He did not think that those we had had influenced the decisions. Social Workers B, the HHO and the OT said that the main data available had been on the population and its distribution over the area. The OT had also contacted colleagues in other areas and obtained information that she fed into the working parties.

The priority that an area centre gives to particular client groups or areas of work can influence decisions made about the allocation of staff to teams and the allocation of work to staff. We did have an informal priority listing system regarding work at the time of the reorganisation. The scaling was largely dependent on the degree of risk and statutory responsibilities involved. Child care work was given a greater priority than other forms of work demand, with mental health crisis work next. This was not a formal priority listing but a generally accepted scaling based on professional judgement of need, awareness of the Department's views and the likely reaction of the public to particular situations. I was influenced by the ideas of Miller and Scott and their writings on priority scaling and work management. The DAM thought that the priority listing of the Area Centre was an informal one based on the degree of risk involved to the client. She thought this was the commonly accepted criterion among all staff but particularly among the management team. The AAM added, "There was an understanding regarding priorities." He reminded me that there had been management discussions regarding work allocation to get common ground on priorities of work other than those where there is a mandatory responsibility set by statute.

Social Worker A did not think that the Area Centre had a work priority policy but relied on professional experience. He thought that child care work was given the

highest priority. He added that there was a "What will appear in the newspapers syndrome" that determined priorities. Social Worker B said that the work priorities before the reorganisation were influenced by agreement and tradition and tended to be applied at the intake and allocation levels. He pointed out that prior to the reorganisation, when it came to considering case transfers from intake to the generic team, this was mainly child care work, whereas work with adults tended to remain with the Intake Team on a short term basis. He saw this as suggesting that work with adults was given a lower priority. Social Worker C and the HHO also thought that statutory child care work was given the highest priority and that the Area Centre was child care biased. Whereas the OT thought that duty work was given a high priority and no particular group was given priority. The AAAO said, "Priorities were almost forced upon you. Some leap out as needing the most urgent work."

DECISION MAKING PROCESS

This section of the interview schedule covered how decisions were made regarding the reorganisation, when and who was involved.
The choice of structures we considered were:

1. Three generic teams with social workers from each team doing duty.
2. Two generic teams with a duty/assessment team.
3. Three specialist teams.
4. A patch system way of working.

I had developed a preference for three generic teams, each of which would cover duty on a weekly basis and follow through any on going work that was required. However, I aimed at a consensus decision of all the staff to what the team structure should be. I thought this would bring more commitment from the staff afterwards. But, I had to ensure that any decision would be operationally efficient and meet the needs of both the Department, the staff and the public in the long term. The decision making process was therefore one of clarifying together aims and objectives. We arranged to involve all staff in the discussions and research leading up to decisions being made. This was through the initial setting up meeting, the establishment of the working parties, staff meetings, a progress report meeting and

the final feedback and decision making meetings. All fieldwork staff, by agreement, opted for participation in groups in examining and making recommendations on the different team formats. The three working parties that were set up were each led by a member of the AMT. The groups were to examine and make recommendations on possible team structures.

The extent of the feeling of involvement varied. The OT felt involved in the working parties, whereas, the HHO said that she had found it difficult to feel fully involved. The HHO was in the working party looking at the patch system of working. She felt that she was an important member, as the HHOs operated on a kind of patch system. They were each responsible for a geographical patch of the area as a whole. She said "At that time, more responsibility for that service was being transferred from Headquarters to area centres and they found it to be an unsettling period. Until the Area Centre reorganisation was established, they did not know where they would fit into the Area Centre structure, and who was going to be their line manager." She also saw that as the HHOs were a large group of people they would not easily fit into a team. She was an advocate of a patch system as she saw it spreading the services more evenly over the area as a whole, particularly the neglected southern part of the area.

We had few part time staff working at the Area Centre. I think that it is often difficult for them to be involved in planning for change. For example the SSO said that she was not involved very much as she was only able to attend a few meetings. The AAAO was interviewed in the absence of the AAO who had left the Area Centre. She said that she had not been involved to any great extent, as it was the AAO who was on the working party. She had not seen the reorganisation as affecting the work of the clerical staff. However, she said that they knew what had taken place and the work of the working groups.

The DAM maintained that everyone was involved, particularly through the working parties. She thought that although contributions varied, everyone had the opportunity to participate in the discussions leading to the decision making. I hoped that it could be seen that it was an "office agreement." At the same time there was recognition by staff that any conclusion could only be brought about with the support of the AMT.

The reports of the working parties were initially discussed at an AMT meeting. There were management team members who held preferences for each of the main choices. There was considerable discussion by the AMT about the advantages of each team structure. Before this, I had been impressed by the merits of each of the proposed team structures. Eventually, I came out in favour of a three generic team format as my preference. I thought that generic teams would satisfy the needs of staff who were mainly keen to operate in a generic manner. By the teams being more truly generic than the previous long-term team, I hoped that we would meet the needs of all client groups. There was no overt opposition to this within the AMT and it was agreed to present it to the rest of the staff for discussion.

A full staff meeting was called to review our objectives regarding the reorganisation and consider the report of the working parties. The working party leader presented these reports to the meeting, with added contributions from the other members. Others asked questions and made comments about what was presented. At this meeting, I outlined my views of why particular structures were suitable or not. I stated my preference and that of AMT for a three generic team system. The duty/assessment system became a matter of discussion and it was proposed by some very committed members of staff, particularly those currently operating in the Duty/Assessment team, that a form of duty/assessment team be retained. It was agreed that this recommendation would be considered by the AMT. This recommendation was later discussed by the AMT and it was agreed that it should be accepted and that the structure for future operation should be two generic teams plus a small duty/assessment team. In accepting this I acknowledged the advantage of retaining a team, which was independent from long-term commitments and able to respond quickly to the needs of clients in crisis situations.
The DAM thought that there had been strong preferences for each structure coming from different quarters. But she added that she thought people were able to accept that they may not get their first preference and could look beyond this to alternatives. The AAM agreed with this and added that the structural choices had been affected by the AMT's decision that the DAM should also be a Team Leader. Social Worker A thought that there had been strong preferences, but when the decisions were made, these were accepted without any major resentment by those involved. Social Worker B added that there had been many people in favour of patch and specialist team working but accepted the decision when these were rejected in favour of generic working.

Social Worker A thought that the views of staff were effectual. He pointed out that members of the Intake team were influential in the groups and thought that their strong views affected the outcome of the reorganisation. Social Worker B thought that the AMT took seriously all views put forward from the groups. The OT said that she did not think that the eventual decisions were predetermined, adding that everyone was influential. The HHO and Assistant Administrative Officer thought all opinions were valued in the groups. Social Worker C thought that the influence of the views expressed depended on who expressed them. This was partly true. I believe that some staff, depending on their management level, experience and possibly the support they had from others, or the forcefulness of their approach, did seem to have more influence than others did.

We did not involve users of the service in the reorganisation discussions directly. I afterwards thought that we should have found a means of doing so. It was thought that staff would represent consumer needs. We tried to supplement this with demographic, referral and caseload figures that showed the demand for our services. The various needs of consumers, staff, the Department and other agencies were discussed in the groups studying the different team structures. The DAM thought that there was no other mechanism for ensuring the views of the users or the needs of other organisations were met. She acknowledged that we could have involved others outside the Area Centre but did not. The AAM also thought that the needs of others were represented by staff views.

Social Worker A thought that the needs of the staff were the major consideration. He thought that the needs of others, such as users, were not considered because they were not directly involved. Social Workers B and C also thought staff needs had been uppermost in consideration when decisions were made. However, The SSO, HHO, OT and AAAO thought that within the working party the needs of others including the public were considered

The DAM said that there had been a consensus about what was a preferable team structure in the AMT, otherwise, the decision would have been made by the AM. The AAM said it was "a consensus decision rather than a vote." Other staff held differing views on how the final decisions were made and the extent of their involvement. For example Social Workers A and B considered that they had been

involved within the consultation process through the working parties. Social Worker B thought that the ideas that the groups put forward had some impact. As an example, he mentioned the proposals for the duty/ assessment team, which came from the staff in the report back meeting. He added that it had been fortunate that the final decisions of the AMT had been the same as the views held by the staff. They thought that the final decision was made by the AM within the AMT. Social Worker C, SSO, OT and HHO thought that the decisions were made by AMT.

CHANGES IN THE ROLES OF TEAMS

This section looks at the team structure decided upon. It also asked questions about the changes in the roles of teams and the work relationships between them. This includes how work was allocated to teams and the way work was transferred between them. It also examines the changes in work priorities of the Area Centre following the reorganisation and how these were put into operation.

We decided to have three teams. These comprised two generic teams plus a small Duty/Assessment Team with a core of two specialist duty workers. Other social workers were to supplement the duty system. The OTs and HHOs were to be located as groups in particular generic teams.

For allocation of work, it was decided that any work picked up by the duty system of an emergency nature should be allocated to a core member of the Duty/Assessment Team and if this was not possible, to any other Social Worker available. The general allocation procedures were that the work to be allocated was considered at a weekly meeting by all members of the AMT. The Team Leaders (deputy area manager and assistant area managers) would take work for their teams. This work would be allocated to their team members within the same week. Transferring work was done as part of the weekly AMT meeting. This was seen as the best forum to ensure that transfer problems were resolved and a balance of work between teams managed.

There were clusters of preferences held by staff. The AAM said that he had a preference for generic working and consequently was keen to manage a generic team. He thought that the patch system of working was inoperable because of the

lack of staff resources. And specialist teams had a too narrow work focus to meet the needs of most staff. He thought with true generic teams, individuals could have a bias in their caseloads, to reflect their interests and capabilities across a range of client groups.

Social Worker A thought that the team structure decided upon allowed staff to work generically but at the same time to develop individual areas of interest. It also allowed for the continuation of a successful Intake service. He thought that other structures did not meet the needs of staff. Regarding a patch system that some might have preferred, there were insufficient staff to carry it out efficiently. Social Worker B thought that the reorganisation decisions met the needs of staff. He said that the old team structure had provided a good child care service, but acknowledged that other areas of social work, for example work with adults, had not received an adequate service provision by comparison. He thought that we had not the facilities to operate a true patch system. He said "There was a feeling that generic work was actually better than specialist work in that you got a more balanced picture of the individuals within their social context." He added, " It also enables people to work in a more flexible way. You should be able to provide help no matter what the age of the persons or what problems they present." Social Worker C said he thought that people opted for team structures that met their own needs. The SSO saw the changes as providing smaller teams that could work more efficiently. She thought that retaining the Duty/Assessment Team was a right decision, as it would provide a better service than the alternatives considered. The HHO thought that, although she would have preferred a patch system, the generic teams had proved to be successful. She also thought that there was insufficient staff for a true patch system and specialist teams would cause an imbalance in the resultant team structure. The OT would have preferred a specialist team structure, but said that the generic team structure gave them the opportunity to work with teams across all client groups.

We recognised the importance of the teams being accommodated adequately. There were rooms suitable as the main team rooms, although the team room of the new Team Leader had less space for expansion on the same floor. The possibility of being on two floors was not seen as good practice by the team involved, although there was no likelihood of this happening for the then foreseeable future. The OTs were placed in one of the generic teams and the HHOs in the other. The OTs and

HHOs were accommodated in their own separate rooms. There was inadequate space to put them in the same room as the other members of their team. I also saw an advantage in this, as the staff within these specialist groups needed to co-ordinate their work and provide each other with mutual support. The HHOs had their own clerical support within their office. The core Duty/Assessment Team members had their own room. It was thought important to have a duty room in which to have a clearly identified duty officer with appropriate information and administrative support nearby. Ideally it should have been on the same floor as the administrative staff, for the obtaining of files and easier access for the receptionists. Unfortunately, because of the lay out of the building, this was not thought possible. Team Leaders had their own separate offices as near as possible to their teams. This provided ease of contact but also privacy for supervision.

The DAM pointed out that the changes of team membership and the move into new rooms inevitably broke up working groups and relationships. Others also mentioned this. Social Worker A said that the planned changes took place during the summer holidays. He said that the target date was set for the changes to be done by June. This gave them two months to adjust to the changes and transfer caseloads. The new Team Leader did not arrive until later to help with this work. He thought that this had led to increased pressure on existing Team Leaders, but there were advantages, as they had good knowledge of the cases to transfer and the capabilities of the staff. Social Worker B said that he thought that the space allocation was about territory and access to resources. He said the OTs and HHOs had wanted clearly defined workspaces and obtained them. He thought that the generic teams did "reasonably well" regarding the office space they obtained. Administrative staff were happy with their new accommodation and the duty room was seen as a useful Area Centre asset. Social Worker C referred to the difficulties of fitting the additional team and team leader into the building. The SSO pointed out that the accommodation decisions were made following discussions with staff. She was critical that the separate staff/rest room was changed into a room for the extra team. This was true, but it had been observed over a long time that staff did not use the staff room as such. We designated a much smaller room as a coffee room, with the agreement of the staff. We retained a large room on the ground floor as a conference and general meetings room.

The HHOs were given a room on the first floor. They were previously in a room on the ground floor. This had the advantage of being easily available to their staff. However, as they frequently called at the office without going though the reception, the HHOs had found it very distracting. At the reorganisation, they were moved, at their own request, to a room that was near to the rest of their team. As they requested, the OTs were located on the ground floor, close to their equipment store and access to the rear exit of the building and car park.

There were policy changes. We aimed to make caseloads becoming more generic. This applied mainly to social workers and associated unqualified staff such as social services offices and social work assistants. Other staff such as specialist social workers, OTs and HHOs by the nature of their contracts of employment retained their workload specialisation. It was also agreed that, providing a workload balance was maintained within the teams, generic staff could take on a bias in their caseloads that reflected their own work interests. An attraction of generic working for social workers was that it enabled them to have caseloads of varying client group composition. From our enquiries in the other areas centres, it was thought that specialisation can result in situations of considerable concentrated pressure, for example where child care caseloads are predominantly work with children who are at risk of abuse or neglect. There was a belief held some social workers that a "good" social worker should be capable of providing help in any situation. This was seen by them as best achieved by generic social working. I understood this view. Although, I recognised the problems experienced elsewhere of the difficulty of trying to maintain generic caseloads against pressures to give priority to child care work, I thought that by being aware of these dangers we could avoid them. I was also aware of the criticism that suggested that social workers that had generic caseloads would not develop in-depth knowledge about any aspect of their work. I recognised the advantages of specialisation as giving opportunities to develop in depth knowledge and experience of particular areas of work. However, there was the view that the resulting narrow specialisation could require more than one specialist social worker visiting a family with multi-problems. These situations are probably not frequent. Some of the dangers of specialisation can be protected by an initial generic social work training and participating in a generic duty system.

Work priorities, to a large extent, remained based on the urgency of the situation. Priority was given to situations of at risk or actual neglect or injury to the person

concerned. This was applied across all client groups but particular importance was given to situations involving children. There had been a decision that more importance was to be placed on the need to improve services to adults. This was stressed during work allocation meetings. Some specialist staff, for example occupational therapy, had their own work priorities and these were used when work was allocated to them. The home help services emphasised a quick response to all new referrals. Social Worker A said that no changes were made in Area Centre work priorities. He saw the reorganisation as predominately a change in the staffing structure. He thought that we opened up the opportunity to provide a greater range of services other than child care. Social Worker B also did not think that there was any discussion that he could recall about changes in work priorities directly.

The DAM thought that the work priorities remained largely influenced by child care statutory requirements. However, the Team Leader of the Duty/Assessment Team when making a judgement on a referral, largely determined priority given to any piece work. She said that there was a group understanding and consensus regarding the priority to be given to areas of work. Regarding changes in policy, she said, "There was a greater awareness of child sexual abuse that was being highlighted at the time but I do not think that it overtly influenced us. Neither did we see ourselves as reducing the level of a service by the reorganisation." She thought that the major effect of the reorganisation was that problems of the past regarding the allocation of work and the internal structure problems regarding the transfer of cases from the Duty/Assessment Team had largely been resolved. The AAM did not think that work priorities had changed directly except, that following the reorganisation, these were set by the AMT in the allocation meetings. This was where balances of team workloads, priorities, and issues were addressed. He said that he saw some priorities as "fixed for us by law and departmental policies; others were dependent on the availability of staff resources." He thought that there had been no major changes in Area Centre policies or philosophies, except that there was an aim to improve the long-term services provided to non-child care client groups. He added that specialist workers and unqualified staff had carried out adult service work in the past: this would continue but it was aimed to supplement this by more such work being allocated to the generic social workers.

STAFF CHANGES

Included under this heading are questions relating to how staff were allocated to the new teams, what determined this and the effect on the staff concerned.

The AMT arranged that staff should express a preference about what team they would prefer to be in. They were then allocated to the teams as closely as possible to their wishes. As the two generic teams were similar in size regarding their social worker numbers, we tried to give each team an equal balance of social worker experience and interests. This was partly the reason for placing the HHOs and OTs, as groups in the two generic teams. To put either of them in the Duty/Assessment Team, would have overloaded that team, particularly the supervisory work of the Team Leader. She was also the DAM and as such already had additional responsibilities. We placed the individual specialist staff in the generic teams, according to the interests and experience of the team leaders and balancing the numbers of them between the teams.

There was little involvement of the administrative staff in the team allocation. The reorganisation of the teams was seen as not greatly affecting them. We saw it as important to bias the influence upon the outcome of the reorganisation in favour of those who would be most affected and have the greatest responsibilities to carry out the decisions. I later thought that the administrative staff should have been more involved and we should have examined the possible consequences of the reorganisation for them in more detail.

The DAM said that allocation of staff to teams was largely based on the structural aim to balance team sizes. She thought that when placing staff into teams, we tried to meet their preferences. Previous experience and commitment was sought from those wishing to be in the Duty Team. She also acknowledged that administrative staff had been little involved in the discussions, as it was not thought to affect them. The AAM reminded me that once we knew the preferences of staff, and information about their strengths and experience, we collated these details and used them to try to get a good team fit. He said that we aimed at a balance of workload preferences, male/female balance (although, we had very few male staff), the level of experience of workers and a balance of staff knowledge and that of their team leader. He added that what was aimed at was a structural balance of staff, a balance of work

between team leaders and a reduction of the pressures on the DAM. Although, the allocation of staff to teams did not directly reflect Area Centre's priorities, I think that the fact that within the teams we were trying to give more commitment to work with adult clients did.

Social Worker A said that as he saw it, staff were allocated to teams by the AM advised by the Team Leaders and trying to establish a balance of staff experience, and the supervisory responsibilities of the Team Leaders. He did not see these staffing placements as reflecting priorities. Social Worker B thought that particular staff were allocated to teams to respond to the need to provide a viable group for generic working. He added that he assumed (and this was correct) that the specialist social work staff were largely allocated to the original team leaders as it was known, by then, that the new AAM was relatively inexperienced. He said that "the generic social workers were distributed in the teams on the basis of there being a reasonable pattern of experience, gender and interests so that you could provide a generic service, but with people in each team who could work with children and families." Social Worker C said that he thought that people were allocated to teams on the basis of individual interests and personality matching. The specialists were allocated to teams to even out the supervision responsibility between the teams. Others interviewed mentioned the balance of staff numbers, interests and experience.

We were concerned that the changes of team, team leader, rooms and work colleagues might affect the morale of staff. I thought that the allocation of staff to particular teams was generally well accepted by them. No particular problems arose except that we had to appoint a new team leader before we could be fully operational. There were no difficulties regarding our new team format either from the Department or other agencies. The DAM also thought that there was general acceptance from members of staff, except for initial reluctance from the specialist groups of staff, such as the OTs, who thought they might be better placed in the Duty/Assessment Team. She said that the allocation of staff to teams went well, given the limitations placed on us by staff numbers. On reflection she thought that there should have been more social workers placed in the Duty/Assessment Team. One problem that arose according to the DAM was that we were becoming more generic, when other areas were moving towards specialist team structures. Consequently, some people outside the office, such as the staff of hostels for

disabled people and for people with learning difficulties, might have preferred that we had had specialist teams relating directly to their area of work. The AAM said that staff accepted their allocation to teams. He thought that the OTs were concerned about being moved away from their team leader, who was the DAM. He thought that we had tried to foresee possible problems and avoid them. He mentioned, for example, although, a team had been created without the Team Leader being in position, staff anxieties had been reduced by their involvement in the selection of that Team Leader. He thought that, given the changes, the reorganisation took place quite amicably.

The team changes did bring some discontent among some staff. Social Worker A said that most of the anxieties that arose were personal and were largely resolved by negotiation and luck. He said that there were vacancies for social workers in the Area Centre at the time of the reorganisation. These provided opportunity for movement between teams, when appointments were made. For example, he was not happy with the team in which he was placed. He wanted to work with adult clients. He achieved this later by obtaining a specialist disability social worker post within the Area Centre. He felt that staff co-operation was obtained, because they had wanted the changes.

Social Worker B said that most of the staff were happy with their allocation to teams but there was some anxiety about what it would be like. He added, that there were anxieties about how people would be able to work together and how they would relate in the new teams. This was particularly so in the team that had no team leader until the newly appointed Team Leader arrived. He thought that the other teams were able to get down to sorting out their relationships quickly. He was initially unhappy and felt rejected by his previous Team Leader when he was not placed in her new team. He also pointed out, that before the appointment of the new Team Leader, the DAM and I split the supervision of the team between us. Consequently, he thought, there was no way in which the team could come together, before the new Team Leader arrived. He said "The team struggled; we did very well but we struggled." (he was a member of the team). He did think that the other generic team ended up with a more skilled group of staff. Social Worker C said that he had been happy with the team in which he had been placed. He thought that the supervision of the staff in the teams had improved with the changes.

The SSO said that staff had the opportunity to express their feelings about the changes and they were generally accepted. The OT said that the OTs had wanted to remain with the DAM because of the good relationship with her but this did not happen. She added that they thought that they had been used to fill up a team. She did not think that they had any particular links with the team in which they were placed and should have been in the Duty/Assessment Team. She did not think that there was any "vast unhappiness" among the OTs as they had an opportunity to say what their views were.

The AAAO mentioned the mutual support that staff gave and received from each other. She thought that there had been a reluctance among staff to change teams, as they did not want to lose the relationships they had made. She said that she could understand this and recalled that when the original administrative group came together, they all had children and "we got a lot of support from one another. Sometimes you came to work with something that seemed important and you were worried about but because you could talk to one another and laugh about it, you realised others were going through exactly the same situations. It made a lot of difference to us and presumably everyone is the same."

The DAM acknowledged that there were anxieties resulting from the reorganisation among staff. However, she thought that the AMT had "a high level of control of what was to happen and was able to keep such anxieties to a minimum. For example, uncertainties about what was happening were reduced, by the issuing of guidelines at each stage of the reorganisation regarding what we hoped to achieve and the processes involved in the reorganisation."

The reorganisation affected the AMT operation. I had to review the functions of the AMT with the appointment of a deputy to my position. Also, with the creation of three teams, the working arrangements that involved AMT members had to be reviewed and subsequently were changed. For example as mentioned above, I tried to avoid the need for much arbitration, which is usually needed when the transfer of work is required between teams. This can become a difficult process when teams are under pressure. It was for this reason that, given the eventual structure of the teams, it was decided that the transfer of cases would be decided upon within the AMT meeting. I had initially expected to set up a system under

which each team would take the referrals that it had taken when on duty. This was based on an original proposal to have three generic teams with each of them on duty on weekly rota. The AAM also mentioned the appointment of a DAM and a new Team Leader as effecting the operation of the AMT.

WHAT HAS HAPPENED SINCE THE REORGANISATION

This section asks questions relating to whether or not people thought that the objectives of the reorganisation had been obtained and how the reorganisation affected the operation of the Area Centre and the staff. Changes in service provision, consumer demand and unexpected changes were also considered.

I think that the objectives of the reorganisation were largely achieved. The teams operated more effectively and developed good working relationships within and between teams. The caseloads of the long-term generic teams became more truly generic, and there was more time to reflect on the work interests of the staff. We had a good reputation among other areas and could attract staff when vacancies arose. We were also able to respond quickly to public demand. The DAM appointment and the creation of the additional AAM were satisfactorily achieved. This meant that I could delegate more of my responsibilities and consequently widen my work horizons beyond the immediate demands of the Area Centre operation. There were no major changes in consumer demand following the reorganisation, except the growth in the child abuse work. Following the establishment of the teams it was seen to be practical to identify team clerks with them. However, we retained them in the central administrative office instead of placing them in the team rooms. This was to maintain their support networks among their colleagues. It was also considered advantageous for them to continue to have the direct support of the AAO.

I did arrange changes in the delegation of responsibilities particularly to other AMT members. It was agreed that one Generic Team Leader would supervise the Home Help Service and the other the Occupational Therapy Service. Previously, on different occasions, the Team Leader of the Duty/Assessment Team and myself supervised these. I also delegated to other members of the AMT, the authority for making decisions relating to financial matters such as those relating to work for

children, the provision of telephones, financial help for holidays for disabled persons and playgroup fees. There was also a greater sharing out of the liaison responsibilities with other agencies and within our own department.

Social Worker A thought that following the reorganisation, one generic team became biased towards child care work, while the other was biased towards work with adults. I think that this was possibly so, but not to a large degree; it was influenced by the interest of the team members. This was seen as of benefit to clients and one of the strengths of the team. Social Worker B thought that following the reorganisation the generic teams took on more short-term work than previously. He saw that transferring work from the Duty/Assessment Team to the generic teams, which had been difficult in the past now became a management exercise. "There were still problems of the Duty/Assessment Team hanging on to work longer than was advisable but less than in the past." This conflicts with the view of Social Worker A, who saw the team retaining cases as beneficial to clients. I think that both were partly right. The timing of such transfers is important; it should be in the client's best interest and not an administrative exercise. But delay in transfer of cases is an inherent problem of the duty/assessment systems. Social Worker C thought the changes in the team structure had smoothed the operation of the Area Centre by people being clearer about the functions of the various teams. The SSO said the increase from two to three teams seemed to work more effectively. There was also a greater provision of supervision because of the improved team leader/staff ratio. The OT thought that the generic teams were able to do more work with adults. As a result this type of work could be transferred more quickly from the duty system and consequently it became less bogged down with such work as in the past. At the same time, as the AAAO pointed out, given the time allowance of three months for a case to remain with the duty workers, it enabled much work to be resolved by these workers without the need for the case to be transferred.

After about two and a half years, the duty/assessment system started to founder. The original core group members, who were very committed to operating the system left. They were replaced by less experienced staff, who could not be used in all areas of work. For example, they were not qualified to do some work in the mental health field. It was also found that the core membership of the Duty Team required three members to cover for sickness and leave. We could not easily achieve this. This brought about a necessity to review and subsequently change the whole

operation of the duty system. We disbanded the core membership and distributed the two core social workers involved to the two generic teams. We placed all social workers on a duty rota operated by duty AAMs. The residual membership of the previous Duty/Assessment Team was formed into a team concentrating on developmental work. It comprised mainly specialist workers and was the responsibility of the DAM. Following this, there was an increase in the number of specialist posts given to the Area Centre. This was the same in other areas due to changes in legislation and Departmental policies. These were placed in the Development team.

The DAM thought that the size of the core membership of the Duty/Assessment Team was insufficient to sustain it, particularly, when the original core members left. She saw the main changes following the reorganisation were the attempts to resolve the problems around the duty system. She said that "impressionistically," she thought that caseloads became more generic. This was part of the aim of the reorganisation, but that some people became more generic than others did. The role of the DAM (her position) also changed. She said that she became increasingly involved in the developmental work of the Area Centre, while retaining overall responsibility for the duty system.

The AAM, as a team leader, thought that some caseloads had become more generic and there was more involvement in short terms work. He added that because his team became more generic, he also became more generic in knowledge, whereas his previous experience was mainly child care. He also became responsible for the home help service. He did not think that there had been any changes in consumer demand following the reorganisation. He also mentioned the changes in the duty system. The duty system changes were mentioned by most of those interviewed.

The OT said that the structure following the reorganisation did not have a long enough run to prove itself before changes with the duty system had to take place. She thought, and I would agree, that the newly established team with the new AAM/Team Leader became more generic than that of the existing AAM/Team Leader. She thought, and I agree, that the specialist workers appointed shortly following the reorganisation, for example the social workers for people with learning difficulties and that for the disabled persons, generated additional consumer

demand in these fields. This reduced the amount of work that was allocated to the generic social workers as these specialist workers absorbed most of this growth in demand. Some staff did not see their personal or group objectives being achieved. For example, the HHO said that the objectives of the HHOs had not been achieved. They did not feel part of the team they were in, which was what they had hoped. She did not think other members of in the team understood the work the HHOs were doing. She said that they should work to a senior HHO rather than a generic team leader. Also, they were too large a group to be part of a generic team.

REFLECTIONS ON THE REORGANISATION OF THE TOWNHAM AREA CENTRE.

When considering the choices of team structures, I saw generic teams as more flexible and adaptable to changes in client demand. However, there was a danger that because of the pressures to give priority to child care work, they could develop into, predominantly, child care teams. It was thought that a patch system would not work, due to the fragmented nature of the area and insufficient staff to maintain such a system. It would probably have meant two large patches based on the same geographical areas as the two Health Districts. This had its attractions but maintaining a balance of resources, work and staff between these patches would have been very difficult. A specialist team structure was of interest to some staff, particularly those staff who worked mainly with adults. But it was not a method of operation of interest to most members of staff. I also thought that a specialist team structure would mean that there would be a concentration of social workers in the child care teams to the disadvantage of work with adults. However, Departmental specialist facilities, such as day centres for disabled persons, found it difficult to liase with generic teams. These specialist units would have preferred specialist teams with which to identify. Yet, as seen elsewhere, the reality was that adult service teams were usually poorly staffed with social workers. Nevertheless, I agree that people working in specialist fields outside the Area Centre, might have found it easier to liase with team leaders with similar specialist responsibilities.

Most social workers, even in generic teams, had preferences for caseloads with a bias towards child care. Some social workers may have been influenced against a specialist structure out of fear of being placed in an adult service team. We should have forecast for staff the likely composition of team formats. For example, if we

had gone into a specialist team operation, the likelihood, as borne out by the structures of other areas, was most social workers would be placed in child care teams rather than adult service teams.

There was uncertainty among the staff about who made the decisions and the degree to which they were involved. Initially, I had an open mind about what the team format I would prefer but later, following informal discussions with other AMT members, I developed a preference for three generic teams. I did not share my initial views with the staff other than AMT members. In my discussions I was particularly interested in factors that supported my preferences. However, I aimed at a consensus of opinion of all the staff. The decision making process was therefore one of clarifying together aims and objectives and ensuring that any decision would be operationally efficient. As it happened, non-management staff greatly influenced the decision to have a two generic teams plus a duty/assessment team format. This was proposed by those in the existing Duty/Assessment Team who wished that a form of duty/assessment operation be retained. I think that the commitment of the core members of the new duty/assessment team was its strength and its weakness. When those committed to operating the system left, about two to three years later, the duty/assessment system had to be reviewed. It is possible that we understaffed the Duty/Assessment Team when it was set up. Consequently, we relied too much on the two core members of the team remaining in post.

We were uncertain as to how best to involve consumers and the public in the reorganisation process. I think, although they were not involved, their needs were still considered but possibly not to the same degree as if they had been present. Varying values were given to recommendations of staff, depending on the experience and knowledge of those who made them. The AAM suggested that when making decisions "It was important to take notice of the views of staff to achieve happy working situations and relationships. It is important to retain staff to get the work done. Therefore, we don't totally respond to public needs." I understand his reasons for saying this, but if such compromises are made, it is important that they are acknowledged. Also, that the overall balance favours the public receiving an appropriate service. Social Worker B mentioned that political ideologies were influential in the Area Centre. To generalise, the social workers to a large extent were to the left of the political centre while the administrative/clerical staff (again generally) were to the right. This had caused differences regarding the

value of Social Work on occasions, but it was an undercurrent rather than overt. I do not think that it was influential to the outcome of the reorganisation discussions.

I know that anxieties arose during the reorganisation, particularly among those who had been placed in the team that was to have the new AAM/Team Leader appointed. To help reduce the anxiety, I arranged for the staff forming that team to be involved in the appointment process of the AAM/ Team Leader. This did not involve them directly in the final decision making process. But it was arranged that members of the team, with the appointment panel, meet and talk to the applicants over an informal lunch meal. They were asked for their opinion of the applicants and these were considered when the decision was made on the appointment. There were dangers with this, which I recognised at the time. One had to rely on the staff being objective in their preferences regarding an appointment. That they might seek to have appointed as their team leader the person who appeared to them to be the least threatening. I had to rely on the team members to judge what leadership the team needed.

Although I hoped to meet the needs of most people in the reorganisation, some people gained and some lost out in the process. I gained, by obtaining a deputy to whom I could pass on some of my responsibilities. I saw the AAMs as having gained from the reorganisation, by having reduced numbers of staff in their teams to supervise. Also, by gaining the wider responsibilities they wanted. Most staff gained by being able to work in a generic way. They could have caseloads that reflected their interests, which was what most of them wanted. Those staff who wanted to work in specialist teams or patch systems lost out. As indicated above, the OTs and HHOs did not gain completely what they wanted. Some staff did leave after the reorganisation but I do not think that they left because of it. We had no difficulties recruiting staff following the reorganisation. Some prospective members of staff were attracted to the new structure with its opportunity to work generically. Social Worker A said we were always fully staffed, although the choice was limited. He added, "We have got away with it because the Area Centre had a good reputation as a work place." Social Worker B thought that the DAM had gained from the reorganisation. With the appointment of the additional team leader some of her previous responsibilities were shared out among the AAMs. He also thought that the Duty/Assessment Team had gained by their Team Leader (the DAM) being more available to them. He said the members of the new generic team had lost out

(he was in this team) by not having a team leader available to them at the time of the reorganisation.

I think that we planned the reorganisation in the right sequence. I also think that the timing was about right. It gave sufficient time to involve staff in the exploratory processes regarding the possible changes and the planning and implementing stages. If we had taken any longer there was a danger that staff could have lost interest and the reorganisation process its momentum. The DAM thought that the planning of the reorganisation was effective and in a logical progression. She said, "Having started (the process) you had to follow it through and adapt as changes brought about unforeseen developments." She added, "We had no spare time to speed things up and it could have taken longer."

In considering what should have been done differently, I think that our objectives should have been clearer and the consequences of particular changes more considered. For example, we should have realised what might happen if the two core members of the Duty/Assessment Team left. I also think that I should have been more open from the start about what my preferences were regarding the future Area Centre team structure. I also think that we should have sought out the views of our clients, the public and other agencies more. The DAM thought that we should have done a user survey, to get a clearer view about what they thought was needed. We could have appointed the new additional AAM/Team Leader before the reorganisation, so that he could have been fully involved. Our thinking regarding this at the time, was that waiting for the appointment to be made would greatly delay things. We decided that we wanted to move ahead on the team structure, so that we knew the type of experience we would need in the new Team Leader. I thought that I had to appoint the DAM before the reorganisation, to enable us (AMT) to consider how best to use this position. The decision that the DAM would lead a team was of major importance.

The HHOs were clear that they wanted to work as a team, not just belong to a team. I think they were right in suggesting that being within a team would improve communication between them and their fellow team members, but it probably would not extend beyond that particular team. I think that following the reorganisation, they remained a separate group within the generic team. This was because they were specialists in their work, and because being four in number, were a fairly large

group that had a group identity. Again, the OTs were also a large specialist group who could express their views well. At the time of the reorganisation, they were the only staff other than social workers who were required to have a professional qualification. However, at that time, no OT had been promoted to the higher fieldwork management grades. This was a source of frustration for them. They saw themselves as supervised by team managers who did not share their professional knowledge or skills.

I did arrange for the operation of the new structure to be reviewed, but it was not a complete review. This was done by the new AMT looking at particular aspects of the operation of the Area Centre. It included an examination of the duty/assessment system, the transfer of work between teams and the procedures of the AMT. The review lead to the changes of the whole of the operation of the duty/assessment system. The duty system is a service that is difficult to get right and to the satisfaction of everyone. However, it is essential that it operates effectively, as it can be the first and only contact the public has with the Social Services. The DAM's advice to others considering reorganising was "while people needed to be involved in the process of the reorganisation, it is also important to exercise managerial control over the process." She thought that people wanted managers to make decisions and take responsibility for those decisions. Managers must also have a sense of ownership of the decisions made. She added "If we did it now, giving the changes in policies that have taken place, we would have involved the consumers more." The AAM also said that the reorganisation had been reviewed, particularly in relation to the duty system. His advice to others was, to aim to strike a balance between trying to consult with staff and giving a firm management lead. Social Worker A thought that the reorganisation had been reviewed but not formally. He saw the review as a continuous process following on from the reorganisation. His advice to others stressed the importance of obtaining statistical information on which to base objectives, see what was happening nationally and the possible effects of any new legislation. The advice of Social Worker B to others was to follow a similar process of reorganisation to us. Be confident about what you are doing, involve people as much as possible and take firm management decisions. Social Worker C said in his view all organisations were like a wheel and things changed back to what existed in the past. The SSO's advice would be that consultation was very important between the AMT and the

Area Centre Staff and that "You should encourage people to voice their opinions rather than complain outside the working groups."

The reorganisation was a challenging exercise for all of those involved. It had the latent function of making all of us more aware of what each of us had to contribute to the operation of the Area Centre. My advice to others contemplating a reorganisation would be, to be very clear about what are your objectives and the long term effect of any proposed changes. Start your planning with a clean sheet and consider the ideal situation. Examine the geography and demographic features of the area and how best to provide a service given these aspects. Use what information is available to help in the process of reorganisation or learn from what others have done elsewhere. Decide what services should be provided and by whom to meet the needs of clients and the public. Consider using the project management methods including critical path analysis at the beginning to help control the process of the reorganisation. Obtain any specialist knowledge that is available to help formulate plans. Try to make roles and responsibilities in the future organisation clear and do not rely too much on the need for continuous negotiation regarding work issues. Involve staff and consumers early and at all stages but be clear about what degree of influence/power they have in the outcome.

CHAPTER FIVE

SOUTHAM AREA CENTRE

The reorganisation of the Southam Area Centre commenced in April 1986. There had been informal discussions among members of the AMT before this. Initially a staff meeting held to introduce the proposal to reorganise the Area Centre to the staff. The planning was completed in December 1986 and the decisions implemented by February 1987.

KEY INFORMANTS INTERVIEWED

The interviews of the key informants took place in May 1989. I had hoped to interview more than the six key informants in the Southam Area Centre. However, the AM found that he could not arrange this, as some staff had left since the reorganisation and others were under considerable work pressures. Those people interviewed included one each of the following forms of staff:

- Area Manager
- Assistant Area Manager
- Social Worker
- Social Services Officer
- Home Help Organiser
- Area Administrative Office

The Southam Area Centre covered a geographical area within the boundaries of a City. The population was about 90,000. It was an area with rapid council housing growth, particularly on its outskirts. The other housing, close to the Southam Area Centre, was mainly property built before the Second World War. Much of this was below the average price for the city as a whole. To the North of the Area Centre

was a large, well-established, area of high cost property. It was considered a busy Area Centre both by those working in it and by others in the Department. The area had a high incidence of child care problems, including children who had been abused. This resulted in high caseloads of child abuse work for some social workers. The Area Centre was in a main local shopping area and had many people calling at the office with requests for services.

THE PREVIOUS STRUCTURES

The AM said that prior to the reorganisation the Area Centre comprised an intake team and two long-term teams. The long-term teams were in theory generic in their work content but in practice there was a strong emphasis on childcare work. The specialist workers were said to be mainly "bolted on" to the long-term teams, for example there was a HHO in each team. The Administrative Officer saw her staff as a further team.

ORIGINS OF THE REORGANISATION

The AM saw the reorganisation as being triggered by the allocation of further AAM in March 1986. The AMT had been aware of the need to review the organisation of the Area Centre. The provision of the additional AAM post gave them more scope to make changes. The AM acknowledged that adult clients had been "getting a bad deal". In addition, he thought that there had been a momentum developing in child care policies, particularly, that relating to child abuse, indicating the need for a review of the operating procedures. Also, there had been an increased stress within the Department on the importance of appropriate supervision of staff.

The AAM saw the pressures of client demand for services, as well as the prospect of an additional team leader as prime causes for the reorganisation. She stressed the difficulties that the intake team had faced. This was not only the result of a rapid increase in the referral rate but also because the complexity of the work had increased, particularly that relating to child sexual abuse work. She said that "Some sections of clients lost out from the generic team operation. It was thought that specialist teams might improve the situation." She added that before the

reorganisation, the work was dominated by long term child care work. This reduced the time available for other areas of work. She thought child care standards were good enough but support to long term fostering situations and residential care for children started to "drift" due to the acute child care pressures. At the same time, there was an instance of a child dying in foster care: this brought home the importance of keeping to departmental child care practice requirements. She saw adult client work as having little priority and thought that the reorganisation was an attempt to provide better services for all client groups. Prior to the reorganisation, she was an acting team leader of the Intake Team.

The Social Worker and the SSO also saw the prospect of an additional team leader as instrumental in bringing about the decision to reorganise. The Social Worker thought that the reorganisation started with the objective to improve services to clients and to consider the possible benefits of specialisation in achieving this. The SSO saw that work with the elderly (with whom she mainly dealt) had become a low priority and did not fit in well in a generic team dominated by child care work. She saw the need to resolve this as a reason for the review of the team structures. The HHO also saw the reorganisation as an attempt to give better services to adults. She saw specialist teams as doing this.

OBJECTIVES OF THE REORGANISATION

The AM said that the process of consultation was started by the setting up of a working party. Each of the existing teams nominated people to the working party. It was agreed that the members of the working party would consult with colleagues. He said that different people came for particular issues.

The AM said that the objectives that he gave to the working party were:

A. To re-examine the organisation and deployment of our fieldwork and domiciliary services in the light of an impending appointment of an additional AAM.

B To propose a structure that maximises the positive features of the present Area Centre structure and encompassed the needs referred to in "A" above.

The AAM, who was a member of the working party, saw more specific objectives leading on from those stated by the AM. These were:

1. To make the intake of work more efficient.
2. To improve the standards of child protection.
3. To improve standards of work with children and families.
4. To improve strategic planning.
5. To give more priority to services for adults.

The Social Worker was also a member of the working party said that the AMT had presented three team model options for the reorganisation at the beginning of the working party meetings. Her view was that, although, everyone was involved in the discussions, or given the opportunity to do so, the AMT had "homed in on a model and sought to obtain a majority agreement to this end." The working party was to consider the possible future structures of teams and to represent the views of their teams at these meetings. The Intake Team came up with a different model to those of the three proposed. This was acceptable, as you could consider other alternatives. The information of the working party and sub working parties was collated and fed into an Area Centre reorganisation training/working day. The recommendations from that day went to the AMT for a decision. The HHO, SSO and AAO thought that all the opinions of all the staff were listened to, but felt that the AMT had the strongest influence in the process of the reorganisation.

The AAM said that the objectives were determined by AMT and taken on by the other staff. She said that generally they were trying to give a better service to the public, although no consumer research was carried out. The needs of the staff were recognised as one of the reasons to consider reorganising. This was in response to them saying that they couldn't cope with the work pressures and were embarrassed by the service they gave to clients. The needs of the Department were not considered at all. Other agencies were involved peripherally concerning child protection liaison aspects but little else.

The Social Worker saw the reorganisation as an attempt to provide a better service in general and the work for adults was to be given a greater focus. She hoped that it would make the office more of a working unit and provide more unity among staff.

The SSO also said that the restructuring was an attempt to give more priority to adults as the services to them were inadequate in the generic teams. The HHO thought that the objectives were a better all round services but, particularly, to improve the services for the elderly. The staff seemed to see the objectives of the reorganisation in terms of meeting their own interests if they improved services to the client groups they served.

The AM said that the working party had nine meetings and a report was produced with recommendations regarding the future organisation of the Area Centre. The working party report was the basis of the process leading to the AMT proposals regarding the reorganisation. He added that he had found it difficult to balance the management responsibilities and consultative aspects of the reorganisation. He thought that they did not get this balance right. He said that people claimed that there were too many boundaries that restricted discussion. The AAM said that there had been a formal and informal process to the reorganisation. For example, initially there had been informal discussions among AMT members, regarding the possibilities of changing the teams. She added, "There were many suggestions on the table about what should be changed, but not enough structure in the discussions to give many of them weight." Following these, the working parties were set up.

The AM acknowledged that the public was not consulted about the objectives of the reorganisation and neither did other agencies "figure much". He stressed that "it was a staff led Social Services reorganisation." It was decided that it was to be an AMT controlled reorganisation but involving the staff group in formulating the reorganisation plans. The AM was in an acting position at the time of the reorganisation and said that he felt a "need to establish control." Just before the reorganisation he had gone into hospital as the DAM and had come back as the Acting Area Manager and started the reorganisation discussions. He asked the question "Do new brooms sweep clean?" He added that as a team leader (when he was DAM) he had little real influence, being unable to affect how other people managed their teams. Although his previous AM was personally very supportive, he found that "support came from one's own team rather than from the AMT." This feeling of isolation among previous AMT members was also mentioned by the AAM. She had been the previous team leader of the Intake Team. She considered a major objective in the reorganisation was to "take the pressure off" that team. Prior

to the reorganisation she had found the AMT members "uninterested and defensive regarding the stresses upon the Intake Team and herself. The reorganisation opened this up to discussion and review."

INFLUENCES

The AM thought that they had been influenced by statistics, particularly, by those relating to the number of children in care. Also by the number of reviews not done because of the work pressures. There was also concern about the number of children home on trial and staff having insufficient time to visit them. Also, by parents not being involved in planning and abused children not being visited. He said that there had been demographic changes in the area resulting in more children coming into care. He added that they had acknowledged that the elderly had received a "lousy" service. The AAM said they considered the statistics of a research document in the working party but only superficially. They did not understand the statistics, and thought that they should have used a statistician to advise them. They had been influenced by the uneven cover provided by the NSPCC to the area that time. This caused them to have to consider alternative provisions. They were also influenced by a departmental report relating to child protection. Before its production there had been a lack of clarity about child protection work procedures. She also saw as influential the withdrawal of the intermediate treatment work with young offenders from the Area Centre. There was a consequent loss of most of the work with children involved in offending.

The Social Worker was not sure of any social need indicators used to help with the reorganisation. She saw the reorganisation as a process of tightening up and using more economically the resources and skills available within the Area Centre. The SSO saw statistics as influential indicators of demand for services that was not being met. For example, they showed the number of very elderly people who could be at risk. No priority had been given to the elderly in the past. She said," we fought for that in our team." The AAO indicated that the working party had statistics on client groups in the community and a breakdown of referrals in the area. The AAO added, "The reorganisation started with the belief that the generic social worker operation was not the complete answer to providing services and social workers were already beginning to specialise."

TIMING

The AM said that they didn't plan a time scale. First they presented a report to the staff from AMT. This gave the AMT's proposals for reorganising the Area Centre. This was followed by the setting up of a working party to look at the AMT proposals and make recommendations. The report of the working party went to the AMT. This was then presented to the Area Centre staff as a whole. Decisions were then made. These were followed by a training day regarding the implementation of the decisions. Finally the reorganisation was put into operation. The AAM's account agreed with this. But she stressed that the timing of the implementation of the decisions was linked to the appointment of staff to vacancies. They were particularly concerned about the appointment of the new additional AAM/Team Leader. They could then identify the AAMs with relevant specialist teams.

The Social Worker saw the time scale of the reorganisation more as it related to the ways it affected the operational work of the Area Centre. For example, there was the need to transfer caseloads. There was much pruning of workloads, "much dead wood" was found. They had help from the recently established Juvenile Justice Unit, in that some child care work had already been transferred to them. The transfer of cases took longer than expected, lasting over 6-7 months. The actual decisions regarding transferring cases were quickly established. But they had the problems because of the shortage of staff available to take on the work needing to be transferred to different teams.

DATA SOURCES AND PRIORITIES

The AM said that he had asked Team Leaders to gather relevant information. This was all "in house" data. They used current caseload information but they did not consider it very reliable. They had a priority listing regarding what work should be done but it was not very formal. It was mainly concerned with children in care and their rights, work with children at risk and the public's right to be treated considerately. He said, "Everyone knows a priority but can't write it down. A low priority can become a high priority quickly, for example if it becomes the basis of a complaint." He added that there were categories of client related work that had to deal with immediately. These included children at risk and what are described as

"life and limb" situations, these have to be given a high priority. For him good supervision of staff of staff had a high priority. He said that this was reflected in the appointments he made. He chose team leaders capable of doing this. The AAM added that priorities were not written down but statutory work was considered a high priority. Part of the reasoning behind the decision to reorganise was based on the aim to raise the priority of work with adults.

The other staff interviewed knew statistical information was used regarding the reorganisation, but had little knowledge of any prioritisation of work. The Social Worker said that there were statistics available for the working party and information was sought from other areas. For example they had the projected demographic figures for adults for the area. She thought that the Area Centre did have work priorities but was unclear what they were. The AAO stated that there had been information on referrals, types of referral, enquiries, caseload figures and population statistics. But again she did not know of any formal work priority system. She said "AMT must have something but it is not written down."

DECISION MAKING

The AM said that the team structure chosen for the Area Centre "emerged." He said that the decisions were brought about to meet the needs that they had identified. The number of team leaders determined the choices of teams that could be created. He said that the AMT decided that they were not going to scrap everything but rather built on what they had. He added that the AMT knew the number of teams they would have and what work had to be carried out. He stressed that it was not a service delivery but needs led reorganisation. The AAM had a preference for two intake teams because of the pressures on intake work, but went along with AMT colleagues and supported having only one. She said that in the working party people got very defensive and concerned about their areas of work, but through time these differences were gradually resolved.

The Social Worker said that there were strong feelings about specialisation. Some saw it as de-skilling. They considered the idea of having intake work on a continuous duty rota basis involving all staff but this was rejected as most social workers were against being on a duty rota. There were some variations considered

including the retention of a generic team plus a child care team. The SSO said that different forms of team structure were considered and that they were not sure which would be best. It seemed right at the end to move into specialist teams. The AAO said that there had been a strong feeling for improving adult services.

The AM saw the working party as having some influence in the decision making but he was clear that the AMT made the final decisions. He said that the staff only made recommendations. He added, "There were some niggles about this." The AAM thought that the AMT was unclear about what they were letting the working party do, what their brief was and what was the status of their recommendations.

The Social Worker acknowledged involvement of staff but saw the views of AMT members as the most powerful influence. The SSO, and HHO also thought that staff were involved in the decision making but were unclear about the extent.

The AM agreed that the AMT had the most influence when decisions were made, but said that they had been receptive to the views of others. He gave as an example of this, that they had recognised the strong preferences expressed by the HHOs and OTs about what team they should be in. The AAM thought that an equal value was given to the views expressed by staff no matter their status. Although there were many suggestions put forward, usually there was not enough structure in the proposals for them to be influential. The views were raised in different forms, for example they included individual contributions in discussion groups to proposals put formally on paper and handed out by special interest groups. The Social Worker acknowledged that AMT was a powerful group in putting their plans forward but still thought that all had an opportunity to contribute to "the democratic view." she acknowledged that groups such as the intake team, were influential in stating their cases. The SSO also thought that all people were listened to, but said that "regardless of what we said, the AMT was the strongest voice." The HHO thought that the social workers' preferences were given the strongest acknowledgement. The AAO also acknowledged the influence of groups over individuals particularly, If in the working party, the group had an affinity to that of the group leader.

The AM was asked how the needs of the Department, consumers and staff were represented. He said that the working party represented the views of the staff of the Area Centre. The proposals were discussed with a Headquarters'

representative but the consumers' views were not sought directly. The AAM thought that views other than those of the staff, were put forward largely by chance representation. This view was supported by the Social Worker who said that social workers represented their own views, but assumptions were made about the views of consumers. The AAO described this as the views of the consumers being looked at "second-hand." It was acknowledged by the AM that he made the final decisions regarding restructuring but it was based on a consensus view of the AMT as a whole. This was also the view of the AAM, who said that there had been an AMT decision-making day. The Social Worker thought the decisions had been influenced by the working party. The SSO seemed less sure of this. She said that "at the beginning one expected much involvement but at the end the decision-making was taken away from us." She indicated that she was not clear who made the decisions; she thought possibly the AM or AMT as a whole. She said that no vote was taken involving all the staff. The Social Worker mentioned that the AM presented a final draft report to all the staff indicating what had been decided.

The AM said that there were disadvantages in the other structures considered. For example, he thought that a patch system required too great a spread of responsibility and expertise right across the teams. He thought the choice of specialist teams "gave the clients a better deal." He added that some staff had wanted to go back to basic principles and review what was needed in an area centre, rather than building on to what they had, which was what he decided. The AAM thought the decision to go into specialist teams did not meet all their objectives. For example, It did not meet the objectives of the intake team. However, she recognised that it could reduce the pressures on the Intake Team Leader to a manageable level, by moving to other teams some child protection work and statutory child care work.

The AM said that decisions were communicated to staff at the Area Centre training day and by the circulation of a report. This was enlarged upon by the AAM, who said that minutes of an AMT "decision making day" were circulated and discussed at team meetings. It was generally accepted that the Area Centre training day and the circulation of the paper by the AM was the main way in which the decisions were communicated. Some saw the training day as part of the decision making process.

CHANGES IN THE ROLES OF TEAMS

The AM said that with the reorganisation, they moved from 3 to 4 teams. This was made possible by the provision of an additional team leader. The names given to the teams were the Adult Services Team, the Community Child Care Team, the Child Care and Development and the Intake Team. He said that it was also decided that the Intake Team would do the duty work. There would be six social workers doing duty on a rota basis, two to three people on duty at any one time The numbers tend to fluctuate. The Intake Team did most of the short-term work. The allocation of work to the appropriate team was decided by the four team leaders meeting at fortnightly intervals. They also decided about the transfer of work between teams when required. He added that the specialist teams had clearly defined roles. Because of the nature of particular cases, for example adoption situations and care proceedings, there was a need for flexibility, so that the clients were not affected by too rigid rules regarding the transferring of cases at specific times. According to the AAM the transfer of work from the Intake Team to the Adult Services Team was automatic. That to the child care teams was more problematic, as there was more than one team dealing with child care matters. Each team devised its own allocation procedures. For example, with intake work, the AAM said she would not let work go to social workers without the relevant experience. Work coming from other Area Centres went first to the AMT for acceptance. Then it was transferred to the appropriate team. If the transfer cannot take place because of difficulties in the appropriate long-term team, the intake team will help on a crisis basis.

The Social Worker said that she and her social worker colleagues, from the previous generic long term teams, had hoped the reorganisation would enable the Area Centre "to home in" on particular areas of child care need. Whereas, they saw The Child Care and Development Team, that covered work with children in residential care, as only dealing with situations that were "at the end of the road for children, with no movement." It was thought the Community and Child Care Team was more dynamic. Despite her reservations, when the opportunity arose she opted to go into the Child Care and Development Team as that was where her interests lay. She was concerned about the past lack of planning or "of drifting" in this area of child care work. She hoped that this would be resolved but had her doubts. The team established a charter for children in long term residential care to

try to avoid past problems. She said that allocation of work was less of a problem than it had been in the past. In her team, team meetings were used to decide upon allocation to work, but work was also given to individuals in supervision sessions. She said that the system was fairly loose and relied on the team leader knowing the workload of individuals. Each team member had workload weighting and each fortnight this would be discussed and cases allocated according to the team workload weighting system. To the HHO, allocation and transfer of work did not arise in the same way. All home help work for her geographical patch came and remained with her.

The re-allocation of rooms as the result of the reorganisation caused difficulties. The AM mentioned the resistance from the HHOs to being in an open plan room. Before this, they had their own room. This situation was caused by the need to create a room for the additional team. There was also a need for a room for the additional AAM/Team Leader. The AAM said that there had been a problem of fitting everyone into the building. She said, "People hated physically moving and this created bad feeling." She thought that they had not had enough space to accommodate the additional teams adequately but that they had made good use of the space available.

The Social Worker was more specific. Her description was of a more hectic situation. She said that the physical movement of the teams and people coincided with telephone system changes and decoration taking place in the building. They did the physical moving of furniture themselves. She said "There was some disquiet about having to do this." She did not know why contractors were not used for moving blocks of desks. There had been arguments about where desks would be situated. She would have valued outside advice. She thought that the result was that the Child Care teams were squashed up together, creating noisy working conditions. The SSO thought that her team (Adults Services) got the best of the room space. She also mentioned the two child care teams being put into a room area, where there had been one team before, creating a "dreadful noise problem." One team leader did not have an office, making supervision of staff difficult.

The AM saw no major changes in Area Centre work priorities following the reorganisation. Certainly there were no changes of categories of "at risk." The AAM and others interviewed, pointed out the increased importance placed on

working with adult clients as opposed to child centred work as a change in work priorities. Regarding changes of policies, The AM said, that with the reorganisation there was an attempt to provide a more open service. He said, "It was a trend rather than an overt policy." For example, a client could change his social worker if he wishes to do so. There was also much more internal openness. An instance of this was the greater awareness of staff views, due to their having better representation within the AMT. He added that there was now more delegation of authority to others in the Area Centre. But he stressed staff had to recognise the accountability that went with such delegation. The AAM saw the changes in policy more specifically as relating to client work. For example, there was a greater emphasis on work with adults, an increased emphasis on the movement of children in long term care towards permanency (permanent care placements) and the child protection work.

The Social Worker saw no changes in policy but thought that the new structure enabled them to work more efficiently. She said that this did not make a great deal of difference to clients, except in the Child Care and Development Team, which improved its provision for such children. She then referred back to the absence of a social worker in the Adult Team, and thought that until it was agreed to make such an appointment, little improvement in adult service provision would take place. She added that the Adult Team was one of individuals rather than a team, and thought the provision of a social worker would "help to bring them together."

The AAM pointed out that there had been an increase in the number of teams without additional clerical support. The clerical staff had been "quite turbulent" and "felt powerless and not consulted" particularly when the main thrust of the discussion was in professional social work terms. This was also recognised by the Social Worker and SSO, who also thought that the administrative staff had to accept many changes, particularly, the team clerks who had to cope with changes of teams and associated change of file location and file formats. The HHO felt relieved at continuing with the same clerical support. The AAO did not see the changes as greatly affecting her team, except that an additional team clerk was needed due to the changes but no additional post provided. Consequently, they had to split a full-time post into two to give half clerical support to two teams.

STAFF CHANGES

The AM said that staff were allocated to teams largely by self selection, that is, that they were placed in the teams they wished to be in. The AAM confirmed this. She thought that most staff were satisfied with their team placements. This was also the opinion of the Social Worker. However, she repeated that some staff saw themselves as disadvantaged by no longer being allowed to carry out certain practice skills due to the narrowing of their work by being in specialist teams. She added that because there were two child care teams, those opting for this area of specialisation had to decide which of these teams to choose. Most people initially considered going into the Community Child Care Team, as this was considered the more prestigious. She thought that there had been little change in the number of people working in child care. The SSO (who opted for the Adult Services Team) saw things differently. She said that there had been many problems and saw the Adult Services Team as a dumping ground. Many people had no choice and were placed in teams because of their specialities. She referred to a letter that had been sent by staff to the AMT saying that those in the Adult Team had been "just thrown together." This was exacerbated, according to her, by the Team being without a team leader for three months and then it took them a further six months to settle down as a team. She added that without a team leader, there was no direction given to the team. She thought that there had been much more discussion and consultation about placing people in the child care teams.

Regarding the specialist groups, the AAM said that it was decided that the OTs would be in the intake team, as this was a team with which they worked closely. This was something for which OTs had fought strongly. The HHOs were previously supervised as a separate group. They were placed in the new Adult Services Team, although they did not want to be in a "big team." The HHOs saw themselves as a group in their own right and did not feel part of the bigger team. The AAM added that the individual specialists fitted naturally into the new teams depending upon whether their work was child care or adult client work oriented.

The AM and AAM acknowledged the reluctance of some staff to change. The AAM said that there had been some bad feelings, but generally people were happy about it afterwards. She acknowledged that the Adult Services Team did not feel that were really a team because of the variation in specialisations it contained.

However, she added, previously these people had no team at all with which to identify. The Social Worker thought that most of the problems caused by resistance to change had been ironed out before the reorganisation took place.

Regarding the AMT after reorganisation, the AM said that different responsibilities were allocated. He said, "I claimed them more as my group. We get on well together." He acknowledged that while most of them were team leaders and represented their teams, they were also committed members of the AMT. The AAM said that because of vacancies and the recruitment of the additional Team Leader, three new people joined the AMT at the time of reorganisation. The AM saw this as having been an advantage as it enabled him to select new team leaders for specific specialist teams. The SSO thought that the AMT had become much more of a team. She said that previously it had been a meeting of team leaders and not a management team.

The AM said that there were many understandable anxieties associated with the changes brought about by the reorganisation. Many of these were simple ones such as "what team will I be in and where will I sit." He thought that most were dealt with by the involvement and participation of staff in the processes of the reorganisation. The AAM said that the changes of the case loads of the staff in new teams had to be done gently and gradually. This included the closing of some cases and the transfer of others to different social workers. This can cause stress to those staff involved because of their commitment to their existing "cases."

The AM considered that he had obtained staff co-operation and commitment during the reorganisation by being open, and letting them know what was planned. He said that he tried to involve all staff in all the processes that led up to the rorganisation and he thought that this had been successful. This was also the view of the AAM. The social worker said that the extent to which the staff were affected by the changes varied considerably. Some people had to change office, work group, team leader and type of work. The Social Worker added the staff generally had felt that there had been a need for change and reassessment, and this helped to gain their commitment to the reorganisation. Even so, it did cause considerable anxiety for some staff.

WHAT HAS HAPPENED SINCE RESTRUCTURING

The AM thought that generally the objectives of the reorganisation had been achieved. As an indication of this he cited the success of the work of the Community Child Care Team. The AAM thought that the caseload statistics showed an improved competence of staff to do the work. She thought that specialisation had brought this about and with it a more relaxed approach to work. At the same time, she acknowledged that people lacked the generic experience of social service work. Consequently, there was a greater need to "move cases around" than there was before. This was necessary in order to match the work to the experience of the staff. The Social Worker thought that in general the objectives of the reorganisation had been achieved, but there remained problems. She thought that the members of the Adult Services Team had still not "gelled" as a team. Also, there was the need for a clearer demarcation line between the work of the two child care teams. Furthermore, there was a need to review the way the Intake Team operates and how this meets the expectations of the other teams which have this work transferred to them at a later stage. The SSO said that, "Now everyone knows what is the role of their team." She thought that there were better assessments being carried out, particularly in the Adult Services Team.

The AM also thought that specialist teams enabled people to have clearer roles. This resulted in them working better together, and in teams that gave them both support and status. The AAM saw an increased awareness in child protection work had resulted from being it being the responsibility of a specialist team. The SSO saw a trend in the increased referral rate of elderly/frail people needing help since the reorganisation. She thought that this was probably the result of the Adult Services Team advertising its services more to other agencies.

The AM said that as a result of the reorganisation, some of his work was delegated the DAM, such as that relating to budgeting and child protection work. The AAM saw such delegation as someone being asked to "take on more work," not part of a formal planning process. The Social Worker thought that any increased delegation of responsibility remained within the AMT.

There were a number of unexpected consequences following the reorganisation. The AM thought that problems remained relating to the teams. As examples, there

was the lack of Social Work support in the Adult Services Team, and the Intake team needed a better staffing level. According to the AAM, a bottle neck developed in the work of the Care and Development Team concerning children in foster parent placements. Also, considerable stress was created by the increase in child protection work to a level they did not anticipate. She said that social workers found that they were "constantly imposing themselves on families." There was also stress resulting from making difficult decisions and because they were exclusively dealing with the 'nasty stuff' without the relief of 'nice cases'. She added "You were an authority figure wherever you went. The stress was caused more by the nature of the work than by the volume." The AAM added there remained a lack of unity in the Adult Services Team.

The AM thought that staff who might have left due to the reorganisation, were dissuaded from so doing by being shown the positive results of the changes such as the reduction in work pressures. The AAM did not think that staff left due to the reorganisation, although she did say some did not "fit in" and left. The Social Worker was less certain. She thought that staff did leave but she was not certain to what extent this was directly related to the reorganisation. Her view was that with specialist teams some people remained because it was work that interested them. Others thought that they needed to widen their experience and to move on to other interests. The others interviewed presented similar views. The AAM did not think that there had been any special problems with recruiting people to the specialist teams. The Social Worker thought that it was now easier to "sell the vacancies" as most people come into social work because of an interest in specific client groups. The SSO said that, although there were some difficulties in recruitment, it was better to advertise vacancies in an adult service team rather than a generic team.

The AM thought that the reorganisation had been planned in the right sequence and took about the right amount of time. The AAM agreed with this. She added that they should have given more thought to planning how long it should take. She said "You can't spend over a year reorganising an area centre. You must, aim for a specific duration and state that at the end of that period, decisions will be made." When asked what should have been done differently, the AM thought that he should have adopted a less controlling and more relaxed approach. The AAM thought that the working party and sub groups should have been given a clearer indication of what was expected from them. She also thought that there should

have been more awareness of the possible work pressures on the new teams. The SSO thought that the reorganisation should have only taken three months, "rather than lingering on for about a year." She pointed out that the time of the year when discussions started was critical. People who were on annual leave missed working party meetings and got out of touch. The AAO thought that the teams themselves should have been given the opportunity to draw up their own ideas. These should have been considered alongside those of the working party.

The AM said that the reorganisation was communicated to some agencies but not many. For example, the G.P's were sent information. He said that a review of the reorganisation had been carried out in June 1988. This had been done with the help of a Headquarters' training officer. Everyone in the Area Centre was involved. He thought the morning of the review day had been successful. But in the afternoon staff tended to concentrate on negative aspects of the reorganisation. These were particularly about the stresses in the Intake and Community Child Care teams. The AAM did not think they should have had the Training Section to help manage the study day. She said "People got very depressed; it was not managed well. Staff used it as an excuse to wallow in self pity; it was terrible. As can happen, a couple of powerful people managed to drag the whole group down. The issues raised were later taken up by the Area Management Team." The Social Worker thought that the problems that arose on the study day, were really about the pressure of work, staff shortages and personalities rather than the reorganisation itself. The SSO, thought that the Team Leaders were blamed for the problems. She said, " They seemed to have become very distant from their team members." She described how during the review day, " We were put into small groups without their Team Leaders. We only talked about the negative matters. This was what was fed back to the main meeting and it became very emotional." Following the study day, the AM said that there was a special AMT meeting to look at the concerns that arose on the day. This included looking at the duty system, occupational stress, unallocated work, common standards of work and team isolation.

The AM acknowledged that he had found it difficult to balance the management responsibilities and consultative aspects of the reorganisation. He said that they did not get this balance right and staff complained that were too many boundaries that restricted discussion. However, his advice to others considering reorganising was to "Allow plenty of time and don't hand over management authority to staff. That is

keep control of the reorganisation but be prepared for some 'horse Trading'." He thought that "A participative style was essential while still maintaining control."

REFLECTIONS ON THE REORGANISATION OF THE SOUTHAM AREA CENTRE

As in Townham Area Centre, the triggering factor for the reorganisation in Southam Area Centre was the provision of additional management staff. In the Southam Area Centre, it was an additional AAM who could also be used as a team leader. The objectives and limits of the reorganisation were decided by the AMT prior to the involvement of staff. Some staff thought that they should have been involved in the setting of the objectives, and the reorganisation should have been more fundamental, rather than largely building on what already existed. Specialisation was seen by some as possible de-skilling and they were concerned about how this would affect their promotion prospects or ability to move to another Authority.

The AM acknowledged that the AMT had the most influence regarding decision making in the reorganisation process. The AM was clear that the AMT made the final decision and although staff had some influence, they only made recommendations. The staff interviewed not aware of the degree to which they would be involved in the decision making at the time of the reorganisation. AMT was unclear about what they were letting the working party do, what their was brief and what was the status of their recommendations. AMT also limited the choices open for consideration by the working parties. The AM appeared to try to maintain an uneasy balance between allowing staff involvement and what he saw as management responsibilities in the reorganisation process. However, the AM pointed out the receptiveness given to the views expressed by some staff. This was particularly true with groups such as the OTs. They put forward a group view and consequently seemed to be more influential than people acting as individuals. This was much the same in the other Area Centres researched. This would suggest that views that most likely to be influential were those presented by a unified work group.

It was thought that the creation of the specialist teams would enable staff to identify with particular areas of work. Also, in creating specialist teams had improved the competence of staff and brought with it a more relaxed approach to work. At the same time it was acknowledged that people lacked the generic experience of social

service work. As a consequence, there is a greater need to move cases around than before to match the experience people had to particular cases. However, It was thought that the referrals taken by duty officers following the move into specialist teams were clearer about what service was being requested. It could also be argued that with specialisation, the work allocated to staff, would be made by a team leader clearer of her role and allocated to a team with a better knowledge of the resources available to resolve the problems. Nevertheless, It seems that the advantages of specialised knowledge may have been partly offset by reduced flexibility of operation.

The AM and the AAM both commented that they had not found the previous AMT supportive. It is interesting to speculate why they got more support from the team they supervised than from their fellow AMT members. It may have been that given that AMT is a hierarchical group, the members had to show competence and confidence to their AM and Team Leader colleagues. With their teams, they could possibly to discuss problems at a professional level.

There were a number of unexpected consequences following the reorganisation. Concern was expressed in the interviews about the pressures from child protection work. Because of specialisation, the team covering this work got little relief from these pressures. The creation of the Adult Services Team seemed to increase the emphasis on that area of work. It also gave its members a forum for discussion and a channel through the team leader to influence AMT planning. However, the team was described as a dumping ground for staff who could not be identified with any other team. Furthermore, the commitment of AMT to services to adults was not reflected in the team staffing. It was found to be difficult to maintain the staff allocation to the duty system on a regular basis.

The field work staff, placed great importance on receiving good supervision. This was particularly so following the reorganisation, when they would have been working with situations that were unfamiliar. This increased the pressure on the team leaders to meet the supervisory expectations. It was mentioned that one AAM carried other functions besides her role as team leader and consequently could only give limited supervision to her team members. This dilemma can arise, particularly, if a team leader has strong interests in areas of work not directly relating to his/her

team leadership role. The team leader must negotiate the allocation of time between these areas of work with her AMT colleagues and her team members.

In the reorganisation, they attempted to place staff in the team of their preference. However, groups such as HHOs and OTs, because of their numbers, were excluded from the opportunity to chose; the AMT decided their team location. There were also problems about the size of rooms and number staff in those rooms. A large size room can provide a situation in which all the team members are together and communication is good, but it also may be a distracting environment. Some offices provide staff with single rooms but these can be isolating. The difficulties associated with allocating of staff to rooms, can be aggravated by a reluctance of staff to change and a wish to retain the social contacts they have established. With specialist groups, there are advantages to grouping together people who benefit from sitting together because of their need to communicate. Being accommodated together gives the opportunity for mutual support, which includes sharing knowledge and experience. The disadvantages include isolation from colleagues in other fields if placed in a room away from them.

It might have been possible that some of the changes could have taken place before the reorganisation. Some matters had been festering for sometime. These included the pressures on the Intake Team, poor services to adults and poor peer support among AMT members. It seems that these needed the reorganisation to get adequate recognition and possible redress.

CHAPTER SIX

MIDHAM AREA CENTRE

The Midham Area Centre was created out of the amalgamation of previous two adjacent Area centres these I will call Area X and Area Y. The offices of these two small centres were about 2 miles apart. The areas that they served were geographically and demographically similar. They were both situated on the same side of a city and within its boundaries. The two Area Centres had had no geographical central focus except two small shopping centres. The two Area Centres covered a population of approximately 90,000. This population was older than average. There was a high proportion of council housing. The amalgamation of the Area Y and Area X areas centres was decided by the Social Services centrally, against the recommendations of the staff of the Area Centres. This decision included accommodating the combined staff in one office building. This provided the opportunity to reorganise and consider how the amalgamated staff should work together and, in particular, what the team structure format should be in the future.

As a consequence of the amalgamation, there was a need for a reduction of the two AMs to one, two AAOs to one and the movement of all staff to one office building. This building was to be the previous office of the Area X centre. This was to be enlarged to take the staff of the previous two Area Centres. While this was being done the staff operated from two offices. The Area Y staff remained in their existing office. The Area X staff moved out of their office and into a nearby building, said to be inadequate for their needs.

The amalgamation of the two Area Centres under one AM took place in 1983. The reorganisation planning started in September 1986. The reorganisation was completed, when the new teams came together in a single Area Centre (the Midham

Area Centre) in the redesigned building on the 1st April 1987. The interviews of the key informants were carried out during May 1989.

The key informants involved in the research comprised the following :

- Area Manager
- Deputy Area Manager
- Assistant Area Manager
- Social Workers A,B,C,D
- Occupational Therapist
- Home Help Organiser
- Area Administrative Officer
- Social Services Officer

PREVIOUS STRUCTURES

The AM of Area X retired before the amalgamation. The AM interviewed was previously the AM of Area Y. He had the responsibility of bringing together the two Area Centres and reorganising them into the Midham Area Centre. He considered the amalgamation to be a departmental decision based upon an attempt to reduce the number of area centres in the County. He said that before the amalgamation and reorganisation, Area Y had two generic teams operating a duty/intake system on a team by team rota. Area X also had two generic teams these operated on a daily rota basis for duty/Intake. Team Leaders alternated as duty seniors. In each of these Area Centres, below the AM, there was a DAM and an AAM. These also operated as team leaders. Following the amalgamation and before the staff physically came together in one building, the Midham Area Centre (the two amalgamated Area Centres) operated from two offices with one area manager. But they knew that they would be moving into one office. The problems they were experiencing with the duty system then, influenced them when they came to look at how the Midham Area Centre should be organised.

The DAM was the DAM of the Area Y before the reorganisation and amalgamation. He thought that he had played a major part in the planning group that worked out the reorganisation plan. He considered that there had been a high level of

consultation with staff. The AAM said that the DAM, another AAM and she planned the meetings of staff in which the foundations for the changes were worked out. She felt very much involved.

CAUSES OF REORGANISATION

The AM thought the reorganisation of the team structure of the centre was brought about by the decision of the Department to amalgamate the two Area Centres. He thought that that was an attempt by the Social Services Committee to rationalise the number of area centres and also a means of making economies in staffing and buildings. The DAM agreed with this but added that the amalgamation gave them an opportunity to review the team structure of the Area Centre. For him the only significant external influences was the creation of a separate juvenile justice unit. As a consequence they lost their intermediate treatment specialist social worker to that unit and much of the work with juvenile offenders. He said that the amalgamation also provided gains in resources and economies of scale in operation. Putting two area centres together amalgamated two budgets that provided greater resource potential. There were also losses, one of which was being seen by the Training Section as only one area centre and not two as previously, with a consequent reduction of training opportunities. The AAM also thought that the reorganisation was the result of the amalgamation. She saw the growth in child care legislation as one external influence affecting the reorganisation, The amount of knowledge and skills required in this specialist area of work encouraged the forming of specialist teams. She thought that her own knowledge as a generic team leader had been spread very thinly and that being a generic team leader was no longer viable.

Social Workers A and B also said that the reorganisation resulted from the amalgamation of the two Area Centres. They thought this was partly an attempt to save money by reducing the number of buildings from one to two and also the number of AMs. Social Worker C said that following the Departmental decision to amalgamate the two Area Centres, while they remained in two separate offices there developed a "never the twain shall meet" attitude that made the reorganisation more difficult." Social Worker D thought that the amalgamation of the two Area Centres, the restructuring of the teams and the change of buildings was very confusing. She said that many did not want the amalgamation of the offices to

happen and did all they could to prevent it. It also meant that an AM, a DAM and an AAO were made surplus to requirements. The HHO did not consider herself as involved in the reorganisation as the home help service was treated entirely separately. She was not involved in the working parties but their Team Leader fed information to them. The SSO also mentioned the resistance to change and despite, the AMT's attempts to get the staff to gel together, she thought that it never did completely.

The AAO thought that the timing had been a major mistake because the amalgamation took place at a time when the building was not ready. He said that there had been resistance to the amalgamation and attempts to persuade the senior management to reverse their decision but this was unsuccessful. They therefore "had to make the best of it."

OBJECTIVES

The AM said that the prime objective of the reorganisation was to provide a more efficient service to clients than through the previous two Area Centres. He acknowledged that the decision to move into specialist teams was largely that of the AMT. He stated that although he saw it as a management exercise, he wanted it to involve staff as well. To this end group workshops were established, to look at aspects of the proposed reorganisation. They included a social survey of the area. A study day took place to look at different ways of operating and to make suggestions about the future structure of the Area Centre. The DAM also said that the main objective of reorganisation was to provide a better service to the public. He added that they attempted to involve staff as much as possible in the discussions regarding the future structure. He thought that the needs of the staff and the public were given consideration. It was also thought at the time that the Area Centre was not responding well to needs of other agencies. It was the recognition of this that led them to consider forming specialist teams. The A AM agreed with her management colleagues but pointed out that, whereas the amalgamation was forced upon them, the decision to reorganise was the AMT's. She thought that during the reorganisation, they gave a high priority to the needs of the public. She added, "when we looked at specialist teams, there were more positive gains for clients going into that direction and more negatives for staff."

There was a particularly strong feeling about trying to improve the services for adult clients. The staff could express their needs through the small group working parties. Apart from the amalgamation, the needs of the Department were given a low priority.

Social Worker A thought that the objectives of the reorganisation were determined by the AMT. In general, staff made proposals but tended to go along with what was recommended by AMT. He thought that the staff represented the needs of the public. The Staff also considered their own needs, for example some staff felt that to restructure into specialist teams would improve the status of the social workers. There was input from the Headquarters' based field services officer but the reorganisation was largely left to the staff of the Area Centre. He thought that it had been a good strategy to get the staff from the two Area Centres "mixed up together in the reorganisation discussions." But it took away from him the support of his own work group. He suggested that the choices given to them by AMT were limited. For example "the possibility of remaining a generic social worker was not addressed. Going into specialisation had to be accepted."

Social Worker B said that the process of reorganising was fairly democratic. He thought that the amalgamation had given them the opportunity to consider more structural alternatives. As they were amalgamating a considerable number of staff they "could afford to specialise and have the luxury of a duty team and a choice of how to work." She thought that staff did represent the needs of the public. She acknowledged that they had considered their own needs as important but also that compromises were needed when making recommendations. The needs of other agencies and the networks that they had established in the past had got lost in the process of reorganising.

Social Worker C thought that the objectives of the reorganisation were primarily to make the amalgamation of the two Area Centres work and in doing so give a better service to the public. Social Worker C thought that most people thought that their own needs and professional development were being met by the reorganisation but some were doubtful.

Social Worker D thought that the objectives might have been set by management staff involving fieldworkers in discussions but was not sure. She felt that her own

needs had not been adequately met, as she was not put into the team that she had requested. The SSO said that she thought that staff needs were considered by AMT or "that they tried to give the impression of this; it was lip service rather than fact." She was one of the staff not happy about the outcome of the reorganisation as she did not see it as meeting her personal needs. The OT, was very new to the area, when the reorganisation took place. She saw the objective of reorganisation was a move towards specialist teams and this was the basis on how decisions were made, that is, whether they led to the achievement of this. The HHO saw the objectives of the reorganisation as giving more uniformity of service across the area and a more positive use of resources.

The AAO saw the reorganisation as attempting to give a better service to the public through specialisation, whereby expertise in particular fields could be built up. He said that he did not mind the changes but had been naturally concerned about who would get the AAO post as these posts were reduced from two to one. He obtained the post.

INFLUENCES

The AM said that they had rough ideas about where work pressures lay and what work was being neglected. He thought that the AMT had a good idea about what was needed and added that the working parties set up came to the same conclusions. The presence or absence of any other organisation did not affect them when coming to their decisions. He said that it was thought that "they had to do things their own way." He felt staff knew that their views would be heard and they were involved from the outset. He said, "It was all very open." The DAM said that there was some discussion with the Headquarters' research section with the intention of embarking on background research of the area. This was not followed through because of shortage of time. He added that the reorganisation was seen by many as an Area Y "take-over" of the whole the Area Centre. The aim therefore was to have a good consultation process to help people feel involved. The AAM also mentioned the meeting with a representative of the research section at Headquarters. She said that this had helped them to see things in a broader way. They became more aware of the large need for adult services, whereas they had been concentrating on children and work with families. She thought that they might

have been influenced by other Area Centres across the County moving into specialist team formats.

Social Worker A thought that little consideration had been given to social need indicators. For example before the reorganisation, more social work support had been given to the child care teams. Whereas, statistics indicated that more resources should be given to the disabled persons but this did not come about. He thought that the prevailing philosophy at the time was that to do the most effective work one needed to be a specialist worker. Social Worker B also thought that little consideration had been given to social need indicators. She thought they should have considered such matters as where the main population lived and how people who needed help would get to the office. Social Workers B and C mentioned there had been interest in patch systems but thought that it would have been too difficult to divide the area up into patches. Social Worker C thought that the amalgamation of the previous two Area Centres brought "grieving and anger" and although this could have influenced the reorganisation she did not think it did. Social Worker D said that they had referral information that was used when setting up the duty system.

TIMING

According to the AM and DAM there had been previous meetings relating to the amalgamation but the reorganisation planning started in September 1986. It was put into operation when the new teams came together in the redesigned building on the 1st April 1987. The building renovation time scale influenced the timing. There had been an AMT meeting followed by two Area Centre meetings in each of the previous two offices to work out what they wanted to do. Small mixed groups had been set up to study areas of work such as the needs of client groups, what tasks had to be performed in the Area Centre and what structure would be best to carry them out. The AAM agreed that the reorganisation timing was largely controlled by the availability of the building.

Social Worker A thought that the delay in the completion of the building allowed people more time to get to know each other. However, he added that the team that he was placed in did not meet together until they moved into the new office. He saw

the meetings as the basis of a sequence of recommendations leading up to the reorganisation. Social Worker D pointed out that much of the planning was done while they remained in separate offices and there was still confusion resulting from the amalgamation of the two Area Centres. The delay in the availability of the building, exacerbated this situation. The HHO said that there had been considerable stress created by the delay in the completion of the building such as one of the two teams having to remain in sub standard office accommodation, "it seemed to go on for ever."

DATA SOURCES AND PRIORITIES

The AM said the Headquarters' Fieldwork Co-ordinator and the Research Officer were used for guidance but to a limited extent. Statistics and demographic data were used but only as indicators of what were the workloads of the Area Centre. Information was not sought from other agencies. The DAM said that they had maintained a tight system of work load management that had been considered useful. The AAM said that the duty systems of other areas were examined. The AM and DAM said that the Area Centre had a priority listing of needs but related to particular areas of work. It tended to be a "life and limb criteria across the board." That is, the most vulnerable clients of any category got the most urgent priority. The manager said that team leaders considered the priority scaling when they allocate work on a weekly basis. He added "The Team Leader of the Duty Team must be very aware of the priority to be given for any particular referral as urgent situations don't necessarily wait for the weekly allocation meeting of the teams." The AAM thought there was a danger in priority scaling in a too clearly defined way. She considered that "It was at the AMT level that there was an understanding and appreciation of levels of urgency."

Social Workers A and B recalled the discussions with the research section and the Departmental Field Services Officer. Social Worker B described the latter discussion as "a morale boosting exercise." She said that her previous Area Centre had had a priority listing policy regarding work allocation, but did not know of one since the reorganisation. Social Worker C said that Individuals looked at data and bought ideas to the groups but the reorganisation was not sophisticated, "We

relied on ideas and feeling rather than statistics." Social Worker D, the SSO, AAO, HHO and OT knew of no data that was used during the reorganisation planning.

THE DECISION MAKING PROCESS

The AM said that they looked at various team structures. They had considered the specialist versus generic team choice, or remaining with the previous team structures. They also considered generic teams plus specialist ones and patch or neighbourhood teams. One thing against remaining as generic teams was the problem of the amount of knowledge and experience required by team leaders. This was less of a problem for specialist team leaders. Factors such as these led to the AMT's preference for specialist teams. He said that "We had to convince staff of the need for change." He said that all staff were involved in the decision making but "we had to get peoples agreement with the AMT views." He added that decisions were arrived at the final meeting in September 1987. This took the form of a feed back session when views were presented and voting preferences were recorded. The AMT preferences came out as the top choice. This was a majority decision including the AMT. He thought it fortunate that this view was in accord with that of the AMT. The DAM largely reported the same decision making process as the AM. He said that consideration had been given to involving a consumer group but "this fizzled out" when the student Social Worker interested in doing this left. He added that each of the working groups had in its terms of reference to look at various models of operation. These were fed back to the final meeting in September 1987 mentioned by the AM. A clear decision was made at that meeting and he thought that technically this was ratified by the AMT. The AAM also added that as the result of the information fed back to the meeting, there was an "overwhelming agreement" in favour of a specialist team structure. However, she considered that the final decision was made by the AMT.

Social Worker A did not remember looking at team structures in the small working groups set up to make recommendations regarding the reorganisation. He said "The specialist team format was decided upon at the general meeting. There was not much consideration given to alternatives. AMT took the lead and the others (staff) went along with it. It was an AMT decision and other preferences were not explored very much." He added that it was difficult to work in the small groups as "

They (the staff) were all mixed up and they were affected differently." He thought that it was difficult to answer how the needs of others such as the public were presented. AMT considered the needs of staff when individuals were given the opportunity to express a preference regarding which teams they wanted to be in. He said that the final decisions were made by AMT "There had been a show of preferences at the main feed back meeting and AMT took this on board." He thought that the Area Centre was meeting its objectives by being organised to go into specialist teams and that was considered the best way to operate.

Social Worker B said "AMT had already decided on specialist teams and hoped that we would come to the same conclusion. As most of the staff agreed, there was no problem." She thought that all could express their views but these had to be fed to AMT as a group view. Although group recommendations were fairly democratically arrived at, she thought that the opinions of the administrative staff were under valued. She did not think that the reorganisation met its objectives as she considered that a better service had been provided when operating as two independent Area Centres.

Social Worker C was previously in a generic team. That team was against moving into a specialist team structure as they thought would it not provide the variation of work that they were used to. She thought that efforts were made to be fair and consider all views, but AMT made the final decisions. She thought the staff commitment to their clients ensured that their needs were met. Social Worker D said that she not feel involved but thought that everyone was given the opportunity to contribute to the discussions. She thought that the Team Leaders had most to contribute "as they knew about the work demand and the competence of members of staff." The HHO thought that they should have been given the reports of the working parties to consider before the final meeting. The SSO thought that although all were allowed to have their say, some had more notice taken of their views than others did. Most of those interviewed thought that the final decisions were made by AMT following the recommendations they received from the working parties and the feedback meeting.

The AM said that staff were informed immediately the final decision was made by AMT. He was vague about how those not involved, for example other agencies, were informed. No communication was made except by informal word of mouth.

CHANGES IN THE ROLES OF TEAMS

Both the AM and DAM said that it was decided to have five specialist teams. These comprised two children and family teams, one children and resources team for children under five, (including the day care officer, family placement officer and two social workers), a disability team and an elderly persons team (which included the HHOs). They had hoped to get an additional team leader. As that did not happen, the DAM had to supervise both a child care team and the team for Elderly Persons. He found this very demanding.

After the reorganisation, the duty work was done by 16 social workers. This was on a rota basis of three social workers per day. Each social worker was on the same day per week and kept to that day for six months. It was said that this enabled social workers to plan their future work commitments more easily. Each of the Team Leaders was responsible for the supervision of the duty system on a weekly rota basis. The social workers on duty were mainly from the child care teams, where they were in greatest numbers. A duty OT was available for immediate referrals. An assistant OT, as well as being a member of the team for elderly persons, would sit in on duty. Allocation of work was done on a weekly basis unless an immediate response was needed. All five Team Leaders met together to carry the allocation. Those staff who might take the referrals sometimes attended. The AM said that with specialist teams much of the allocation of intake work was automatically identified with a particular team. The Team Leader who takes the new referral would indicate to whom it would be allocated basing the decision on information given to him by the workload management scheme of his team. According to a social worker they could make known what work they most wanted. The AM added that transfer of cases between teams was usually not necessary because of the specialist nature of the teams matching the requests for help. Following the reorganisation the Area Centre priorities remained the same, being based on a "life or limb" criteria, but within the specialist teams. He added that other than the revised team format to specialist teams there were no changes to the philosophies or policies of the area. But, the DAM said that the change into specialist teams reflected an alteration in priorities and the teams in turn developed new ways of working. The AAM was also of this view.

Social Worker A said that the work is allocated by team leaders, was often done on an individual basis but staff could make known their work preferences. The Team Leaders met weekly to discuss the distribution of the referrals between the teams. He said that they had no case transfer procedures. The duty system had to hold onto cases if the case load weighting system showed that caseloads were full. Work priorities were considered but not always followed through. Originally it was decided to have a social worker in the disability team but this post was finally put in a child care team because of the demand of that area of work. Social Worker B also said that allocation was done on an individual basis with the Team Leader matching this with the caseload weighting of the staff. She did not know of any formal work priorities. Work was directed to where the need was thought to be greatest. She complained of the amount of paper work that was then involved in the work. She described it as "More like a business exercise. It doesn't meet the clients' needs." Social Worker C was critical of the duty system. She considered that using 16 social workers gave the clients no sense of continuity. Furthermore, she thought that specialisation strictly followed could cause stress, as it provided little variety and relief from difficult and demanding work. Social Worker D said that there was a change in philosophy that encouraged staff to go out into the community more and set up neighbourhood schemes. The HHO thought the change in the referral procedures was an improvement as they now came directly to them.

Most people were critical about the Area Centre office building, either the delay in its completion or the lack of space it provided. A number complained about insufficient space and poor lighting. There were also reservations about the size and adequacy of the interviewing rooms and reception area for the public. The AM had been concerned about the delay in the completion of the building that had made the move into new teams a longer process than desirable. The building was the previous office of the previous Area X. This was renovated to house all the staff of the Area Centre. Rooms were earmarked for different functions before the move. The DAM mentioned that the old Area X team moved into the office first (this had previously been their office before its modification), shortly followed by the previous Area Y staff. In order to try to avoid any problems or complaints about seating positions these were decided before either move was made. However there were still complaints from some teams and staff about the rooms in which they were placed. For example one child care team complained strongly about the lack of

daylight in their room. A number of changes were made to the occupation of rooms during the reorganisation process. The AAM also expressed concern about the delay in the completion of the building. She said it caused stress among staff and when they did move in disputes followed about the allocation of rooms, instigated particularly, by those inadequately accommodated. They also, seemingly as an afterthought, moved the team clerks into the team rooms with the rest of the staff. This was not to the liking of everyone. The AAM said that the building became the focus for any grievance.

STAFF CHANGES

The AM said that staff were allocated to particular teams following discussions by the AMT regarding the necessary size and structure of each team. Staff were asked to indicate their first and second choices of team preference. He said that they had a spread of preferences; all except one person got their first choice. He said that aim was to meet the wishes of the staff regarding team allocation as closely as possible. The individual specialists were allocated to the teams most appropriate for their work. In the allocation of staff to teams, recognition was given to past inadequacies regarding some areas of work. The DAM added that the HHOs were seen as a separate group and had a room of their own. They were also supervised separately by the DAM. He said that this was in recognition of the fact that their work cut across many client groups. However, the OT pointed out that they also cover the whole age range of clients, but were placed in the disability team, although they and others saw the placement as inappropriate.

Social Worker A said that as well as giving their preference they had to give reasons for their choice and state how this fitted into the structure. He thought that most staff, like him, were generally pleased with their allocation to teams. No major problems arose, although there were some complaints from social workers that missed the generic aspect of the previous working pattern. The child care teams got most of the social workers allocated to them and that seemed to indicate that that was where the Area Centre's priorities lay. Anxieties did arise. He said that these were associated with the transfer of cases and the loss of generic work. Some people thought that they were being de-skilled. Part-time workers who were not allowed to do duty work, also felt that they missed opportunities to gain further

experience. Regarding staff co-operation and commitment to the reorganisation, he thought that the issues regarding the amalgamation of the two Area Centres were still around but people were becoming resigned to it and encouraged to make the best of it. But some of these feelings were transferred to the reorganisation. Social Worker B said that most of staff members were put into the teams they requested. However, she was concerned that no qualified social worker was put into the Elderly Persons Team and the Disability Team lost a social worker to one of the child care teams. She said that there was general anxiety among the fieldwork staff. She thought that the staff of the previous two Area Centre offices felt that they would lose something in the reorganisation as a majority had been happy with how things had been. She thought that these anxieties were reduced by AMT involving them in deciding how things would operate in the future.

Social Worker C also said that most people went into the teams they requested with the possibility of future transfer if they wanted to change their specialism. She thought that there had been no resistance to the reorganisation but there were many anxieties. Most of the anxieties related to the staff coming together into one office and having to establish new relationships. The work relating to transferring cases was also found stressful by some. She said, "People were aware that the amalgamation of the two areas had been foisted on them. With the reorganisation we had to sort out what was best for the future."

Social Worker D agreed that they were mostly happy with the teams they were in but the allocation of rooms to teams created problems. Like others, she also criticised the waiting rooms, toilets and kitchen. She also thought there were difficulties associated with new teams coming together and personalities clashing. Also, with difficulties over the positioning of desks and the lack of furniture. She added "We had to make it work and run smoothly for the benefit of the clients. It took many team and Area Centre Staff meetings to achieve this."

The AAO officer said that following the disbandment of the typing pool system and the creation of team clerks, the administrative staff had shown some reluctance to accept the new order. The older clerks were less happy than the younger members were but they settled down. He acknowledged that the move away from a centralised administrative support system to that of having team clerks, reduced the flexibility of their use, and the work load had to be more carefully balanced.

Other staff said that the team clerks were used differently depending upon the Team Leader. Some used them as secretaries and others as clerks. Some liked this but others did not. There was also an unequal work distribution due to the differing sizes of the teams they supported. The AM added that the reorganisation and the creation of an additional team meant that the administrative /clerical support had to be spread more thinly.

The AM was pleased with how the placement of staff worked out. He thought that the arrangements were happily accepted by staff but acknowledged that there was a natural reluctance in some people to change. However he thought that confidence in the proposals had been built up by the previous mixed group discussions. He said that the number of the teams was decided upon, then the size of the teams determined, then social workers were allocated to them. Specialist workers were placed in the appropriate teams relating most closely to their specialisation.

The DAM largely thought the same but acknowledged that although the staff were generally happy about their placements and changes, there were some that regretted losing the type of work they had previously done. There were also difficulties regarding the transfer of cases. He was aware of the criticism mentioned by the administrative officer of the clerical staff being used as team clerks. He also mentioned that some social workers found it hard to "gel" with others in their new team, particularly those who had previously worked in a different area centre to the rest. He said that some staff left about this time, although he did not identify this directly with the reorganisation. He also said that the functions of the AMT did not change, as the previous two units had been co-ordinated at management level for sometime before the reorganisation. The DAM added that the AMT recognised the anxieties for its members resulting from the reorganisation and they helped each other in respect of the problems they faced in their teams. There was also encouragement of social events to help the teams "gel". He thought that there had been a particularly high level of anxiety in the physical move of the teams into the building.

The AAM also acknowledged that there was resistance to change. Some staff felt negative about what was happening and left or retired although people were told

that it would be possible to change the team in which they were placed. She also mentioned the stress placed on the administrative staff and thought that the need for clerical support outstripped the Area Centre's ability to provide it. The AAM also spoke of the typical anxieties that arose among staff, such as who would be their supervisor. They did not know this until they were allocated to teams. There was also concern about how they would get on with working with people from the other Area Centre. There were also the worries concerned with managing a different form of workload and becoming completely specialist. She said that they gave people as much information as possible to try to allay these fears. Regarding staff co-operation, she mentioned that people were positively encouraged to get involved and mix formally and informally.

The Social Worker A also said that there were anxieties due to having to hand over their generic case loads. He said that they thought they were being de-skilled. Some were helped to see that they could retain some of their past generic skills by their work when on duty, as the duty work retained a generic character. However, as only full time social workers were used in the Duty Team, part time workers thought that they lost out. He added that, depending on the Team Leader, some social workers were helped on an individual basis to overcome these anxieties. Concerning the obtaining of staff co-operation, he thought that an important factor influencing this was that the issue of the amalgamation of the two area centres had been around for some time. People were resigned to it happening and encouraged by the management staff to make the best of it. This attitude was then transferred to the reorganisation.

Social Worker B did not recall any resistance to the changes but thought that everyone was anxious about what was to happen. She said that both the Area Y and Area X staff thought that they would lose something with the changes and were cautious about the future. The means of attempting to resolve these doubts was to have them aired and talked about.

Social Worker C obtained a place in the team of her choice, with the Team Leader she preferred. She did not think that there was resistance, but there were anxieties about the change. She put them out of her mind. The most significant of the anxieties of staff, as she saw them, were fears about the staff coming together in one building.

Social Worker D also said that generally staff were happy with the teams they were in. She mentioned the practical problems such as dissatisfaction with the room allocations and with the kitchen and toilet facilities. There were also problems relating to the bringing together of people who had not previously worked with each other. There were clashes of personalities, dissatisfaction about the positioning of desks and the lack of furniture. Meetings were held to discuss these issues and most were resolved. She also shared the view of Social Worker C. "We had to make it work to run smoothly for the benefit of the clients."

The SSO thought that although the AMT worked hard to get the staff to "gel" as an Area Centre, she did not think that it ever really happened. Staff left, not directly because of the reorganisation but the changes led them to look around for other areas of work. She reminisced about her past Area Y office that she described as a happy one. She described them as working well as a team and having social gatherings together; this ended with the reorganisation. She described her initial period in Area Y as a difficult time. Initially she felt excluded from the work group until she established herself. Following the reorganisation, she was placed in a room with three other workers all of whom came from the Area X office. She again felt somewhat excluded from the group. She thought that the amalgamation was the cause of much unrest and "niggles". She thought that people were treated as "things". At the same time she said that all the senior staff were open to discussion. She worked out her own problems as did others. The HHO thought that there had been resistance to the reorganisation. She also thought that there had been a "them and us" feeling between the Area Y and Area X staff that took some time to settle down.

The manager said that following the reorganisation, the functions of the AMT remained the same, except the changes resulting from the Team Leaders having responsibilities associated with the specialist teams. The main anxieties that arose during the reorganisation were those associated with the process of the change itself. He thought that he gained the co-operation of the staff by involving then in the discussions and the decision making which led up to the change.

WHAT HAS HAPPENED SINCE THE REORGANISATION

The AM said that since the reorganisation and amalgamation of the two Area Centres a number of problems had arisen. However, he considered that the objectives of the reorganisation had on the whole been achieved. He thought that there was a better service to those groups of clients who had lost out in the past. Regarding the changes in consumer demand, case loads reflected the improvements in the provision of services to groups less well served in the past. Also, specialist teams had attracted more demands for liaison with other external groups. He said that there had been no unexpected outcome from the reorganisation nor had there been changes in the delegation of responsibility. When asked who gained and who lost out in the reorganisation, he did not think that any member of staff had gained or lost more than anyone else. He did think that the Children and Families Resource team may have felt that they were missing out from the more involved child care work. He added that the merging of the two Area Centres resulted in larger staff numbers. Consequently, it was likely there would be a bigger staff turnover. It was difficult to say if staff left as the result of the reorganisation but one or two might have done so. Others left for positive reasons such as promotion. Concerning the recruitment of staff to the new structure, he said that there were difficulties in recruiting social workers for specialist positions such as to the disability team and the post of specialist worker for mental health. Regarding the changes in the duty system, he thought that, although there was a commitment to having three duty officers on duty each day, there were still days when was only one duty officer was available. Generally the duty system works but it is under regular review.

The DAM agreed with the manager regarding the duty system. Regarding the achievement of their objectives, he also thought that, subjectively, he considered there was much more concentrated knowledge and experience in the specialist teams than in the previous structure. They now do very specialised pieces of work within their teams and developed specialist knowledge about resources. He thought that there had been a change in consumer demand due to moving the Area Y work base. This Area Centre had served the local area directly and had a large concentration of referrals from nearby. With the new Area Centre, people had to

travel to the new office location. He stressed the importance of locating offices for ease of access to the public. The DAM thought that caseload changes had reflected objectives particularly in the Disability Team, which he said, "Is over burdened in taking on work we did not know was there. Sometimes we cannot allocate the work." He added that "a most unexpected result of the reorganisation was the loneliness and isolation that people felt in a bigger building and people missing social contact with former colleagues. He said "I think that we were asking people to take on more responsibilities than in the past and split up groups much more. This brought about anxieties." He thought that things had improved as the team members integrated.

The DAM thought that the identification of people with specialist knowledge had caused what he saw as a change in the delegation of responsibility. Such members of staff expertise were now given more responsibilities. For example, one social worker has been acknowledged as the disability rights adviser to the area. In his view this was a good model for the future. He added that some staff left because they didn't like the new arrangements and the new ethos that went with it as "They thought it was more 'hard nosed' than they were used to." The staff who left were mainly from the previous Area X and from child care teams. He acknowledged that as a generalisation, Area X staff had been seen as "low key" compared with those from the Area Y office. He repeated what others had said, that the Area X staff saw the amalgamation and reorganisation as a "take over" by the Area Y. There had been difficulties with recruitment, particularly to the disability team. This was partly because of the type of the available vacant posts. Part posts had been made up into whole posts. For example, the adult placement social worker post was combined with a role of a social work post working with persons with learning difficulties. These posts did not attract applicants. He pointed out that one post in the Disability Team was transferred to a child care team because it could not be filled.

The DAM thought that the reorganisation had been planned in the right sequence but that it was slightly too long. They took a decision to hold back because they were waiting for the building to be completed. They then got complacent and did not do the social needs survey. He thought they could have done so if they had started it right from the beginning, but it was left, and then it was too late. He added, that given the time scale, he thought they should have obtained more data

about the area. But there was a changing time scale relating to the completion of the building. He thought that a critical path exercise relating to the reorganisation would have been helpful. If this had been done, they could have adjusted the critical path to the changing time scale.

The AAM agreed with the DAM. She also saw as an indicator that objectives had been achieved, that they provided a better knowledge-based service to the clients. She thought because of the specialisation, they receive more appropriate referrals as people were clearer about what they could or could not do. She thought that there had been changes in consumer demand, particularly in child protection work. She added that the duty system problems were unexpected. She thought these were also due to an increase in consumer demand. She thought that the length of time taken for the reorganisation gave people the chance to prepare for it emotionally. She said that the main problems that arose were mostly related to the building. The AAM added that there were also problems of "people being separated and isolated from their past team colleagues but possibly that they had been "too groupie" in the past." She thought the social activities and network meetings that were established helped reduce these problems.

Social Worker A thought that since the reorganisation more work was done on duty than before but he did not think that there was any greater cohesive understanding of what were the work boundaries of "duty." With three people on duty it was more likely than in the past for a duty officer to go out and visit a client regarding a referral and joint visits of people on duty were more common. He thought that the objectives of the reorganisation were probably achieved in that there were higher standards of knowledge and work with the specialist teams. He was fairly positive about the timing and sequence of the reorganisation and the outcome. He knew that staff had left but did not think that this was due to the reorganisation.

Social Worker B was neither sure if the general objectives of the reorganisation were achieved nor if there had been changes in consumer demand. She thought that the disabled people had a higher priority with the establishment of specialist teams, whereas in the generic team they took "second place." She added that some staff waited to see how things worked out following the reorganisation and then some left quickly. Regarding recruitment she thought that generally social workers looked upon the work of the disabled persons team as of lower status and

consequently this made recruitment to that team difficult. When asked about current problems, she returned to those related to work relationships. She said that with people leaving, others have been recruited and this had increased the feelings of not knowing people as well as previously, particularly if they are in different teams. She thought that they were still at the stage of finding where things like stationery were and who was responsible for its control.

Social Worker C commented on the reduction of resources that resulted from the amalgamation into one building, for example, there was only one photocopier compared with two when they were in two buildings. She also found the actual moving into the office building frustrating. She described the feeling like "moving house when, until you have your belongings around you, you cannot settle down." She thought that there was not enough help with the physical moving and following the move, the office arrangements were in a disorganised state. This caused friction between social workers and administrative staff. She felt that more planning should have been before the move. As well as others, she thought that "it did not have the same cohesive feeling. She added that people had developed "team" identity rather than "area centre" identity. The support of colleagues was now weak in the team whereas in the previously small Area Centres it was easier to exchange points of view across the room and members of different teams used to talk when having lunch together. She thought that such mutual support was impossible in the current large office. It was not a major problem but she found the office "unwieldy" and the relationships not as good as they were in the previous two smaller area centres. However, in general she thought that although the reorganisation had been stressful, she could not see any better way by which it could have been carried out.

Social Worker D also mentioned the practical problems relating to the reorganisation as causing the main problems. The delay in the availability of the building was followed by the men moving the furniture not being co-operative, too few telephones and difficulties in finding files. She thought that more consideration should have been given to enabling the administrative staff to sort out the setting up of the administrative/clerical side of the reorganisation, before the move into the new office. She considered that the remaining problems were due to there being inadequate space. For example, she said that there was no staff room or adequate rooms for the access arrangements of parents to their children. She also thought

that a better reception area was needed. She belonged to a small working group to look at possible improvements for the reception area, but she thought that any changes would be restricted by the structure of the building itself.

The OT said that there had been some resistance to the changes due to the different views of the staff of the previous Area Centres. There had been a strong team spirit among the previous Area X staff, whereas, Area Y had a much quicker team turn-over and were a younger staff group. She said with the combined Area Centre, "team members never meet informally and people don't have the opportunity to meet. New staff find it difficult to get to know people in the Area Centre."

The HHO thought that, following the reorganisation, decisions were being taken higher up the Area Centre management chain. Most of the other non management staff interviewed were of the opposite opinion. They thought that there was more opportunity to influence decisions.

The AAO said that the duty/intake work volume had increased as it now flowed into one office rather than two as previously. He thought that the timing of the changes could have been better. He said that there had been a rush at the beginning with the decision to amalgamate the two areas centres without there being any office building suitable for them to go into. He thought that they should have remained as two independent Area Centres until suitable accommodation was available. He considered that the team rooms were at "saturation point" and the major current concern was that there were too many people in too small a building.

The AM thought that the reorganisation had been planned in the right sequence but it might have taken too long. He considered that this was because there were two stages, that is the amalgamation and the reorganisation, which influenced each other. There had been a waning of enthusiasm mainly due to the delay in the completion of the building. He did not think that anything should have been done differently but it could have been shorter by three months if the building had been ready on time.

THE FUTURE AND RECOMMENDATIONS

The AM said that the reorganisation would be fully reviewed but that this would have to wait for the Department's proposed reorganisation to be established. His advice to others considering reorganising would be that you have to take your staff with you by keeping them informed and persuading them of the need for the changes. The DAM saw a partial review as having taken place. Consequently team clerks were established. It was also decided that an OT would do duty and people from the Elderly Person Team would do duty for clients who relate to their area of work. He added that there was also a greater use of the duty system appointments system for the public than previously. He also referred to plans to consider the amalgamation of the Elderly Persons and Disabled Persons Teams into an Adult Team, as there was a substantial overlap between the two areas of work. He was supervising two teams, one of which was the team for older persons, and he found this onerous. His advice to others was that the most successful thing they did was the involvement of staff. He said that it seemed at the time "pretty laborious" and took up much time, but he thought it "paid off." He thought that AMT was "fortunate in being able to go along with the recommendations of the staff." He acknowledged that to a certain extent the staff were led in the direction preferred by AMT. He added that in reality, they had led staff away from what AMT did not want. For example, he said that he and two of the other Team Leaders were strongly against the long term and intake team format and this was always a factor in the discussions. He recognised that some staff favoured that format. He was not initially in favour of specialist teams but became committed to them as the discussions progressed. He supposed that once he was committed to a specialist team structure that he "pushed for it." He also thought that people with strong personalities influenced the outcome of the discussions. But he did not think that the decisions were influenced by AMT to the degree that people thought it was a "confidence trick."

The AAM said the reorganisation had been reviewed. This took place after six months but she acknowledged that it did not look in depth at the structure of the Area Centre teams or their specialist operation but rather at how the system was working. Her advice to others was, "the AMT should make clear policy statements. Everyone should be involved in the working groups. It should be made clear that the AMT was in control, but committed to total participation of staff."

Social Worker A to said that the success of reorganisation had a lot to do with the AM. He had been in a difficult position in having to amalgamate two offices and restructure the teams and their functions simultaneously. He had done much preparatory ground work that had "paid off." The AMT had realised that they would have to work together following the amalgamation and consequently supported him. Social Worker B thought the review of the reorganisation had taken place about six months afterwards. She knew of no plans for further changes following from the review. Her advice to anyone contemplating reorganising, was to avoid it unless it was going to provide a better service. She said that it was hard work and stressful. She had been against the reorganisation that she saw as having been imposed upon them by the decision of the Department to amalgamate the two Area Centres. She still questioned the usefulness of this. Social Worker C also saw a review as having taken place. She said the review changed the use of the reception and interview rooms as well as the placing of the team clerks in the team rooms. She saw this latter move as beneficial to working but, because of the nature of their work, very noisy, particularly, if there was more than one person typing in an office. Her recommendations to others considering reorganising was to have more discussions with staff about the reorganisation than they did. She added, "take into consideration personalities and how they can work together. Open plan offices make working for some people more difficult, particularly, if it is a complete contrast from their previous working conditions. More consideration should be given for the need for staff rooms and rest rooms." Social Worker C reiterated that large area centres were not good for staff communication. Previously they had talked about their client cases and could exchange views in a supportive manner. She added that it was important that the building should be planned to facilitate good communication and contact between staff. The SSO said that she thought that they had been presented with a "fait accompli" regarding the reorganisation by the management team. Her advice to others was to give the staff a lot of time to get used to the idea of reorganisation and adjust to it and take their views into consideration as "they are the ones who have got to do the work." The AAO could not recall a review taking place or planned. His advice to others was to take your time and make sure that all staff felt involved and not passed by.

REFLECTIONS ON THE REORGANISATION OF THE MIDHAM AREA CENTRE

The Area Manager said that he attempted to involve all the staff in the process of the reorganisation. Those interviewed generally felt involved and thought that the AMT had worked to achieve this particularly through the meetings of the working parties that were set up. However, as in the other Area Centres members of the AMT did seem to cloak their intentions and the degree to which they would allow staff to participate in the decision making. The AM admitted that although he tried to involve all staff in the decision making, "We had to get peoples agreement with the AMT views." As said above, he acknowledged that he saw the reorganisation as a management exercise. He thought it fortunate that eventually the staff view was in accord with that of the AMT. He said, "We had to convince staff of the need for change." Also, "we had to get peoples agreement with the AMT views." Furthermore, the Dam said that AMT was "Fortunate in being able to go along with the recommendations of the staff." He acknowledged that to a certain extent the staff were led in the direction preferred by AMT. He added that in reality, they had led staff away from what AMT did not want.

It was mentioned that it had been difficult to get the staff of the two amalgamated offices to "gel." To get teams to "gel" they must have common objectives and the commitment to achieve these. This can be difficult in a situation, such as in this Area Centre, where there was a strong resistance to the changes being made, originating from a Departmental decision to amalgamate two Area Centres. Opinions varied regarding which decisions were made by the AMT made and those made by the rest of the staff. It seems that the AMT did not want to be seen as relinquishing its management responsibilities but still wanted to involve staff as much as possible in the reorganisation. A compromise can be possible; the extent of which will depend on the willingness of the management team to be receptive to the ideas of staff.

The most social workers seem to have supported the move into specialist teams. It was suggested being a "specialist", could improve the status of the social workers. The reasoning appeared to be that a person having knowledge about a specialist area of work could have a higher prestige compared to that of a generic worker with possibly a thin but wide ranging knowledge and experience.

It was mentioned that with the amalgamation of the two Area Centres, the combined numbers of staff enabled them to consider a greater range of possibilities of operating. There are economies and more opportunities for modification and experiment in a more highly staffed area centre but the number of team leaders is also important. For example, small areas with only two team leaders had a limited opportunity for change.

The objectives of the reorganisation, as seen by the staff, appeared to be vague. They were a mixture of trying to make the best of the amalgamation of the previous Area Centres and generally of giving a better service to the public. The objectives were seen as being set by the AMT but with staff involvement. Again there was uncertainty among them as to the degree of influence of the staff. It seemed to most to have been an attempt at democratic decision making. There was confusion between means and ends. Although ends, such as improving services to the public were mentioned, it was the means of achieving this, the provision of services through specialist teams, which became the focus of attention.

Most of those interviewed thought that the needs of the public were given high priority. However, much of the discussion that followed on from this concerned the needs of their own group or personal needs in relation to the team structures. It was acknowledged that at the start of the reorganisation that they would have to make compromises. Not all staff were satisfied by the eventual decisions. It was generally thought that once the decision to move into specialist teams was proposed by AMT, the rest of the staff adapted their thinking to fit in with those proposals. It would seem that the choices available to staff were limited by AMT.

It is possible that specialist teams can have a more refined priority scaling system than generic teams because of their, in theory, greater knowledge of the problems involved and resources to solve them. However, having specialist teams raises problems about client group priorities. For example, should those situations given greatest priority in a child care team have the same or more resources and available to them as a high priority situation in an adult team. Priority scaling over the Area Centre as a whole cannot easily deal with this except at the intake/duty level when the Area Centre may continue to operate on a generic basis. There appeared to be an agreement that they relied on "life or limb" criteria for their work priority setting.

This may be satisfactory for the most urgent situations but does not give adequate guidance for work below this level. This can mean that those groups of clients whose vulnerabilities may be of the greatest current concern of the public are most likely to be given the highest priority.

There was little apparent consideration given to social need indicators and statistics in the planning processes. One person interview summoned it up by saying that they relied on their feelings rather than statistics. It was thought that they might have been influenced by changes to specialist team formats elsewhere in the Department.

A majority of the social workers interviewed thought that little consideration was allowed by AMT to be given to other possible team structures. It seemed, as one interviewee said, "The Area Management Team took the lead in deciding what the team structure should be and others went along with it." Another said that she thought that the AMT had already decided upon specialist teams and hoped that they would come to the same conclusion. She added that as most people agreed with AMT, there was no problem. It was recognised that ultimately the final decision was made by the AMT, but at the same time, the rest of the staff thought they were all given an opportunity to have their say.

The AM acknowledged that the AMT had a preference for a particular team structure and then set out to convince the staff that this should also be their choice. The AMT with their knowledge of information and control of meetings were in a strong position to influence the views of other members of staff. It is probable that if people were interested in a particular structure they became increasingly receptive to information that reinforced that view and were likely to try to persuade others to share their views. As the DAM indicated above, once he was committed to a specialist team structure, he "pushed for it." He also thought that people with strong personalities influenced the outcome of discussions. This influence would be greater if they were also in senior positions.

Most of the staff interviewed were positive about the amount of involvement they were given and the extent to which they were kept informed. It is difficult to judge how this involvement actually influenced the final decisions. Some said that it was

inevitable, as one put it, "That some expressed their views more forcefully than others."

It was generally held that, although it was decided to give a better service to adults, the priorities of the Area Centre remained biased towards child care work. People differed on the degree to which this happened. Creating an adult team from people who were already working in that field in the previous generic teams may provide for an improved co-ordination of services, but did not provide more resources. However, in generic teams, it is probable that greater priority was given to child care work than to adult work. Specialist disability teams generally have few social workers. Therefore, it could be that the total time given to adult work by social workers in generic teams is at least as much as that given by specialist teams. What does seem to happen is that specialist teams gave their area of work a higher profile and probably a more concentrated knowledge base.

The AM had considerable problems caused by the delay in the completion of the building and its suitability. When an area centre office in being built or modified, as with the Midham Area Centre, the manager needs to be clear what his staff and office needs will be in order to advise the architects. However, the cost of the building modifications often restrict what Departmental Management can approve. Another problem is planning for future growth. It is difficult to justify additional space requirements unless you can clearly identify expansion that would get departmental support. This can be difficult. Consequently many relatively new offices have quickly become overcrowded. This appears to have happened in the Midham Area Centre. This caused some AMs to become very imaginative about their current space requirements.

People were generally satisfied with their allocated teams, although those who chose a child care team did not necessarily get the team leader they wanted because there were two teams. Some concern was expressed because no qualified social worker was placed in the Elderly Persons Team. This was also the Southam Area Centre and probably indicates that this area of work was of low priority.

The growth in numbers of staff of an area centre can reduce the likelihood of people meeting together. This was acknowledged by some people as one of the

disadvantages due to the amalgamation of the two smaller Area Centres. Specialist teams may also isolate staff from other members of staff because of the reduction of inter-working and common work experience you would get with generic teams. At the same time, it is possible that within specialist teams there is a greater feeling of working for a common interest. It was said that some new people did not know all the people in the Area Centre. It could be argued that this does not matter, providing they know the appropriate people to enable them to carry out their work efficiently.

Some staff were unhappy at being transferred to new teams with people they did not know. Managers can put staff into isolating situations without being aware of it. For example, the breaking up of previous supportive groups can cause stress and anxiety. Mutual support that may come from such groups can help reduce the stresses that can arise in social services settings. Some staff reported reluctance to transferring clients to other workers following the reorganisation. Professionally staff should not get emotionally involved with clients but the reality is that this sometimes happens. The feelings of rejection by clients in such circumstances must also be coped with. This places additional pressures on staff at the time of a reorganisation.

Changes such as reorganisation can cause staff, who might already be unsettled, to leave. The AM said that it was difficult to recruit a social worker to the disability team and the post of specialist worker for mental health in the adult team. Such posts can be difficult to fill. Newly qualified social workers, which are probably a major source of recruitment, see these posts as too specialised for the start of their career. Managers, for their part, are often looking for experienced social workers for this type of post.

It was reported that many Area X staff saw the reorganisation as a "take over" by Area Y although they all moved into the building previously occupied by Area X. This feeling of "a take over" was probably reinforced because the AM, the DAM and the AAO all held these positions previously in Area Y.

In any reorganisation, there are likely to be changes made to rooms and sitting places of staff. This was particularly so with the Midham Area Centre, where the staff of two previous Area Centres had to be brought together into a modified

building. Some staff, including the AAO, thought they should have waited until the building was available before they amalgamated. That is, the two centres should have remained independent, until they moved into the new building together. That might have caused more disturbance. They would have had to amalgamate, reorganise the teams, appoint an AM, DAM and AAO for the new Area Centre as soon as they moved into the new building.

CHAPTER SEVEN

SUMMARY AND CONCLUSIONS

CAUSES OF THE REORGANISATION

Challis and Ferlie in an article in the British Journal of Social Work April 1987, referring to Donabedian (1980) state, "Organizations may change aspects of structure or of process. Structure is defined as the organisational setting in which work is undertaken, process as the type and style of work activities. Although certain kinds of structural change are seen as leading to changes in process this linkage is often assumed rather than proven." What I have included in this research is an examination of the processes the three Area Centres used in their reorganisation with particular reference to the changes of their team structures, the involvement of staff in the decision making and the subsequent results.

The Area Managers of the Townham and Southam Area Centres, and most of their staff interviewed, linked their reorganisations with the provision of the additional posts that were used as team leaders. With the Midham Area Centre, it was the amalgamation of two Area Centres that was seen as the cause of the reorganisation. I will show below that the AMs had ideas of changes they wanted to bring about prior the reorganisations. All three decided that a reorganisation of the operations of their Area Centres was necessary, particularly the restructuring of the teams. They made substantial changes, especially the Midham Area Centre that had to bring together staff located in the two previous Area Centres. The functions of the staff and teams of all three Area Centres were changed considerably by the reorganisations. Apart from the decision to amalgamate Area Y and Area X, the Departmental Headquarters left the Area Centres to make their own decisions about their reoganisations.

SETTING OBJECTIVES

Miller and Scott (1984) stress that when setting objectives, it is important to involve all levels of staff plus the public. The Area Centres were probably aware of this but their objectives were very general and consequently made it difficult to assess their success afterwards. Bamford (1982, p. 42) states "The key to management by objectives is clarity about the objectives required by the agency and about how performance in striving for those objectives will be measured." The AMs said they wanted it to involve staff in planning but also retain their management roles. They had difficulty in getting this balance right. It was, therefore, not clear who was involved in the objective setting. All three AMTs had a view of what they aimed to achieve and what form of reorganisation they wanted, before discussions with staff started. Then, to a greater or lesser degree, they attempted to persuade staff to come to the same conclusions. Therefore, although they encouraged staff involvement, managers attempted to restrict this. Hayes et al. (1989, p. 72) say there was "The insistence on a hierarchical rather than a colleague relationship between experienced practitioners and resource managers. There can be little doubt that this impedes more effective planning in resource usage and client services." When it comes to objective setting, Miller and Scott (1984, p. 14) hold that "this has the effect (where senior management sets objectives) of both imposing a consensus and artificially reducing the objectives the agency plans to pursue." These conflict of interests came up in different forms from managers and staff in the research when decision making was considered. Hugman and Hadley (1993, pp.1,2) say "in the absence of clear goals, or the presence of covert goals, participation is not sufficient to motivate organisational members." They add that "other studies have suggested an explanation for this 'failure' by noting that it is not the experience of participation as such that serves to motivate organisational members but rather the opportunity to direct work effort towards clearly defined goals, although participation in goal definition may enhance this process."

Miller and Scott go on to provide a method of objectives setting that can be used when considering reorganising. They show how evaluation can be linked with objective setting. They say, "The context of the evaluative criteria is dictated by the operational objectives. These objectives need to be translated into actions. Each requires particular resources to mount the services to produce the desired impacts on clients and communities. Whether the team is effective or not (evaluation)

depends on how well the impacts they finally obtain match up with their evaluative criteria." It can be seen that it is essential that this initial objectives setting is carried out correctly, both in order to be clear what it is hoped to achieve and also, afterwards, to be able to asses their success. Miller and Scott (1984) help to clarify objective setting by suggesting the involvement of all staff in a "problems and remedies" identification exercise. These in turn are classified using a means/ends distinction. By using the information gained an "impact objective tree" is constructed. This should be headed with a banner objective and lead down to how this would be achieved. The Areas Centres had very general banner objectives but were unclear about how they were to be achieved.

PRIORITIES

As mentioned previously, Miller and Scott (1984, p. 26) differentiate priorities from objectives as follows, "Objectives give the overall rationale for action. Priorities decide the order and extent of actions." Because of the shortage of resources to meet the demand for services, all three Area Centres had to make decisions about which need for services should be met and which should be given the greater priority.

The Area Centres were vague when it came to stating their work priorities. Cockburn (1990, p. 54) in his examination of team leaders and team managers says, " In general team leaders did not have specific 'priority criteria'. Where they existed at all, the client groups were joined together under such headings as 'high', 'medium, and low risk."

The research found that the AMs and most of those interviewed, all agreed on "life or limb" situations being top priority but after this they relied on generally accepted but not stated judgements about what was a higher or lower priority of work. The "life or limb" view of prioritisation was that the more at risk the clients were of death, neglect or injury, the more likely they were to get a service. This was influenced by the possibility of any "bad publicity" if a wrong decision was made. Cockburn (1990, p. 54) also found " In reality the people most likely to receive service quickest were non-accidental injury cases, regardless of risk, and the elderly at the extreme end of risk."

Glastonbury, Bradley and Orme (1982, p. 58) quote Brearley, who suggests that there are four major elements in the management of risk taking:

1. The balance of potential losses against potential gains.
2. The element of choice.
3. The element of responsibility.
4. The recognition of the social work paradox that sometimes no change is a gain over time.

While the gravity of individual need is of prime importance, it does not rule out the ranking of need to establish a priority scaling system below the life or limb level to be used by Area Centres. Miller and Scott (1984) suggest the compiling of a "client problem dictionary" in which client needs are put into priorities across client groups. However, Parsloe (1981) warns that using systems, for example problem dictionaries, to promote the work of the team, have the possible disadvantage of reflecting the authors' values. They also present the danger of putting/forcing clients into pigeon holes/categories. But, she points out that without such a classification the quality of assessment remains a personal matter.

Glastonbury, Bradley and Orme (1987, p. 57)) maintain that "A great deal of the task of personal social services is about assessing and reacting to risk-risk of suffering, of continuing deprivation, of vulnerable people being exploited, of a clients circumstances getting worse, of offenders re-offending, and of many other occurrences." They add, "There is, therefore an inverse relationship between risk and resources. More resources will be seen as reducing risks; fewer resources increase the risk." They point out that most people take risks in their lives. If there is any difference in the helping professions, it is only a matter of degree and rests on three factors. They give these as, "One is the frequency with which very difficult assessments have to be made of risk; the second is the pressure imposed by a scarcity of resources to push risk-taking to the limits of safety (and of course risk taking too far); the third is the complexity of balancing the desirable against the undesirable potential outcomes of risk taking."

In all three Area Centres there was a hierarchy of client groups with child care work being the highest priority. Stated priorities regarding clients were not generally reflected in the structures of the teams. For example, in the Midham and Southam

Area Centres, recognition was given to the importance of providing a better service to adults but adult specialist teams appeared to be staffed inadequately to meet this end. Most qualified social workers were placed in child care teams. It seems that in a generic team and duty/assessment team arrangement, that priority setting regarding allocation is determined according to the client group of the referral and then to the urgency factors relating to the referral within that client group. The child care client group probably being given highest priority. With specialist team structures this may also be the case, but these priorities towards particular groups can also be reflected in the number and quality of staff in the teams committed to that client group. Miller and Scott (1984, p. 43) state, "structural priorities are often used in an attempt to roughly guarantee a certain profile of direct and indirect services across a geographical area." They describe structural priorities as "choosing a particular mixture of team types, geographical boundaries and recruitment of particular workers to staff the teams." This was certainly a major factor in the area centres researched. However, the research shows the aims regarding clients were not generally reflected in the structural priorities of the teams. It was noticeable that those committed to specialist team operation, with the objective of improving the services to adults, did not follow up this commitment by placing any substantial number of social workers in adult teams. The Hayes et al. report (1989, p. 64) indicates that this was a common trend, "We have passed through more than a decade during which each agency's major development activities have been led by a preoccupation with child protection, while the main changes in the condition of society and patterns/levels of need have involved adults, especially elderly people."

It is possible that specialist teams can have a more refined priority scaling system than generic teams because of their greater knowledge of the problems involved and resources to solve them. However, having specialist teams raises problems about client group priorities. For example, should those given greatest priority in a child care team have the same or more resources available to them than the highest priority situation of an adult team. Priority scaling over the area centre as a whole cannot easily deal with this except at the intake/duty level when the area centre may continue to operate on a generic basis.

It was the aim of those area centres that moved into a specialist team format to give a better service to adults. However, as said above, there was little evidence of

more resources being provided for adult services. Creating an adult team from people who were already working in that field in the previous generic teams, may provide for an improved co-ordination of services but did not increase the resources. The specialist teams for the elderly or disabled persons generally had few professional social workers. What seems to happen is that specialist teams give their area of work a higher profile and probably a more concentrated knowledge base. As Miller and Scott (1984, p. 43) say "specialist workers or subgroups who devote all their time to a particular client group or service automatically raise that group to a position of high priority."

Generally, the research shows that most staff below management level were unclear what were the priorities of the Area Centre. Peters and Waterman (1981, p. 65) stress the importance of all staff knowing the direction the organisation is going. They suggest, "The focus on a few key values lets everyone know what is important." They add that if there are clear management decisions regarding priorities, it relieves staff of the feeling of sole responsibility.

DATA

Very little data was used by any of the Area Centres, when planning their reorganisations. That which was available and used, does not seem to have led to any definite conclusions concerning the planning. What data they did use seemed mainly to be that which related to caseload balance and composition and population statistics.

Parsloe (1981, p. 46) provides some guide lines about what information could be useful to collect. She says, "if teams are to understand community need, there are four kinds of knowledge they would require about their area:

(1) general information about demographic trends;
(2) information about recurring social problems amongst local families and groups;
(3) information about local resources for dealing with local problems;
(4) information about how the policies of the social services department affect people in the area.

Social needs indicators can show where services may be needed and the type and extent of services required. Managers need this information at the time of a reorganisation to decide what their objectives should be and to plan the best use of the resources at their disposal. McKillip (1987, p. 43) defines social indicators as "aggregate statistical measures that depict important aspects of a social situation and of underlying historical and developments." He offers the following guidance regarding need analysis "A primary question in needs analysis is who (the target population or market) is potentially in need of services. This descriptive information has many uses: it sets the boundary on the potential problems and solutions; it reveals characteristics of the population that can be related to problems and service usage; when combined with information on use of services, it shows utilization patterns for sub groups." Social need indicators could be used as part of an priority system for example McKillip (1987, p. 47) states "By far the most frequent use of social indicators is risk factor analysis. Social indicators are chosen on their basic ability to predict problems or use of services at the individual level. For example epidemiological surveys found that an individual's social status predicts survey methods of mental dysfunction."

As well as indicating social need, data can help with objective setting and formulating plans to achieve them. McKillip (1987, p. 44) says that identifying relevant characteristics of the target population begins with service eligibility requirements and agency mission statements. Mckilip adds "Beyond eligibility restrictions, target population descriptions should include important demographic characteristics:

- Age
- income
- sex
- ethnicity
- location of population

A more detailed analysis may be required to identify specific problems and solutions."

Other data that could help when making decisions at the time of the reorganisation of an area centre discussed by McKillip (1987, p. 65) is that of "use analysis." He

says that "Use analysis combines expected use with analysis of actual use seen and services provided by an agency or program." He goes on to show how this "will identify heavy-use groups, who currently use services and may be interested in using more services, and light-use groups, who may need additional or different services, or a different delivery system."

CONSUMER INVOLVEMENT

Commitment to consumer participation developed about the time of the research but had not been greatly taken on board by these Area Centres. Most of those interviewed thought that the needs of the public had been given consideration, but much of the discussion that followed on from this concerned the needs of their own group or personal needs in relation to the team formats. The research showed that all three Area Centres saw the public that included "consumers" as mainly represented by "staff". This was based on a belief that social work staff had their clients' best interests at heart and this was the view accepted at the time. Webb and Winslow (1987, p. 232) when talking about people with learning difficulties and normalisation, point out "In practice, some of these principles are less clear-cut than they seem. For example, normal life in the community has many different patterns and there is always the danger of imposing our views of 'normality' and 'ordinariness' upon people unaccustomed or unable to participate fully in decision-making processes about their own future." An example of the dangers of staff thinking that they know what the Public want is given by Challis (1990, p. 74) when writing about community care, she says, "The most important objection to the hierarchical view of community care is that it is predicated on the idea of people being slotted into services rather than services being provided for people as and when they need them."

To participate, consumers need to have adequate information and training or support to enable them to so do. Brandon (1987) provides a seven stage pathway towards real participation. My summary of his recommendations are as follows:

1. Dissemination of information that consumers need in order to have knowledge about their situation.
2. Information is not useful unless people are consulted.

3. Consumers require skilled support in decision making - this might include self advocacy training.
4. Consumers need access to independent representation.
5. We need to develop structures to help consumers shape new services.
6. People need to experience a gradual devolution of wider decisions.
7. The process of devolution eventually results in effective management by consensus with staff help where needed.

Hugman and Hadley (1993, p. 15) found little evidence of consumer involvement regarding the reorganisation plans in their research and state "Given the value orientations of social services professionals, especially social workers, the lack of increased consumer involvement for service users was regarded as a failure of the reorganisation."

DUTY AND ASSESSMENT

The duty system arrangements caused particular difficulties to all three Area Centres. They all came up with different means of dealing with the work but none of them were completely satisfactory. Getting the duty process right is vital for the effective provision of services. The duty officer may be the first and only person clients may see in a Social Service Department. It is therefore very important that they get efficient and appropriate service. This includes the point of reception to the concluding assessment of need and any immediate help by the duty officer. The duty system is also a part of the area centre priority allocation system. In the duty assessment process decisions are made about the needs of a client, the appropriateness of the agency to help and what form this may take. A clear priority system is the basis of good assessment and allocation but, as said above, it was an aspect service management that was given inadequate consideration in their reorganisations.

The duty system can place responsibilities on those involved in making major decisions. Smale and Tuson (1988, p. 21) maintain, when speaking about social workers as gatekeepers, "social workers not only deliver services, they also play a role in making judgements about who should have the resources within the policies of their agencies. This dimension of their task has implications for the skills and

knowledge they require." It requires people to have a wide knowledge of resources, skills in interviewing and assessment of need. Unless it is a client-based specialist team duty system, it is the most generic work in an area centre. A generic duty system, can put specialist social workers in a position where their knowledge does not cover the field in which help is being sought. It is sometimes held that duty work can help widen the knowledge of specialist workers, but having to deal with situations outside their usual field of interest does not enable specialist staff to provide the best service to the public.

CHANGES IN THE ROLES OF TEAMS AND MEMBERS

Hadley and Young (1990, p. 65) state "the responsive organisation accepts the importance of seeking to establish what have usefully been defined as 'synergic' structures and methods of work. In other words, it strives wherever possible to create conditions for work that are mutually satisfying and reinforcing. Nevertheless, the dynamism of the responsive organisation necessarily involves tensions and conflicts in the search for more relevant and effective services. These are accepted as part and parcel of organisational life and a source of creativity as well as stress and problems."

There was a tendency in the Area Centre reorganisations to get the structure right and then consider the needs of staff. This was also found by Hayes et al. (1989, p. 72) who reported, "The attention given to management improvements in the personal social services had been very much on putting structures and systems in place, on the fair assumption that getting the structure right will result in better service delivery. However, senior managers have given a lot of careful thought to structural reorganisation but less to how the reorganisation is achieved. We found there was a lot of resentment and distress about reorganisations, almost regardless of what resulted from the changes. If front line staff are to accept changes then there needs to be sensitivity in the way they are implemented." Only a few choices of team structure were given serious consideration by the Area Managers. Mainly they looked at generic team working, specialist team working or patch system working or a mixture of these and an intake team. All three Area Centres opted for the traditional structures of generic or specialist team formats with the teams located together in offices. This also required fewer changes compared to patch systems,

for example, None of them considered alternatives to not having teams. A criticisms of services being provided from area centres is that they only give limited accessibility to the public. Bamford (1982) maintained that following the Seebohm recommendations, common to all structures had been the preoccupation of service managers with area offices. He thought that this had two detrimental effects. Firstly offices had rarely been local enough to meet the spirit of the Seebohm Report (1968) in terms of being a readily accessible focus for neighbourhood activities. Secondly the potential for collaboration with other agencies had been impaired by the concentration of fieldwork resources in the area office rather than developing the role of "outposted workers".

It is difficult to judge the degree to which specialist teams improved the support provided to adult services compared with previous support given by generic teams. As Davies (1991) says, in the previously mainly generic teams there was a large amount of informal specialist commitment. Judging by the outcome of the three areas centres examined, those with specialist team operation, with commitments to improve the services to adults, did not follow up by placing any substantial number of social workers in adult teams. The Townham Area Centre tried to judge the success of improved services to adults by comparing the caseload compositions of staff before and after the reorganisation. This showed an increase of the number of social work cases providing support to adults. However, it not certain if it was the structure or the commitment to improve services to adults that brought about the increase. The reorganisations took place at a time of rapid growth of child protection work with associated public scrutiny so, it was not surprising that managers gave this area of work a high priority when allocating staff to teams. The Hayes et al. report (1989, p. 50) found that, apart from child protection services, the staff of other client groups were being reduced and this was having an impact on the self-image and morale of fieldwork staff.

At time of the research there had been a growth of specialist social worker posts in Hampshire. The Social Services Department had agreed to support any increase in staffing associated with changes in legislative responsibility. This tended to result in an increase in specialist posts rather than generic ones. Having specialist social workers working in teams made the move into specialist team structures more likely, although generic teams were still a possible form of operations. Once the team structure was decided upon, managers could consider what the roles of the teams

would be and how work would be divided between them. Allocation of work is affected by the structure of the teams. With specialist teams the work was, generally, allocated to the team with the appropriate specialisation. It was more difficult with generic teams. That was why in the Townham Area Centre, I originally opted for three generic teams for the Area Centre. I decided that each generic team would do duty by rotation. Each team would follow up the referrals they took on duty that needed to be allocated for further work to be done. When I accepted the alternative proposal for the creation of a duty/assessment system, it radically altered the proposed team format to two generic teams and a duty/ assessment team. This was proposed by some very experienced and committed members of staff operating the existing Intake team. It operated very successfully for about two years until some of those originally committed to operating the system left, then duty/assessment system foundered and brought the need for a substantial change in the operation of the Area Centre.

It was thought by the AAM of one area centre team, that specialisations had improved the competence of staff and brought with it a more relaxed approach to work. At the same time, she acknowledged that people lacked the generic experience of social service work and, consequently, there was a greater need to move cases around and to match the experience people have to a particular case. It seems that the advantages of specialised knowledge may have been offset by reduced flexibility of operation, brought about by restriction of knowledge to a particular area of work. However, it was also thought that the content of the referrals following the move into specialist teams were clearer about what services were being requested. It could also be argued that with specialisation, the work allocated to staff would be made by team leaders clearer of their roles and that of the team and with a better knowledge of the resources available. One AAM had found that her previous position as a generic team leader brought with it a great deal of anxiety because of the range of knowledge required of her. It was further suggested that specialist departmental facilities such as day centres for disabled persons and child care establishments found it easier to liaise with specialist teams. But the adult service teams that were set up following the reorganisations were poorly staffed with social workers and such liaison was consequently tenuous. Nevertheless, I agree that they might have been able to liaise more easily with the team leaders of related specialist teams.

There were indications that it was difficult to appoint staff to some positions particularly those of a very specialised nature. These were not attractive to or recommended for newly qualified staff who were often the most available staff looking for employment. The Townham Area Centre found that generic working at that time of the reorganisation was attractive to newly qualified staff, who saw it as an opportunity to gain wide experience before considering specialising.

Managers must continuously be alert to the possibility of stresses developing within teams. These can affect the team as a whole or particular sections. Tom Cook (1987, p. 14) says, "Part of the problem in creating good teams in social work, and part of the reason why teams fail is because there is a lack of agreement about what teams are and what they should do." Attempts were made at the time of the research to bring a more controlled approach to the workloads held by staff. This involve determining the priority given to certain areas of work and a recognition of the various demands involved in such work. Glastonbury, Bradley and Orme (1987, p. 4) show how workloads can be managed for the benefit of the worker and the service. They state the form of workload management they advocate aims to:

1. Provide the basis for converting a potential into an actual workload, by setting and implementing rational priorities.
2. Ensure that the workload taken on is as near as possible to the capacity of the staff and other service resources.
3. Offer a procedure for identifying and handling and identifying or notifying headquarters of problems caused when high-priority tasks expose a shortage of appropriate resources.
4. Offer a means of ensuring that the work taken on and the way it is treated corresponds to statute and agency policy.
5. Provide for a balance of deployment of work across the staff group, taking into account not only the quality, but also such factors as specialisation and stress.
6. Ensure a high standard of service to clients.
7. Enable services to be offered of a kind and in a way which meet the references and aspirations of clientele.
8. Provide for an administrative and support system, which enhances the efficiency and welfare of staff.

9. Facilitate good communication within front-line teams, and between teams and clientele, community, allied services and headquarters.
10. Review the whole process of receiving clients, assessing needs and closing cases, with a view to maintaining standards and maximising productivity.
11. Minimize the disruption caused by emergencies and fluctuations in the pressure of work.

There are various ways of measuring workloads such as time-based weightings and numerical systems where tasks are given a numerical weighting with one objective being to ensure that each social worker is fully but not over occupied. It then becomes necessary to identify an optimum workload for each member of staff.

One of the difficulties that managers had in the reorganisations was deciding in which teams to place specialist staff, particularly the specialist groups such as OTs. The OTs and HHOs interviewed did not see themselves as team members to the same extent as, for example, the social workers. Challis (1990, p. 44) when discussing 'hard to place' specialisations said of occupational therapy, "This appears difficult to fit in to SSDs which have a functional structure, very difficult in geographical determined structures, but relatively easy to fit into client group based SSDs if the differentiation of client group is sufficiently fine, particularly if it is a client group classification depends upon 'problem 'as well as 'age'." I do not think that any area centre researched had resolved this problem completely. As said elsewhere, they were teams within teams. For example, the home help managers and OTs saw themselves as working groups. Challis (1990, pp. 43,44) says, "incorporating some specialisms within SSD has proved very difficult; this difficulty seems to be one of the features common to most, if not all SSDs which have redesigned their Structures."

It is difficult for a team that is built up partly as a matter of supervisory convenience to have a common purpose except in the most general way. Cook (1987) quotes Douglas as saying, "One of the most common problems where social workers mix with other occupations is a failure to agree on a common criteria to judge the effectiveness of a team. Each occupation will "input" its own standards to judge the team by. Assuming social workers will want to use what could be termed "caring criteria" to judge the team's success, these could come into conflict with criteria, for example with cost efficiency." Glastonbury, Bradley and Orme (1987, p. 112), when

talking about the management of OTs suggest that "The supervision provided by an area team leader will not cover professional guidance/decision making related to discrete skills of an OT. This responsibility should correctly rest with a senior practitioner who would also have executive responsibility for approving expensive adaptations or equipment designed to help disabled people to remain in their own homes with the maximum level of independence."

The decisions regarding the location of staff in rooms also caused difficulties for managers. When considering the placement of specialist staff such as OTs, I think that there are advantages and disadvantages in keeping such staff together. Keeping them together gives them the opportunity for mutual support that includes sharing of knowledge and experience. However, if they are placed in a room of their own, they can become isolated from colleagues in other fields of work. I found the advantages of grouping together people with the same specialist areas of work outweighs the disadvantages.

Because of the change in team structures of all three Area Centres, and because in two of them there was an increase in the numbers of management staff, there were changes in the delegation of responsibilities. The Area Centres where the number of team leaders increased benefited from the improvement in the ratio team leader to staff supervised. The AMTs were also able to share out responsibilities among the increased number of team members.

WORK SATISFACTION

At the time of the research, most people who were service providers were probably attracted to the work because the work itself was satisfying. AMs thought that work satisfaction was something to be aimed at in the reorganisations. Consequently they aimed at giving the views of the staff high priority. But work satisfaction can be undermined if the stresses related to the work get too great. For example, those working in the child care fields reported that with the growth of child abuse work, the stress levels came to a point where the work satisfaction became questionable.

The Haynes et al report found that women felt more aggrieved about the inadequate working conditions than men did. This was also the case in this

research. The also found that most fieldworkers in the area centres surveyed by them were women but they were in a minority in management positions. It might be that being under represented at management level, women members of staff had their views acknowledged less than men did. Coulshed (1990, p. 156) examined what accounted for low entry and advancement of women as managers in organisations. She says, "The literature suggests there are three barriers: personal, interpersonal and structural: personal and psychological barriers are essentially those of 'blaming the victim' kind: that women lack self-responsibility, are afraid of success and are not as career-oriented as men. Interpersonal constraints are said to include an unwillingness to take risks with a desire to please others, dependence and avoiding competitive or assertive behaviour." She stresses that none of these hypothetical barriers is supported by research which shows that they are more likely to face "structural obstacles" associated with "masculine" theories of organisation and management.

Not all members of staff were satisfied by the eventual decisions. Some felt that they had lost out in the reorganisations. Many of these were staff most affected by the break-up of the previous work groups that had provided social support. Hadley and Hugman (1992) divided up people into winners and gainers, maintainers and losers, according to how they saw the outcome of the reorganisations they examined. About 2/5 of the sample were seen as gainers and 2/5 as losers. The conclusion they came to was that while organisations can expect some temporary drop in staff morale, particularly if it was high before the change, by appropriate action, organisations may be able to minimise the adverse impact of change. People did leave following the reorganisations, but those interviewed were mostly uncertain about whether or not it was the reorganisation that caused staff to leave. It might have encouraged people to change jobs that they had previously been considering doing so or have been seen as a suitable cut off point at which to retire. The staff turnover in area centres can be high any time.

Hadley and Hugman (1992) saw a fall in job satisfaction when examining the effects on staff of Stockport's reorganisation of Social Services. They say "Change is an everyday experience in Social Services Departments and voluntary organisations." They add "we are exhorted to embrace it as a positive force and see it as an opportunity rather than a threat" but go on to point out the evidence of low morale that can follow. In their research before reorganisation a high level of job

satisfaction was found and "substantial satisfaction from day to day relationships with colleagues in their work groups." However, most accepted the case for reorganisation. They reported that the turbulence of the next few years was marked by a steep fall in work satisfaction. They hold that "organisations may be able to minimise the adverse impact of change."

The following is my summary of their recommendations:

- Try to establish the nature of work satisfaction equilibrium in the pre-change organisation.
- By discussion, identify with people the most valued elements in their work, their competence and degree of autonomy.
- Be alert to the potential significance of conditions surrounding the job, including the network of informal work relationships.
- Ensure that in re-allocating jobs and people, the potential impact of change on the work satisfaction equilibrium are considered, and design jobs with and for people, not simply as part of a system.
- Help people reframe their work and explore new opportunities that may present.
- Reduce the uncertainty and confusion of change, even if this means its pace must be slower.
- Build in review processes that make it easier to pick up failings in the new system and to adapt.

STAFF CHANGES

When a reorganisation includes the appointment of an additional team leader, as in the Townham and Southam Area Centres, the AM will be faced with the problem of whether or not to appoint the additional team leader before or after the reorganisation. The AM of the Southam Centre saw an advantage leaving the appointment of team leaders to existing vacancies until after the reorganisation. This enabled him to select team leaders for specific specialist teams. A similar view was held in The Townham Area Centre. However, the disadvantages the Townham Area Centre found was that the person appointed faced the dual problems of having to take on immediately the supervision of a newly formed team and being inexperienced and unaccustomed to the Area Centre and departmental procedures.

The staff in Townham and Southam Area Centres were given the opportunity to express a preference about which team they wanted to be in and most of the requests were met. In The Townham Area Centre, each team leader knew the preference of their existing team members through discussion with them. An attempt was made to create a balance of interest and experience when people were allocated to the two generic teams. It might have been better for the staff had the new Team Leader been in post before they were allocated to his team. As it was, the team had to be jointly supervised by the DAM and myself until the new AAM arrived.

There were staff who resisted the changes associated with the reorganisations in all the Area Centres. In the Townham and Southam Area Centres this was less of a problem as the changes were identified with the provision of additional management staff, which was seen a positive contribution to the Area Centre. To get staff to "gel" there must be common objectives and commitment. In the Midham Area Centre it had been difficult to achieve this with the staff of the two amalgamated offices. There was a strong resistance to the changes brought about by the Headquarters' decision to amalgamate the two Area Centres. However, after the amalgamation, the combined staff were able to consider a greater range of operational possibilities. There can be economies or more opportunities for modification and experiment in a more highly staffed area centre. The number of team leaders is also important. With all three Area Centres the possibility of having more than two teams gave an increased opportunity to consider specialisation, although, the number of staff below the Team Leader level remained much the same.

The administrative staff did not appear to have been greatly involved, or shown much interest, in the reorganisation in any of the area centres. It would appear that they did not appreciate the possible "knock on" effect of the changes in team structure to their ways of working. For example the siting of clerks in team rooms had advantages to those teams but changed the pattern of working of all the administrative/clerical staff.

AMs need to be aware of the likely resistance to change. Hugman and Hadley (1993) quote O'Shaunghnessey (1976, pp. 265-6) who states that resistance to

change in organisations can arise from several factors. He identifies four, these are:

(i) a high level of 'sunk' costs (i.e. the accumulated time, effort and money invested in developing and maintaining the existing structures);
(ii) the degree of change being implemented (greater change is likely to produce greater resistance);
(iii) the degree of system integration (a highly integrated system may be effective in achieving action but may be difficult to change);
(iv) the extent to which change requires individual behaviour to alter (this may relate to role security, learning capacity and social relationships)

O'Shaunghnessey, saw these factors as relating to departmental divisions but they could equally relate to changes in area centres.

WORKING CONDITIONS

Managers need to be clear about their office requirements, in order to advise the architects when building changes are likely. The cost of the building modifications can be restricting factors. Another problem is planing for future growth. It is difficult to justify additional space requirements unless you can clearly identify expansion that would get departmental support. This can be difficult. Consequently, many relatively new offices can be quickly become overcrowded. This has caused some managers to become "imaginative" about their existing space requirements.

Staff can strongly react to physical changes in their environment. The allocation of rooms to staff caused difficulties in all three Area Centres. The problem is usually that of the size of rooms and staff numbers and the mix of staff in those rooms. A large room can provide a social atmosphere in which all the team members are together and communication is good but it can be also a distracting environment. Some area centres, but not many because of the lack of office space, provide staff with single rooms; these can be isolating. Small group rooms require a careful balance of personalities. The situation can be aggravated by a reluctance of staff to change and a wish to retain the social contacts that people have established in a previous team or office room. There is no easy answer. It seems from the research

that there may be advantages in grouping together in the same room people who benefit from being together because of their specialisation or need to communicate. However, they should not be isolated from the rest of the staff as most of the work in an area centre is interrelated.

CHANGE AND STRESS

The Hayes et al. report (1989, p. 14)) showed that "A major role of the social worker in the 1980's is a rotation of limited resources including that of their own time. This is a highly stressful situation contributing to worker anxiety at a number of levels: concern over quality of work, non-allocated work, unmet need and relations with users."

The research shows that staff at all levels experienced some degree of stress relating to their work. Hayes et al. (1989, p. 46) found that "those working in the child protection field feel under pressure both from the nature of the work, and from the increased public scrutiny of the social worker's task." It was hoped the stress that caused by work demands that existed before the reorganisations would be removed or reduced by the changes. There was also stress that was associated with the changes involved in the reorganisation itself and there were unexpected stresses with the new team structures. Despite the advantages of specialisation, it does not necessarily reduce the stress related to the work. Specialisation in a narrow area of work can in itself bring about stress. For example, the stress relating to continuous child protection work was mentioned in the Southam Area Centre. The Hayes et al. report (1989) found specialist social workers to be among those finding their work most stressful.

The breaking up of previous supportive groups in the Area Centres by the reorganisations caused stress and anxiety to some staff. "Parsloe (1981, p. 105) referring to the roles of teams, quotes the Rowntree Report (1969). That stated that one of the essential purposes of the "team" is to give formal and informal support to workers particularly at times of stress and crisis among their clients, and this would be especially necessary in the new departments in helping workers to share experience as the team learned to work with different kinds of clients in new settings. This was found in the Area Centres researched. Some staff were

unhappy at being transferred into new teams with people they did not know. One person commented that some did not know all the people in the Area Centre. It could be argued that this does not matter providing they know the appropriate people to enable them to carry out their work efficiently. However, mutual support that can come from established informal work relationships can help reduce the stresses that can arise in work settings.

Staff in all areas mentioned the reduction of the informal support either directly or indirectly. It was usually seen as a loss of colleague support or a less supportive environment than that which had existed before the reorganisation. It could be that people were merely feeling anxious about new situations. It was probable that new groupings offering peer support would arise to replace those of the past. But, at the time of the reorganisations, many staff interviewed felt the lack of informal support from colleagues very strongly. These work-based friendships had provided formal and informal support. Given the pressures under which social services staff work, it is important to have colleagues with whom work-based worries can be discussed in addition to the supervisor. Glastonbury, Bradley and Orme (1987, p. 99) maintain that "If staff are working with complex and stressful interpersonal problems, and making very far-reaching decisions that will affect the lives of others, their working environment will need to be as supportive as possible." They add "social workers under stress can derive considerable emotional support from colleagues who are willing to give the time that is needed to explore the areas of pain and difficulty gently and carefully."

Stress is particularly likely when the teams are first set up. Cook (1987) says that it is important to spot "warning signs" which indicate that something is wrong in a particular team. He says that according to Tom Douglas, "typical signs are a fall in the level of job satisfaction and commitment shown by team members and a tendency to complain over seemingly trivial matters." He follows on "Another factor often seen in problem teams is the "blame syndrome." Although a clash of personalities is rarely the root cause of a problem it is often identified by protagonists as such. In terms of solution to team breakdown, Tom Douglas believes that the best strategy is to call in outside consultants who will be seen as impartial and objective and who can speak with all sides, thus gaining the fullest possible information about a situation." Cook's view is that "A team is a dynamic

unit which if properly set up will generate solutions to problems as well as problems themselves. A well set up team finds solutions to its own problems."

TEAM LEADERS AND SUPERVISION

The team leader's (AAMs or DAMs) role is a difficult one. It could be seen as the first step in the management hierarchy and the one that links management with the staff. It is at that level that most allocation of work, staff supervision and control of resources takes place. It is a very demanding role and is usually carried out by staff with little management experience. The time that a team leader can give to his team members can be reduced by their other work commitments. This is particularly likely if a team leader has strong interests in areas of fieldwork not directly related to his or her team leadership role. An area centre has to carry out these functions, and so the team leader must negotiate the allocation of time between these areas of work with his or her AMT colleagues and staff supervised.

The Team Leaders interviewed felt under considerable pressure. They were sometimes in a quandary about where to seek support. If it came from their own team members, as does happen, it may create difficult situations, if, for example, the team leader later needs to discipline the person involved. The Team Leader interviewed in the Southam Area Centre expressed strong feelings of frustration regarding her role before the reorganisation. Her remarks indicated feelings of lack of support, isolation and competitiveness between team leaders. Cockburn (1990,p.83) found that most team leaders, especially newer and inexperienced ones thought that they were unsupported by their senior managers and consequently had no way of assessing their progress. He adds "Team leaders felt that support was not seen by senior management's to be a legitimate need, and felt aggrieved by this attitude" Such situations can result in an unstable management team, which can find difficulty in focusing on positive developments.

All three Area Centres sought to reduce the ratio of staff to team leader to improve the quality of supervision and relieve the pressures on the team leaders. It was for this reason that the AMs used the DAM post also as a team leader. Staff always seeks good supervision; it can reduce stress and improve morale. However, the quality of supervision found in the research varied considerably.

DECISION MAKING AND MANAGEMENT STYLE

Reorganisations are infrequent and managers are not necessarily equipped adequately for the tasks involved or able to learn from experience. In the Area Centre reorganisations researched, most of the members of the management teams and a majority of the staff were professional social workers. It was noticeable that managers, including myself, wanted to be seen as both managers and social workers. This was reinforced by our involvement in some of the social work decisions in individual cases, particularly those of a politically sensitive nature. As social workers committed to involving clients in decision making AMs were anxious to be seen as involving staff in the decision making process regarding the reorganisation. This would have been in accord with social work beliefs as it relates to clients. As managers they recognised a responsibility to the Department for the decisions regarding the reorganisation. There was, therefore, conflict in the minds of the AMTs, particularly for the AMs, between the planning and controlling of the changes and the involvement of staff in the associated decision making.

All three managers, with their AMT colleagues, had ideas of what they wanted to achieve before it was formally discussed with other staff. Once a reorganisation became possible, as in Townham and Southam, or necessary as in Midham Area Centre, each AMT saw it to be important to involve staff in the plans for change. It seems that, initially, preferences regarding the reorganisation outcomes were discussed in an unstructured manner within the Area Management Teams. This included the purpose of the discussions with staff and the means of obtaining staff commitment to the views that were already being formed by the AMTs. It is not surprising that members of the AMTs had preferences for particular team structures and then as managers set out to "sell their ideas" to staff. But in such situations managers should be open about their views and remain receptive to the ideas of staff. Furthermore, the staff need to know the extent of their involvement. It would appear that the prime concern of the AMTs was what team structure would be best to provide an effective service.

It is difficult to isolate those elements in the management processes of the reorganisations that could be linked to professional social work training influences, management training and those of a general management style. The type of management approach that encourages the involvement of staff in decision making

was claimed by all three of the AMs. As they had had the same social work training as their staff and shared the same values and principles it should have helped making change easier. Nevertheless, differences can arise because social work principles are not always the same as those of management, when it comes to service provision. Resource shortages particularly, can bring about different views about what choice is the best for services to clients.

Hugman and Hadley (1993, p. 5) highlight the significance of management style in their account of the reorganisation of the Social Services Division of Stockport Metropolitan Borough Council. They aimed to explore, particularly, the ways in which issues of the involvement and motivation, as in the classic neo-human relation's theories, could be seen to operate in the major restructuring undertaken by this large public sector organisation. They state "In doing so we focus on the perceptions of 'management style' as a crucial issue, taking it as a touchstone of the pattern of social action that shaped both the emergent structures and staff responses to them." They suggest that "as opposed to the stark choice between autocracy and democracy, goal setting if pursued participatively (that is, through the direct involvement of staff at all levels) could provide a means of operationalising the vision for change." Coulshed (1990, p. 5) found that women managers, in particular, found it "soulless" to use current management styles and concepts which emphasise control and what might be termed 'manipulative gamesmanship'. She says "Women colleagues tell me that they have been trying to persuade their managers to see that concern for people's needs at work and honest relationships are signs of strength, not weakness."

Area Managers said that they considered the recommendations of staff and all opinions or views were listened to. However, the research found that varying values were given to the views depending on the experience and knowledge of the persons who expressed them. Bamford (1982, p. 153) states, "Decision-taking is central to the management task at all levels." While decision making might be a management task, there was evidence that managers did remain open to influence from the views of staff when decisions were made. At the time of the research most HHOs and administrative staff did not have qualifications directly relating to their work, whereas social workers and OTs had professional qualifications. As a consequence, I think that there was an unacknowledged hierarchy with professionally qualified social workers at the top of the non-management staff

hierarchy. This was reinforced by the accepted procedure at the time, that only those with a social work qualification were appointed to the management positions of teams at area centres

A major finding of the research was that Area Managers used the reorganisations as a cloak to bring about changes they already had in mind. A prime factor in this was their confusion between work practice and management principles. They wanted to involve staff but also maintain the management role. As a consequence AMs were not open about the extent to which they allowed the participation of staff in the decision making. This resulted in their using the reorganisations as a cloak to attempt to make changes they wanted to achieve. Hugman and Hadley (1993, p.1) also saw the danger of the pretence of involving staff in decision making. They say that within the classic framework the task of good management may be seen as that of involving and motivating subordinate colleagues rather than directing them, while more recent critics of that view hold that "it was a pretence, although managers might be seen as deceiving themselves as much or more than their workforce."

When it comes to staff influencing management, staff are at a disadvantage if their views are fragmented. A manager suggested elsewhere that to get changes made it is necessary to "hunt in packs." This may be the reason why those most listened to by management in the reorganisations were sub-groups such as OTs and HHOs. Such group influences would also depend on such things as leadership, a good spokesperson and presentation. This was very much the situation in The Townham Area Centre, where the AMT had a preference for three generic teams. However, when members of the existing intake team presented a strong case, a decision was made to have two generic teams and a duty/assessment team. The management teams of the other Area Centres were also receptive if a strong alternative proposal was made. These also usually came from groups such as the HHOs and OTs who had close group commitment and work patterns and consequently tended to put proposals as a group rather than as individuals. It was also noticeable that those whose views were influential, presented them in an organised and formal way. I suspect that this was partly the basis of the strong influence of the views of the AMTs. They were in a better positions to structure their views and had the administrative and clerical back up to present them in a formal way besides the hierarchical considerations.

The external influences on decision making were mainly regarding the notice taken of the general increased service demand. There was also the influence of the increased particular types of demand for example that concerned with child abuse and the heightened awareness of these situations in the minds of social workers, the Public and the Press. This was reported to have influenced the way those systems were designed for the future. Geography can also be influential and plays an important part in the development of good working relationships with other agencies. Usually it is easier to establish closer working links with offices near to your own. Close proximity can facilitate frequent personal and social contacts. The better these relationships the more they are likely to be of influence.

It is difficult to assess influences of personal opinions on decision making. For example staff may be influenced by their political and moral beliefs. Political beliefs were fairly strong in the Townham Area Centre. Jordan and Parton (1983, p. 1) maintain that "social work is essentially a political activity." They go on to argue (p. 17) that " the act of drawing attention to client's needs, or to declining standards, is clearly political." However, I do not think that political beliefs were influential to the outcome of the discussions regarding the reorganisation of the Townham Area Centre. Little was reported about external influences regarding decision making. However, AMs were aware of changes and reorganisations in other area centres and of other possible forms of operation.

Most non-management staff interviewed believed that final decisions were made by the AMT or the AM but thought that they had been involved in the decision making. However, not many of those interviewed in the research programme were aware that their AMT had definite ideas of what they wanted to achieve at the start of the decision-making exercises, although some suspected this. AMs acknowledged that once AMT had formed a preference, they set out to carry the rest of the staff with them, although, being willing to consider alternative suggestions. Hugman and Hadley (1993, p. 10) found that "managers expected to be involved more in management activities and policy formulation than did professional practitioners or front line workers." They add that the "organisational position of staff affects perceptions for involvement, which can only be meaningful to certain levels of staff, because involvement is associated with social power that is differently distributed within the hierarchy." However, the staff interviewed thought that their Area Centres had attempted to arrive at decisions in a way that acknowledged the views of all

staff while recognising the manager's ultimate authority to make the final decision. To a large extent the decisions were made by AMs but with attempts to obtain staff *consensus. They were also largely biased towards the needs of the staff* particularly those of the most influential members.

REORGANISATION TIMING

Most people interviewed thought that the reorganisation in which they were involved took place in the right sequence. Only the Midham Area Centre thought that the length of time was inappropriate. There, they thought that it had taken too long but blamed this on the delay in the building being available. The Townham Area Centre attempted to put the plans for the reorganisation in a chronological sequence. However, there might have been more in control of the reorganisation if we had used formal critical path analysis. Very few people thought that anything should have been done differently. It is possible that some changes could have taken place before the reorganisation. It seems that difficulties that were festering for some time such as pressures on intake teams, poor services to adults could have been dealt with earlier.

POST REORGANISATIONS AND REVIEWS

Following their reorganisations all three Area Centres thought their objectives had been achieved. In respect of creating new teams, this was so. However, any improved efficiency coming from the new team structures was difficult to assess. There was little information available to show improvements in service provision. Claims that were made of improved quality of service, tended to be subjective.

There was considerable uncertainty about whether or not they had carried out a review of their reorganisations. What were said to have been reviews seemed more like actions taken to deal with problems resulting from the reorganisations. The Area Centres researched had been too general when they set their objectives, consequently, it would have been difficult for AMs to carry out adequate reviews to see if these had been achieved. It is difficult for teams to judge whether or not they have achieved their objectives without preconsidered measurable standards of

success. Generally in social services, measuring the quantity of work is easier than the quality. Hadley and Young (1990, p. 118) put forward four main points to be considered in the evaluation of public services:

1. Are they reaching those for whom they were intended?
2 Are they being delivered according to the intentions of the legislation?
3. Are they being provided within the budget allocated?
4. Are they answering the needs they were created to meet?

It would appear that area centres will continue to have reasonable autonomy for organising team structures in the future. Consequently many of the same factors found in this research will arise again in future reorganisations. The research aimed at showing how three area centres dealt with their reorganisations and looked at the difficulties that arose and how the process could have been more efficient and less stressful. It is important for managers who have to make such major decisions, as those concerned with the reorganisation of an area centre, should receive management training to enable them to deal with the matters involved. Hopefully, their social work training will further assist them to deal sensitively with those issues that affect the welfare of the public and staff.

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APPENDIX 1.

DEFINITIONS

The terminology used in social services departments to describe such things as roles, functions, organisations and responsibilities may vary from one local authority to another. I will use the following terms with the meanings as given below. I have put the abbreviations that I will use alongside the relevant term or position.

Area Administrative Officer (AAO). This was the Senior Administrative post of the area centre. The Officer was responsible for all clerical and administrative support for the Area Centre. The AAO in most area centres was seen as a member of the area management team.

Assessment. This the process of determining the needs of a referral or existing case. It can involve judging the referral's priority rating and the resources available to meet the needs identified. It may also include recommendations as to whether or not the referral should be dealt with further and how.

Assistant Area Manager (AAM). These were generally team leaders. They worked to the area manager or the deputy area manager in his/her absence. As team leaders they were responsible for the supervision of staff within their teams. This would include the responsible for the supervision of staff within the teams, the allocation of work to the staff, the quality control of the work. They would be involved in the recruitment of staff to their team. They were part of the Management team.

Area Centre. The County at the time of the reorganisations examined was decided into I7 Area Centres plus 4 independent hospital /health based teams that had the same responsibility. The area centre included the building in which the local social services provisions, which were the responsibilities of the AM, were located. It was usually situated in the geographical area that its services covered. They mostly had geographically boundaries conterminous with those of local district council authorities. The cities were covered by more than one area centre, for example there were three independent area centres covering the City of Portsmouth.

Area manager (AM) This was the person appointed to manage the resources that are provided from the area centre. These include the social work provisions, occupational therapy services, home help services, specialists services such fostering recruitment and support day care services, support to the Courts, the administrative support services for the area centre, plus other special areas of work.

An area manager was also responsible for the assessment of need of people for residential and day care services. But the operation and management of these services at the time of the research was the responsibility of centralised staff at the Headquarters. In short an area manager was responsible for all the services from the area centre and the staff that provided them.

Area Management Team (AMT). This refers to the management team of an area centre. The Department never formally instituted them but area managers increasingly established them. Their composition varied but generally they comprised the area manager, deputy area manager, assistant area manager and the area administrative officer. Their functions and responsibilities also varied but generally they were designed to co-ordinate the management of the area centre. This included the maintenance of the services provided and future planning.

Client. This generally refers to a member of the public who has requested a service that the Social Services have agreed to provide or who has accepted a service that the Social Services have offered.

Community Care. At the time of the research there were many views about what community care. Most of them stressed that services should be provided to enable people to remain in their own homes as independently and as long as possible.

Deputy Area Manager (DAM). This was the deputy to the area manager. Not all area centres had a DAM. The DAM could also lead a team that reduced the deputising function. The area manager determined the way the DAM was used.

Duty Work is generally seen as the system of receiving referrals particularly from clients calling at the office or by telephone requests for help. It also includes referrals from other agencies and professionals. Duty work is usually carried out by staff on a rota basis and often they are on duty only for that particular day. They are usually only required to receive and record the information regarding the referral but not carry out the work involved. Duty work can be part of the work of the Intake Team where one exists but it can also be, and often is, a separate operation.

Fieldwork. This refers to those services provided directly from an area centre. It does not include the residential or day care services provided by a department.

Generic refers to work related to all forms of Social Service referrals. I use it specifically regarding the caseloads of social workers in which there is a mixture of cases with a wide spread of client groups. "Generic team" refers to teams that comprise social workers with generic caseloads.

Home help organisers (HHO) are employed to manage home helps that provide domiciliary and personal care services to members of the public in their own homes.

Intake refers to the reception of new work or referrals from all sources and generally by any method by which it comes in to an area centre. It includes requests received from clients calling at the area centre and written referrals from clients or other agencies. Duty work and assessment together are often called intake

Intake Team refers to a specific team that deals with the intake of work. Duty work usually deals with new referrals that need immediate attention. Intake work tends to be with planned assessment and short term work. The boundaries between duty work and intake work are sometimes blurred.

Referral is a request for a service received by any means from the public, another agency or other profession.

Reorganisation, I use this as a general term to mean planned changes related to the area centre including a restructuring of the teams.

Restructuring, I use this to relate to a reorganisation of the structure of the teams of an area centre including the number of the teams.

Social Services Department (SSD) refers to a Local Authority Department of a County Council or Metropolitan Council that has the responsibility for providing, or arranging to be provided, those services that the Local Authority is required or can provide under the various statutes associated with that Department. They were established by the Local Authorities Act 1972

Social services officer (SSO) **and social services assistant** (SWA). These were grades of unqualified staff who carried out fieldwork provisions associated with social work. The social services officer was the senior of the two positions.

Specialist refers to staff who work with clients with specific needs. For example they may work with children or adults only. Specialist teams comprise such social workers

Teams -the composition of these varied from one area centre to another. They could comprise only social workers working in a specialised area of work such as work with children and young persons. Or, they could have a mixture of staff such as social workers, occupational therapists, home help organisers and other specialist staff. Most were mixtures of staff.

Team Leaders were DAMs or AAMs directly responsible for teams. They were professionally qualified social workers and on higher salary grade than the staff they supervised. Their teams could contain a mixture of staff in specialised fields and unqualified staff.

APPENDIX 2

INTERVIEW SCHEDULE

QUESTIONS TO BE ASKED OF ALL KEY INFORMANT STAFF INTERVIEWED

PRE-REORGANISATION - (questions relating to this period)

A. PREVIOUS STRUCTURES.

1. What was the departmental structure at the time of the reorganisation?

2. Describe the Area Centre's structure prior to the reorganisation?

B. CAUSES OF REORGANISATION

1. In your view, why did the reorganisation take place?

2. What external changes had taken place effecting the Area Centre?.

3. Were there any changes in resource allocation, for example, new resources in specified areas of work or cuts in others?

4. How did the reorganisation take place and how were you involved in it?

THE PROCESS OF REORGANISATION - (Questions relating to the processes used and timing)

C. OBJECTIVES

1. What were the aims and objectives of reorganisation? What did you hope to achieve?

2. How were these objectives determined and who was involved?

3. Whose needs were considered? What priority was given in the reorganisation to the needs of a) the Public, b) the staff, c)The Department d) other agencies, e) your own work group, f) Your own personal needs?

D. INFLUENCES

1. What considerations were given to social need indicators of the Area Centre such as socio/economic groups, housing structure, the number of single parent families, juvenile crime figures, the number of children in care or at risk and other vulnerable groups?

2. Were you influenced by the presence or absence of other statutory or voluntary resources in the area?

3. Were there any influential group pressures, ideologies or social work methods existing at the time of reorganisation, which affected the outcome?

E. TIMING

1. When did the Area Centre reorganisation take place?

2. What length of time was aimed at for the reorganisation and how long did it actually take?

3. What was the planned sequence of events in the reorganisation process and did you keep to this plan?

F. DATA SOURCES

1. What out side help or information was sought including
   a) From within the dept?
   b) From other agencies?
   c) From written material?

2. What statistical or demographic data did were used in order to lead to decision making?

3. Has the Area Centre a priority listing policy regarding work allocation. If so, how does it set priorities and did this influence the planned changes?

G. DECISION MAKING PROCESS

1. What choices of team structure were considered and were there any strong preferences held prior to decisions being made?

2. Who was involved in decision making?

3. What value was given to various preferences expressed and did this depend on who expressed them? If so why?

4. How were you able to ensure that the needs of the Public, the staff, and the Department were adequately represented when decisions were made?

5. How were fieldwork staff involved?

6. How were administrative and clerical members of staff involved in the restructuring plans?

7. How were decisions arrived at?

8. Who made the final decisions?

9. How were the final decisions made?

10. How did you see the changes involved in the reorganisation as helping you meet your objectives?

11. Why were the other structures considered thought to be unsuitable?

12. How were these decisions communicated to those not involved in he decision making process?

13. What documents are available regarding the reorganisation?

H. **CHANGES IN THE ROLES OF TEAMS - What decisions were made about the following:**

1. The number and type of teams.

2. Duty/intake work arrangements.

3. Work allocation procedures.

4. Case transfer procedures.

5. Any special roles of the teams regarding service provision.

6. The process of reorganisation regarding the building and operational requirements.

7. Area Centre work priorities.

8. Any changes in Area Centre policies or philosophies regarding the provision of social services to the public.

I. STAFF CHANGES

1. How were staff allocated to teams and what determined this?

2. How were specialists e.g. home help organisers and occupational therapists etc located in teams and why?

3. Did decisions regarding the number of staff in teams and types of specialists in the teams reflect Area Centre priorities in any way?

4. Did these changes affect the administrative staff ?

5. What were the feelings about allocation of staff to teams?
   a) by the staff concerned.
   b) by you personally.

6. What Problems were encountered, for example, were there resistances to changes of team or roles from within the Area Centre, the department, and other agencies?

7. What was decided should be the staff composition of the teams?

8. Were the functions of the management team or membership changed?

9. In the process of managing the changes, what anxieties arose and how were these resolved?

10. How was staff co-operation and commitment to reorganisation obtained?

AFTER REORGANISATION - (questions relating to this period)

J. WHAT HAS HAPPENED SINCE RESTRUCTURING?

1. Have the changes affected the duty/intake work?

2. Have objectives been achieved and what indication is there of this?

3. Have any other related changes taken place in consumer demands?

4. Have caseloads reflected objectives?

5. What unexpected results have arisen?

6. Have there been any changes in the delegation of responsibilities since the reorganisation?

7. Who gained and who lost out in the change?

8. Did staff leave and if so why?

9. Have there been any difficulties in recruiting staff for a particular team?

10. Do you think that the reorganisation was planned in the right sequence?

11. Do you think that the time given for the reorganisation was inadequate or too long?

12. What should have been done differently?

13. How was the restructuring communicated to other agencies?

14. What problems arose and how were they resolved?

15. What are the current problems relating to the structure of the Area Centre?

K. THE FUTURE AND RECOMMENDATIONS

1. Will the reorganisation be reviewed? If this has been done, what was the outcome of the review?

2. What future plans to reorganise are there?

3. What advice would you give regarding reorganisation to someone else?

4. Is there anything else you would like to say?

L. PERSONAL MATTERS

1. What is your job title?

2. What is your profession, Specialisation or special interest?

3. What are your work responsibilities or duties?

4. Are you full-time or part-time employed?

5. What team were you in before the reorganisation?

6. What team are you in now?

APPENDIX 3.

CORRESPONDENCE

FOLLOW UP LETTER TO AREA MANAGERS

Dear

You will recall our discussion and my request for your help with my research project. I would now like to start interviewing at your Area Centre. I enclose some proposals as to how I would like to go about it. Would you please let me know if you see any difficulties. I would be happy to come to your office and talk to the staff about what I am doing, if that would be convenient.

I would also like to interview you and discuss with you how to select the key informants as defined in the attached notes. In order to do this, you would need to know who were present at the time of your reorganisation and who are still working in the area.

If I do not hear from you, I will assume that you see no difficulties and will phone you shortly to make arrangements to come over and talk to you.

I will try to not get in the way of anyone.

Yours sincerely

EXPLANATORY REPORT INCLUDED WITH THE LETTER TO THE AREA MANAGERS

Research Into the Reorganisation of Area Centres

The research project is to examine how area centres carry out major reorganisations. This will include the causes of the reorganisation, the objectives of the reorganisation, the process of the reorganisation and the outcome. As well as interest in the research itself, it is hoped it could be helpful to others considering future such reorganisations.

I have decided to qualitative research approach based on case studies in 3-4 Area Centres. This will include my own Area Centre.

I would like to interview about ten key informants in each Area Centre. Key informants are staff who were present at the time of the reorganisation and are still working at the Area Centre. Each interview will take about 1-1.5 hours.

I hope to interview staff who prior to the reorganisation were in the following positions. Area manager, deputy area manager, assistant area manager, occupational therapist, home help organiser, area administrative officer, unqualified member of staff such a social services officer, three or more social workers. If possible the social workers should have been in different teams prior to the reorganisation.

I attach a list of the of questions that relate to the reorganisation of your Area Centre that will be the basis of the interview and a guide to selecting key informants.

Questions to be asked of all key informant staff interviewed will cover the following points.

PRE-REORGANISATION - questions relating to this period.

CAUSES OF THE REORGANISATION.

PROCESS OF CHANGE - questions regarding the process of change and timing involved.

OBJECTIVES OF THE REORGANISATION.

INFLUENCES ON THE REORGANISATION.

DATA SOURCES AVAILABLE.

DECISION MAKING PROCESS.

STAFF CHANGES.

TIMING OF THE REORGANISATION.

AFTER THE REORGANISATION - questions relating to this period.

THE FUTURE AND RECOMMENDATIONS.

PERSONAL DETAILS.

GUIDE SENT TO AREA CENTRE MANAGERS

Guide For Selecting Key Informants

Key informants are staff who were present at the time of the reorganisation and are still working at the Area Centre.

1 Area Manager

2 Deputy Area Manager

3 Assistant Area Manager

4 One Social Worker from each team. Try to get a spread of experience and length of service.

5 Home Help Organiser

6 Occupational Therapist

7 Area Administrative Officer

8 Unqualified member of staff

If more than one type of staff is available, select persons to get a spread of length of service and experience.

FIRST LETTER TO KEY INFORMANTS

Dear

Research Into the Reorganisation of Area Centres.

I have spoken to .... and he suggested that I contact you regarding help with the research project I am doing as part of a part-time M.Phil. at Southampton University.

The research project is to examine how area centres carry out major reorganisations of their structures. This will include the causes of reorganisation, the objectives of the reorganisation, the process of reorganisation, and the outcome. As well as the interest in the research itself, it is hoped to produce guidelines for the use of others considering future such reorganisations.

I have decided to do research based on case studies on 3-4 Area Centre reorganisations. I shall interview about 10 key informants in each area. I am defining Key informants as staff who were present at the time of the reorganisation and are still working at the Area Centre,

I understand that you would meet this criteria, and I am writing to ask if you would be willing to be interviewed by me. Each interview will take about 1-1.5 hours. I think you will find the content of the interviews interesting and I will try to make the timing of them as convenient as possible to you.

I attach a list of the question areas of the interview to give you some idea of what form it would take. Some of the questions you may be able to answer fuller than others depending on your involvement in the reorganisation.

I will telephone you within the next few days and if you agree arrange to come and interview you.

I hope that you will be able to help me

SECOND LETTER TO KEY INFORMANTS

Dear

Thank you for offering to help me with my research. As I said in my previous letter. what I want to do is interview you regarding the past reorganisation of your Area Centre.

I am writing to confirm that I will come to your office at ..... on ..... The interview will take about 1.5 hours. It would be useful for the interview to take place in a quiet room with a power point, as I would like use a tape recorder for part of the time.

I attach a list of the of questions that relate to the reorganisation of your Area Centre that will be the basis of the interview.

Once again, thank you.

GUIDE TO INTERVIEW QUESTION AREAS SENT TO KEY INFORMANTS

Questions to be asked of all key informant staff interviewed
will cover the following points.

- PRE-REORGANISATION - questions relating to this period.
- CAUSES OF THE REORGANISATION.
- THE PROCESS OF CHANGE - questions regarding the process of change and timing involved
- OBJECTIVES OF THE REORGANISATION.
- INFLUENCES ON THE REORGANISATION.
- DATA SOURCES AVAILABLE.
- DECISION MAKING PROCESS.
- STAFF CHANGES.
- TIMING OF THE REORGANISATION.
- AFTER THE REORGANISATION - questions relating to this period.
- THE FUTURE AND RECOMMENDATIONS.
- PERSONAL DETAILS.