DOCTOR OF PHILOSOPHY

Innovative practice and occupational stress in care managment

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Award date:
2003

Awarding institution:
University of Wales, Bangor

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by

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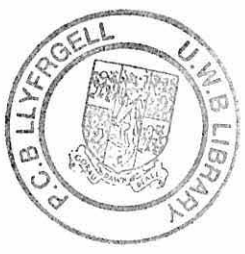

SUMMARY

Alongside the implementation of the NHS and Community Care Act 1990 came the wide-scale introduction of a new style of case management. *Care management* was to involve the design, monitoring and review of care packages based on a thorough assessment of service user need. Official documentation urged practitioners to "give full rein to their creativity in devising new ways of meeting needs". However, it was unclear how it could be achieved, why it might be beneficial and what factors might hinder or facilitate such practice. Two studies were conducted to investigate how innovative care management practice is characterised and undertaken by practitioners and what barriers and supports to such practice exist. The first study used case study methodology to examine in depth the innovative and non-innovative care management practice of five social work care managers. A model of the innovative care management process emerged along with provisional indicators of the factors influencing innovative (and non-innovative) care management practice.

The second study involved a survey of care management practitioners in Wales (N = 181). Since stress in the workplace is both deleterious, apparently on the increase in community care practitioners and potentially has an adverse impact on individual innovation, stress level change indicators were examined alongside self-reports of innovative practice. Both quantitative and qualitative findings from the survey provide insight into frequency, type and influencing factors of innovative practice; levels of stress and job satisfaction; the demands on and levels of discretion of care management practitioners; and the inter-relationships between innovation frequency, stress level change, job demands, job discretion and other relevant variables. Methodological issues are addressed and policy and practice implications outlined.

CONTENTS

LIST OF TABLES

LIST OF FIGURES

ACKNOWLEDGEMENTS

The two studies reported in this thesis were undertaken simultaneously with two funded pieces of research: (1) *Transitions in Community Care: Changing Assessment Practices* (1994-99); and (2) *The All-Wales Assessment and Care Management Project* (1994-97). These projects were funded by the Welsh Office/ Department of Health initially and by the Wales Office of Research and Development for Health and Social Care, National Assembly for Wales, latterly. I worked on the projects as a Research Assistant/Officer and agreement was gained from the funding bodies to conduct the PhD work. I am very grateful for their support.

There are many individuals who have helped me journey the long road from the germ of the idea for the research to completion of the thesis. I am indebted to each and every one, for without them I would never have reached the starting point, never mind the end! To my supervisors, first, an enormous thank you: to Professor Gordon Grant for helping me to formulate the overall plan and his support in the early days; to Professor Clare Wenger who has provided unflinching support and guidance since Gordon's departure from CSPRD; and to Professor Bob Woods for his invaluable comments and supervision during the thesis writing stage. To all my colleagues at CSPRD and IMSCaR who, over the years, have given me much needed encouragement, assistance and guidance at various stages. In particular, I wish to thank Kerry Caldock, Gordon Grant (again), Morag McGrath, Catherine Robinson and Paul Ramcharan, my co-researchers on the funded projects. Also, a very big thank you to Sue Howard, Research Administrator, for her help in compiling appendices and in type-setting the thesis, and for numerous tasks conducted as part of the funded research. I am grateful to Chris and Rhiannon Whitaker for statistical support and guidance, and to Brain Jones for technical and computer support.

Then, there's my family. To my two precious children, Cai and Madrun, who were born during the course of my PhD work and never quite understood why mummy had to work all those evenings and weekends – I look forward to spending more time with you! To my loving husband, Lodwig, who has shared all the ups and downs, done more than his fair share of the childcare, and given me his unwavering support – I can never thank you enough. To my father and brother who helped motivate me to keep going when I had numerous competing demands, forever confident that I would reach the end. And, to my mother, who involved me in psychological research as a child – thank you for giving me inspiration and a yearning to conduct research.

Finally, but definitely not least, I am exceedingly grateful to the practitioners who participated in both studies; to the service users, who's assessments and care packages were scrutinised in Study 1; and to the mangers who participated in Study 1 and those who assisted with distribution of questionnaires in Study 2. Without them the research could never have been conducted.

Beth Parry-Jones

February 2002

PART I

Thesis rationale and context

CHAPTER 1 INTRODUCTION

This thesis on innovative practice and occupational stress in care management consists of four parts:

- The first part introduces the rationale for the thesis and the reported research (*Chapter 1, Introduction*). The context in which the research is set is included as a series of three literature reviews (*Chapter 2, Care Management: A Vehicle for Innovative Practice*; *Chapter 3, Innovative Practice in the Workplace*; and *Chapter 4, Stress at Work*).

- The second part focuses on the methodology, findings and conclusions of the first of two studies (*Chapter 5, Implementing Study 1*; *Chapter 6, Care Management and Innovative Practice: Characteristics and Influencing Factors*; and *Chapter 7, Innovative Care Management Practice: Conclusions from Study 1*).

- The third part presents the second study's methodology (*Chapter 8, Implementing Study 2*), findings (*Chapter 9, Stress, Demands and Discretion in Care Management*; and *Chapter 10, Innovative Practice and Occupational Stress in Care Management*) and conclusions (*Chapter 11, Occupational Stress, Innovative Practice and Care Management: Conclusions from Study 2*).

- The fourth and final part, consisting of a single chapter (*Chapter 12, Discussion and Implications*), outlines the limitations of the findings, places them in the context of relevant policy and contemporary literature, and indicates what the implications are for policy and practice.

This introductory chapter includes the following sections:

- Thesis rationale
- Research overview
- Personal and professional influences.

Thesis rationale

The White Paper "Caring For People" (Department of Health 1989) and subsequent policy guidance (*e.g.* Department of Health 1990a) outlined proposals for changing the way in which community care practitioners were to undertake client assessments and care planning. A care management approach was envisaged based on needs-led assessments and the design of individually tailored packages of care. Although assessment of need and good care management were seen as "the cornerstone of high quality care" (Department of Health 1989, paragraph 1.11), practitioners were not provided with a framework of how to assess need or devise packages of care.

The generation of options to meet the needs of each client was deemed to be imperative to individual choice and self-determination, one of the main objectives of care management (Department of Health 1990a, paragraphs 3.3 and 3.5). However, little advice was offered within policy guidance documents as to how this was to be done. Several references were made to the need for creative, imaginative or innovative thinking when planning care; for instance, "...practitioners should give full rein to their creativity in devising new ways of meeting needs, picking up clues from users and carers about what might be most relevant and effective" (Social Services Inspectorate 1991a, paragraph 4.12). Nevertheless, it was not clear why this practice might be beneficial or how it could be produced. It therefore seems appropriate to endeavour to find out what characterises innovative practice in care management, what factors facilitate and hinder such practice and why it might be useful.

Occupational stress has been a popular and important field of study in recent years because of its apparent deleterious effect on employee well-being and productivity. However, its impact on creativity and innovation has been a neglected area of research, even though constantly changing organisations require individuals to be adaptable, flexible and imaginative in order to both

keep pace with change and initiate it. The National Health Service and Local Authorities have been subject to enormous change over the past 10-15 years and studies have recorded high levels of stress amongst their employees, such as social workers (*e.g.* Bennett, *et al.* 1993), ward and community psychiatric nurses (*e.g.* Leary & Brown 1995) and district nurses (*e.g.* MacLellan 1990). Social workers and community nurses (including community psychiatric nurses) have, to varying degrees, been practising care management following the implementation of the NHS and Community Care Act 1990 (McGrath *et al.* 1996; Ramcharan *et al.* 1999). Their stress levels have also increased during this time (Parry-Jones *et al.* 1998a).

Stress may be one of the factors that influences the process of innovation in care management practice. Since stress appears to adversely affect productivity at work (Kompier & Cooper 1999a), it is plausible that being under stress reduces an employee's ability to be innovative. However, other relationships between stress and innovation are plausible. For instance, if being innovative provides alternatives to events or situations that would otherwise be perceived as stressful, then innovative practice may actually be a coping strategy. Innovative practice in this sense may be akin to the problem-focused ways of coping strategies espoused by Folkman and Lazarus (1980) and Carver *et al.* (1989).

Thus, the characteristics of innovative practice in care management, what prevents and what facilitates its occurrence, and the relationship between stress and innovative practice in care management are uncharted empirical territory. The reasons for being innovative during the care management process are also unclear. This thesis aims to explore these aspects, develop theory and suggest implications for policy and practice. In so doing, findings from two studies of innovative practice and occupational stress in care management are reported. The research aims and design are outlined below.

Research overview

The main aims of the research, its design and fieldwork timing are included in this section. A working definition of innovative care management practice is also provided.

Main aims

- To investigate how innovative practice in care management is characterised and undertaken by practitioners.
- To identify which factors facilitate and which constrain innovative care management practice.
- To investigate the relationship between innovative practice and occupational stress.

Design

The research consisted of two studies. Study 1 was qualitative in nature and involved examining in-depth the practice of five care managers (based in North Wales) during their assessment and care management work with one or two service users each (n=8 cases in total). The focus of this study was on the characteristics of innovative and non-innovative care management practice and on the factors influencing innovative, and general, care management practice. The strength of Study 1 lies in the depth of the findings; the 'qualities' of practice are explored. However, as only a small sample of care managers participated in this study generalising from the findings is difficult. Additionally, since the relationship between occupational stress and innovative practice could not be appropriately investigated using the methods employed in Study 1, a second study was conducted.

Study 2 involved undertaking a postal survey of care management practitioners across Wales. The survey consisted of both pre-coded and open ended questions and, thus, the data from this phase were both

qualitative and quantitative. The focus of Study 2 was partly (again) on the characteristics and influencing factors of innovative practice. Study 2, however, also aimed to provide data on the perceived frequency of innovative care management practice and explore the relationship between stress and innovative practice through statistical analysis.

Fieldwork timing and context

Study 1's fieldwork occurred between January and May 1996, immediately before and during local government reorganisation in Wales. Local government reorganisation involved a change in local government boundaries: the 'old' eight counties of Wales became 22 new unitary authorities. Study 1 fieldwork, consequently, began in one county and finished in two unitary authority areas in North Wales. The Study 2 survey was conducted in seven unitary authorities across Wales in the summer of 1997.

Definition of innovative practice

Reviews of both the care management and innovation literature (see Chapters 2 and 3) revealed no prior definitions of innovative practice, whether of care management or otherwise. However, an established definition of innovation (West & Farr 1989) was found to be sufficiently encompassing to permit a working definition of *innovative care management practice* to be generated (see Chapter 3 for details). This working definition is presented here in order to provide ease of accessibility to the definition.

Innovative care management practice is defined (for the purposes of this thesis) as:

> "..the intentional introduction and application of ideas, processes, products or procedures, new to the practice of the care management practitioner, into the assessment, care planning, monitoring or reviewing stages of care package design and implementation, for the benefit of service users and/or carers."

Personal and professional influences

Research does not occur in a vacuum. It is important to consider the context in which it is conducted. This is formally undertaken through reviews of relevant literature and the seeking of context relevant information during data collection. However, the personal and professional backgrounds of researchers also directly influence the research process, from the development of research questions and hypotheses to the interpretation of findings. Thus, the author's personal and professional background is briefly considered to help illuminate the course taken with the present research.

The author's interest in the thesis topic arose from combining a professional background in psychology, particularly occupational psychology, with work on funded research into community care as a Research Officer at the Centre for Social Policy Research and Development (CSPRD), University of Wales, Bangor. Already having gained a Bachelor of Science degree in Psychology from The City University, London, the author's interest in job stress began whilst studying for a Master of Science degree in Applied Psychology (Occupational Psychology specialism) at the University of Wales College of Cardiff in 1989-1990. After working for three-and-a-half years as an Occupational Psychologist (practitioner) with the Employment Service, the author became a social policy/social care researcher at CSRRD. Specific interest in occupational stress, innovative practice and care management arose whilst being involved with other colleagues at CSRPD on funded research into the assessment and care management practices of community care practitioners in Wales following the implementation of the NHS and Community Care Act 1990.

Taking into account the author's background and specialist interests, this thesis draws upon the psychological knowledge base on occupational stress and individual innovation, the social policy literature on care management and the author's personal experiences and observations as both a

practitioner and a researcher. Although care management in the United Kingdom is strongly linked to previous and contemporary social work practice (see Chapter 2), it is also practiced by those with other professional backgrounds, such as community nursing and occupational therapy. In order to help maintain focus within the thesis and to work within both time and word constraints and the author's own competencies, the innovative practice of care management practitioners is not considered from a social work, community nursing or occupational therapy perspective. Whilst this has limited the conclusions drawn, it is hoped that those with social work or other backgrounds will be stimulated by the topic presented and interpret the findings from their own perspectives.

* * *

The next three chapters review relevant literature surrounding care management, innovative practice and occupational stress.

CHAPTER 2 CARE MANAGEMENT: A VEHICLE FOR INNOVATIVE PRACTICE

This chapter aims to explore care management as a vehicle for individual innovative practice. It contains a critical overview of the relevant policies, guidance and evidence surrounding the introduction of care management in the United Kingdom, with reference to the potential for practitioner innovation. Details of the origin, processes and implementation of care management are provided as context. The following headings will be used in the chapter:

- Care management: what it is and where it came from
- The innovative potential of care management practitioners
- Implementing care management: facilitating and hindering factors
- Care management as a vehicle for innovation: summary and conclusions

Care management: what it is and where it came from

Care management (originally known as *case* management) was introduced as a method of coordinating and planning service delivery to individual service users through the United Kingdom community care reforms of the early 1990s. It appears to have been adopted out of the then Conservative Government's imperative to find more cost effective and efficient means of supporting and caring for disabled and vulnerable people (Jack 1992; Lewis & Glennerster 1996; Walker 1997). Previously, such groups as frail older people, people with physical or learning difficulties, and people with mental health problems needing support were placed within long-stay hospitals and residential or nursing homes, with little or no options available for remaining in the community and at considerable public cost (Davies & Challis 1986; Knapp *et al.* 1990; Walker 1997). Health and social care practitioners typically assessed individuals for their eligibility for certain services, and little reassessment or monitoring occurred unless the circumstances of individuals changed dramatically (Beardshaw & Towell 1990). Care management, on

the other hand, was to involve the design of individualized care packages based on a thorough assessment of need, and included monitoring and reviewing elements, with the alteration of the care provided if need be (Department of Health 1990a, paragraph 3.9). It was considered to be 'an effective method of targeting resources and planning services to meet specific needs of individual clients' (Department of Health 1989, paragraph 3.3.3) and for 'promoting individual choice and self-determination' (Department of Health 1990a, paragraph 3.3).

Social services departments were given the lead responsibility for conducting needs assessment and care management for individuals requiring social care and support through the NHS and Community Care Act 1990. The White Paper, *Care in the Community* (Department of Health 1989), and the subsequent policy guidance document (Department of Health 1990a), laid out these responsibilities. Later, practitioner and manager guidance (Social Services Inspectorate 1991a, b) provided further details of how the new system of community care was to be implemented. Full implementation was to occur by April 1993 (Department of Health 1990a, paragraph 1.3).

The social care and support for which social services departments were to assess need included personal care, help with domestic tasks, mobility, financial affairs, accommodation, leisure and employment, and was intended for those unable to undertake these tasks for themselves (Department of Health 1989, paragraph 3.2.2). Individuals with mainly health care needs which could be met in the community, were to receive assessments and care directly from community and primary health services, as before (Department of Health 1989, paragraph 3.2.1). Where individuals have both health and social care needs "the assessment procedure will …need to be flexible enough to be able to take as broad a view of the situation as necessary" (Department of Health 1989, paragraph 3.2.4), and "all agencies and professions involved with the individual and his or her problems should be brought into the assessment procedure when necessary" (Department of Health 1989, paragraph 3.2.5). People with learning difficulties and mental health problems (including people with dementia), in particular, were

considered likely to benefit from multidisciplinary assessment of need (Department of Health 1989). Thus, the practices of needs assessment and care management were to involve both health and social care practitioners.

Needs assessment was to form part of the process of care management, with the latter considered consisting of three distinct stages:

- "assessment of the user's circumstances in the round, including support required by carers;
- design of a 'care package' in agreement with users, carers and relevant agencies, to meet the identified needs within the care resources available, including help from willing and able carers. Any preferred solutions which prove unavailable either because of resource constraints or because the services have not been developed will be fed back into the planning process;
- implementation and monitoring of the agreed package; review of the outcomes for users and carers; and any necessary revision of service provision." (Department of Health 1990a, paragraph 3.9).

Although such process details were provided in official documents, a precise definition of care (or case) management was not. In order to better understand what care management is and how it provides opportunities for innovative practice by practitioners, definitions, models and the origin of care (and case) management are traced and explored next.

Defining care, or case, management

There is no consensual definition of care or case management (Beardshaw & Towell 1990) and the terms have been used interchangeably (Challis 1994). In the 1970s and 1980s the term *case management* was used in documentation, but by the late 1980s and early 1990s the term *care management* gained favour (Challis 1994). Challis (1994) suggests that the switch from *case* to *care* management was more a recognition of the potentially demeaning implications of *managing a case* (a person and their circumstances) as opposed to *managing care* (services and resources), than a shift in meaning or emphasis. However, as summarized by Lymbery (1998), a number of commentators considered that the shift of reference

from case to care management was a political one. It enabled a managerialist response to need, with its emphasis on resource management, to be superimposed upon the previously professional response to need, in pursuit of the political agenda to introduce market principles and structures into the welfare system. Both terms are used in the definitions and descriptions of models below, with *case* as opposed to *care* management used only where applied by the original author(s).

From North America, where case management developed in the 1970s and 1980s in response to concerns regarding long-term care cost containment and service fragmentation (Davies & Challis 1986; Zawadski & Eng 1988), Weil & Karls (1985) describe case management as:

> "..a set of logical steps and a process of interaction within a service network which assure that a client receives needed services in a supportive, effective, efficient and cost-effective manner" (p.2).

This definition highlights the core component of case management as being a process, whilst acknowledging the importance of both context and outcome (the latter emphasizing efficiency and cost effectiveness). In recognition of the complexity of both case management and the individuals who receive case management services, Ballew and Mink (1986), also from North America, characterize case management as a procedure for helping individuals with multiple problems:

> "Case management is the only method that addresses the 'gestalt'. Its dual emphasis is on the network of services needed by multi-problem clients and the interaction between members of the network. Case management is certainly concerned about the effectiveness of each individual service, but the techniques and strategies it employs focus on the mix of services and the way these services relate to each other rather than on the individual service." (p.8)

The targeting of case management to particular service user or client groups is implied in this definition. This is recognized as appropriate by others (*e.g.* Davies & Challis 1986; Kane 1990) and is explicit in community care policy documentation, for instance:

> "Where an individual's needs are complex or significant levels of resources are involved, the Government sees considerable merit in nominating a 'case manager' to take responsibility for ensuring that individuals' needs are regularly reviewed, resources managed effectively and that each service user has a single point of contact." (Department of Health 1989, paragraph 3.3.2).

Dant and Gearing (1990) suggest that the role of case managers is to attempt to overcome the practical problems that the service user experiences, and compare this with casework, a different form of intervention:

> "..the main aim of their work [case managers] is to assess systematically and find solutions to these problems or assist the client to solve them. This can be contrasted with casework which aims to change the client through a particular relationship, either so that they can solve their own problems or learn to live with them." (p.340-341)

This focus on case management as a problem solving method was reflected in community care policy and guidance documents, for instance, in the emphasis given to case, and later care, management as a process (Department of Health 1989, paragraph 3.3.4; Department of Health 1990a, paragraph 3.9; Social Services Inspectorate 1991a, p.9-18). There was also a lack of attention given in these documents to using more traditional practitioner skills, such as relationship building or counselling. Instead, case management was to be an active contributor to the new role of local authorities as 'enablers', rather than providers, of services; an aid to the development of a purchaser-provider separation in community care, as described in policy guidance:

> "Care management is based on a needs-led approach which has two key aspects: a progressive separation of the tasks of assessment from those of service provision in order to focus on needs, where possible having the tasks carried out by different staff; a shift of influence from those providing to those purchasing services." (Department of Health 1990a, paragraph 3.7).

In summary, care (or case) management appears to be a type of problem-solving process, consisting of a series of stages or steps, which is intended

to devise ways of both meeting the assessed needs of vulnerable individuals and make the best use of resources. Additionally, the British version of care management envisaged in community care policy and guidance was that of a 'purchaser' rather than a provider of services. The origins, and a fuller description of, this *social entrepreneurship* model of care management (Beardshaw & Towell 1990) will be elaborated upon next. Alternative models will also be explored.

Social entrepreneurship models of care/case management

Many potential models or approaches of care (or case) management exist, but the one propounded in the policy and policy guidance of the community care reforms (Department of Health 1989, 1990a; Social Services Inspectorate 1991a, b) developed out of the work of the Personal Social Services Research Unit (PSSRU), University of Kent (Department of Health 1989). The PSSRU undertook the first United Kingdom 'experiment' of case management in the Thanet ('Kent') Community Care project (Davies & Challis 1986), and subsequent similar 'experiments' were conducted in Gateshead (Challis *et al.* 1988, 1990) and Darlington (Challis *et al.* 1989), all during the late 1970s and the 1980s. The Department of Health and Social Security, now the Department of Health, also funded a series of demonstration projects around the United Kingdom, with the aim of investigating whether care in the community could replace some forms of long-term care hospital accommodation (Knapp *et al.* 1990). The PSSRU were asked to "promote, monitor and evaluate them" (Knapp *et al.* 1990, p.2). The precise nature of the case management model used in the early experiments and later demonstration projects varied (Knapp *et al.* 1990). However, it is generally regarded that the model used in the early 'experiments' was that of *social entrepreneurship* (Beardshaw & Towell 1990; Hughes 1995; Payne 1996).

In the Thanet project, a specialist group of case managers (qualified social workers) based in a generic social services area team, intervened with frail older people otherwise on the verge of residential care to find alternative

community-based care (Davies & Challis 1986). The case managers had small caseloads (25-30 cases), operated with a devolved budget (two-thirds of the cost of a residential home placement for each service user), and were responsible for identifying and drawing together suitable community-based care and support for individuals based on their needs. Conventional social services support, such as home helps and day care, could be utilized or more individualized service provision devised, for instance by use of employed 'helpers' to perform domestic or personal care tasks. Support given by informal carers could also be interwoven into the care arrangements. Davies and Challis (1986) described the aim, and the benefits, of the care planning, implementation and monitoring stages of case management in the following way:

> "The goal set for these tasks of the case management system [in Thanet] was to respond flexibly to need in an environment, providing incentives and information to make the best use of resources; and in so doing to mobilise – indeed, virtually to create – resources. This was seen to be the key to enhancing 'output mix' and input mix' efficiencies, aspects of overall efficiency which we [have] argued .. the British care system had done the least to promote." (p.241)

Thus, responding "flexibly to need" was considered likely to involve a degree of creativity, and that this creativity on the part of case managers would help to develop the resources necessary to meet individual needs. It was this 'consumerist' approach, characterized by access to a devolved budget (real or nominal) and responsibility for developing individualized care arrangements, that lay at the heart of the *social entrepreneurship* model of case management. The application of this model in Thanet, Gateshead and Darlington to groups of frail older people, as evaluated by the PSSRU, apparently led to reasonably successful outcomes. There was evidence that service users lived longer, that fewer were placed into residential care or used health services (reducing actual care costs), that both quality of life and quality of care improved, and that the stress levels of informal carers decreased (Challis *et al.* 1990, 1991; Davies & Challis 1986; Knapp *et al.* 1990).

The core tasks of the PSSRU form of case management have been described as: case finding; screening; assessment; care planning; monitoring, re-assessment and adjustment; and closure (Davies *et al.* 1990). They are listed in detail in Figure 2.1. Providing advice, counselling and relationship building were considered to be essential elements of a case manager's work, especially where highly dependent individuals with complex needs were concerned (Challis 1992).

Case finding	The recruitment of appropriate cases.
Screening	Ensuring the appropriateness of referrals to the system.
Assessment	The identification of needs [and unmet needs].
Care planning service packaging and gap filling	The setting of goals, devising of plans and ensuring the availability of the resources required or substitutes. Mobilising resources to fill gaps in informal/social services provision.
Monitoring, re-assessment and adjustment	Enabling an awareness of and responsiveness to changing circumstances and needs.
Closure	In circumstances where individuals are no longer in need of the services that can be provided or arranged by the agency in question.

Figure 2.1 Core tasks of case management (adapted from Davies *et al.* 1990)*

* Davies, B., Bebbington, A. & Charnley, H. (1990) *Resources, Needs and Outcomes in Community-Based Care*. Aldershot, Hants: Avebury.

Case management models in North America

The PSSRU *social care entrepreneurship* approach appears to have been influenced by the development of case management in the United States (Lewis & Glennerster 1996; Payne 1996). In the US case management arose, as mentioned above, in the 1970s and 1980s from the need to coordinate the otherwise relatively uncoordinated and independent health and social care services provided to individuals (Beardshaw & Towell 1990; Dant & Gearing 1990; Davies & Challis 1986; Davies 1992; Pilling 1992). The lack of coordination was particularly noticeable following de-institutionalization of, for instance, those with long-term mental health problems or learning difficulties, or in the development of community options to prevent admission to long-term care facilities, for instance for frail older people (Pilling 1992; Dant & Gearing 1990). The health and social service industry in the United States was regarded as very different from that in the United Kingdom at the time. Dant and Gearing (1990) describe the situation for older people:

> "The problem that old people faced was not merely the complexity of services but also their absence and the difficulties of financing their use. Because Medicaid and Medicare insurance schemes did not fund long-term care in the community, there were few services available and those that were, were difficult to find and fund. When case managers were introduced they acted as 'brokers' channelling demand to encourage potential sources of services. They were not simply concerned with coordinating appropriate services for individual clients but they were also concerned with controlling the number and type of cases and managing overall federal expenditure in the projects." (p.342)

The change in eligibility criteria for Medicaid in 1981, which permitted reimbursement for case managed long-term care services, has been considered critical for consolidating case management as a distinct and separate service for frail older people in the United States (Beardshaw & Towell 1990). Zawadski and Eng (1988), cited in Beardshaw and Towell (1990), have described three models of case management for frail older people in the US: the *prior authorisation screening model*, the *brokerage*

model, and the *consolidated model*. In the *prior authorisation screening model* an individual on the verge of institutional placement is assessed by a professional to determine if community services are a viable alternative to the placement and, if so, these services are arranged by the professional. In the *brokerage model*, the older person is assessed, has services arranged, and provision monitored, with reassessment of the individual as appropriate, by a single professional. The *consolidated model* involves assessment of need and provision of services by a multidisciplinary team. Which model is chosen depends on the level of dependency, complexity of needs and circumstances immediately prior to assessment. For those with moderate impairment and a little or no informal support the brokerage model may be sufficient, whereas the needs of more severely impaired individuals may be more appropriately met through the consolidated model (Zawadski & Eng 1988). Beardshaw and Towell (1990) compare the Zawadski and Eng (1988) models with those that have emerged early on in community care in the United Kingdom. They consider that the prior authorisation screening model is similar to the UK keyworker system, that the brokerage model is akin to the UK service brokerage model of case management, and that the consolidated model resembles the operation of some multidisciplinary teams in the UK. These UK models will be elaborated upon later.

Service brokerage

Service brokerage models originated in Canada and arose out of the independent living movement for people with physical disabilities and, later, for people with learning disabilities (Beardshaw & Towell 1990; Payne 1996). A variety of forms exist, but core components include the location of the case manager within an agency independent of the source of funding or provision; assisting individuals and carers to identify needs and the resources able to meet those needs; and, the identification and negotiation of funding for individual care arrangements (Beardshaw & Towell 1990; Pilling 1992). Service brokerage developed along such lines in some early UK community care projects, notably those documented by Pilling (1992).

Pilling (1992) describes an independent brokerage or advocacy project in Camden and Islington for people with physical disabilities set up in 1986 through funding from the King's Fund. The main features of this project were similar to those of the Canadian models, including independence from both resource allocation and service provision, the arranging of services from other agencies in accordance with an understanding of users' needs and local knowledge, and the use of advocacy for the individual seeking assistance if necessary. The case managers were two experienced social workers and 150 clients with physical disabilities received the service over the two-year life span of the project.

The project evaluation, also described by Pilling (1992), concluded that the project was reasonably successful, in that the majority of clients were satisfied with the service and that what the case manager had agreed to do had wholly or partially been achieved by the time of the evaluation. However, the main reason for non-completion of action plans was the lack of availability of services. This finding provides support for the argument propounded by those within the PSSRU that control over resources is needed to influence services in an effective model of case management (Challis 1990; Davies *et al.* 1990). Taking into account both British and North American case management systems, Moore (1992) has additionally argued that brokering is most appropriate when the level of resources is high, but the level of service integration low. He explains, however, that the British system demonstrates the opposite environment, of high degrees of service integration and low levels of resources, which befits a rationing model of case management more appropriately.

Keyworking

Case management has been referred to as a model of keyworking (Dant & Gearing 1990). Keyworking as a concept originated in the 1970s, several years before case management was first introduced into the UK, in an attempt to define the role of the primary worker in residential care establishments (Dant & Gearing 1990). Sackville (1978, cited in Dant &

Gearing 1990), who was involved in devising the original keyworker specifications, identifies the main keyworker responsibilities as:

> "(a) ensuring that an individual plan is evolved, and that there is a continuous updating of this care plan;
> (b) implementing the care plan, using all appropriate resources;
> (c) monitoring progress and making recommendations for amended or alternative care plans;
> (d) calling regular reviews;
> (e) keeping appropriate working relationships with the client;
> (f) ensuring maintenance of adequate working records;
> (g) ensuring that the most appropriate arrangements are made for continued social work help (if indicated) on discharge from residential care" (p.43)

Dant & Gearing (1990) describe a project – the Gloucester Care for Elderly People at Home project (GEPH) - involving three 'care coordinators' based in primary care teams, who used a keyworker approach with older people. The project was established in 1986 and lasted for two years. The care coordinators held degrees, teaching or nursing qualifications, and were not professionally trained as social workers, although their work was essentially social care work. Their role was very similar to that of a service broker case manager, such as in the Camden and Islington project outlined above. The care coordinators were to:

> "(i) become expert in the availability of local services for elderly people;
> (ii) explore new ways of helping elderly people that did not necessarily rely on existing statutory services;
> (iii) attend to the needs of carers, recognizing that supporting elderly people in remaining at home often means supporting their personal carers. (Dant & Gearing 1990, p.349)

However, unlike the Camden project, the care coordinators were based in a team of professionals working with the same set of older people and were employed by a statutory agency (not an independent agency). They differed from case managers in, for instance, the Thanet Community Care project, by virtue of not having access to a budget for the purchase of care. Apart from these exceptions, the tasks of the care coordinators developed in much the same way as both the Camden and Thanet projects. The following activities

were listed by Dant & Gearing (1990) as having been performed by the care coordinators: engagement (or referral and preliminary assessment of need); assessment (which included a documentation process); care planning; setting up a package of care (involving liaison with statutory, voluntary and private sector providers and informal carers); monitoring and reviewing (including altering care packages in response to changes in need, and regular 6 monthly reassessment); and disengagement (although this only happened in a few cases, since typically long-term support was needed for clients, with monitoring an integral part). Other activities listed included community work with local groups, such as carers groups and luncheon clubs; counselling (despite the anticipated focus on coordinating rather than providing services); advocacy; and being a resource person to older people, carers and other workers. Whilst similar problems to the Camden project were acknowledged, of not having direct control over resources, the advantages of both these schemes were highlighted as the provision of advocacy to vulnerable people:

> "..the keyworkers acted as advocates for their clients, negotiating with bureaucracies and service providers in all sectors to obtain what was needed by the person. In these two schemes there was no compromise of interest between their client and the administrative or resourcing problems of the service they represented." (Dant & Gearing 1990)

The disadvantage of having case managers with delegated responsibility for resources is clearly outlined in this statement. The difficulties of applying a truly needs-led approach to case or care management with an embedded gate keeping or rationing role, of the type propounded in community care policy and guidance, has been noted by others (*e.g.* Lightfoot 1995; Richards 1994).

Case management in multidisciplinary teams

Keyworking can be incorporated into the role of workers with other responsibilities than coordination, such as members of multidisciplinary teams who may have clinical or other support roles (Beardshaw & Towell

1990; Dant & Gearing 1990). Difficulties of undertaking this form of case management may include a lack of recognition of the keyworking role by managers and other workers; identifying who is most appropriately placed within a team to become the keyworker for a client; and, that its time commitments would limit both the number of case managed cases a worker could be engaged in and their 'casework' caseload (Dant & Gearing 1990). Other problems of keyworking in multidisciplinary teams have been noted as: variations in the service delivered to clients due to differing interpretations of case manager or keyworker roles by workers from different professional backgrounds; replication of assessment by service managers when accessing services for clients within and across agencies; and, difficulties balancing the monitoring function of long-term case-managed cases with short-term work with other clients (Beardshaw & Towell 1990).

The Care Programme Approach

Key working, service brokerage and the social care entrepreneurship models of case management, as indicated above, were all in existence in the UK prior to the publishing of the White Paper, *Care in the Community* (Department of Health 1989). Whilst the social care entrepreneurship approach appeared to be the bedrock of the care management model espoused in policy and guidance, another form of case management was introduced specifically for use with people with mental health problems (including those with dementia), the Care Programme Approach (CPA). The CPA was devised to help coordinate community-based services for people eligible for, and receiving, specialist psychiatric services, including those on the verge of being discharged from hospital (Department of Health 1990ab). People with the most severe and enduring mental health problems have been progressively targeted as recipients of the CPA (Downing & Hatfield 1999). Having an implementation date of April 1991, district health authorities, the Bethlem and Maudsley Special Health Authority and the Special Hospitals Service Authority were given the responsibility for ensuring the CPA was introduced (Department of Health 1990a). Social services

departments, in collaboration with district or special health authorities, were intended to provide any social care assessed as being required.

The CPA is characterized by having a keyworker who both co-ordinates service inputs and provides a continuing supportive relationship (Downing & Hatfield 1999). Consequently, it differs from care management in that the keyworker does not have access to a devolved (or shadow) budget for purchasing care, whereas the care manager in theory does, and has instead a supportive 'provider' role, whereas the care manager in theory does not. Bachrach (1993) construes the differences as indicative of a continuum of (theoretical) case management practice, with an administrative model at one end (the 'indirect' service approach) and a clinical model (the 'direct' service approach) at the other. 'Direct' case management work with service users can include advocacy, psychological support, 'assertive outreach', and therapeutic help (Bond *et al.* 1988; Moxley 1989). Despite the apparent differences between care management and the CPA, the Department of Health (1995) suggested that where service users with severe mental health needs also have considerable social care needs, the keyworker and care manager roles could be integrated, drawing upon the resources of both health and social services.

Care management and social work

Community care policy and guidance of the late 1980s and early 1990s made little mention of the type of practitioner most likely to undertake care (or case) management. However, since local authorities were given lead responsibility for needs assessment through the NHS and Community Care Act 1990, social workers were in the most appropriate position to undertake care management: the vast majority were employees of, and therefore directly accountable to, local authorities. Social workers were also the professional group with the most appropriate knowledge and skills base, as noted by commentators (*e.g.* Bamford 1990; Orme & Glastonbury 1993; Sheppard 1995).

Prior to the introduction of care management, the Barclay Report (1982) identified two distinct activities of social workers: social care planning and counselling with individual clients or families. The former is a natural forerunner of care management, with its emphasis on a task-focused process of individual care planning. Sheppard (1995), in a critique of social work as it relates to care management, has highlighted three traditional core skill areas of social work: task/support centred practice, working with social networks and interpersonal skills and considered all are pertinent for care management practice. Others (*e.g.* Orme & Glastonbury 1993) have noted that the values of individualisation and self-determination, core to social work practice, are central to the ideas of consumer choice and the mixed economy of service provision associated with care management. The Griffiths Report (1988), which recommended to central government that case management be introduced, and subsequent official documentation, however, made little reference to social workers. Bamford (1990) observed that that this could either mean social workers would have a more managerial role or that the new role would require a "wholly different approach" to the then current practice, but to which "social work has a contribution to make".

The introduction of care management and the lack a clear role for social work in the Griffiths Report (1988) and subsequent policy and guidance documentation have been criticised as devaluing and deconstructing the social work profession (see review by Phillips 1996). Within the rhetoric, care management could be undertaken by various professions and disciplines, thereby implying that 'social work' was a non-specialist task. There was concern that the emphasis placed on the care manager as 'enabler' rather than 'provider' would erode the traditional social work areas of counselling and ongoing support and that the devolution of budgets would take "social workers into unfamiliar and rather uncomfortable territory as market mechanisms enter the professional-client relationship" (Phillips 1996, p.8).

However, others, such as Aldridge (1996), have argued that social work has never been a true profession, in the sense of a specified core and exclusive set of activities and skills, and that there is a history of resistance by more

radical social workers to the professionalization of social work. Sheppard (1995) has commented that the practice of social work, whilst partly based on theory, has necessarily been defined by social policy:

> "Social work..., as a *state occupation*, arose as a job whose task was to deal with certain areas of social life. The state, then, largely defined the social work task. Attempts to develop knowledge for social work, therefore, have largely occurred for a pre-existing occupation in response to a perceived need for this knowledge to carry out the social work task." (p.192)

Orme and Glastonbury (1993) viewed the lack of a consistent operational framework for care (or case) management in post-Griffiths official documentation as typical of the way in which social work roles and tasks have evolved in the past:

> "This is a common phenomenon in British social work, that new practices come about by innovative thinking in methods of intervention or are imposed by major policy changes. Social workers, chameleon like, adapt to these circumstances and only at a later stage realize that their workloads have changed in size or composition and that this has implications for their ability to perform the task." (p.66-67)

Others have suggested there was little new in care management. For instance, Beardshaw (1990) commented that it is "simply good practice that has been around for a long time" (p.ii). Orme and Glastonbury (1993) went further by devising a framework for *good* care management based on the best of prior social work practice (see Figure 2.2). This framework is useful in that it incorporates system as well as process elements, both of which need to be considered in the establishment and operation of care management. However, the broad coverage of the framework and its lack of clarity regarding the specific role of the practitioner reduce its potential as either a practitioner's tool or an analytic device for research purposes.

Client contact	The initial presentation of need.
Recording and tracking	Starting the sequence of contacts and the data collection and recording which formally establishes the client as a customer of the agency.
Assessment	The process being introduced in the UK as a legal right of those client groups for whom care management is recommended.
Advocacy	Ensuring the strong involvement or representation of the client/customer's viewpoint.
Choosing a care manager	Identifying the person in the social services agency who is to have an overview and overall responsibility for enabling the customer/client's needs to be met.
Planning the care package	Identifying the services required to meet needs, the cost and potential location of services, and the intended outcomes of service provision.
Framework for purchasing the care package	(a) devolution and resource flexibility – providing an administrative and support system which facilitates the execution of the role of the care manager; (b) resource raising and brokerage – identifying and generating a broad base for the resources which will be used to provide the care package.
Putting the care package into action	The service purchasing process.
Providing the care package	(a) initiating services – mobilising the chosen range of services and ensuring their provision to the client/ customer; (b) maintaining the care package – establishing high quality provision, dealing with problems and complaints, and initiating reviews in the light of developments and outcome targets.
Involving the independent sector	Current and future scope to move outside the traditional UK system of direct provision through central and local government agencies.

Figure 2.2 A framework for *good* care management (Orme & Glastonbury 1993)*

* Orme, J. & Glastonbury, B. (1993) *Care Management*. BASW Practical Social Work series. Basingstoke, Hampshire: Macmillan.

* * *

In summary, a variety of case management models exist, but the main one propounded in community care policy and guidance appears to be the social entrepreneurship model. Whilst most models of case management typically involve assessment of need, the coordination and implementation of service inputs, monitoring, reviewing and conducting readjustments to the care package, the social entrepreneurship model has these features combined with access to a devolved budget. The version of case management advocated in policy and guidance documents is that of *care* management, which is characterized by a distinctly managerial and administrative nature. However, officially it was recognized that there may be a need to incorporate a 'provider' element into care, or case, management work with particular service users, such as those with mental health problems (including those with dementia).

Social workers appear to be in the best position to undertake the role of care manager. However, whilst care management seems to build on *good* social work practice, other professions and disciplines may also conduct assessment and care management. There are, therefore, professional and practice implications for all involved in implementing care management.

The innovative potential of care management practitioners

With or without a devolved budget, case management has been introduced as a means of devising, and implementing, individually tailored care packages based on assessed need. Thus, there is room for creative or innovative practice by case managers, as they strive to find the best solutions to service users' needs. As mentioned earlier, evidence indicates that having access to a budget can assist case managers in securing care and support identified through a needs-assessment process. Consequently, if care managers in practice work with a devolved budget, they may be best placed of all case managers to be creative and innovative. Policy and

guidance advocated the devolvement of budgetary responsibility to care managers and recognized that one of the benefits would be increased potential for innovation in the meeting of individual need (Department of Health 1989, 1990a; Social Services Inspectorate 1991a, b). There were several other stated benefits, including helping the management of resources and bringing decision-making closer to users (Department of Health 1989, 1990; Social Services Inspectorate 1991a, b). The White Paper (Department of Health 1989) endorsed the devolvement of budgets to maximize resource potential:

> "The Government ...sees advantage in linking case management with delegated responsibility for budgetary management. This need not be pursued down to the level of each individual client in all cases, but – used flexibly – is an important way of enabling those closest to the identification of client needs to make the best possible use of the resources available." (paragraph 3.3.5)

Whilst devolved budgets were seen as a useful device to mobilize resources, official rhetoric did not insist on their use. Therefore, it was left to local authorities to decide on the degree of devolvement of budgets to care managers:

> "..responsibility does not necessarily have to be devolved to individual care managers. It may be kept at team or district level, particularly in the early stages, while the necessary skills and systems are being developed." (Social Services Inspectorate 1991a, p. 15)

The purchasing, or 'enabling', role of social services departments was, however, clearly specified. For instance:

> "The Government will expect local authorities to make use wherever possible of services from voluntary, 'not for profit' and private providers insofar as this represents a cost effective care choice. Social services authorities will continue to play a valuable role in the provision of services, but in those cases where they are still the main or sole providers of services, they will be expected to take reasonable steps to secure diversity of provision." (Department of Health 1989, paragraph 3.4.1)

Being an 'enabling authority' was considered to lead to benefits for 'consumers', such as:

- "a wider range of choice of services;
- services which meet individual needs in a more flexible and innovative way;
- competition between providers, resulting in better value for money and a more cost- effective service." (Department of Health 1989, paragraph 3.4.3)

Thus, utilizing and stimulating the independent sector was seen as a key role for local authorities in order to enhance consumer choice, provide more responsive and innovative ways of meeting needs, and of making best use of financial resources. A type of consumerism, therefore, lay at the heart of the reforms, with the use of innovative practice one of the key methods for responding to the needs of individuals. Indeed, 'responding to need' appears to be the main rationale for encouraging innovative care management practice, although not explicitly stated. Under the heading 'Making services more responsive', the *Practitioners' Guide* (Social Services Inspectorate 1991a) links the devolvement of budgets to a combination of increased professional autonomy and enhanced motivation for innovative practice:

> "In the past, services have often been purchased centrally, on a block basis, so that practitioners undertaking assessments have had limited capacity to adapt services to individual needs. Giving purchasing responsibility to practitioners offers them the scope and the incentive to develop new ways of responding to individual needs." (p. 15)

Policy guidance (Department of Health 1990a) indicated that training in care management skills would be vital. Included in the text was reference to the need to develop 'imaginative' care planning skills:

> "..basic and post-qualifying training arrangements should reflect the need for care management skills to be developed in such areas as assessing care needs, developing imaginative care packages, managing delegated budgets and fully involving service users and carers." (Department of Health 1990a, paragraph 3.55)

Practice guidance (Social Services Inspectorate 1991a) more openly acknowledged that a change in working style would be necessary for practitioners to meet the new care in the community agenda. Practitioners were challenged to:

- "acquire needs-led attitudes and approaches;
- develop the skills of needs assessment, defining objectives in terms of the outcomes desired by users and carers;
- promote greater participation by users and carers, building on their strengths;
- think creatively about service options within and between agencies;
- adjust to more devolved responsibility for resource allocation and financial management;
- give higher priority to the specification and monitoring of quality standards;
- increase their skills in negotiation and co-ordination." (p.29)

Whilst the need to 'think creatively' was again apparent, little advice was given as to how to achieve this. As indicated in the next chapter, creative thinking is characterized by a process of problem identification, the generation of potential options, and making judgements as to the appropriateness of potential solutions. In care management, assessing need, identifying current resources and considering alternatives, and deciding which options are most suitable, can be viewed as similar to these three creative thinking stages. The lack of a clear, workable definition of need and a framework for assessing need have been major criticisms of policy and guidance documents (Parry-Jones & Soulsby 2001). The void leaves practitioners open to interpreting needs in their own idiosyncratic way, albeit undoubtedly based on professional training, values and past experience (Twigg & Atkin 1994). A framework for the care planning element of care management was somewhat more evident. For instance, the *Practitioners' Guide* (Social Services Inspectorate 1991a) prescribed beginning this stage by examining the strengths and abilities of users, and the willingness and ability of carers to meet certain identified needs. This was to be followed by a review of any formal service provision that the user may already be receiving, and then by a consideration of alternatives. It is in this latter part that practice guidance becomes less useful. For instance:

> "Care planning should not be seen as matching needs with services 'off the shelf' but as an opportunity to rethink service provision for a particular individual. Within resource constraints, practitioners should give full rein to their creativity in devising new ways of meeting needs, picking up clues from users and carers about what might be most relevant and effective." (Social Services Inspectorate, 1991a, p.63)

This is more a specification of what care planning aims to achieve rather than a course of action, with 'picking up clues from users and carers' the only attempt at suggesting an actual method. Notably, though, two antecedents were specified in text associated with this section. These were having delegated budgets and knowledge (or access to knowledge) about local statutory and independent sector provision and community resources. Having delegated budgets in particular was seen as enabling practitioners "..to press service providers into arranging different forms of service" (Social Services Inspectorate 1991a). This was the final piece of advice offered to practitioners as a way of conducting creative care planning.

Despite encouraging the use of innovative practice by care managers, rhetoric was also prescriptive about the type of care arrangements suitable for inclusion in care plans. For instance:

> "The objective of ensuring that service provision should, as far as possible, preserve or restore normal living implies the following order of preference in constructing care packages.. :
>
> - support for the user in his or her home including day and domiciliary care, respite care, the provision of disability equipment and adaptations to accommodation as necessary;
>
> - a move to more suitable accommodation, which might be sheltered or very sheltered housing, together with provision of social services support;
> - a move to another private household *i.e.* to live with relatives or friends or as part of an adult fostering scheme;
> - residential care;
> - nursing home care;
> - long-stay care in hospital." (Department of Health 1990a, paragraph 3.24)

The great emphasis placed in policy and guidance documents on ensuring that care arrangements fit within available resources, may be considered a disincentive for innovative practice. Indeed, the dual role of local authorities of determining what a need is and of containing costs, appear to lead practitioners to be reluctant to discuss needs with users and carers that cannot easily be met (Parry-Jones & Soulsby 2001). Consequently, practitioners may in reality design care packages which only meet local authority recognized needs, ones for which resources are clearly available. Innovative practice may also be constrained by insufficient devolvement of budgets. The role of devolved budgets in the stimulation of innovative practice was explicit within policy and guidance documents, however, local authorities were given leeway as to the degree of devolvement. Whilst delegated responsibility for budgets to care managers was encouraged, no guidance was given on what might happen if budgets were insufficiently devolved nor, even, of what was a sufficient level of devolvement for the facilitation of practitioner innovation.

In the original PSSRU case management experiments, not only did case managers have devolved budgets, they also had relatively small caseloads (20-30 cases) and were trained and supported in their case management roles (Challis *et al.* 1988; 1989, 1990; Davies & Challis 1986). Whilst some of the case management demonstration projects did not delegate budgetary responsibility to case managers, small caseloads were again typical (Beardshaw & Towell 1990). Although policy and guidance documents indicated that training would be necessary to skill practitioners in the art of care management, they failed to mention the benefits of small caseloads. Indeed caseload size was not referred to once. This blatant omission suggests that officials either did not recognize that caseload size might be an issue in the successful implementation of care management on a nationwide basis, or that they knew in reality it would be difficult, or impossible, to achieve small caseload sizes for the majority of practitioners. Focusing on what was achievable, may have led officials to concentrate on other aspects such as devolving budgets and encouraging a mixed economy of care.

Implementing care management: facilitating and hindering factors

Various studies of the implementation of care management in England (*e.g.* Department of Health 1993a; Frith 1989/99; Syrett *et al.* 1997; Lewis & Glennerster 1996; Lewis *et al.* 1997; Lloyd 2000), Scotland (*e.g.* Myers & MacDonald 1996; Petch *et al.* 1996; Stalker 1994) and Wales (*e.g.* McGrath *et al.* 1996, 1997; Parry-Jones 1998; Parry-Jones & Soulsby 1999; Ramcharan *et al.* 1999) have been undertaken. Whilst such studies differ in design, methodology and focus, making direct comparison of findings difficult, they nevertheless provide insights into the practical difficulties and issues involved in implementing care management.

The emphasis on assessment

The Department of Health published a series of reports (1993a, b, c; 1994) on the early implementation of the community care reforms, which reflected upon progress made in assessment and care management to differing degrees. The *Assessment Special Study* (Department of Health 1993a) involved an investigation of assessment procedures for older people in five local authority areas of England in June/July 1993, approximately 3-4 months following the 1 April 1993 deadline for implementation of the reforms. Local authority documentation and monitoring data surrounding assessment were gathered and studied, and interviews were conducted with health and social services managers, health and social services practitioners, local authority and independent providers, and a small number of users and their carers. Local authorities were found to have concentrated efforts on initiating assessment procedures, to the apparent detriment of other aspects of care management, such as reviewing. Since local authorities were given statutory responsibility for conducting needs assessments via the NHS and Community Care Act 1990, it is understandable that they focused efforts on assessment early on after the implementation date. However, the Department of Health raised concern regarding the disproportionate number

of assessments compared with the availability of resources, and a recommendation was made that assessment be more fully integrated "into a comprehensive set of care management arrangements" (1993a, p.3). This suggests that the Department of Health was keen to ensure that assessment of need would be closely linked to the rationing function of local authorities. The key gate keeping and rationing role of care management practitioners was, therefore, implied.

The emphasis given to assessment, as opposed to other elements of care management, by local authorities was apparent in other studies such as those conducted by the Centre for Social Policy Research and Development (CSPRD), University of Wales, Bangor (McGrath *et al.* 1996, 1997; Parry-Jones *et al.* 1998b; Parry-Jones 1998; Parry-Jones & Soulsby 1999; Ramcharan *et al.* 1999). For instance, in a study of the roles and tasks of care management practitioners conducted as two postal surveys (one in 1995, the other in 1997), care management respondents were found to more frequently undertake assessment tasks than to design, cost or monitor/evaluate individual care packages (McGrath *et al.* 1996; Parry-Jones *et al.* 1998b; Ramcharan *et al.* 1999). The main problem with focusing attention on assessment is that insufficient time is given to other aspects of care management, with the potential to adversely affect the outcome for users and carers.

Care packages may be hastily set up, based on a standard 'menu' of options, rather than individually tailored. Whilst the use of a 'menu' may meet many common needs of users and carers, this approach is likely to blinker the practitioner from identifying less common needs and constrain his or her innovative potential. Innovation may not always be necessary in constructing a suitable care package, however, limiting options too early is likely to reduce the likelihood of needs being met in the most appropriate manner. Insufficient monitoring and reviewing of established care packages means that changing needs and circumstances are not taken into account, thus allowing a potentially ever-widening gap between needs and care arrangements

through which users or carers might 'fall', resulting in the need for crisis intervention.

Workload

Insufficient time, caused by increasing workload, appears to be one of the main reasons why practitioners have had to focus on assessment (McGrath *et al.* 1997; Ramcharan *et al.* 1999). Workloads appear to have particularly affected the ability of care management practitioners to conduct reviews of care packages (Lewis *et al.* 1997; Parry-Jones 1998). In a study of implementation in five local authorities in England conducted by the London School of Economics (Lewis & Glennerster 1996; Lewis *et al.* 1997), it was apparent that where clients were considered to be relatively stable, providers typically had an informal reviewing function. Thus, providers were expected to contact assessors if changes occurred. Whilst this might alleviate the resource issue in the short-term, long-term implications could arise where providers are reluctant to notify when *reduced* packages of care are appropriate.

Practitioner workload has been affected not just by increased demand for assessment following implementation, but by increased caseload size also (Ramcharan *et al.* 1999). In particular, average caseload size has been reported to have increased for care management practitioners working with older people (including those with mental health problems) and people with physical disabilities in Wales (see Figure 2.3). Such findings indicate average caseload sizes (*e.g.* 64 cases per practitioner in services for older people or people with physical disabilities in 1997) far in excess of the case management experiments that presaged the reforms, where caseloads were typically between 25 and 30 cases per practitioner (Beardshaw & Towell 1990).

Client group	1995	1997
Older people or people with physical disabilities	55 cases	64 cases
Older people with mental illness	41 cases	50 cases
People with mental health problems	36 cases	34 cases
People with learning disabilities	33 cases	32 cases

Figure 2.3 Average caseloads of respondents of care management surveys in Wales in 1995 and 1997 (Ramcharan *et al.* 1999)*

* Ramcharan, P., Grant, G., Parry-Jones, B. & Robinson, C. (1999) The roles and tasks of care management practitioners in Wales – revisited. *Managing Community Care*, 7, 3, 29-37.

Separating assessment from provision

The way in which care management was operationalised was found to vary between authorities in a number of studies (Department of Health 1993a; Lewis *et al.* 1997; McGrath *et al.* 1997; Stalker 1994). For instance, in the Department of Health (1993a) study, care management appeared to be viewed as a distinct role in some English authorities, with 'care managers' appointed to specialist care management teams focusing on small numbers of users with complex needs (such as older people with mental health problems). In other authorities, the elements of care management appeared to be considered a series of tasks, with staff expected to integrate the tasks into their current roles. Task-based and role-based models were also in evidence in authorities in Wales and Scotland (McGrath *et al.* 1997; Stalker 1994).

The role-based model appears to be the most similar to the social entrepreneurship model espoused by the PSSRU (Davies & Challis 1986). However, it differs in that care management is viewed as a purchasing role, with no room for a provider function. The separation of assessment and

purchasing from provision was in accordance with policy and official guidance (Department of Health 1989, 1990a), however in reality it appears to have led to considerable challenges to practitioners, not least of which is the challenge of attempting to reconcile needs with available resources (Parry-Jones & Soulsby 2001). It has been argued that "assessment must remain rooted in the appreciation of the realities of service provision" (Cheetham 1993, p.165), in order to conduct the type of continuous assessment and negotiation of service provision required in cases with complex needs. Indeed, practitioners appear to have experienced difficulty in identifying needs without reference to services despite welcoming the needs-led approach (Department of Health 1993a; Lewis *et al.* 1997; MacDonald & Myers 1995; Parry-Jones & Soulsby 2001). Practitioners have also appeared to be reluctant to relinquish their professional skills, such as providing emotional support, counselling and therapy (Lewis & Glennerster 1996; Parry-Jones *et al.* 1998a; Parry-Jones & Soulsby 1999; Syrett *et al.* 1997), and it may have been this that in part led to the development of the task-based model of care management.

Devolving budgets

The five local authorities in the Assessment Special Study (Department of Health 1993a) had made plans to devolve budgetary responsibility to lower levels, though not necessarily as far as practitioner level. Two of the authorities had provided assessors with access to small budgets to allow a degree of purchasing of external provision. In these authorities, the Department reported:

> "..practitioners were enthusiastic about the opportunities for more creative care planning." (Department of Health 1993a, p.5)

They continued, however, by warning that:

> "If there is a significant time-lag between the introduction of the new assessment arrangements and the development of some measure of budgetary flexibility, or if there are bureaucratic impediments to

> accessing such funds, there is the danger that this will lead to frustration and a potential undermining of practitioner commitment to the changes." (Department of Health 1993a, p.5)

As well as the devolvement of budgetary responsibility practitioner motivation was, therefore, recognized by the Department as important for the successful delivery of the community care reforms. There was also a recognition that frustration could easily arise amongst practitioners if insufficient attention was paid to achieving the right organizational conditions for creative care management practice. Insufficient budget devolvement, however, appears to have been a recurrent finding in other studies of the implementation of care management in England, Scotland and Wales (Lewis & Glennerster 1996; McGrath *et al.* 1996, 1997; Ramcharan *et al.* 1999; Stalker 1994). Lewis and Glennerster (1996) explain this in the following way:

> "..we have seen that SSDs proved resistant to devolving budgets to care managers, both because of reluctance to give up the economies of scale and the control that attach to centralised purchasing, and because of the long-standing British reluctance to mix social work with money." (p. 123)

Thus, one of the core elements of the social entrepreneurship model of case/care management appears not to have been operationalised. Since having some measure of devolved financial responsibility is likely to be one of the main preconditions for innovative care management practice (McGrath *et al.* 1996; Ramcharan *et al.* 1999; Stalker 1994), insufficient budgetary devolvement may pose a serious challenge to practitioners as they attempt to find flexible and appropriate ways of meeting needs.

Assessment: analysis or administration?

The Department of Health (1993a) picked up on other issues crucial for the development of needs-led care management. For instance, they indicated that there appeared to be a lack of recognition by both practitioners and managers of the analytical skills required for comprehensive needs

assessment. This was suggested as potentially occurring because of the attention given to developing and completing assessment documentation:

> "By tabulating all of the areas of knowledge that may be relevant to an individual's circumstances, such [assessment] proformas may foster the notion that assessment consists merely in the collection of data. They do not acknowledge that the essence of assessment lies in the definition and analysis of selective data with a view to formulating a hypothesis for action." (Department of Health 1993a, p.10)

Such analysis and formulation are likely to be core components in innovative care management practice (see Chapter 3).

The administrative nature of care management has been noted in other studies of the implementation of care management (*e.g.* Frith 1998/1999; Lewis & Glennerster 1996; Lewis *et al.* 1997; McGrath *et al.* 1997; Myers & MacDonald 1996; Parry-Jones & Soulsby 1999; Ramcharan *et al.* 1999; Syrett *et al.* 1997). Accountability to budget-holding managers, rather than accountability to users or carers, appears to have been a feature of the shift to a more managerial and bureaucratic form of front-line practice (Frith 1998/1999). Practitioners have complained of the 'control' exerted over them by having to conform to a highly bureaucratic form of practice and the resultant loss of professional autonomy (Frith 1998/1999). Reduced time for client contact and opportunities for direct work with clients, linked to increased bureaucracy and form filling, appear to have been major sources of dissatisfaction for care management practitioners (Parry-Jones *et al.* 1998a). Conducting financial assessments appears to have been particularly disliked, and was reported by social services practitioners to be in conflict with social work values (Parry-Jones & Soulsby 1999). Thus, the administrative nature of care management not only appears to hinder the type of analytic work necessary for innovative practice, it may limit practitioner discretion and create conflicts and dissatisfactions. As will be seen in the next two chapters, these latter elements may indirectly impact upon the innovative potential of practitioners.

The low rate of unmet need identification and reporting by care management practitioners (Caldock 1995; Keddie & Bauman 1999; Parry-Jones & Soulsby 1999), is suggestive that insufficient analytical work is conducted during assessment. There are several reasons why unmet need recording may not be taking place systematically. For instance, practitioners seem reluctant to raise users' and carers' expectations by discussing needs which are unlikely to be met (Caldock 1993a, 1994a; Ellis 1993; Hardy, Young & Wistow 1999). Due to the legal requirement for local authorities to meet identified needs, practitioners appear not to be recording unmet need information for fear of legal repercussions (Caldock 1995; Keddie & Bauman 1999; Parry-Jones & Soulsby 1999). Lack of unmet need recording may also be occurring because of the difficulties of identifying what constitutes an unmet need (this argument is elaborated upon in Chapter 6). If practitioners are repeatedly failing to identify or acknowledge unmet needs they may be by-passing a crucial stage in the innovative care management process.

Multidisciplinary working

Team working has the potential to enhance the innovative practice of care management practitioners through informal exchange of information amongst team members about local resources and the innovations of others. Multidisciplinary team working may provide opportunities for a greater diversity of information than single-discipline team working, since practitioners of differing disciplines are likely to bring different perspectives to the same problem or issue. Despite official recognition of the benefits of joint working during assessment (Department of Health 1989, 1990a), no mention was made of the possible difficulties of doing so and little indication given of how joint working might be achieved (Caldock 1993b, 1994b). The roles of health professionals, such as community and hospital nurses, appear to have been neglected by policy makers (Caldock 1993b). It was unsurprising, then, that early on the Department of Health (1993a) found joint working between health and social services had become strained due to a lack of clarity about the role of multidisciplinary teams in relation to assessment and care management. The Department could only suggest that:

> "More work is needed on the inter-relationship of care management systems and multi-disciplinary teams." (Department of Health 1993a, p.4)

The 'fuzziness' of the relationship between care management and the care planning approach (CPA) in multidisciplinary teams was evident when the Department of Health undertook a separate special study of mental health services early after implementation (1993c).

Prior to the implementation of the community care reforms, health and social services had a considerable history of poor collaborative working (Higgins *et al.* 1995; Nolan & Caldock 1996). Traditional barriers have included insufficient shared understanding and poor communication, exacerbated by differences in organizational culture and professional ideology, and lack of joint budgetary arrangements. Health and social care practitioners would have to find ways of overcoming such barriers in order to achieve the type of joint working envisaged in policy rhetoric. Whilst some positive examples of joint working by practitioners since the implementation of the reforms have been documented (*e.g.* Parry-Jones & Soulsby 1999; Ross & Tissier 1997), weight of evidence indicates that effective joint working in community care has proved elusive, due to the same barriers as before (Lloyd 2000; Higgins *et al.* 1995; Wistow 1997/1998; Worth 1998). Since exchange of information, as indicated above, is likely to enhance innovative care management practice, ineffective joint working may mitigate against such practice.

Resources

Funding shortages appear to have been commonplace during the implementation of the reforms (McGrath *et al.* 1997; Parry-Jones *et al.* 1998a; Parry-Jones & Soulsby 1999; Roughton 1995; Stalker 1994; Wistow 1995; Worth 1998). Whilst in the first year (1993-94) finances appeared to be plentiful in many areas, the second and third years (1994-96) were characterized by strained budgets (Parry-Jones *et al.* 1998b; Parry-Jones & Soulsby 1999; Wistow 1995). Following local government reorganisation in

Wales (1996-97), resource constraints appear to have become chronic (Parry-Jones *et al.* 1998b; Parry-Jones & Soulsby 1999). In 1998 there was an estimated shortfall of approximately £95M for social care services for older people in Wales (Singleton *et al.* 1999). Practitioners have indicated that large needs-based packages of care had been instigated in the 'honeymoon' first year, but in the years following needs-led practice had progressively become undermined by resource inadequacy and ever tightening eligibility criteria (Parry-Jones & Soulsby 2001). Assessment appears to be becoming increasingly crisis orientated (Worth 1998). Financial constriction, therefore, seems likely to seriously jeopardize the innovative potential of practitioners.

The development of a mixed economy of care was intended as one of the key features of the new community care, with the aim of increasing consumer choice and the provision of more innovative and responsive ways of meeting needs (Department of Health 1989). However, budget restrictions and reservation, and/or a lack of planning, regarding use of the independent sector appear to have hindered local authorities in fulfilling their enabling role (Hardy & Wistow 2000; Hunter 1993; Parry-Jones *et al.* 2001; Wistow 1995). Whilst there is evidence of expansion in the private domiciliary care sector in England since the implementation of the reforms (Hardy & Wistow 2000), progress in Wales appears to have been much slower (Parry-Jones *et al.* 2000). Care management practitioners in Wales have indicated that choice of providers and arrangements for negotiating services are inadequate (McGrath *et al.* 1997; Parry-Jones *et al.* 1998b, 2001).

The need to have sufficient information technology in place was suggested by the Department as likely to hold up the process of change in financial management systems (Department of Health 1993a). Evidence from Wales suggests that budgeting problems arose, in part, from delays in establishing information technology financial systems (Parry-Jones & Soulsby 1999). There is also an indication that front-line staff in Wales did not have adequate information regarding independent sector provision and the state of the local community care budget (McGrath *et al.* 1997).

The development and support of practitioners' own personal resources appear not to have been adequately addressed. Training in community care legislation, needs assessment, care management, financial assessment and budget management appears to have come too little too late, if at all (McGrath *et al.* 1997; Parry-Jones *et al.* 1998b; Parry-Jones & Soulsby 1999). It has been suggested that inattention to training early on resulted from the prioritisation of managerial and organizational changes and to the interpretation of care management as a relatively simple, administrative task (Bradley *et al.* 1996). Uncertainty about the skills required in assessment and care management practice may also have contributed to the apparent neglect of training (Hudson 1996). Hudson (1996) suggests the following practitioner skills are important:

> "..a close working knowledge of the needs of a particular user group; knowledge about services in the community, covering both the range and quality of providers; some experience of working with a range of providers; an understanding of the workings of local authorities, health agencies and the voluntary sector; communication skills; an ability to work with or for users, rather than making plans on their behalf; technical skills in conducting an assessment; and an ability to anticipate the likely costs of care and record the actual costs." (p.81)

It could be argued that all these skills and knowledge, excepting specialist knowledge of the needs of user groups, could be adequately gained from learning on the job. Indeed, practitioners in Wales have indicated that insufficient time and resources were far greater constraints to effective practice than having inadequate skills (McGrath *et al.* 1997), suggesting they felt sufficiently competent to conduct their care management work despite many acknowledging that training for community care was inadequate. Reporting on research surrounding the training needs of assessors, Bradley *et al.* (1996) considered that professionally trained and experienced social workers appear to have some of the skills and knowledge required for assessment, but skill deficits were noted in the areas of conflict resolution (between user and carer), accessing specialist help (deciding when to refer on) and reflective practice. Training in all these areas would most likely

enhance the innovative potential of care management practitioners, but training in reflective practice may be the most useful in this respect. The ability to be reflective is likely to promote identification and analysis of the problems and issues requiring a response, and the formulation of potential care and support solutions geared to meeting the needs of individuals. However, such practice depends on there being sufficient time.

Care management as a vehicle for innovation: summary and conclusions

Whilst policy and official guidance advocated the use of creative and innovative practice in tailoring care packages to meet the needs of individuals, there was little clarity about what *creative or innovative practice* meant and some of the rhetoric appeared to contradict, or be unsupportive of, such practice. The emphasis on containing costs and the right of agencies to determine what constitutes need, leaves practitioners relatively powerless to devise care arrangements based on the specific requirements of individuals. Although policy and guidance endorsed the devolvement of budgets to assist in innovative care management practice, it was left to authorities to decide on the level of devolvement and, even, whether to devolve at all. Additionally, the failure of official documents to acknowledge the potential benefits of small caseloads, despite empirical evidence that they appear to support innovative practice, is symbolic of a general lack of forethought of the operational structures and resources required to support effective care management. Even where rhetoric proffers guidance on the process of care management and on practitioner training, the frameworks provided are operationally inadequate. It is unsurprising, then, that the circumstances practitioners seem to have found themselves in following implementation do not appear to have been conducive to innovative care management practice.

The social entrepreneurship model, upon which UK care management was premised, depended for its effectiveness upon having adequately skilled

practitioners with sufficient time and access to a devolved budget in both British and American studies (Davies *et al.* 1996). However, from the evidence of UK implementation to date, training in care management appears to have been 'too little, too late', time pressures endemic, and budgets insufficiently devolved. The failure by local authorities to devolve budgets to care management practitioners appears to have gone hand-in-hand with the need for ever-tighter control of budgets, as finances constrict. Demand for needs assessment and care management services appears to have increased over time without the necessary investment of resources, resulting in increasing practitioner caseloads and reduced time for work with individuals. The emphasis placed on assessment by local authorities appears to have further limited the time available for other aspects of care management practice, notably care planning and reviewing, aspects vital for the tailoring of care arrangements.

On top of these constraints, there appear to have been a number of other features of implementation that may have further impeded innovative practice. Attention to form-filling and bureaucracy appears to have reduced opportunities for analytic work and practitioner discretion. It has also been associated with practitioner dissatisfaction. Despite the potential benefits to innovative care management practice of identifying unmet needs and working with multidisciplinary colleagues, problems appear inherent in both these areas.

Since assessment and care management were to form the 'cornerstone' of community care, it could be said that ascertaining whether practitioners have been able to be innovative in constructing care packages for individuals is the ultimate test of the implementation of the reforms. If practitioners have managed to achieve a degree of innovation within just some of the care packages they devise, in the face of political and structural barriers, then investigating how they have succeeded will provide insights for policy makers, managers and practitioners as they strive for improvements in services.

CHAPTER 3 INNOVATIVE PRACTICE IN THE WORKPLACE

Whilst a vast literature exists on creativity and innovation, in keeping with the substantive area of interest of this thesis, the focus of this chapter is on innovative practice at work. Care management practitioners conduct much of their practice as individual workers. Particular attention is therefore paid to the literature surrounding the innovation of individual workers, rather than that of work groups or organisations as a whole. In order to better understand what is meant by innovative practice, and the factors that appear to affect it in the workplace, definitions, models and empirical work on creativity are referred to where it seems appropriate to do so.

The following themes are considered in the chapter:

- Defining innovation and creativity
- Theories of creativity and innovation
- Antecedents of individual innovation and creativity
- Summary and conclusion

Defining innovation and creativity

Defining innovation is not easy. There is no single, agreed upon definition. The term appears to have been used in a multitude of ways, depending upon the main area of interest of the researcher or theorist. To complicate matters, the terms creativity and innovation have frequently been used interchangeably (King 1990). The innovation literature has been divided into three or four levels of analysis, varying by unit of (innovation) adoption or production. Staw (1984) identified individual, group and organizational levels. Others have indicated there is a fourth level, that of the socio-cultural level (*e.g.* Grønhaug 1988; West & Altink 1996). Within and across these levels of analysis, innovation (or innovativeness) and creativity have been viewed variously as aspects of person, process and product.

Creativity

Research and theory development in the area of creativity has preceded that of innovation and, to a degree, appears to have influenced its definition and study, certainly at the individual level of analysis. An early definition of creativity or, rather, the creative process, is:

> ".. the emergence in action of a novel relational product, growing out of the uniqueness of the individual on the one hand, and the materials, events, people, or circumstances of his life on the other." (Rogers 1954, p. 251)

Rogers' humanistic perspective includes the key elements of novelty (of product) and uniqueness (of the individual) The former appears to be characteristic of definitions of creativity and the latter appears to be pertinent to those writers with a particular interest in individual differences. Rogers' definition recognises the importance of the interaction between an individual and his (or her) social, environmental and historical contexts. Both behaviour ("action") and outcome ("product") are essential, according to Rogers' definition, for creativity to have occurred. The use of the terms "novel" and "relational" before "product" infers that creativity can only be recognised as such when judgements have been made about the uniqueness of the product in comparison with other, previous products in a similar domain.

Rogers' definition fails to stipulate who would be responsible for making relational judgements: the creator or others with knowledge of the domain in which the creative product has arisen. King and Anderson (1995) suggest that novelty to the creator is favoured by writers in the creativity field. They give the example that if two scientists, unknowingly to themselves, make the same discovery, they are both creative because they have both produced something novel. If absolute uniqueness was the criteria applied instead, then only one scientist could be classified as creative, the one who produced the creative outcome first. Csikszentmihalyi (1996), on the other hand, stipulates that for certain types of creativity, for example *cultural creativity*, it

is necessary for others, not just the originator, to be able to recognise a product as creative:

> "To have any effect, the [creative] idea must be couched in terms that are understandable to others, it must pass muster with the experts in the field, and finally it must be included in the cultural domain to which it belongs." (Csikszentmihalyi 1996, p. 27)

Csikszentmihalyi's definition points to the potential outcome or product of creativity as being that of an idea. In suggesting that the idea must become part of the relevant (cultural) domain, it can be inferred that there must be some form of implementation or integration of the idea. Appropriateness of the product as a response to a particular problem within a domain (or situation) has been considered one of the key elements of creativity definitions (King & Anderson 1995). King and Anderson give the example that if a car manufacturer designed a car with square wheels it would be a novel product, but not an appropriate response to competition. The judgement of appropriateness (or value) and novelty, relative to a particular domain (or context), of an outcome are clearly and concisely specified in Ford's (1995) definition of creativity.

> "Creativity is a context specific, subjective judgement of the novelty and value of an outcome of an individual's or a collective's behaviour". (p. 17)

The subjective nature of creativity judgements is explicit within this definition. One of the challenges to researchers of creativity (and innovation) has been its measurement, since measurement implies objectivity.

Ford's (1995) definition seems to encapsulate most of the elements of creativity identified or inferred by others. Notably, he includes groups of people, as well as individuals, as potential originators of creativity. He does not, however, include the notion of an idea (a thought) as a product or outcome in its own right, since "behaviour" is one of his main precursors to a creative outcome.

There is one important element that none of the above definitions explicitly include, that of the relevance of time to both the creative process and judgements of value and novelty. For instance, judgements of creativity or originality can only be made after a period of time elapses that allows for comparison with (and emergence of) other related creative products. The lapsing of time has been particularly important, for example, in the recognition of the creative worth of the work of some artists, such as Vincent van Gogh, and in the generation of creative output by musical composers, such as Beethoven. Although not explicit in definitions, writers of the creativity field have indicated that time is an important element (*e.g.* Amabile 1988a; Rogers 1954; Wallace 1989).

Innovation, creativity and organizational change

The relatedness of the concepts of innovation and creativity (and organizational change) have been noted by many writers (*e.g.* Amabile 1988a; King & Anderson 1995; West & Farr 1990). Such writers have indicated that the main difference between creativity and innovation is that the former requires novelty, and the latter requires merely the introduction of something as new, to "bring in novelties, make changes" (Oxford English Dictionary). There also appears to be a distinction in purpose or intent: creativity can occur for its own sake, whereas innovation appears to require intention to bring about beneficial outcomes. Organizational change has been indicated to differ from innovation and creativity in that it requires neither novelty, nor the bringing in of novelties, and may involve unintended or undesired outcomes (West & Farr 1990). King and Anderson (1995) suggest the difference between organizational change and innovation, as fields of study, is to do with a difference in perspective of writers from these fields. They add:

> "The label 'organizational change' generally indicates a macro-level approach, which is more concerned with the organization as a whole and its major subsystems, than with the experiences of small work groups and individuals. ..the focus is very much on large-scale changes, whereas innovation research sometimes concerns itself with

> changes which are quite localized in their impact within an organization. ..innovation research tends to be at least as much concerned with the origination and initiation of changes as with their implementation, while organizational change research places its emphasis firmly on implementation." (p. 4)

A similarity in the operationalisation of innovation and organizational change concepts is that they both involve the study of change in the context of organisations. Creativity, on the other hand, has been applied to both organizational and non-organizational contexts. In terms of the latter, for instance, much of the early study of creativity (*e.g.* Barron & Welsh 1952; Galton 1869; MacKinnon 1962) was on what characterised creative individuals, such as artists, writers and scientists, irrespective of whether they were members of employing organisations.

For all the apparent differences, the link between creativity and innovation appears to be reasonably strong. Some have implied that the concepts lie at either end of a process continuum: creative thoughts starting the process and innovation acting as the implementation phase. For instance,

> "Creativity, if it is associated with the process [of innovation], occurs through the generation of a potentially valuable idea – either at the start of the innovation process or even earlier, in which case it is imported to start the innovation process." (Rickards 1996, p. 15)

> "Innovation is the successful implementation of creative ideas about products or processes within an organization". (Amabile 1988a, p. 146)

Defining innovation

The differences, similarities and connectedness of innovation with the related concepts of creativity and organizational change, thus, have been outlined. But what is innovation itself? There have been numerous, diverse definitions of innovation. Some definitions are general in nature, such as Zaltman *et al.'s* (1973):

> "[Innovation is] ... any idea, practice, or material artifact perceived to be new by the relevant unit of adoption". (p.10)

Some definitions make reference to the context in which many innovations occur, the organizational context. For instance, innovation is viewed as:

> "... the process of bringing any new problem-solving idea into use. Ideas for reorganizing, cutting costs, putting in new budgeting systems, improving communication or assembling products in teams are also innovations. Innovation is the generation, acceptance, and implementation of new ideas, processes, products or services". (Kanter 1983, p. 20)

Other definitions distinguish different forms of innovation within organisations. For example, Damanpour (1990), integrating the work of others, described differences between technological, administrative and ancilliary innovations:

> "*Technological innovations* are defined as those that bring change to the organization by introducing changes in the technology (Dalton *et al.* 1968). They occur as a result of the use of a new tool, technique, device, or system, and produce changes in products or services, or in the way products or services are produced. *Administrative innovations* produce changes in the organization's structure or its administrative processes. They are only indirectly related to the basic work activity of the organization and are more immediately related to its management (Kimberly & Evanisko 1981). An administrative innovation is 'the implementation of an idea for a new policy pertaining to the recruitment of personnel, the allocation of resources, the structuring of tasks, of authority, of rewards' (Evan 1996, p.10). *Ancillary innovations* ... are organization-environment boundary innovations that pertain to programs and services that go beyond the primary functional activities of the organization. For instance, in public libraries, ancillary innovations are those that go beyond traditional functions of collecting, maintaining and providing information, and include services to the community such as career development programs, tutorial services, and adult continuing education programs (Damanpour 1987)." (p. 126-127)

Individual innovation

Whilst Damanpour and others focused their attention on organisations as whole entities, others have considered the innovation of individual's within

organisations. For instance, Nicholson (1984) describes *role innovation* (originally referred to as *role development*) as the initiation of

> "... changes in task objectives, methods, materials, scheduling and in the interpersonal relationships integral to role performance" (p. 175)

West (1987a) distinguishes between different types of role innovation, those of *development* – where innovations are entirely new to the individual – and *conversion* – where the individual has carried over an innovation from one situation to another.

West and Farr (1990) discuss an analysis of overarching definitions of innovation. They conclude that whilst there is wide disparity, there are also common themes:

> "..such as novelty (either absolute or novelty simply to the unit of adoption of the innovation); an application component (*i.e.* not just the ideas but the application of ideas); intentionality of benefit (which distinguishes innovations from serendipitous change or deliberate sabotage), and some reference to the process of innovation." (p. 9)

West and Farr (1989) proposed their own general definition of innovation:

> "... innovation is the intentional introduction and application within a role, group or organization of ideas, processes, products or procedures, new to the relevant unit of adoption, designed to significantly benefit role performance, the group, the organization or the wider society" (p.16)

Nicholson (1990) noted that there were conceptual limitations to this definition since, he argued, using the terms *intentional*, *new* and *benefit* merely pushed back the definitional difficulties one step. However, he indicated that such a definition was nevertheless useful, because it helps reveal the underlying sources of conceptual indeterminacy and makes apparent the centrality of social values to the identification of innovation. It also, he added, emphasizes that innovation is an umbrella term for a multitude of phenomena.

Definition of innovative care management practice

No definitions of *innovative practice* per se exist. However, drawing directly upon West and Farr's (1989) definition of innovation, it is possible to generate a specific definition of *innovative care management practice*. Thus, for the purposes of the present research, *innovative care management practice* is defined as:

> "..the intentional introduction and application of ideas, processes, products or procedures, new to the practice of the care management practitioner, into the assessment, care planning, monitoring or reviewing stages of care package design and implementation, for the benefit of service users and/or carers."

Whilst this definition assumes that the benefits of innovative care management practice are ultimately for service users and carers, benefits may also be accrued by care management practitioners and their employing (and other) community care organisations. For example, designing and implementing an innovative care package that is tailored effectively to meet a users' needs may reduce the need for further practitioner intervention and, consequently, lead to a reduced workload for the practitioner and their colleagues and to more efficient organisations. A key aspect of the definition, however, is that there must be intended benefit for service users and/or carers for the care management practice to be deemed *innovative*.

Such a definition of innovative care management practice is similar in some ways to the idea of *good* care management proposed in the care management literature. For example, Orme and Glastonbury (1993) in their *framework for good care management* (see Chapter 2) placed the consideration and meeting of consumers' needs at the very heart of the care management process. The intent in both *good* and *innovative* care management practice is that service users and/or carers will benefit, irrespective of whether they actually do or not. *Innovative* care management practice differs only in its focus, in that a degree of novelty is required in the practice of care management by the individual practitioner.

* * *

Consideration will now turn to the research on the processes and antecedents of individual innovation, with the aim of illuminating the mechanisms and influencing factors of individual innovative practice.

Theories of creativity and innovation

Nicholson (1990) suggested that because of the breadth of phenomena that fall under the innovation heading, theory building should be focused on specific phenomena or domains of relevance to innovation rather than on attempting to examine innovation as a single, unitary concept. Some theorists, however, have attempted to unravel the complexities of innovation (and creativity) by providing overarching models. Such generalised models, whilst having their limitations, have the benefit of providing a starting point from which to examine individual innovation (and creativity) phenomena and can be useful for drawing together the threads from individual phenomena. Both generalised theories and models specific to individual innovation phenomena are discussed.

Since creativity research has a longer history than innovation research and because it has been considered to have influenced the innovation field (*e.g.* King & Anderson 1995), this section begins with a consideration of theories of creativity. The theories of creativity and innovation given below focus on the individual level, as opposed to the group or organisational levels, because this is the most relevant level in a consideration of the innovative practice of care management practitioners. A multitude of theories of individual level creativity exist. Those presented do not represent the entire field, but examples are given from each major theoretical orientation applied to the area. Few theories of individual level innovation exist. The one's given are all those known to the author. Overall, the creativity and innovation theories are presented in an approximate chronological order, although there is some overlap in the time frames when theories emerged. When this does

occur ordering is more to do with the content of the theories, rather than following exact chronology of publication date.

The beginning of creativity research is often cited as stemming from the work of Galton (1869). Galton proposed that genius was down to heredity and attempted to prove his theory by examining the degree to which eminence ran in families. The families chosen for study were those where at least one family member was an eminent artist or scientist with exceptional creative talent. He used a statistical, archival approach which inspired many others (*e.g.* Raskin 1936; Simonton 1984) to use this technique for studying the characteristics of creative individuals.

Wallas's creative thinking process theory

Wallas (1926) appears to have described the first ever model of the creative thinking process. His work has been considered to be highly influential in creativity and innovation research (King 1990; King & Anderson 1995). Wallas's model consists of four stages of creative thinking: *preparation*, *incubation*, *illumination*, and *verification*. *Preparation* occurs when an individual identifies a problem and makes definite goals. *Incubation* follows, whereby conscious effort to deal with the problem is deferred. *Illumination* consists of the 'Eureka!' moment when a solution, or partial solution, suddenly emerges into consciousness. *Verification* then occurs, whereby the insight is turned into an appropriate solution, evident to others, through the individual's rational and logical thought processes. King (1990), in his review of the literature on innovation at work, gives a brief critique of the model based on the research and theorising of others. He indicates that the model has been considered too rigid in its stages, and that overlap between the stages has been found in reality. He continues that the incubation stage, in particular, appears to have received a lot of attention, with contradictory evidence found for its existence and influence in creative thinking.

Psychodynamic and personality approaches to creativity

While Wallas's model was apparently based on studies of introspective accounts of the creative thinking of creative individuals, such as the mathematician Poincarė, his incorporation of an unconscious element (through *incubation* and *illumination*) into his model may have in part stemmed from the psychoanalytic stance on creativity. From the late nineteenth century the psychoanalytic view had been that the unconscious influences the thoughts and behaviour of individuals, including, and especially in relation to, creativity (Helson 1988a). Helson (1988a) gives a brief outline of psychodynamic formulations in a review of literature surrounding *the creative personality*. She indicates that other factors (to the unconscious) considered by psychodynamic theorists as influencing creativity included motivation and developmental circumstances (*e.g.* Rogers 1954; Rank 1945). For instance, **Rogers' (1954) theory of creativity** focuses on the motivation for creative activity, self-actualization. He defines self-actualization in the following terms:

> "By this I mean the directional trend which is evident in all organic and human life – the urge to expand, extend, develop, mature – the tendency to express and activate all the capacities of the organism, to the extent that such activation enhances the organism or the self." (1954, p.251)

He continues by explaining what limits self-actualization and how it leads to creativity:

> "This tendency may become deeply buried under layer after layer of encrusted psychological defences; it may be hidden behind elaborate facades which deny its existence; it is my belief however, based on my experience, that it exists in every individual, and awaits only the proper conditions to be released and expressed. It is this tendency which is the primary motivation for creativity as the organism forms new relationships to the environment in its endeavor most fully to be itself." (1954, p.251-252)

Rogers (1954) argues that individuals are creative because being creative is satisfying – it satisfies the need for self-actualization. This need is just one of

the motivators behind creativity postulated by Rogers' (1954). His theory is quite biological in its nature, in that it recognises an individual's need to live in accord with one's environment and that being creative helps to achieve this. Other 'inner' conditions Rogers (1954) specifies as being associated with creativity include being open to experience ('extensionality'), having an internal locus of evaluation, and the ability to toy with concepts and elements. Rogers (1954) describes the creative act as arising:

> ".. when [an] organism is open to all inner and outer experiencing, and when it is free to try out in flexible fashion all manner of relationships. Out of his multitude of half-formed possibilities the organism, like a great computing machine, selects this one which most effectively meets an inner need, or that one which forms a more effective relationship with the environment, or this one which discovers a more simple and satisfying order in which life may be perceived." (p.255)

Motivation as a precursor to creativity is considered to be a key element of the later theories of others who have different theoretical orientations to Rogers (*e.g.* Amabile 1983 – see below).

Rank's (1945) developmental theory postulates that there are three types of adjustment to separation from parents, namely *creative*, *conflicted*, and *adapted* types. The *adapted* person is unlikely to be rebellious, having early on been able to identify with the will of his/her parents. The *conflicted* personality type consists of being aware of differences between his/her own will and that of parents or society in general. Unless the individual can overcome the conflict, he/she is likely to suffer from feelings of guilt and inferiority. A third level of development is achieved by the *creative* type, a person who recognises the separateness from parents and others and who has become a goal-seeker in order to resolve the conflict of different wills. Support for this theory has come from the Institute of Personality Assessment and Research (IPAR), in which assessments of creative architects, research scientists, mathematicians, and writers were conducted whilst 'living-in' for a day or weekend (*e.g.* MacKinnon 1965; Helson & Crutchfield 1970). Whilst a developmental theory like Rank's on the whole appears to have little utility in a workplace setting, it is nevertheless useful to

reflect that different personality types may exist in the workplace and that not all workers may be orientated towards creative (or innovative) activity.

Kirton's Adaption-Innovation trait theory

A trait model of personality types in the workplace does in fact exist (Kirton 1976, 1988). Known as the Adaption-Innovation theory, Kirton's focus is on problem-solving and decision-making style. The theory arose from a study of management initiative (Kirton 1961); an investigation of how ideas resulting in radical changes in the organisations studied were developed and implemented. The stages through which initiatives went (such as the introduction of a new product or accounting procedure) prior to becoming accepted were examined. Stages included perception and analysis of the problem, solution analysis, agreement and acceptance of change, delegation, and implementation (Kirton 1988). Difficulties encountered during this process were also examined and it was this analysis which led Kirton to postulate two different styles of thinking: adaption and innovation. Kirton (1988) defines *adaptors* and *innovators*:

> "*Adaptors* characteristically produce a sufficiency of ideas, based closely on, but stretching, existing agreed definitions of the problem and likely solutions. They look at these in detail and proceed within the established mores (theories, policies, practices) of their organizations. Much of their effort when initiating change is in improving the 'doing better'…" (p.67-68)
>
> "*Innovators*, by contrast, have a taste for producing a proliferation of ideas, are more likely in the pursuit of change to reconstruct the problem, separating it from its enveloping accepted thought, paradigms and customary viewpoints, and emerge with much less expected, and probably less acceptable solutions.. They are less concerned with 'doing things better' than with 'doing things differently'." (p.68)

Adaptive solutions, Kirton (1988) states, are those which are paradigm-supporting within an organization and are, thus, more readily acceptable to others. Innovative solutions, on the other hand, are those which are paradigm-cracking and, consequently, are more likely to be resisted.

Innovators "..are liable to be treated with suspicion and even derision. This rejection of individuals tends to persist even after their ideas are adopted and acknowledged as successful" (1988, p.70). Adaption and innovation were considered to be at either end of a continuum. Kirton developed an inventory to measure adaption-innovation style. There is evidence for its validity (Kirton 1987; Torrance & Horng 1980) and, consequently, for the validity of the theory upon which the measure is based. However, there have been many criticisms of the theory and of other personality theories of creativity. Whilst the Adaption-Innovation theory has been developed from research in organisations, and Kirton (1988) recognizes the influence of organizational culture on the acceptance of new ideas and solutions, the theory and its associated measure fail to take into account social and organizational factors. King (1990) indicates that "..this may be justifiable in discussing creativity, but not innovation" (p.18). King (1990) also suggests that Kirton's work has many of the flaws of other creativity trait research identified by Nicholls (1972), such as a reliance on cross-sectional studies which cannot explore directions of causality. Studying creative personality traits, King (1990) argues, cannot lead to guidance on how creative performance in the workplace can be facilitated, except through selection strategies.

Cognitive approaches to creativity

Despite the early process model of Wallas (1926), cognitive approaches to creativity have been very scant (Kaufmann 1988). Kaufmann, in his review of problem solving and creativity research, suggests that this may be the case because of "..the intrinsic complexity and elusive nature of the phenomenon" (1988, p.87). Those cognitive models that do exist are mainly problem solving models, with some theorists considering creativity to have a specific problem solving process and others considering that creativity arises from everyday problem solving activity (Anderson & King 1995). Models that contain elements pertaining to the *incubation* and *illumination* stages of Wallas's (1926) theory represent examples of the former. For example, Sternberg and Davidson (1983) proposed that 'insightful thinking' characterised creative cognition, and that this has three components:

selective encoding, *selective combination* and *selective comparison*. *Selective encoding* consists of identifying those aspects of information from a complex problem which are likely to be most useful in an eventual solution. *Selective combination* involves being able to recognise how the selected information can be combined in an attempt to solve a problem. *Selective comparison* involves recognising how new information can usefully be applied to existing knowledge to aid problem solution.

Critics of the 'creativity as a special type of problem solving' school of thought include Weisberg (1986, 1993). He proposed that ordinary trial and error or learning by experience, lay at the heart of so called insightful problem solving. Other proponents of the view that creativity stems from ordinary problem solving include Simon and colleagues. In some early experiments, Chase and Simon (1973a, b) investigated the aptitudes of chess players of different skill levels to reconstruct game board positions after brief exposure. Expert level players were more likely than novices to be able to accurately reconstruct game positions when logical patterns of positions were used, that is, those that would apply in real games. However, when chess pieces were placed randomly, that is, in ways that would not be found in real games, expert players were no more likely to be accurate in their reconstructions than novices. Chase and Simon concluded that expert players' superior performance on reconstructing 'real game' positions was due to their ability to compare present game board states with stored information about a vast range of possible game positions, learnt over time. Thus, the apparent creativity of experts in a field may be more to do with their ability to find relations between information presented in new problems with that of prior acquired relevant knowledge, built up over time, than to do with a sudden flash of inspiration.

Since logical problem solving combined with sufficient domain knowledge, as argued by Simon (1985; cited in King & Anderson 1995), may be all that is required for creativity to occur, it makes sense to briefly highlight the general problem solving process. This process typically appears to consist of three phases (Kaufmann 1988). Each phase has been given a different name by

different theorists, but they essentially fit with that of Johnson (1955). Johnson's (1955) phases are *preparation*, *production*, and *judgement*. *Preparation* involves identifying and understanding a problem. *Production* consists of developing a variety of alternative solutions. *Judgement* involves choosing the best solution. Simon (1977) argued to extend the trichotomy in a practical management context to include a fourth phase, that of *review*, which involves evaluating previously implemented solutions. Logically, judgement, however, should involve an evaluative element, whereby choice of solution is informed by knowledge of prior problem solution. Extensive research by Mintzberg *et al.* (1976) confirmed that a trichotomy of phases in problem solving exists. Even within Sternberg and Davidson's (1983) model of 'insightful thinking', three components were proposed. Despite their assertion that creative problem solving is different from ordinary problem solving, their three components appear closely related to those in Johnson's (1955) model, especially if a *review* element is included in the *judgement* phase.

Perhaps the real difference between creative activity and ordinary problem solving is to do with problem definition, the entry point into the problem solving process. Newell, Shaw and Simon (1979) assert that problems requiring creative thought are (usually) initially vague and ill-defined, making formulation of the problem a crucial task. Perkins (1981) has additionally argued that 'premature closure', where a problem is too narrowly defined, can be a major obstacle to creative thinking. In process terms, having a narrow perspective on a problem prevents the generation, and subsequently the consideration, of alternative solution options.

Even when sufficient problem definition has occurred for creative problem solving, there may be constraints in devising alternative solutions. Simon (*e.g.* 1945, 1957, 1979) developed a theory of *bounded rationality* in response to the classical Subjective Expected Utility (SEU) theory. Within the SEU theory it is assumed that an individual will be able to generate "..an exhaustive set of alternative strategies, probability calculation of scenarios for the future associated with each strategy, and a policy maximizing

expected utility" (Kaufmann 1988). Simon has argued that apart from the unrealistic expectations of complete knowledge, the cognitive capabilities of the human brain are far too limited to be able to function at the level implied in the SEU theory. The theory of *bounded rationality* states that:

> "The capacity of the human mind for formulating and solving complex problems is very small compared with the size of the problems whose solution is required for objectively rational behavior in the real world – or even for a reasonable approximation to such objective rationality" (Simon 1957, p. 198).

An individual will, consequently, use a strategy of *satisficing* rather than maximising, following a realistic appraisal of what is 'good enough'. Indeed, it is assumed that the thinker will choose the first solution generated which meets certain minimum criteria of satisfaction. Using a satisficing, in place of a maximising, strategy is considered to reduce the computational demands placed on the thinker (Kaufman 1988). Schiffrin (1978) considers that the computational limitations involved in cognitive tasks may be linked to the basic limitations of short-term and working memories, where typically only 7 ± 2 pieces of information can be stored and manipulated.

The limitation of the cognitive theories described above, including Wallas's (1926), are that they do not take into account social factors. They portray creativity as a purely individualistic mental activity, albeit with behavioural outcomes, failing to acknowledge the social environments in which we all live and act. In terms of innovation in the work place such theories are, consequently, insufficient. However, they do provide insight into the mental processes that may occur during creative or innovative activity at work or elsewhere.

Amabile's social psychological model of creativity

Amabile's (1983, 1988a) social psychological model of creativity appears to be a landmark in the creativity and innovation fields. It was the first theory to directly take into account the influence of social psychological factors in the creative process (Amabile 1983; King & Anderson 1995). It also appears to be one of the first theories to attempt to synthesize research and theories from the various different approaches to creativity. Whilst archival researchers of creativity such as Simonton (1975) found evidence for the importance of sociocultural factors in creative lives, it was not until Amabile (1983) that a relevant model was devised to take into account such factors. Since then it appears that "creativity researchers have become increasingly aware of and concerned with the social conditions which facilitate or inhibit creativity" (King & Anderson 1995, p.63).

Amabile's (1983) is a componential model and consists of the linking of creativity process elements with social psychological components, those of *domain-relevant skills*, *creativity-relevant skills*, and *task motivation*. The model is shown in Figure 3.1. It is suggested that it is applicable at both high and low levels of creativity (Amabile 1988a). Amabile (1983) describes the three components:

> "*Domain-Relevant Skills* can be considered as the basis for any performance in a given domain. This component includes factual knowledge, technical skills, and special talents in the domain in question. *Creativity-Relevant Skills* include cognitive style, application of heuristics for the exploration of new cognitive pathways, and working style. *Task Motivation* includes motivational variables that determine an individual's approach to a given task." (p.67)

There are five process steps involved in the model and they include (1) *problem or task presentation*, (2) *preparation*, (3) *response generation*, (4) *response validation*, and (5) *outcome*. Task motivation is considered important during step 1, *problem or task presentation*, which involves interpreting external and/or internal stimuli in problem or task terms. Step 2 in the process, *preparation*, is considered to be influenced by what domain

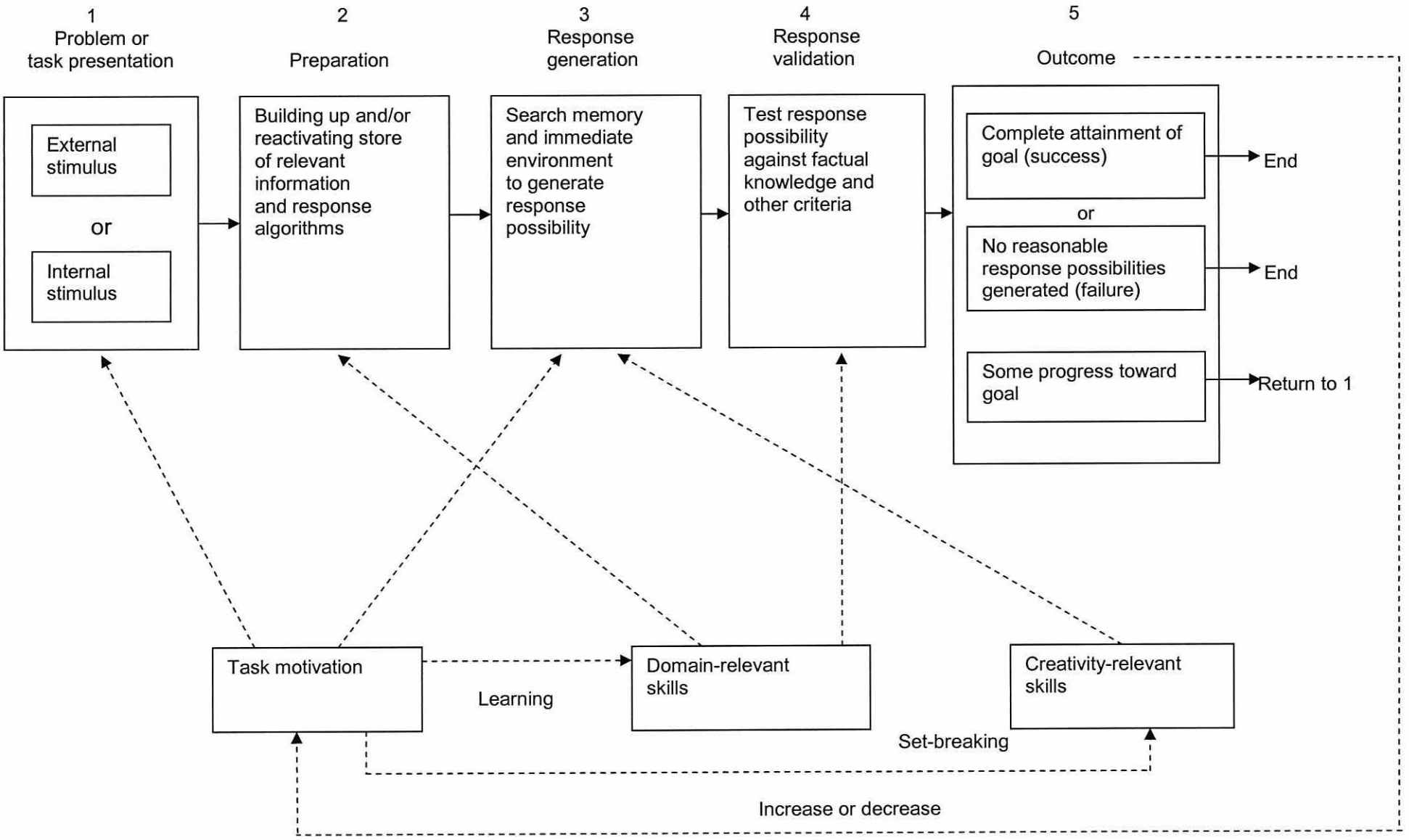

Figure 3.1 Componential model of the social psychology of creativity (Amabile 1983)*

* Amabile, T.M. (1983) *The Social Psychology of Creativity*. New York: Springer-Verlag.

relevant skills an individual has. It involves gathering, storing or retrieving relevant information and response algorithms for use during the response generation step. Task motivation and creativity relevant skills are both considered important during step 3, *response generation*, whereby the individual's memory and immediate environment are 'searched' to aid the generation of potential responses. How the searches are conducted will be influenced by an individual's type and level of motivation and ability to activate suitable creativity skills. Domain relevant skills are considered to affect step 4, *response validation*, which requires tapping into relevant knowledge and skills during testing of possible responses. Reaching an *outcome* is step 5 and consists of one of three options: complete attainment of a goal (deemed to be a successful outcome); lack of reasonable response possibility generation (deemed to be a failed outcome); and, some progress toward a goal, requiring a return to step 1. Whatever outcome is achieved is considered to increase or decrease level of task motivation, which in turn will influence how the creative process is conducted in the future. Task motivation is considered to be highly influential in the creativity process, since it not only impacts upon the problem or task presentation and the response generation steps, but also affects the learning (or improving) of domain-relevant skills and the 'set-breaking' necessary to utilise creativity-relevant skills.

Amabile (1983) indicated that the three components of the model work at different levels of specificity. Creativity-relevant skills were considered to operate at a general level, capable of being drawn upon in any content domain. Amabile (1983) suggested that "..highly creative individuals may indeed appear to be creative 'types', behaving atypically in many domains of behavior" (p.69). Domain-relevant skills were considered to work at an intermediate level of specificity, functioning within a content domain, but not solely attached to a specific task within a domain. Task motivation was considered to operate at a specific level: "..motivation may be very specific to particular tasks within domains and may even vary over time for a particular task" (p.69).

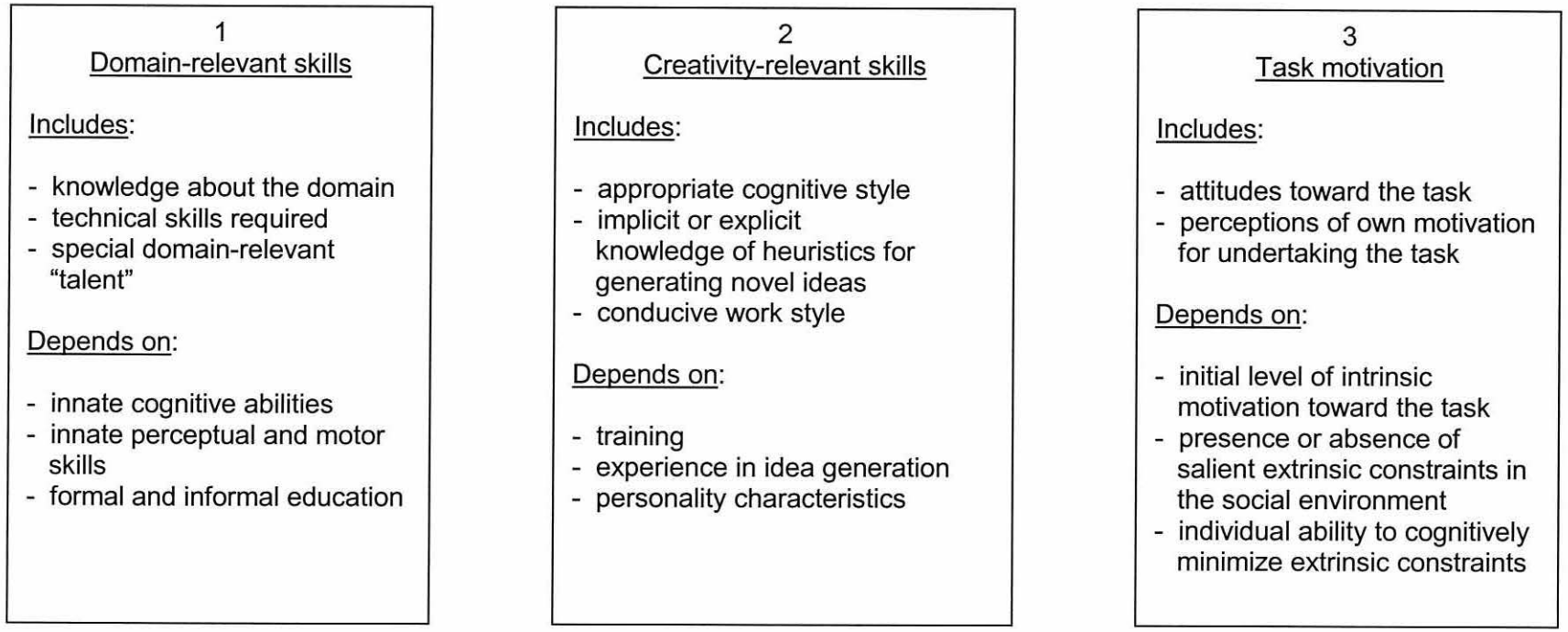

Figure 3.2 The three components of Amabile's model (Amabile 1983)*

* Amabile, T.M. (1983) *The Social Psychology of Creativity*. New York: Springer-Verlag.

Amabile (1983) gave a clear indication of the factors that might underlie use of the three domains (see Figure 3.2) and provided evidence from the literature for her assertions. For domain-relevant skills, innate cognitive abilities, perceptual and motor skills, and formal and informal education were considered influential. For creativity-relevant skills, training, experience in idea generation, and personality characteristics were suggested as important influential factors. Task motivation was considered to depend on the initial level of intrinsic motivation towards a task, the presence or absence of notable extrinsic constraints in the social environment, and an individual's ability to cognitively minimise extrinsic constraints.

In her book, *The Social Psychology of Creativity*, Amabile (1983) focused much attention on the motivational component of the model. She proposed that "..the intrinsically motivated state is conducive to creativity, whereas the extrinsically motivated state is detrimental" (Amabile 1983, p.91). This Amabile (1983) named the intrinsic motivation hypothesis. Amabile (1983) herself indicated that this hypothesis was derived from social-psychological theories of motivation (*e.g.* McGraw 1978) and from the creativity research and theorising of others, such as Koestler (1964), Rogers (1954) and Crutchfield (1962). Amabile (1988a) eloquently described the effect of extrinsic and intrinsic motivation in the following terms:

> "Someone who is extrinsically motivated is motivated primarily by something *outside* of the maze – the extrinsic goal. Since that goal can only be achieved once the maze has been exited, the best strategy for the extrinsically motivated person is to take the safest, surest, and fastest way out of the maze: the well-worn pathway, the uncreative route." (p.160)
>
> "Someone who is intrinsically motivated, on the other hand, is motivated primarily by the interest, challenge, and enjoyment of *being in the maze*. Surely, there is no point in being in the maze if there is no desire to exit – to find a solution. Indeed, there may be strong desire to exit, often caused by external factors (such as dire need of the organization for a solution to this problem, or strong competition from other organizations who are trying to achieve the same thing). But the important distinction between intrinsic and extrinsic motivation arises from both the individual's basic interest in the activity and the amount of freedom from extrinsic constraint in the immediate work

> environment. The intrinsically motivated person, because enjoyment of being in the maze is so high and concern about extrinsic pressures is so low, will be more likely to spend the cognitive energy exploring the maze, and will not be overly concerned about the possible dead-end risks involved. Thus, it is the intrinsically motivated person, working in an environment with low extrinsic controls, who is most likely to happen upon one of those elegant exits." (p.160-161)

Amabile found support for her motivation hypothesis through her and her colleagues' experimental and field study work (cited in Amabile 1988a). For example, in a qualitative study of factors influencing the creativity of research and development scientists working in a variety of organisations around the world, specific aspects of management style appeared to inhibit individual creativity: factors included reward structures where specific rewards are attached to achievement of specific tasks; evaluation and constant performance appraisal pressure; competition; and limited choice of methods for conducting a task (Amabile 1984). Despite finding evidence in this field study to support her motivation hypothesis, it has been noted that Amabile failed to provide an explanation as to why some extrinsic motivators, such as 'challenge', 'pressure' and 'recognition', were described by the interviewees as facilitators (King 1990). King comments: "It seems likely that in real-world settings a simplistic intrinsic-extrinsic dichotomy is inadequate" (1990, p.21). Whilst this may be the case, thus disproving Amabile's intrinsic motivation hypothesis, her model of the social psychology of creativity remains reasonably intact.

Amabile (1983, 1984, 1988a) not only examined and postulated how individual creativity might occur, but attempted to link the process of individual creativity with that of the wider process of organizational innovation. She suggested that the process of organizational innovation might be similar to that of individual creativity –

> "There appears to be a stage where the general problem or innovational direction is set, a stage where the idea is actually produced, a stage where the innovation is tested and implemented, and a stage where the outcome is evaluated." (1988a, p.163)

— and that components similar to those within the individual model apply in the organizational innovation context. Domain-relevant skills were considered to be akin to the organisation having basic resources for the innovation process; in place of creativity-relevant skills, an organisation would need to have ways of managing the stages within the innovation process; and, task motivation was deemed to be akin to having the highest levels of management in the organisation communicating genuine support for innovation (Amabile 1988a). Amabile (1988a) suggested that individual creativity would impact on the organizational innovation process only at the idea generation stage, but that the organizational innovation process would impact on individual creativity at a number of stages, both directly and indirectly. She concluded that more research was needed in order to pinpoint exactly where, and in what ways, organizational innovation influences individual creativity within organisations.

The importance of the social psychological approach to creativity and innovation is that it acknowledges the interaction between individuals and their environments, thus taking the creativity field out of its individualistic focus (King & Anderson 1995).

Systems approaches to creativity and innovation

Taking the social psychological stance to creativity a stage further, or rather taking a related though different perspective, a number of theorists have postulated systems theories (*e.g.* Csikszentmihalyi 1988, 1996; Gruber 1980, 1989). These theories essentially revolve around the interplay between the individual creator and the social, historical and cultural settings of the domains in which they operate. They take into account both processes and interactions that the individual creator experiences and influences. The approach has stemmed out of the study of the lives of creative people, such as artists and scientists (*e.g.* as described in Wallace & Gruber 1989). Whilst the role of personality and mental processes are acknowledged, systems theorists such as Csikszentmihalyi (1988) and Gruber (1989) argue that creativity should not be viewed as located in the individual alone.

Gruber (1989) describes the five principal elements of his evolving-systems approach in the following terms:

> " The approach is *developmental* and *systemic*: Creative work evolves over long periods of time. It is purposeful work and there is a constant interplay among purpose, play, and chance.
>
> The approach is *pluralistic*: The creative person enjoys and exploits not one but many insights, metaphors, social relationships, projects, heuristics, and so on.
>
> The approach is *interactive*: The creative person works within some historical, societal, and institutional framework. The work is always conducted in relation to the work of others. At the same time, the creator works alone, even when intimately bound up with others. This interaction produces varying patterns of conflict, influence, and collaboration.
>
> The approach is *constructionist*: The creator participates in choosing and shaping the surroundings within which the work proceeds, the skills needed for the work, and the definition of the ensemble of tasks. Little is given and nothing that is taken is accepted as is. The creator must reconstruct and take possession of whatever he or she needs for the work.
>
> The approach is *experientially sensitive* (or phenomenologically aware): The creator is not considered simply as the doer of the work, but also as a person in the world. Such a person has emotions and aesthetic feelings as well as social awareness of the relation of his or her work to the world's work, its needs, and feelings." (p.4-5)

The developmental and interactional nature of creativity lies at the heart of Guber's (1989) approach. Csikszentmihalyi's (1996) systems model places emphasis on where creativity is located within an interrelated system comprising three parts: the *domain*, the *field*, and the individual *person*. The *domain* is a set of symbolic rules and procedures, for example, algebra in mathematics, or mathematics itself. They are considered to reside in culture, "the symbolic knowledge shared by a particular society, or by humanity as a whole" (Csikszentmihalyi's 1996, p.28). The *field* consists of people who make decisions about including or excluding a new product or idea into a domain. Such people include critics, academics, sponsors and others working in, or supporting, a domain. The *person*, or creator, is someone who employs the symbols of a domain to produce a novel idea or product that is later accepted as appropriate to the domain by others. Csikszentmihalyi

(1996) acknowledges that certain individuals may have developed new domains, such as Freud with psychoanalysis, but that these stemmed out of the creator's knowledge and use of earlier, related domains, such as the domain of neuropathology in the case of Freud. 'New' domains, Csikszentmihalyi (1996) argues, are only likely to become established if followers begin working in these domains.

Whilst the systems and social psychological approaches to creativity described above acknowledge the interaction and inter-dependency between individual creators and their context, they have not been directly developed to study the innovation of individuals in the work place. Although Amabile (1983) states that both high and low degrees of creativity may apply to her model, she does not explicitly consider how individuals might apply innovation, as opposed to creativity, within their work. Theories that directly relate to individual level innovation are discussed next.

Individual innovation: theoretical accounts

Theorising about individual innovation has been limited (Bunce & West 1995). Early efforts concentrated on the ability of individuals to innovate within their work place roles. Such theorising in an organizational context appears to have begun with Schein's (1971a, b, 1978) proposition that the role innovative behaviours of new job incumbents is influential in the process of organizational change. Nicholson (1984) took this a stage further when he proposed his theory of work-role transitions. Nicholson's (1984) definition of role innovation has been given earlier. It essentially consists of an individual making changes to the nature of his or her role. Nicholson (1984) postulated four extreme outcomes of work-role transitions: *exploration*, *absorption*, *determination*, and *replication*. *Exploration* consists of changes to the individual (personal change) and to the new role (role innovation). *Absorption* is where change is mainly to the individual. *Determination* occurs when the main change is to the role rather than the individual. *Replication* is the outcome when little notable individual or role change occurs following work-role transition. The particular outcome that results can be predicted,

Nicholson (1984) proposes, from knowledge of prior occupational socialization, an individual's personality, a job's present characteristics, and the organizational culture. High levels of job discretion or freedom to alter aspects of one's work-role and a high desire to control one' s external environment (a personality characteristic) were considered by Nicholson (1984) to be factors which were highly likely to lead to role innovation following work-role transition.

West (1987a) reported on a longitudinal (postal survey) study of United Kingdom managers designed to test out Nicholson's (1984) theory. Approximately 1,500 male and 800 female managers responded to the initial survey and 44% of male and 53% of female respondents completed follow-up questionnaires 15 months later. A variety of measures were incorporated into the questionnaires, including role innovation, personal change, work preferences and work characteristics, job discretion, job novelty (degree of difference between one's present job and previous jobs held), self-concepts (a personality measure) and post-transition satisfaction. Regression analyses were conducted to examine the robustness of Nicholson's (1984) predictions. Job discretion was found to be predictive of role innovation, supporting Nicholson's (1984) theory. There was some inconclusive evidence that personality factors akin to having a high desire to control one's external environment predicted role innovation. Other factors, not present in Nicholson's (1984) theory, were found to be equally or more highly predictive of role innovation suggesting, as West (1987a) indicates, "other role requirements and motivational factors need to be incorporated into the theory" (p.313). Such requirements and factors included 'need for growth opportunities at work', (un)predictability of work, and role innovation in previous jobs. The identification of the motivational factor supports the association of creativity with self-actualization, postulated by Rogers (1954), and with intrinsic motivation, proposed by Amabile (1983). As West (1987a) noted himself, however, only small proportions of the variance (15% in the first survey and 27% in the second survey) were explained by the factors entered into the regression analyses. West (1987a) concluded that a more elaborate theory than Nicholson's (1984) was required to explain role

innovation in applied settings, one that takes into account situational, motivational and social factors.

Farr and Ford's model of individual role innovation

Farr & Ford (1990) devised a model for organising the theorizing and research about individual role innovation that they reviewed (see Figure 3.3). They stipulated that their's was not a 'theory' of role innovation, but rather a 'first step' to help understand work role innovation. It is nevertheless worth including their model since it appears to take into account motivational, situational and social factors and, in terms of work role innovation theory, appears to be the most advanced. Four key factors were identified in the model as increasing the likelihood of work role innovation: *perceived need for change*, *self-efficacy*, *perceived payoff from change*, and *technical knowledge*. *Perceived need for change*, what might be viewed as the entry point into the model, consists of the individual worker identifying a problem, or gap in performance, in relation to his or her own role. This, then, appears to be the motivating force behind role innovation. Farr & Ford (1990) consider that a problem recognition or problem finding process occurs at this stage, which involves scanning one's environment for relevant stimuli. Triggers for problem finding, they postulate, could be recognising that one's work performance is poor, or that someone else is better able to progress their work because of having learnt how to use a new piece of computer software or equipment. Although not explicitly acknowledged by Farr & Ford (1990), a desire to improve one's ability to do a job, or task, appears to underlie *perceived need for change*.

Self-efficacy, the second stage in Farr & Ford's (1990) model, refers to an individual worker's perception that he or she is capable of successfully making relevant role changes. Their ideas are based on the *self-efficacy* theory of Bandura (*e.g.* 1977, 1982). Those workers who conceive that they are unlikely to succeed, Farr & Ford (1990) explain, are less likely to pursue a course of action. Feelings of *self-efficacy* can help the individual to face challenges involved in implementing innovation, such as resistance from

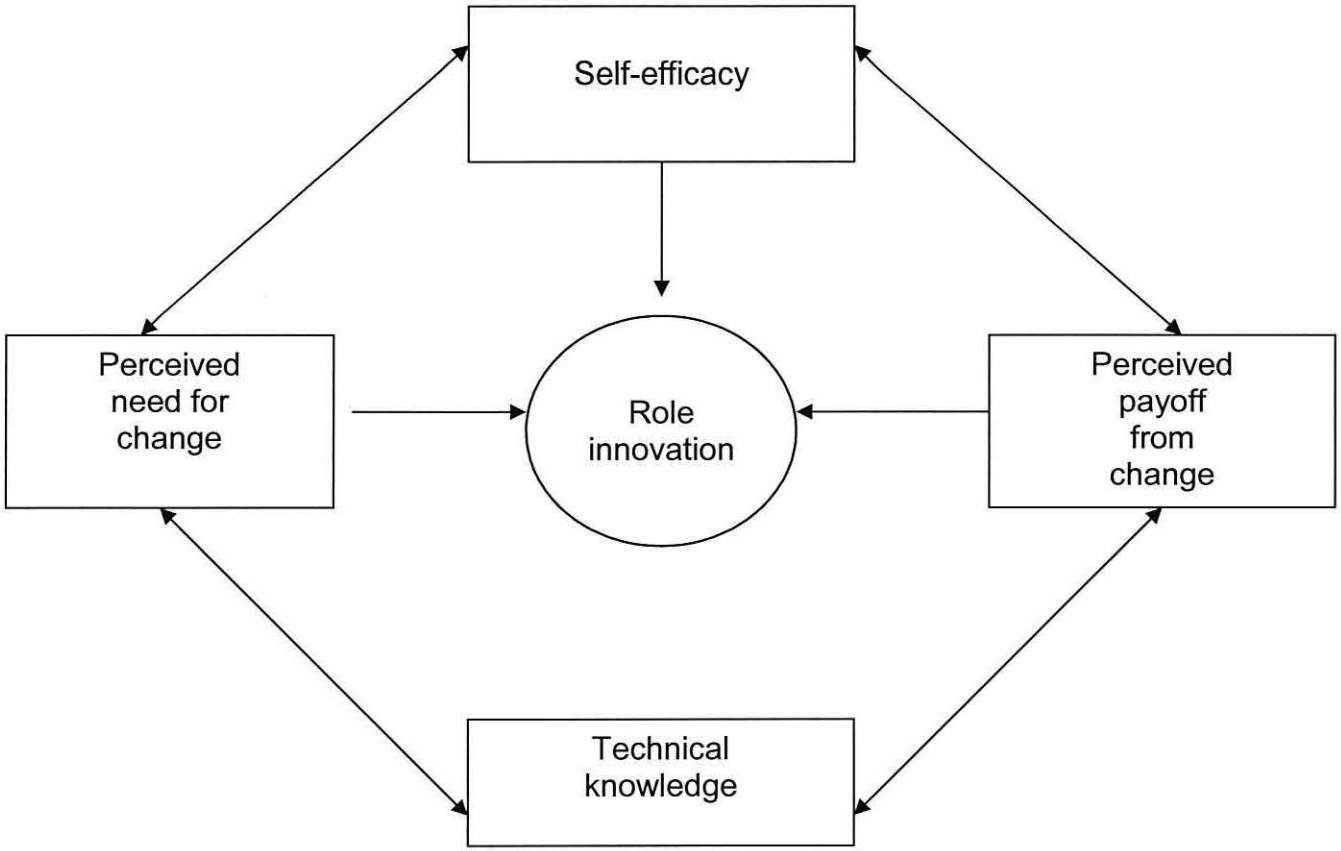

Figure 3.3 A model of individual innovation (Farr & Ford 1990)*

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* Farr, J.L. & Ford, C.M. (1990) Individual innovation. In M.A. West & J.L. Farr (Eds.), *Innovation and Creativity at Work: Psychological and Organizational Strategies*. Chichester: John Wiley & Sons Ltd.

peers or managers. Farr & Ford (1990) consider that *self-efficacy* will be influenced by formal training and education, previous relevant job experiences, personal explanatory style (optimism versus pessimism), organizational support and information systems.

The third stage in Farr & Ford's (1990) framework, *perceived payoff from change*, consists of an individual worker's perception of benefit following introduction of the innovation. Factors influencing this stage are considered to be degree of support for the innovation from peers and managers, and organizational factors, such as the way in which performance is measured and rewarded by the organisation, the availability of resources and time to think through innovations, and organizational culture that values and promotes innovation. *Technical knowledge*, the fourth stage in the model, consists of the ability of an individual worker to devise new and useful ideas. Farr & Ford (1990) consider that there are two main factors influencing this stage. These include being effective in searching for possible solutions to a problem and having sufficient creative ability. The former may involve searching through one's memory of previous related experiences, utilising skills and knowledge learnt through training and education, examining innovative solutions developed by others in response to a similar problem, and consulting with the organisation's customers. Individuals are considered to vary in their degree of creative ability. Farr & Ford (1990) make reference to the evidence within the creativity literature. Completing the innovation process may end at stage four or, alternatively, searching for ideas may uncover further problems, or clarify the nature of a particular problem identified earlier, leading back into the four stage cycle. However, Farr & Ford (1990) comment that role innovation may result from any of the stages taken in isolation, or from any combination of the four. They predict that role innovation will be most likely when a combination of all four stages is activated.

Whilst the Farr & Ford (1990) model does indeed appear to incorporate motivational, situational and social factors, its focus on role innovation limits its applicability. Individual workers innovate not only when changing the

nature of their roles, but also in fulfilment of the roles they have. Care management practitioners, as explained in the last chapter, have the opportunity to be innovative during the care management process. Such innovation is aimed at benefiting the individual service user for whom a care package is being designed, to change the circumstances of a service user for the better. Its objective is not to alter the role of the individual practitioner. Consequently a broader theory of individual innovation is required, one that can take into account both role innovation and the innovative practice of individual workers in pursuit of their roles.

West and Farr's model of individual innovation at work

West and Farr (1989) proposed a model of individual innovation at work, referring to it as "a starting point for psychological research in this area" (p.23). The model is presented in Figure 3.4. It indicates the main psychological and organizational antecedents of individual innovation within organisations. These are considered to be *factors intrinsic to the job*, *group factors*, *relationships at work*, *organizational factors*, and *individual characteristics*. Consequently, the West and Farr (1989) model can be considered an antecedent model of individual innovation. Despite the directional arrows and feedback loops incorporated into the model, it is not a process model, nor does it attempt to combine process and antecedent factor elements. Therefore, this model does little to progress the individual innovation research field other than to encourage attention to facilitators of individual innovation. Both process and antecedent factors need to be explored in the same research. The relationships between process and antecedent factors, how they interact and impact on one another, also need to be determined. This was implied in West's (1989) conclusion following the partial and inconclusive testing of the West and Farr (1989) model:

> "..[there is a] need for theory development in this area above and beyond model-building, which simply portrays the relationship between multiple variables and individual innovation."(p.182)

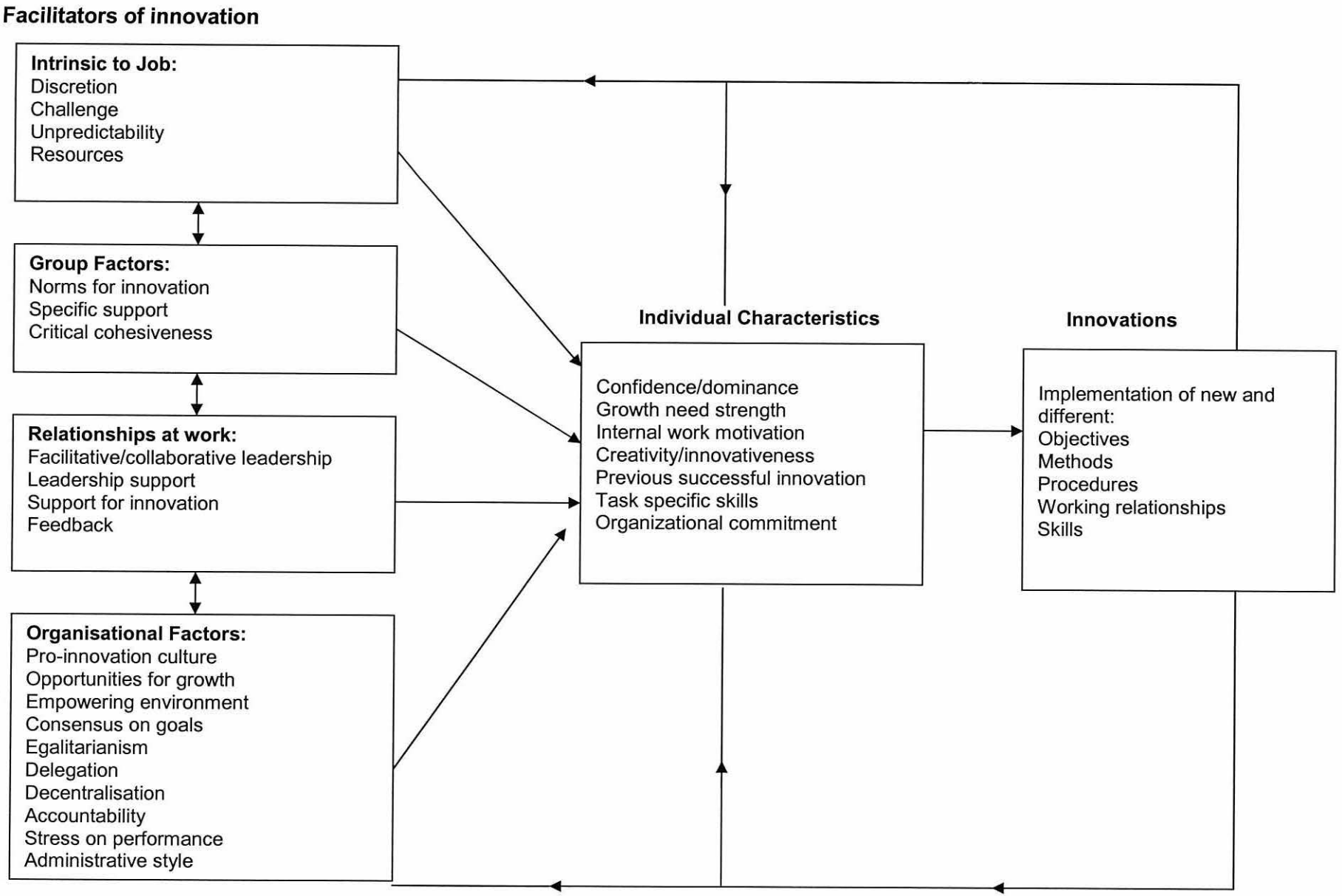

Figure 3.4 A model of individual innovation at work (West & Farr 1989) *

* West, M.A. & Farr, J.L. (1989) Innovation at work: psychological perspectives. *Social Behaviour*, 4, 15-30.

Although West and Farr (1989) refer to their model as *a model of individual innovation at work*, it appears from their definition of individual innovation – "the implementation of new and different objectives, methods, procedures, working relationships and skills" (p.23) – that theirs is, in fact, a model of role innovation. They even acknowledge that their definition follows from the prior theoretical and empirical work of Nicholson (1984) and West (1987b) on the concept of role innovation and its measurement. Consequently, it is unclear whether the West and Farr (1989) model is a model of general individual innovation, applicable to all types of individual innovation, or whether it is solely a model of role innovation.

Unsworth and West's model of employee innovation

Attempting to unravel some of the process-antecedent factor relationships, Unsworth & West (1998) separated out the process of *idea generation* from that of *idea implementation* in their model of employee innovation. They proposed that *idea generation* would be influenced by job competence, creative personality and intrinsic motivation, following Amabile's (1983, 1988a) componential model of creativity. *Idea implementation* was considered to be moderated by idea generation and influence over decision making. Unsworth & West (1989) found some support for their model through postal surveys of employees of four organizations. Creative personality was found to be a predictor of idea generation, and both idea generation and influence over decision making were found to be predictive of idea implementation. They concluded that the fact that there were different predictors for idea generation and idea implementation helps to support the principle of a two stage process in employee innovation. However, the idea generation measure they used for the survey instrument contained just one item - "I have ideas which would significantly improve the way the job is done" – and implies that it is a measure of role innovation, rather than of individual innovation more generally. A more complete measure would have included items on the generation of ideas that could benefit the organisation and/or consumers. Hence, Unsworth & West's (1989) testing of their model appears empirically unsound. Also, their model does not contain a problem

finding or problem definition stage which, as indicated above, has been considered an important first step for innovative and creative problem solving, nor does it take into account the potential effect of the social features of a worker's environment. This model, therefore, appears to be a somewhat incomplete model of individual innovative practice.

Scott and Bruce's social interactionist model of individual innovative behaviour

Drawing upon research in the fields of innovation, creativity and organizational climate, Scott and Bruce (1994) posited, and empirically tested, a social interactionist model of individual innovative behaviour. They consider innovation to be a multistage process which is influenced by many social factors. Incorporating a quotation from Kanter (1988, p.191), they describe the process in the following terms:

> "..individual innovation begins with problem recognition and the generation of ideas or solutions, either novel or adapted. During the next stage of the process, an innovative individual seeks sponsorship for an idea and attempts to build a coalition of supporters for it. Finally, during the third stage of the innovation process, the innovative individual completes the idea by producing 'a prototype or model of the innovation ... that can be touched or experienced, that can now be diffused, mass-produced, turned to productive use or institutionalized'". (p.581-582)

Scott and Bruce (1994) indicate that each stage is not necessarily sequential, but rather that an individual can be engaged in any, or more than one, stage at a time. Their hypothetical model of individual innovative behaviour (see Figure 3.5) consists of social and psychological factors that interact with each other and with innovative behaviour. Which factors impact upon which stage of the innovative process is not clear from the visual representation of the model. However, the factors are grouped into four clusters, or systems: psychological *climate* for innovation, *leadership*, *work group*, and *individual attributes*. *Climate* at the individual level, Scott and Bruce (1994) indicate, is "a cognitive interpretation of an organizational situation.. Climate represents signals individuals receive concerning

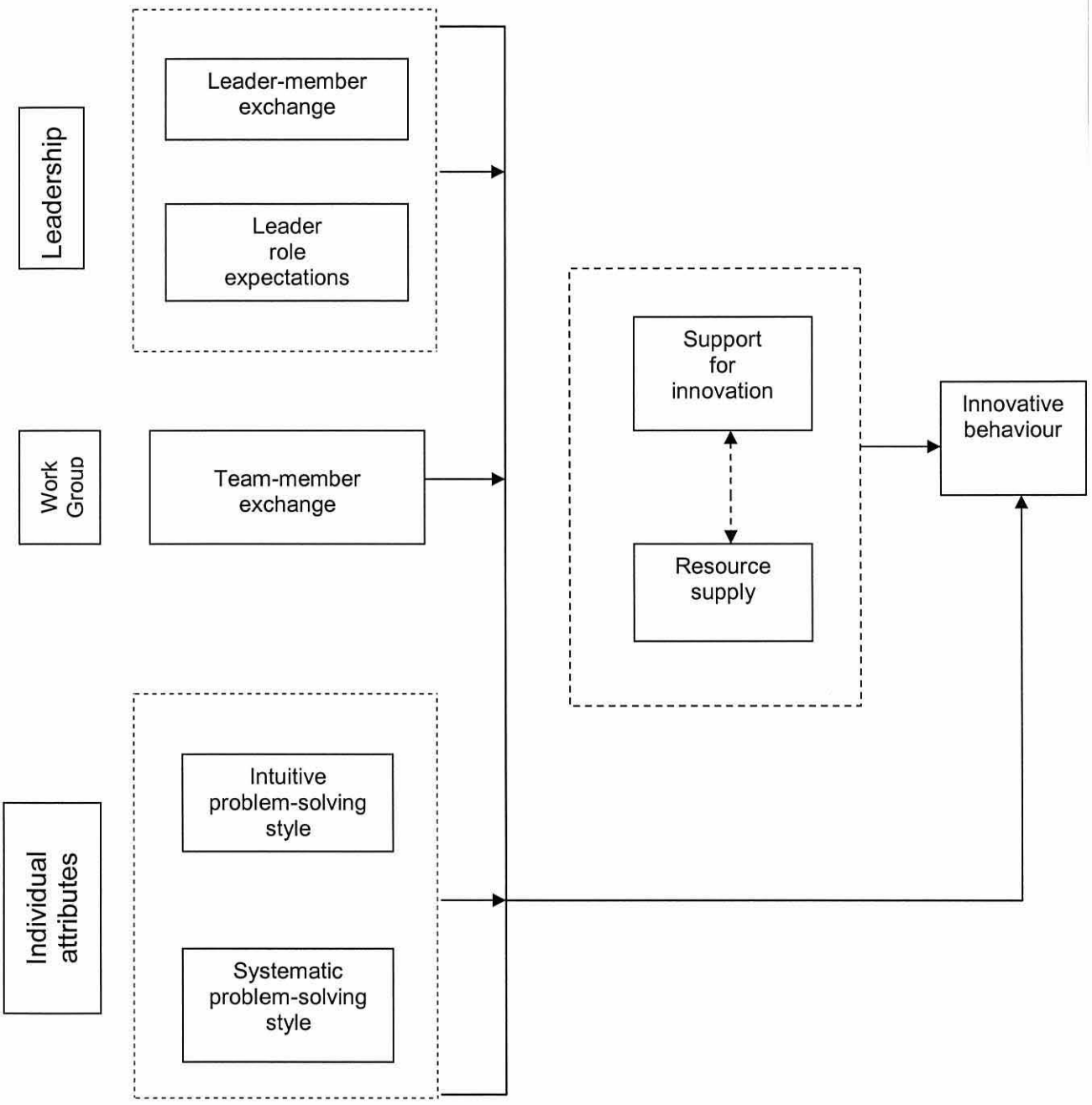

Figure 3.5 Determining innovative behaviour: a hypothetical model (Scott & Bruce 1994)*

* Scott, S.G. & Bruce, R.A. (1994) Determinants of innovative behavior: A path model of individual innovation in the workplace. *Academy of Management Journal*, 37, 3, 580-607.

organizational expectations for behavior and potential outcomes of behavior" (p.582). Summarising evidence in the field, Scott and Bruce noted that innovative climate was characterised by organisations having reward and support systems that encourage creative and innovative behaviour, such as enabling individuals to work independently to develop new ideas, rewards which recognise excellence, tolerance for diversity, and the provision of adequate resources, including time. Scott and Bruce (1994) hypothesised that an individual's innovative behaviour would be positively related to the extent to which organizational climate was perceived as supportive of innovation by that individual.

In describing the association between *leadership* and innovative behaviour, Scott and Bruce (1994) enlist the support of two theories from the leadership field: Leader-member exchange (LMX) theory (Dansereau, Graen & Haga 1975; Graen & Scandura 1987) and leader role expectations or the 'Pygmalion effect' (Livingston 1969). LMX theory, according to Scott and Bruce (1994), specifies that subordinates and supervisors engage in a process of role development which leads to understandings surrounding the degree of discretion the subordinate is permitted. Since high degrees of discretion have been associated with innovation, Scott and Bruce (1994) hypothesised that an individual's innovative behaviour is positively related to the quality of the leader-member exchange that individual has with his or her superior. Leader role expectations, Scott and Bruce (1994) describe, are the expectations that superiors have of an individual that are not negotiated through the leader-member exchange process. These, in due course, are considered to modify the focal individual's behaviour (the 'Pygmalion effect'). Based on this notion, Scott and Bruce (1994) hypothesised that a subordinate's innovative behaviour is positively related to the extent to which his or her supervisor expects the subordinate to be innovative. Due to the influence of superiors (and co-workers) on perceptions of psychological climate, Scott and Bruce (1994) also hypothesised that the extent to which an individual perceives a climate to be supportive of innovation will be positively related to supervisor expectations for innovative behaviour and to the quality of the relevant leader-member exchange.

Scott and Bruce (1994) indicated that typically within organisations, work groups or peers influence individual innovative behaviour, since individual innovation is not usually a solitary experience. *Work group* factors were considered by Scott and Bruce (1994) to be moderated by the quality of team-member exchange (TMX), with high quality TMX characterised by collaborative, co-operative, respectful and trusting actions. Consequently, they hypothesised that an individual's innovative behaviour will be positively related to the quality of the team-member exchange. They also hypothesised that the degree to which an individual perceives the organisation's climate to be supportive of innovation will be positively related to the quality of team-member exchange.

Scott and Bruce's (1994) model also implicates *individual attributes* as influencing individual innovative behaviour, with a particular emphasis on problem solving style. Scott and Bruce (1994) differentiate between intuitive and systematic problem solving styles. The intuitive problem solver is likely to produce the most novel solutions, they indicate, by the application of several separate domains of thought at the same time without constraint from conventional rules and domain boundaries. The systematic problem solver, on the other hand, is considered to remain within domain boundaries whilst thinking, applying established rules, procedures and methods and, as a consequence, producing routine solutions. Scott and Bruce (1994) hypothesised that an individual's innovative behaviour will be positively related to the extent of use of intuitive problem solving and negatively related to the extent of use of systematic problem solving.

Although not apparent within the visual representation of their model, Scott and Bruce (1994) postulated that individual innovative behaviour and perceived climate are moderated by task type. They specified this in the following terms:

> "When a task is routine or when individual discretion is low, the relationship between climate and innovative behavior is likely to be weaker than when the task is non-routine and high discretion is granted." (p.588)

Scott and Bruce (1994) tested their hypotheses through questionnaire surveys of managers, engineers, scientists and technicians in a large research and development facility of an industrial organisation in the U.S. Managers (n=26) rated the degree of innovative behaviour (six items), problem solving style and role expectations for each of their subordinates. The engineers, scientists and technicians (n=172) rated their own problem solving style, leader-member exchange quality and team-member exchange quality. Managers and subordinates both rated climate for innovation. Information on job type (aka task type), career stage and education level of all the engineers, scientists and technicians was also gathered. Scott and Bruce (1994) applied pathway analysis techniques to the data to examine the relationships between variables. Variables found to be predictive of innovative behaviour included managerial role expectations, leadership, support for innovation, career stage and systematic problem solving style. The fact that a considerable proportion of the variance, 37 percent, could be explained by the hypothesised model provides good support for it.

In their discussion, Scott and Bruce (1994) comment on the lack of support for *climate for innovation* as a mediating variable between individual and work group characteristics and innovative behaviour, concluding that "the role of climate as a mediator may be overstated in the literature, at least as it related to innovative behavior" (p.602). They also indicated not finding supportive evidence for a relationship between work group variables (team member exchange) or resource supply and innovative behaviour. Scott and Bruce (1994) acknowledge the limitations of the cross sectional design that they employed, particularly in their inability to examine causality, and the problems of generalising the findings to non-research and development specialists and, indeed, to other types of organisations. They recommend use of longitudinal designs for studying individual innovative behaviour and for testing the overall model in other settings.

Whilst the model did not stand up in its entirety to Scott and Bruce's (1994) own empirical testing, it nevertheless appears to represent the only complete model of individual innovative behaviour currently in existence. It is also a model that applies itself to empirical testing as a whole, with clearly specified concepts and hypotheses. However, because it is so specific it is possibly too constraining for the study of individual innovation. It also fails to link which individual or situational factors influence which stage of the innovative process, and how. Although the model seeks to take into account qualitative aspects, such as the quality of relationships between workers and supervisors, the method chosen for examining 'quality' was quantitative. A combination of both qualitative and quantitative methods may, therefore, be more appropriate to attempt to further unravel the complexity of interactions between the innovative process and its antecedent factors.

Antecedents of individual innovation and creativity

Many of the theories and models described above postulated the influence of specific factors on the individual's ability to be creative or innovative. Such factors included personality and the ability to think creatively; motivation and rewards; presence or absence of extrinsic constraints (such as of resource or time constraint); job competence, knowledge and technical skills; job discretion and other intrinsic job factors (such as challenge and unpredictability); social factors (such as peer and superior support, and feedback); and organizational, societal and domain-relevant culture. Evidence is provided below to determine which of these factors, and any others, appear to be antecedents of innovative and creative practice.

The creative personality

Much of the early research on creativity was on attempts to establish whether there was a 'creative personality'. The relationships between numerous personality traits and creative ability were examined to this effect.

King and Anderson (1995) summarised the traits that had emerged from research in this area where consensus appeared to have been reached regarding their association with high levels of creativity. Such traits were self-confidence, tolerance of uncertainty and ambiguity, originality, unconventionality, above average intelligence, intrinsic motivation, and determination to succeed. King and Anderson (1995) note that highly creative individuals need not possess all of these traits, but are likely to have at least some. Other traits for which evidence exists of associations with creativity include social independence, propensity for risk-taking, desire for autonomy, and moderate levels of anxiety (King 1990).

One trend in creative personality research has been to study the lives of eminent people, who were considered to be highly creative. For instance, Cox (1926) examined the lives of 1,000 eminent people using archival information. She reported finding that the most outstanding eminent people showed, as children, intellectual prowess, energy, originality, persistence, confidence and ambition. They also came from privileged backgrounds. Helson (1985, 1988b) conducted a prospective study of the characteristics and outcomes of women graduates who were nominated for their creative potential whilst at college. They were restudied at ages 27 and 43. Those who became successful careerists were found to be more forceful and ambitious, and scored higher on inventories of creative traits. Such women appeared to be unsure of themselves at age 27, focusing on femininity and gender role issues. By 43, however, they had resumed their earlier creative achiever traits. Of those creative nominees who were without successful careers at 43, many seemed particularly interested in relationships, spirituality and inner development.

Another trend in creative personality research is in the development and use of psychometric measures to identify creative traits. As indicated earlier, Kirton (1976) devised the Kirton Adaptation-Innovation scale to test his theory of different styles of creative decision-making and problem solving. And, Cattel and colleagues (*e.g.* Drevdahl & Cattel 1958 – see below) used the 16 Personality Factors test to investigate the personality characteristics

of creative individuals. Cattel and Butcher (1968) summarised the key findings for creative men across fields. Such men showed high self-sufficiency, seriousness, low conformity, disregard for sentimentality, willingness to experiment and a dominant independence. Using a variety of inventories, interviews and observation, a team of researchers at the Institute of Personality Assessment and Research (IPAR) from the 1950s onwards studied the personality characteristics of groups of writers, scientists, mathematicians and architects. MacKinnon (1962), being part of this team, reported trends for introversion (as opposed to extroversion) and of being perceptive (rather than judging) on the Myers-Briggs Type Indicator, and that the pattern of interests on the Strong Vocational Interest Blank indicated concern with meanings and their implications, intellectual curiosity, relative disinterest in curtailing their own (or others') impulses, interest and accuracy in communication, and cognitive flexibility. Barron (1965), also part of the IPAR group, reported that the characteristics of creative groups of writers, mathematicians and architects had much in common when described by staff. These were need for autonomy, aesthetic sensitivity, high aspirations, ascriptions of intellectual values, intelligence, and inquiringness.

There is evidence that type of creativity-related trait varies by occupation, gender and age of highly creative individuals (King & Anderson 1995). For instance, Roe (1952) in her study of 64 eminent American scientists (mainly physicists, biologists and social scientists), found that physicists and social scientists differed in their interest in personal relationships and engagement in social activity. The former typically felt lonely and different from peers at school and married late, whereas the latter tended to be more extroverted and exhibit more concern over personal relationships. The social scientists also showed higher levels of aggression in projective tests than either physicists or biologists. Using the 16 Personality Factors test, Drevdahl & Cattel (1958) found that artists and writers were more emotionally sensitive and indicated more inner tension than scientists, although they were very similar in other ways. Regarding gender differences, Helson (1988a), in her examination of the evidence surrounding sex differences in creativity, concluded that:

> "Increased awareness of the influence of gender roles has taken most of the 'mystery' out of the question of why there are many more creative men than women" (p.49).

A major criticism of the creative personality field, especially in its pursuit of 'creativity' traits, has been the considerable reliance upon cross-sectional studies (King 1990; King & Anderson 1995). However, the tradition of archival research in the field and the existence of a number of longitudinal studies (*e.g.* Cox 1926; Helson 1985, 1988b; Simonton 1975) have led to a considerable body of knowledge supporting creative personality characteristics. Additionally, researchers in the individual innovation field are beginning to reveal a consistent link between personality traits and individual (role) innovation using longitudinal methods (*e.g.* Bunce & West 1995; Unsworth & West 1998; West 1987a). Consequently, personality can be viewed as an important antecedent of the creative or innovative activity of individuals.

Motivation and rewards

Amabile (1983, 1988a) developed the intrinsic motivation hypothesis out of evidence that herself and others found for the facilitating influence of intrinsic motivation and the inhibiting effect of extrinsic reward (*e.g.* Amabile 1979; Amabile, Goldfarb & Brackfield 1982). It followed on from a developing stream of research on the impact of external reward on intrinsic task interest that appeared to originate in the 1950s and which has been actively pursued into the 1990s (Eisenberger & Cameron 1996; Deci, Koestner & Ryan 1999). Amabile (1983) summarised the intrinsically and extrinsically motivated person as:

> "Persons who engage in an activity for its own sake are intrinsically motivated; persons who engage in an activity to achieve some goal external to task engagement are extrinsically motivated." (p.93)

Intrinsic motivation is about enjoying the experience of cognitively engaging in the process of a task. It is not necessarily about reaching the end goal, but

rather is about the pleasure, and the competency, gained in being immersed in, and in control of, a task (Amabile 1983). Crutchfield (1962) described the relationship between intrinsic motivation and creativity:

> "..the creative man may invent a new device, paint a new picture, or construct a scientific theory for the sheer intrinsic pleasures involved… This, then, is the kind of motivation in which the creative act is an end, not a means." (p.122)

Extrinsic motivation occurs when behaviour is directed towards attaining an extrinsic goal, such as meeting a deadline, obtaining a reward, gaining a positive evaluation or approval from an important other (Amabile 1983). Simon (1967) proposed that the control of attention is the main function of motivation. When attention is focused on obtaining an external goal, less heed may be paid to information and stimuli that appear to be irrelevant. Amabile (1983) considers that extrinsic motivation may reduce the likelihood of the application of "the creativity heuristics of exploration, set-breaking, and risk taking" (p.95). Deci and Ryan (1985) suggested that intrinsic interest decreases when self-determination decreases, which occurs when rewards are offered for completion of tasks by others. Thus, either, or both, control over one's actions or locus of attention may lie at the core of the relationship between source of motivation and creative productivity.

Early evidence in support of Amabile's (1983) intrinsic motivation hypothesis came mainly from studies of verbal or artistic creativity under experimental conditions (*e.g.* Amabile 1979; Amabile *et al.* 1982; Koestner *et al.* 1984). Such experiments typically compared creative endeavour on specified tasks under external control (evaluation expectancy) conditions and non-control conditions. Those who performed under non-control conditions were judged to be significantly more creative in their output than those under control conditions. Moving into the sphere of field research in organisations, Amabile and Gryskiewicz (1987) appear to have found support for the positive influence of intrinsic motivation on creativity. However, their study was limited to self-report data from research and development scientists and, consequently, generalising to other settings and workers is difficult.

The detrimental effect of reward on intrinsic motivation is not, however, entirely certain. Some researchers, having conducted meta-analyses of the experimental evidence, have concluded that it is only certain types of reward that have a negative impact upon intrinsic motivation (*e.g.* Deci *et al.* 1999; Eisenberger & Cameron 1996). For instance, tangible rewards, such as money or sweets, appear to reduce intrinsic motivation for interesting tasks in both children and college students, whereas verbal rewards (positive feedback) appear to enhance intrinsic motivation, at least for college students (Deci *et al.* 1999). Eisenberger & Cameron (1996) distinguished between *performance-independent rewards*, *completion-dependent rewards*, and *quality-dependent rewards*. *Performance-independent rewards* are those that are given for merely participating in a task. *Completion-dependent rewards* are the type given for finishing a task. *Quality-dependent rewards* are those given when performance on a task reaches a certain standard. Eisenberger & Cameron (1996) conclude that tangible *completion-dependent* and *quality-dependent rewards* are not necessarily detrimental to intrinsic interest. They, like Deci *et al.* (1999), reported verbal reward enhanced self-reported interest in tasks and, in addition, that tangible *quality-dependent rewards* had a similar positive effect. Whilst such meta-analyses concentrate on the effect of reward on 'interesting tasks', rather than creative tasks per se, Eisenberger & Cameron (1996) give some attention to the literature surrounding extrinsic rewards and creativity. They consider that many of the creativity studies in this field have used *performance-independent rewards* and it is this type of reward, they state, that has a particularly negative impact on intrinsic motivation.

The Eisenberger & Cameron (1996) and Deci *et al.* (1999) meta-analyses only take into account experimental findings. Studies examining the impact of reward on intrinsic motivation in organizational settings are rare (the Amabile and Gryskiewicz 1987 being one of the few). However, evidence is growing for the positive effect of verbal reward (feedback) from supervisors on creative and innovative practice in the workplace (*e.g.* Oldham & Cummings 1996; Scott & Bruce 1994; Stahl & Koser 1978; West 1989).

Manager and co-worker support and organizational culture

According to Scott and Bruce's (1994) model, interactions between supervisors and their subordinates, and between co-workers, have an impact on the innovative behaviour of individuals in the work place. As described above, Scott and Bruce (1994) found support for the influence of leadership variables, such as the quality of supervisor-subordinate relationship, on individual innovative behaviour. The quality of interactions with one's supervisor also appears to reflect how supportive an individual considers his or her organisation to be. Those who reported high degrees of autonomy, trust and support as outcomes of their relationships with their supervisors also reported their organisation to be supportive of innovation and that sufficient resources existed. Scott and Bruce (1994) did not find support for their hypothesis that team-member exchange would be positively related to innovative behaviour. In fact, no significant relationship was found between these variables. In explanation of this finding, Scott and Bruce (1994) suggest that where work group member interaction and task interdependence is low, as may have been the case with the participants of their study, the collaboration and co-operation between team members may be low and, consequently, the influence of team members on an individual's innovative behaviour may be low or nonexistent. They recommend that task interdependence be measured in future research on work group-individual innovative behaviour associations.

Other studies have found evidence of the facilitative influence of supervisory support on individual innovation. For instance, West (1989) explored the innovative practice of health visitors (n=92) using a self-completion postal questionnaire and ratings of innovativeness of the health visitors by first-line managers (senior nurses). The health visitors were asked to indicate who they turned to when they needed someone (a) to listen to them about work problems, (b) to help in a crisis situation, (c) to provide emotional support when upset about something at work, and (d) to give positive feedback regarding their work. In all instances the health visitors reported their

colleagues as most supportive, except in the provision of emotional support, when they more frequently turned to their spouses (those who had husbands). However, colleagues were the second most commonly turned to in such situations. Senior nurses were their least favoured party to turn to for social support. However, when a regression analysis was conducted to investigate possible predictors of innovation, senior nurse support, and none of the other sources of social support, emerged as a predictor. The only other predictor found was work overload (other possibilities were discretion and knowledge of results of innovation). Despite the lack of evidence for an association between individual innovation and colleague support in this study, colleague support nevertheless appears to have been important in helping individual health visitors to cope with their work. Supervisors may, however, provide the right environment or 'culture' for nurturing innovative practice, one that encourages and supports appropriate risk taking and diversity of approach. They may also encourage their subordinates to use innovation as a way of coping with work overload and stress. This will be discussed more fully in the next chapter.

Supervisors may not always be viewed as being supportive of innovative practice. Oldham and Cummings (1996), citing the work of others, distinguish between supportive and controlling supervisory styles. Supportive supervisors typically provide positive feedback, facilitate employee skill development and show concern for the needs and feelings of employees (Deci & Ryan 1987), whereas controlling supervisors attempt to manipulate employee behaviour and thinking through providing controlling feedback, closely monitoring employee behaviour, making decisions without consulting employees, and applying pressure (Deci *et al.* 1989). Oldham and Cummings (1996) examined the influence of supervisory style on employee creativity in two technical component manufacturing facilities. Participants (n=171) held one of eighteen job types, such as manufacturing or design engineer, toolmaker, or technician. They were asked to complete a questionnaire on job complexity, supervisory style, personal characteristics and intention to quit. Supervisors were also provided with questionnaires and asked to rate the creative and overall performance of the participant

employees that they supervised. Information on other indicators of creative behaviour, such as written patent disclosures and suggestions made for change, was gathered from human resources managers. Oldham and Cummings (1996) reported that the most creative participants were those who had complex and challenging jobs, relevant creative personal characteristics, and supportive, non-controlling supervisors.

In a rare qualitative-only study of individual innovation, King and West (1987) described the findings of unstructured interviews conducted with 27 managers and professionals from a variety of public and private sector organisations. Participants were asked to describe their job and innovation-relevant issues that had arisen from their work experiences. Facilitators and inhibitors of innovation that emerged from content analysis of the interview transcripts are summarised in Table 3.1. Support from both superiors and colleagues were found to be facilitators, and 'characteristics of key people in the organisation' and 'aspects of organisational ethos/culture' were found to be inhibitors. This appears to be one of the few studies where support from co-workers has been implicated as having any influence on the individual innovation process (although Amabile & Gryskiewicz 1989 reported co-workers to be positive, predictive stimulants of creativity when describing development of the Work Environment Inventory). As King & West (1987) themselves note, care needs to be taken in making conclusions from the study's findings, since the interviews relied upon individual's retrospective accounts of innovation that may be prone to error or inaccurate reconstructions of events. They suggest the use of longitudinal methods to observe innovations as they emerge.

Table 3.1 Factors reported as facilitators and inhibitors of innovation in King & West 1987* (p.7, Table III)

Main category	Sub-category	Number of participants with responses (N=27)
External facilitators	Pressure (mostly economic) from outside the organisation	13
	Freedom/discretion in job	11
	Attitudes and attributes of particular colleagues and/or superiors	10
	Support from the work group	6
External inhibitors	Aspects of organisational ethos/culture	14
	Characteristics of key people in the organisation	13
	Aspects of organisational structure	12
	Lack of resources	8
	Time pressure	7
Internal facilitators	Desire to achieve personal satisfaction and fulfilment through work	7
	Need for variety in work	5
	Having a creative personality	5
Internal inhibitors	Own personality and attitudes	4
	Own lack of abilities	2

* King, N. & West, M.A. (1987) Experiences of innovation at work. *Journal of Managerial Pschology*, 2, 6-10.

Intrinsic job factors

Discretion or freedom of time and decision making within one's job appear to be intrinsic job factors which have consistently been found to be associated with creative or innovative endeavour (*e.g.* Amabile 1984; Glassman 1986; King & West 1987; Unsworth & West 1998; West 1987a). For instance, as shown in Table 3.1 taken from the King and West (1987) interview study, 'freedom/discretion in the job' emerged as one of the key facilitators. However, freedom appears to need to be tempered with a degree of control by supervisors, as found in studies of innovation in N.A.S.A. teams (Farris 1973) and in research and development scientists (Amabile & Gryskiewicz 1989; Pelz & Andrews 1976). Amabile & Gryskiewicz (1989) suggest that it is in the territory of goal setting that the balance between supervisory control and employee autonomy is required in the pursuit of creative endeavour:

> "..creativity may be maximized when supervisors provide a balance by giving clear direction, concerning the ultimate goal of a project, but allowing autonomy in the approach to attaining that goal. This delicate balance in *goal-setting* is the balance between what Pelz and Andrews (1966) called coordination and freedom. Similar balance points may be necessary in *reward systems*, *evaluation*, and *pressure* (Amabile 1988b)." (p.252)

Noteably, in the West (1989) study of health visitors, no significant relationship was found between innovation and discretion scores. West (1989) suggests that the job of health visiting might be characterised by relatively high levels of discretion and that insufficient variance in discretion scores made it difficult to detect statistically significant effects. He also suggests that job discretion may not be necessary for innovative practice, and that different factors may influence innovation in different occupational groups.

Other intrinsic job factors found to be associated with individual innovation or creativity include job complexity (Oldham & Cummings 1996), challenge (Amabile & Gryskiewicz 1989; Oldham & Cummings 1996), and work overload (as a facilitator in West 1989; as a constraint in Glassman 1976).

Extrinsic constraints

There appears to be a shortage of studies that have investigated constraints to innovative or creative practice extrinsic to the individual, excepting studies that consider the negative impact of supervisory style (*e.g.* Oldham & Cummings 1996). It appears that the main pursuit of researchers in the field has been to find facilitators of individual innovation or creativity and that this has been done through quantitative means, usually by use of inventories and scales. However, this lack of attention to constraints may leave less critical readers of evidence on creativity and innovation to assume that all that is required to stimulate creativity and innovation is to get the right mixture of facilitating factors in place. Attention also needs to be given to removing or limiting the negative impacts of constraints, to achieve a more thorough approach to stimulating creative or innovative behaviour in the work place.

Those studies that do report constraints have used a qualitative approach to reveal these negative influences (King & West 1987; Amabile 1984; Glassman 1986; West 1989). Factors reported as inhibitors of individual innovation or creativity include insufficient resources (King & West 1987; West 1989; Glassman 1986), time pressure (Amabile 1984; West 1989; King & West 1987; Glassman 1986), bureaucracy and paperwork (Glassman 1986), the need to be productive rather than creative (Glassman 1986), interruptions and demands from others (Glassman 1986), and organizational structure, policies and procedures (West 1989; King & West 1987).

Summary and conclusion

The terms individual innovation and creativity appear to have been used interchangeably within the literature, with no clear, consensual definition of either. However, creativity appears to be distinguished by the production of novel or original thoughts, ideas or products, whereas individual innovation seems to involve the application of either new or adapted ideas, products, procedures or processes into the individual's role, work group, organisation or wider society for the benefit of self or others (or both).

A multitude of theories exist regarding the processes and factors involved in individual creativity or innovation. Theories of creativity have taken personality, cognitive, social or systems approaches. Theories of individual innovation have mainly been developed to explain individual role innovation, although Scott and Bruce's (1994) social interactionist model of individual innovation is one notable exception. However, this model, and most others in the creativity and individual innovation fields, fail to illuminate the relationships between specific elements of the creative or innovative process and particular antecedent factors. Indeed, many models only take into account either process or antecedent factors, with no attempt to combine them, such as the creative problem solving process models and West and Farr's (1989) antecedents model. The most comprehensive model, which incorporates both process and antecedent factors, appears to be Amabile's

(1983, 1988a) social psychological model of creativity. Although it is stipulated to be a model of creativity, it appears to be equally applicable to individual innovation which, indeed, is how individual innovation researcher's such as Unsworth and West (1998) seem to have treated it. Amabile's model, however, is not without problems. The intrinsic motivation hypothesis, which underpins the task motivation domain within the model, appears to be too simplistic to explain some fieldwork findings.

Much of the research in both the creativity and individual innovation fields has been devoted to investigating the antecedent factors of creativity and innovation. Considerable attention has been paid to elucidating the personal characteristics of creative people. Evidence has been found for associations between creative individuals and traits such as independence, desire for autonomy, risk taking, self-confidence, determination to succeed, unconventionality, and tolerance of ambiguity and uncertainty. Variability in the traits of creative people has been observed by gender, occupation and age. Support for the existence of creative personal characteristics has come from both the creativity and individual innovation fields.

Other antecedents of individual innovation or creativity found through empirical studies include intrinsic motivation, certain types of rewards (such as feedback from supervisors), manager, co-worker and organizational support, and intrinsic job factors (such as discretion and freedom of time). Few studies have investigated factors that inhibit individual innovation or creativity. In those that have, the use of qualitative methods appears to have been productive in revealing inhibiting factors. Such factors include resource constraint and time pressure, organizational structures, policies and procedures, bureaucracy, demands of others and interruptions, and the need to be productive rather than creative.

Since care management practitioners operate in large bureaucracies under many of the constraints listed here (see Chapter 2), it may be difficult for innovation and creativity to flourish, even if policy advocates that creativity and imagination should be applied in the development of care packages.

However, it may be that in circumstances where there are care management practitioners with creative tendencies, and some of the facilitating environmental factors mentioned above, that creativity and innovation will occur irrespective of the presence of inhibiting factors. On the other hand, since the care management process is a routine procedure, laden with administrative requirements and there appears to be considerable demand for assessments and rapid implementation of care packages, it may take extraordinary individuals in preferential circumstances to devise and implement innovative solutions for service users.

CHAPTER 4 STRESS AT WORK

The aim of this chapter is to provide insight into the theoretical and empirical knowledge in the area of occupational stress. Definitions and theories of stress, both general and specific to the world of work, are explored. How stress impacts on individuals, and what factors appear to buffer or aggravate stress in the workplace, will be investigated. Attention will be paid to theories and evidence surrounding the effects of job demands and job discretion, since these variables appear to be particularly important in predicting and ameliorating stress at work. The potential relationship between stress and individual innovation at work will also be examined. Finally, stress will be explored from the perspective of community care practitioners and some early conclusions drawn regarding stress, innovation and care management. The following headings are used:

- Defining stress
- Theories of stress and occupational stress
- Sources, moderators, and manifestations of stress at work
- Occupational stress and individual innovation
- Stress and care management practitioners
- Stress, innovation and care management: some early conclusions

Defining stress

Stress is a multifaceted concept, an umbrella term incorporating a number of meanings. Stress is undoubtedly something that is experienced by individuals, both consciously and sub-consciously (Fletcher 1991). Use of lay terms, such as 'being under stress', 'feeling stressed' or 'suffering from stress', can imply one of three meanings (Parry-Jones *et al.* 1998a): stress as a stimulus, stress as a response, or stress as perception of an imbalance between environmental or personal demands and resources. In the first instance, one might be feeling threatened or anxious because of a current, past or anticipated event or situation, or a number of these. Such stimuli are typically referred to as *stressors* (sources of stress) in the stress literature

(*e.g.* Beehr 1995; Fletcher 1991; Wheaton 1997). Wheaton (1997) defines (social) *stressors* as:

> "..threats, demands, or structural constraints that, by the very fact of their occurrence or existence, call into question the operating integrity of the organism." (p.46)

He qualifies this by distinguishing between stressors and non-stressors:

> "..the kinds of environmental conditions or changes that operate as potential stressors must be capable of challenging the integrity of the organism if they occur in their more extreme form. ..there are many experiences in life that simply fail to meet minimum standards of serious threat or demand, even at their most extreme. Losing a tennis game to a long-term and valued partner is probably not an experience that will ever be stressful to any significant number of people. Such experiences dot the landscape of day-to-day life: They are defined by a combination of their regularity, their mundanity, and their inherently low potential for threat." (p.47)

Stress can also refer to the manifestation of a physiological, behavioural or psychological response to a stressor, or series of stressors. The term *strain* tends to be applied to this meaning of stress (*e.g.* Fletcher 1991; Beehr 1995). Beehr (1995) explains:

> "Strains are states that are harmful and usually aversive to the individuals experiencing them. In the present language, the strains to individuals are the outcomes that define stress in the workplace and they are usually states associated with ill health, broadly defined. These outcomes can be divided into three categories: psychological, physical or physiological, and behavioural. These correspond roughly to (poor) mental health, (poor) physical health, and behaviours likely to be deleterious to one's own health and well-being." (p. 109)

Beehr's (1995) book was on *Psychological Stress in the Workplace*. Hence, his reference to strains as outcomes of 'stress in the workplace'. However, strains could equally arise from non-work situations, such as unemployment, family and home situations and, indeed, from the home-work interface (Eckenrode & Gore 1990; Gottlieb 1997a).

The terms *stressors* and *strain* imply stress is a stimulus-response process. The third meaning of stress extends this conceptualisation, whereby *stress* is considered an appraisal by an individual of a mismatch between perceived demands and perceived resources at his or her disposal. For instance, when one agrees to give a public presentation only later to discover the title of the presentation in the programme is different to the one you had been preparing for! Feelings of anxiety, helplessness and even anger may initially overwhelm the presenter. However, he or she is soon likely to consider alternative courses of action to alleviate the situation, such as contacting the organiser of the meeting, if there's time, to ask if a different title would do (the one prepared for), or apologising to the audience on the day, explaining what had happened and presenting the prepared for piece. Or, if the prepared presentation is radically different from the programmed title and one is feeling absolutely terrified at the thought of looking foolish, the presenter may suddenly find a more pressing engagement for the day and apologise profusely to the organiser. This conceptualisation of stress as an appraisal of an imbalance, leading to some form of coping, recognizes the influence of the *organism* in the stress process. Whilst stress might be experienced as a linear stimulus-organism-response process, contemporary stress theories recognize the complexity of the stress process and apply transactional frameworks with feedback loops (see below).

Although the following definition of *stressors* does not explicitly mention the word *appraisal*, there is nevertheless acknowledgement of the interactive nature of the various elements of the stress process:

> "Stressors are.. discrete events of differing intensities occurring in different parts of one's life. These events not only happen in the same life but also may create the context in which other events are experienced. Considered in this light, the increment of strain produced by an event may be greater when it occurs in a situation that is already stress filled. In such cases, stressful events would be interactively related to strain. The presence of one stressor would magnify the effect of another." (Greller *et al.* 1992, p. 35)

The conceptualisation of stress as consisting of three basic elements (stress as stressor, stress as appraisal of imbalance, and stress as strain) has its roots in the engineering analysis of stress by Robert Hooke, a physicist-biologist of the 17th century (Hinkle 1973). Hooke suggested that external forces (*load*), such as weight or wind, produce *stress* in areas of manmade structures, like bridges, that are exposed to load; *strain* is the resulting structural deformation from the interaction between stress and load. If the term 'stressor' or 'stress stimulus' are used instead of 'load', it is easy to see how this theory of stress in manmade structures can be applied to stress in psychological, physiological or sociological systems. The engineering analogy appears to have been highly influential in 20th century models of stress (Lazarus 1999; see below).

Whilst there is general agreement in the stress literature that there are at least three different meanings of stress (*e.g.* Cox 1978; Payne 1999), Kasl (1996) distinguishes five different uses of the term, as follows:

> "1. Stress is an environmental condition, susceptible to an objective definition and measurement. (The term *stressor* may often be used in this context.) The emphasis is on stress as a stimulus, an independent variable, a risk factor, an exposure variable, and on its objectively measured properties.
>
> 2. Stress is a subjective perception or appraisal of an objective environmental condition. This definition, which embraces the notion that *stress is subjective*, reflects a psychological tradition which assumes that the meaning of the objectively characterized stressor will vary across individuals and that such variation determines the impact of the stressor.
>
> 3. Stress is a particular response or reaction. Included here would be a variety of proximal and distal outcomes, including dysphoric mood, psychophysiological symptoms of tension, biological parameters (*e.g.* neuroendocrine levels), as well as incidence of specific disease states.
>
> 4. Stress is a particular relational term linking environmental characteristics and personal characteristics, in particular, the excess of environmental demands beyond the individual's capacity to meet them. The theoretical formulation known as the Person-Environment Fit (*e.g.* French *et al.* 1982) is an example of this relational approach to concepts.

5. Stress is a process, which includes other important components such as appraisal, coping, reappraisal, and cannot be reduced to a simple stimulus-response or cause-effect formulation." (p.14-15)

When three definitions of stress have been offered these include stress as a cause or stimulus and stress as a response or outcome, as in Kasl's (1996) first and third items. They also typically include stress as a process involving subjective appraisal of overwhelming demands leading to some form of coping, a combination of Kasl's (1996) second, fourth and fifth definitions.

Acute and chronic stress

Recently, a distinction has been made in the literature between *acute stress* and *chronic stress* (Gottlieb 1997b; Lazarus 1999). Reflecting on the literature in this area, Lazarus (1999) defines these in the following way:

> "*Chronic stress* arises from harmful or threatening, but stable, conditions of life, and from the stressful roles people continually fulfill at work and in the family. *Acute stress*, conversely, is provoked by time-limited, major or minor events that are harmful or threatening at a particular moment in life or for a relatively brief period." (p.144)

The distinction is, thus, in terms of stress as resulting from a time-limited, discrete stressor (*acute stress*) or from an on-going or frequent stressor (*chronic stress*). Wheaton (1994) describes chronic stressors more specifically as:

> ".. problems and issues that are either so regular in the enactment of daily roles and activities, or so defined by the nature of daily role enactments or activities, that they behave as if they are continuous for the individual." (p.82)

Wheaton (1997) argues that the distinction between acute and chronic stressors is more than a simple difference in time course of short- versus long-duration. He suggests that the nature of the time course is different. Acute stressors have definite points of offset and resolution, for instance in job loss this might involve being giving a redundancy notice and the passing

of the last day of work. Chronic stressors, on the other hand, may have only an approximate starting point, continue in existence for years and have a variety of outcomes or no clearly defined resolution. For example, a spouse may only gradually become aware of the stress of caring for their partner with dementia as the condition worsens and, even when a decision has been made to place their loved one in a residential or nursing home after years of struggling to cope, the individual may be racked with guilt for failure to care until death.

Although identifying acute and chronic stressors appears clear cut, the reality often involves a blurring, or fluidity, of conceptual boundaries (Gottlieb 1997b). Whilst car accidents, earthquakes, death of a close relative, marital separation or job loss might be considered acute stressors in the sense that they are time-limited and trigger specific stress reactions, they may lead to long-term problems of adjustment. For instance, Post Traumatic Stress Disorder, whereby individuals relive traumatic events and frequently feel agitated over periods of months or years, can occur in individuals exposed to an 'acute' event, such as car accidents, rape or physical assault at work. Some specific traumatic events, for instance marital separation, might be precipitated by exposure to a series of chronic stressors, such as years of arguments, feelings of distrust and insecurity, financial problems, and difficulties in raising children. The 'acute' stressor might then be considered the consequence of a prolonged period of chronic stress. Indeed, in the case of marital separation, what appears to be the 'acute' stressor might actually be the outcome of coping processes, albeit with potential stressful consequences, such as financial hardship and the difficulties associated with being a single parent.

McLean and Link (1994) have devised a four-fold classification of chronic stressors. These are role strains, persistent life difficulties, strain from discrimination, and community strains, such as arising from natural and technological disasters. The latter in particular takes into account the fluidity of the acute-chronic stress interaction. Alternatively, Wheaton (1997) considers there to be nine forms or characteristics of chronic stress. These

are (1) the perception of continuing threat of potential harm; (2) feelings of unrelenting or excessive demands (overload); (3) complexity of demand (as opposed to level of demand); (4) structural constraints that limit opportunity or choice; (5) restriction of choice (resulting from structural constraints); (6) prolonged uncertainty; (7) conflict (where resolution is difficult); (8) under-reward; and (9) resource deprivation. Such forms of chronic stress are likely to apply in the workplace and, indeed, this appears to be the case (see section below on occupational sources of stress).

Theories of stress and occupational stress

Theories of stress typically fall into three main categories: response-based models, stimulus-based models, and interactional models of stress (Cox 1978). Cohen and Kessler (1995) have additionally noted that these three categories reflect biological, epidemiological and psychological approaches respectively to the conceptualisation and study of stress. Examples of each of the three categories are given below. Attention is then paid to Karasek's (1979) model of job strain, since this model is employed in the analysis of data from the care management survey conducted in Study Two.

Response-based models

The pioneering work of Hans Selye (1956/1976) on physiological stress is a prime example of a response-based model. Selye (1956/1976) considered that a similar stress response, a non-specific physiological defence reaction, occurred in all animals irrespective of species, and that this was initiated to protect and preserve the integrity of the animal in the presence of a stressor. In addition to the physiological response, humans were considered to have an emotional response (Selye 1976). Selye (1956/1976) postulated that the type of stressor made no difference to the stress response, but that duration of exposure to the stressor did have an impact. Enduring or repeated exposure to the stressor would lead to progression through three identifiable

stress reaction stages, known as the *General Adaptation Syndrome* (see Figure 4.1).

The first stage of the General Adaptation Syndrome (GAS) is the *alarm reaction*. Physiological changes occur in the body as a result of exposure to a stressor. Initially, resistance to stress is reduced and, if the stressor is particularly severe, resistance may collapse altogether and the animal dies. However, a second stage may be reached through continued or repeated exposure to the stressor, that of *resistance*. In this phase the animal shows signs of adaptation, rising above normal levels of resistance. A third phase may ensue following prolonged exposure to the stressor. The term *collapse* is used to denote this stage by Selye (1956), although this is really the end point. Later the term *exhaustion* has been applied (Lazarus 1999; Payne 1999). In the third phase, the body's adaptive energies are depleted, resistance drops below normal levels, bodily signs of the alarm reaction return and, finally, resistance collapses and the animal dies. Selye (1956) argued that the defence responses, if sufficiently prolonged or severe, could lead to illness and disease. The theory is that the bodily resources used to mobilise defence reactions may be reduced to the extent that the physiological system has insufficient capacity to fight infection or other noxious agents.

Despite the appeal of the GAS as a universal theory, applicable to all types of stressors, evidence suggests that some noxious physical elements or conditions do not lead to anticipated GAS responses. For instance, Mason and colleagues (Mason 1971; Mason *et al.* 1976) found that physical harms, such as physical exertion, fasting and heat did not produce GAS responses in rats, monkeys and humans when psychological awareness of potential harm was eliminated. In such situations they found that adrenal corticosteroid secretion was absent or minimal. However, when the animal became consciously aware of harm or threat, active secretion of corticosteroid was apparent. Findings from an early study by Symington *et al.* (1955) add support to the idea that awareness influences response to adverse physical conditions. In this study, people who were conscious whilst

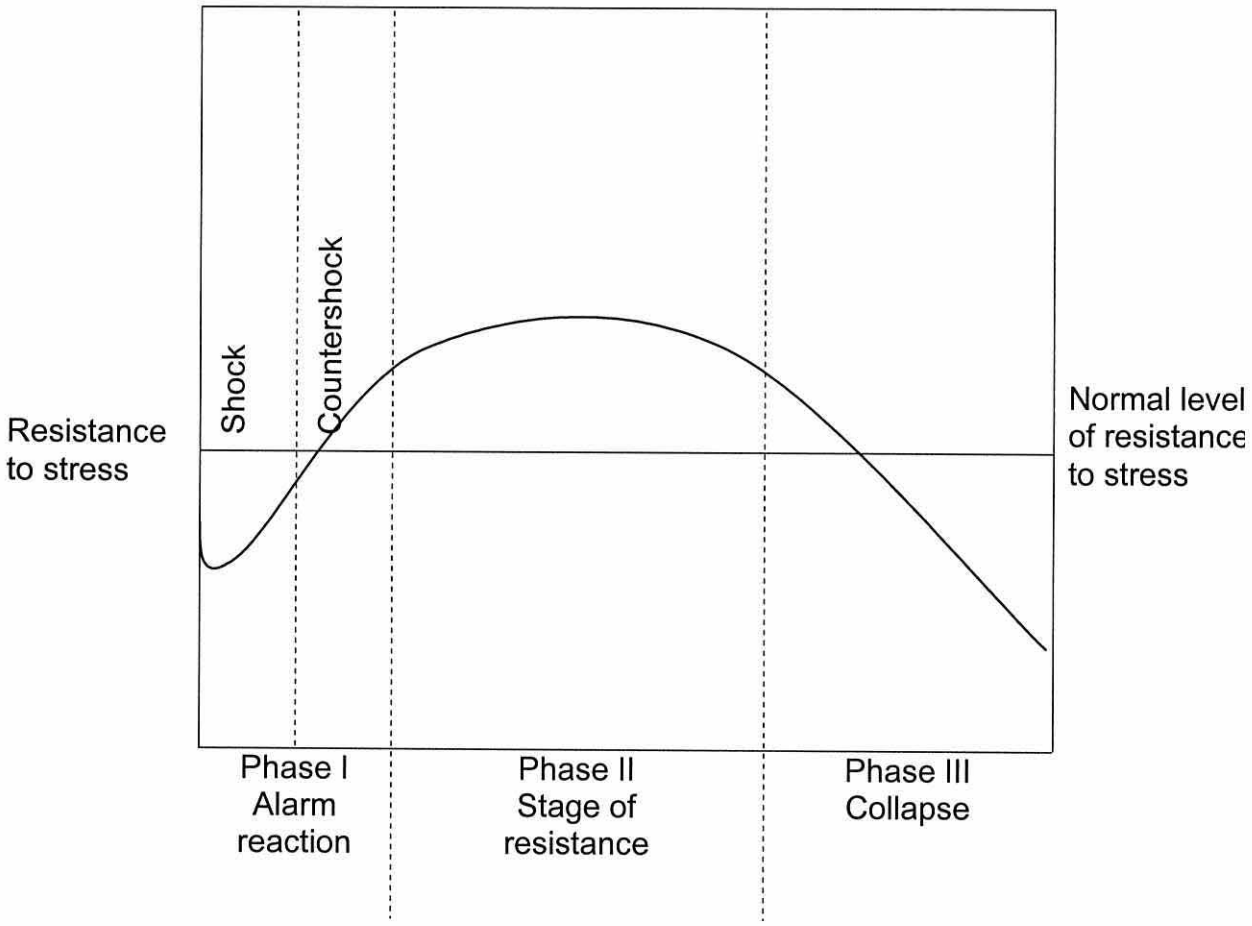

Figure 4.1 Selye's General Adaptation Syndrome*

* Selye, H. (1956/1976) *TheStress of Life*. New York: McGraw Hill.

dying of an illness or injury had elevated adrenal cortical levels, measured during post-mortem examination, whereas those who were unconscious showed normal adrenal cortical levels. Such research highlights the importance of psychological appraisal in the stress process.

Even with the reservations regarding the non-specificity of the General Adaptation Syndrome, Selye's (1956/1976) theory appears to have been considerably influential in stress research. For instance, the exhaustion phase has been a key element in the conceptualisation and study of *burnout* (Payne 1999; Schaufeli 1999). *Burnout* was a concept developed out of observations of the emotional exhaustion, and associated depersonalisation and reduced personal accomplishment, of social and health care professionals (Schaufeli 1999).

Stimulus-based models

The stimulus-based approach places emphasis on identifying stressors and their characteristics, rather than focusing on outcomes (responses) or intervening processes. It has its roots in the engineering analogy drawn from Hooke's Law of Elasticity (Cox 1978). In this law, if the *stress* (load/demand) produces a *strain* (deformation) that is within the *elastic limit* of a material, permanent damage will not result when the stress is removed, the material returning to its original shape and condition. However, permanent damage will occur if the strain goes beyond the material's elastic tolerances. In engineering, stress and strain can be measured and the degree of a material's elasticity calculated. This quantitative approach to stress appears to have appealed to psychologists in the 1960s, '70s and '80s, because of its simplicity and its connection with 'pure' science (Cox 1978).

Following on from the observations of Wolff (1950), a cardiologist, that patients reported stressful life events as occurring 6-12 months prior to becoming ill, Holmes and Rahe (1967) developed the Schedule of Readjustment Rating Scale (SRRS; see Table 4.1). This was the first attempt to systematically quantify the severity of stress associated with particular life

events. Holmes and Rahe (1967) asked several hundred respondents from different countries to rate the amount of adaptation or 'life change units' (LCUs) on a scale of 1 to 500. On average, respondents indicated that death of a spouse required the most amount of adjustment (100 LCUs), followed by divorce and marital separation (73 and 65 LCUs respectively). When used in clinical practice or research, individuals who score high on LCUs over the past year, whether from exposure to a few high ranking life events or a number of more moderate life events, are considered more prone to develop illnesses 6-12 months later. Whilst there has been considerable support for this in research, the typical correlation found between life event scores and later illness ($r = 0.3$ or less) suggests little predictive value (Lazarus 1999).

A drawback of the SRRS is that it contains an incomplete list of stressful life events – for instance, difficulties characteristic of the very young or very old are not included. Whilst numerous life events scales were developed for use with specific populations, such as the older adults, children and adolescents, and individuals from certain ethnic groups or gender, they are prone to the inherent problems of all self-report measures, namely the vagaries of human memory and social desirability responding (Aldwin 1994). There are at least two other problems with the life events approach. Firstly, the approach is based on the assumption that stress arises from acute stressors alone, failing to take into account the chronic nature of many stressors. Secondly, this approach does not offer an explanation for individual differences in the experiencing of, and dealing with, stress. Interactional process models incorporating cognitive mediation are likely to provide more operationally useful frameworks for studying and understanding stress.

Table 4.1 Social Readjustment Rating Scale (Holmes & Rahe 1967)*

Rank	Life event	Mean value
1	Death of spouse	100
2	Divorce	73
3	Marital separation	65
4	Jail term	63
5	Death of close family member	63
6	Personal injury or illness	53
7	Marriage	50
8	Fired at work	47
9	Marital reconciliation	45
10	Retirement	45
11	Change in health of family member	44
12	Pregnancy	40
13	Sex difficulties	39
14	Gain of new family member	39
15	Business readjustment	39
16	Change in financial state	38
17	Death of close friend	37
18	Change to different line of work	36
19	Change in number of arguments with spouse	35
20	Mortgage over $10,000	31
21	Foreclosure of mortgage or loan	30
22	Change in responsibilities at work	29
23	Son or daughter leaving home	29
24	Trouble with in-laws	29
25	Outstanding personal achievement	28
26	Wife begin or stop work	26
27	Begin or end school	26
28	Change in living conditions	25
29	Revision of personal habits	24
30	Trouble with boss	23
31	Change in work hours or conditions	20
32	Change in residence	20
33	Change in schools	20
34	Change in recreation	19
35	Change in church activities	19
36	Change in social activities	18
37	Mortgage or loan less than $10,000	17
38	Change in sleeping habits	16
39	Change in number of family get-togethers	15
40	Change in eating habits	15
41	Vacation	13
42	Christmas	12
43	Minor violations of the law	11

* Holmes, D. & Rahe, R. (1967) The Social Adjustment Rating Scale. *Journal of Psychosomatic Research*, 11, 213-218.

The engineering analogy applied to human stress not only falters on grounds of measurement and its inability to take into account appraisal, it also fails to explain the stressful nature of low or non-demanding situations which are insufficiently stimulating and boring. Such situations can lead to lethargy, withdrawal and deterioration in skills (Payne 1999). Welford (1973) theorized that stress occurred when optimum conditions of demand could not be maintained, particularly where the individual is unable to easily restore optimal conditions. He postulated that humans perform best in conditions of moderate demand, and that both high demand and low demand situations reduce performance.

Payne (1982, 1999), too, has suggested that moderate demands could be beneficial, providing challenge, satisfaction and enhancement of feelings of adequacy and competency. Payne (1982, 1999) additionally stipulated that duration was as important as strength of stressors, and that psychological outcomes varied as a consequence (see Figure 4.2).

Stemming from the stimulus-based approach to stress, there have been a number of stressor-strain models of occupational stress (*e.g.* Beehr & Newman 1978; Fletcher 1988). Such models attempt to take account of stressors, strains (outcomes) and moderating or mediating variables (both environmental and personal predisposition). For instance, Fletcher's (1988) stressor-strain model of occupational stress links occupational stressors, such as lack of autonomy, organizational climate and workload, with moderators and mediators, such as personality and motivation, and suggests these lead to strain symptoms, such as suppression of immune system, depression and absenteeism, and eventually to coronary heart disease, immune disorders and/or mental ill-health (see Figure 4.3).

		DURATION OF STRESSORS		
		Short term	**Medium term**	**Long term**
STRENGTH OF STRESSORS	**Weak** **Low demands**	Bored Restless Lethargic	Torpidity Loss of direction Helplessness	Dismay Disillusionment Depression Sense of failure Alienation
	Moderate **Challenging** **demands**	Aroused Liveliness Fun	Challenge Enjoyment Satisfaction Self-efficacy	Achievement Feelings of adequacy or competency and high self-esteem
	Strong **Excessive demands**	High arousal Tension Excitement	Anger Fear Worry for future Tiredness Accomplishment (if coping)	Anxiety Depression Exhaustion Loss of self-confidence

Figure 4.2 Psychological outcomes of different stress situations (Payne 1999)*

* Payne, R. (1999) Stress at work: A conceptual framework. In J. Firth-Cozens & R. Payne, *Stress in Health Professionals: Psychological and Organisational Causes and Interventions*. Chichester: John Wiley & Sons Ltd.

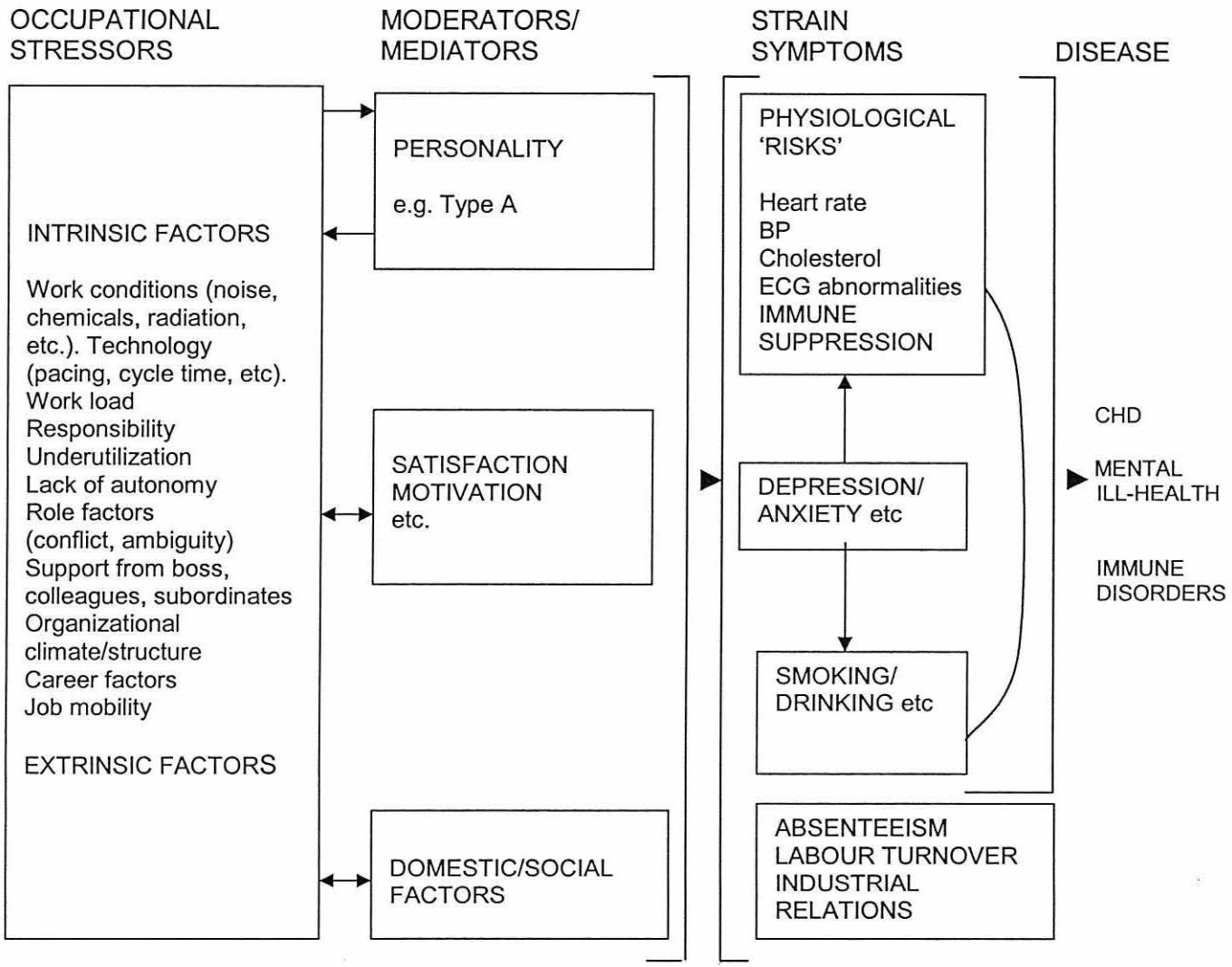

Figure 4.3 A stressor-strain model of occupational stress (Fletcher 1988)*

* Fletcher, B.C. (1988) The epidemiology of occupational stress. In C.L. Cooper & R. Payne (Eds.), *Causes, Coping and Consequences of Stress at Work*. Chichester: John Wiley.

The long list of occupational stressors identified in the model is reminiscent of the life events approach, albeit that the majority of the occupational stressors appear to be chronic rather than acute stress factors. Fletcher's model also differs in that it is specific to the world of work, and that the influence of moderators/mediators is recognized in production of strain and disease. Fletcher (1988) acknowledges there are limitations to models of this type:

> "Such models make no real attempt to predict the levels of strain, or the subtle interactions between their many variables, or to facilitate in the conceptual understanding of what occupational stress is. They are useful, however, as thumbnail sketches to envelope and list the critical factors which any predictive model should deal with, and to provide a chart of the current state of knowledge (and belief)." (p.11-12)

Cox (1978) additionally comments that stimulus-based models of stress have a major problem in "identifying with some surety what is stressful about particular real-life situations. Intuition and consensus seem to be the main agents of decision" (p.17). Again, an interactional framework for conceptualising and studying stress, taking into account the appraisal processes and outcomes of individuals, appears more appropriate. This suggests that research should attempt to unravel the elements of stress (factors and interactions) through taking a longitudinal approach with individual participants, incorporating both personal accounts and quantitative measures over time.

Interactional models of stress

The interactional approach to stress highlights the importance of the individual's relationship with his or her environment and the role of perception and cognitive appraisal. This person-environment fit approach, as it is known, whilst having its roots in a linear stimulus-organism-response (S-O-R) perspective, actively advocates a more cyclical or transactional relationship between the person (organism) and his or her environment. French and associates at the University of Michigan (*e.g.* French & Caplan 1972; French *et al.* 1974; French *et al.* 1982) pioneered the person-

environment fit approach in the area of occupational stress. Figure 4.4 shows the basic framework for the model.

The key thrust of the model is that it is the person's own subjective perception of the environment and his- or herself that results in appraisal of a fit or misfit, with the latter leading to strain and the former to no strain. Fletcher (1991), in his review of models of occupational stress, suggests that in this model if the objective person and the objective environment do not appear to (objectively) fit, then this merely provides a context with a propensity for strain, rather than a definitive stressful position. He comments that one of the strengths of the framework is that it can provide explanations as to why lack of autonomy and underutilisation of skills and abilities can be stressful:

> "The model posits that it is the degree of misfit *per se* between the person and the environment elements of each dimension that is causally related to strain levels. Thus, an inadequately demanding job, as well as an over demanding job, should produce strain." (p.23)

The University of Michigan group found considerable support for their person-environment fit model utilizing psychological and physiological data from 2030 workers in 23 different occupations (Caplan *et al.* 1975; Van Harrison 1978; French *et al.* 1982). Perception of job complexity and workload 'misfits' were the job dimensions found to be associated the most with indicators of psychological and physiological strain.

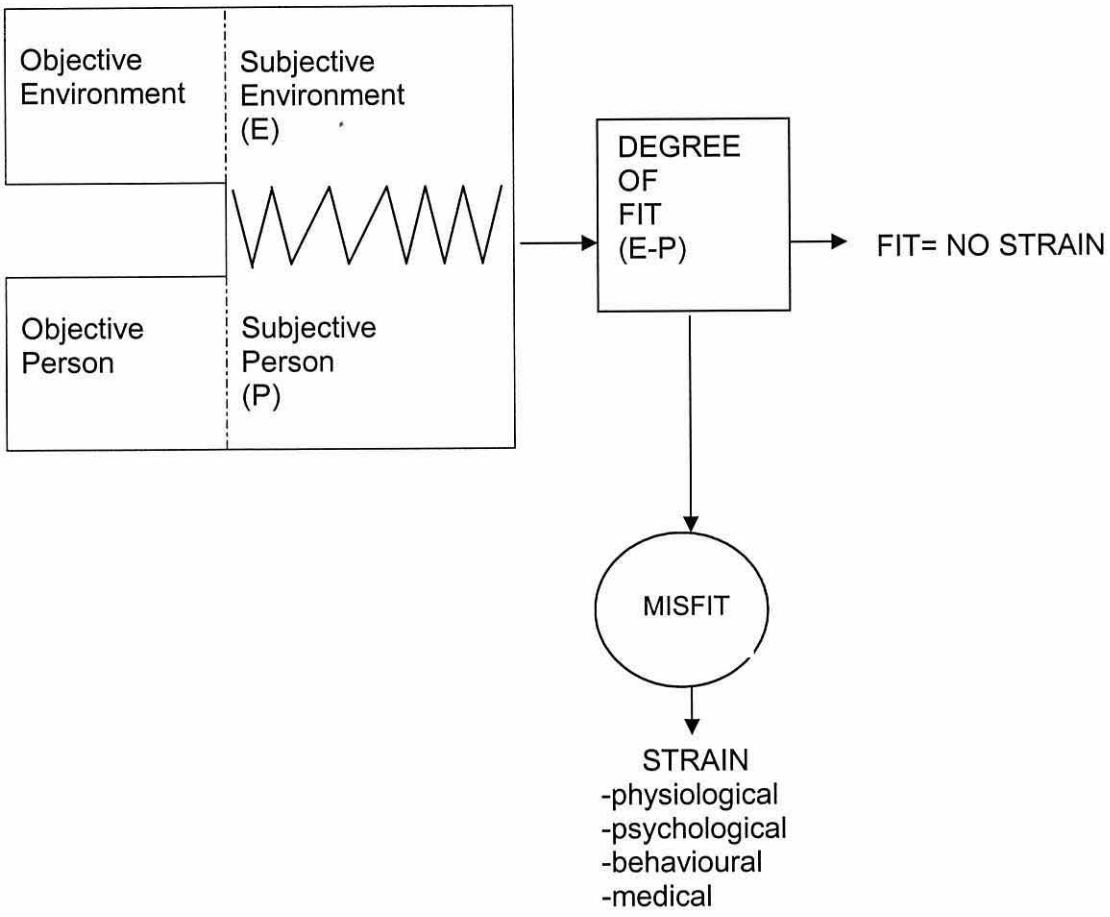

Figure 4.4 The person-environment fit model of stress (French and associates)*

About the same time as French and colleagues were developing their person-environment fit model, Cox and Mackay (Cox 1978; Mackay & Cox 1976) were devising a transactional model of stress (see Figure 4.5). In this model the terms *demand* and *capability* are used instead of *environment* and *person*, but imply a similar relationship, that is, an appraised imbalance between the two lead elements results in stress (strain). *Perceived capability* and *perceived demand* are interpreted as more crucial than *actual capability* and *actual demand*, similar to French *et al.'s* emphasis on *subjective* rather than *objective* person-environment fit appraisal. In keeping with French and colleagues' model, the *actual* (*objective*) environment and person characteristics influence *perceived demand* and *perceived capability*. Cox (1978) indicates that demands can be both internal (to the individual) and

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* French, J.R.P., Caplan, R.D. & Van Harrison, R. (1982) *The Mechanisms of Job Stress and Strain*. Chichester: John Wiley & Sons Ltd.

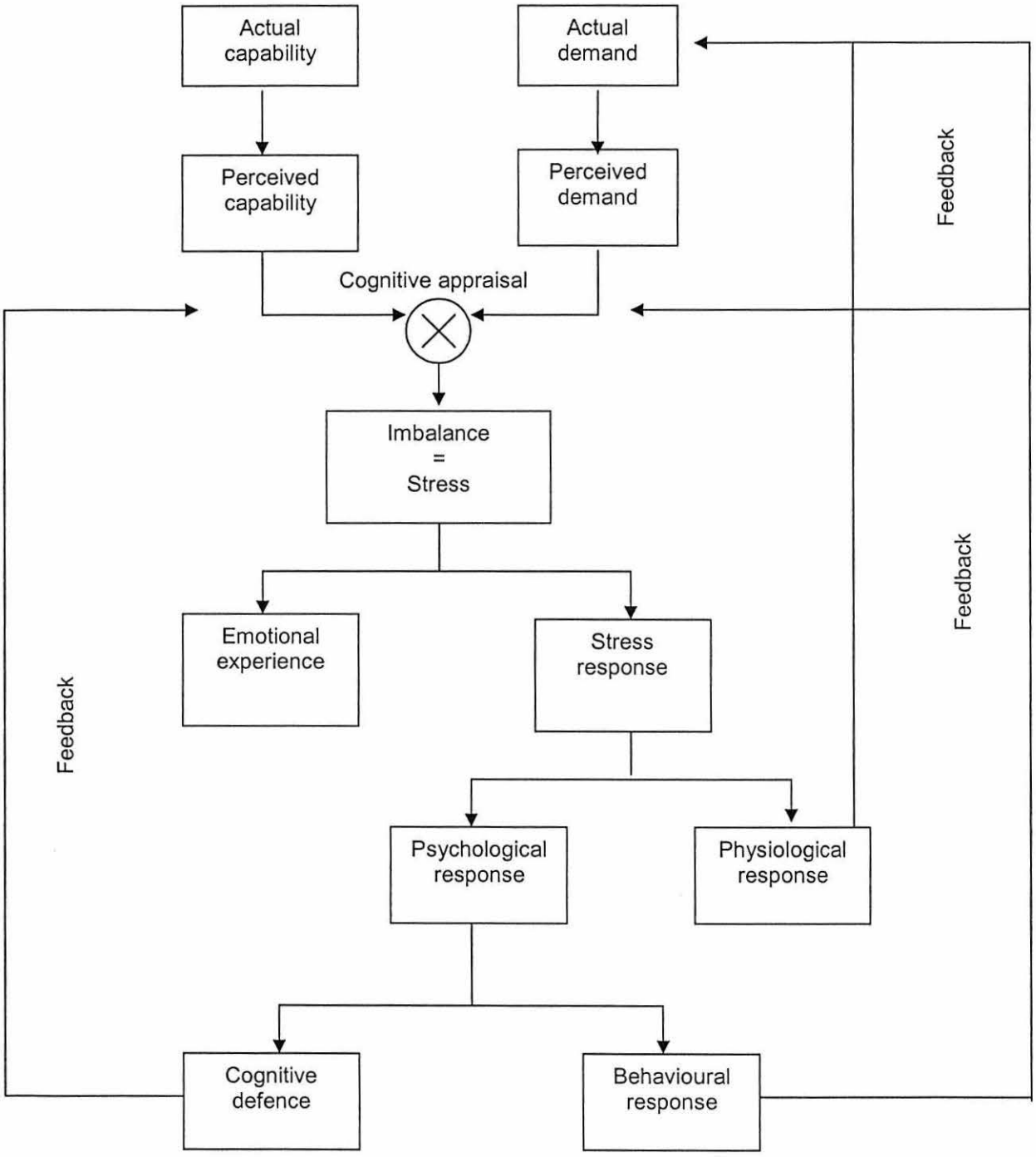

Figure 4.5 Transactional Model of Stress (Cox and Mackay) *

* Cox, T. (1978) *Stress*. London: The Macmillan Press Ltd.

external (arising from the situations outside of the person). Cox and Mackay's model differs from French *et al.'s* in that feedback loops link stress responses, whether psychological or physiological, back to cognitive appraisal processes (and actual demand), indicating the cyclical nature of the stress process.

Notably, emotional experience is deemed one of the outcomes of a perceived imbalance in the Cox and Mackay model, yet appears to have no purpose in the stress process cycle. Lazarus and others (*e.g.* Lazarus 1966, 1995, 1999; Lazarus and Folkman 1984) have argued that emotion plays a key role in stress appraisal and coping. Figure 4.6 shows the Lazarus and Folkman (1984) model of stress, coping and adaptation, as adapted by Lazarus (1999). The schematization indicates how person and environment demands interact with mediating processes to produce immediate and long-term effects. The mediating processes, include *primary appraisal* ("Is the environment threatening?"), *secondary appraisal* ("Can I cope?"), *reappraisal*, and *coping*. Emotion is both an integral part of coping (as in *emotion focused coping* under the *mediating processes* column) and a response to appraisal and coping (as in *positive or negative feelings* under the *immediate effects* column). The interactional nature of the Lazarus and Folkman (1984) model is emphasized by the inclusion of *time* and *encounter* change indicators under the *mediating processes* heading.

Whilst the Lazarus and Folkman (1984) schematization usefully links antecedent factors with stress appraisal and coping processes, and outcomes of stress and coping over time, Lazarus (1999) himself noted there are difficulties in diagrammatically representing stress and coping:

> "..there seems to be no handy way to portray the multiple contents of these processual changes, except in a set of schematizing snapshots, like the separate frames of a film. ..we must not go overboard about the value of a few simplifying diagrams. They obscure as much as they clarify." (p.201)

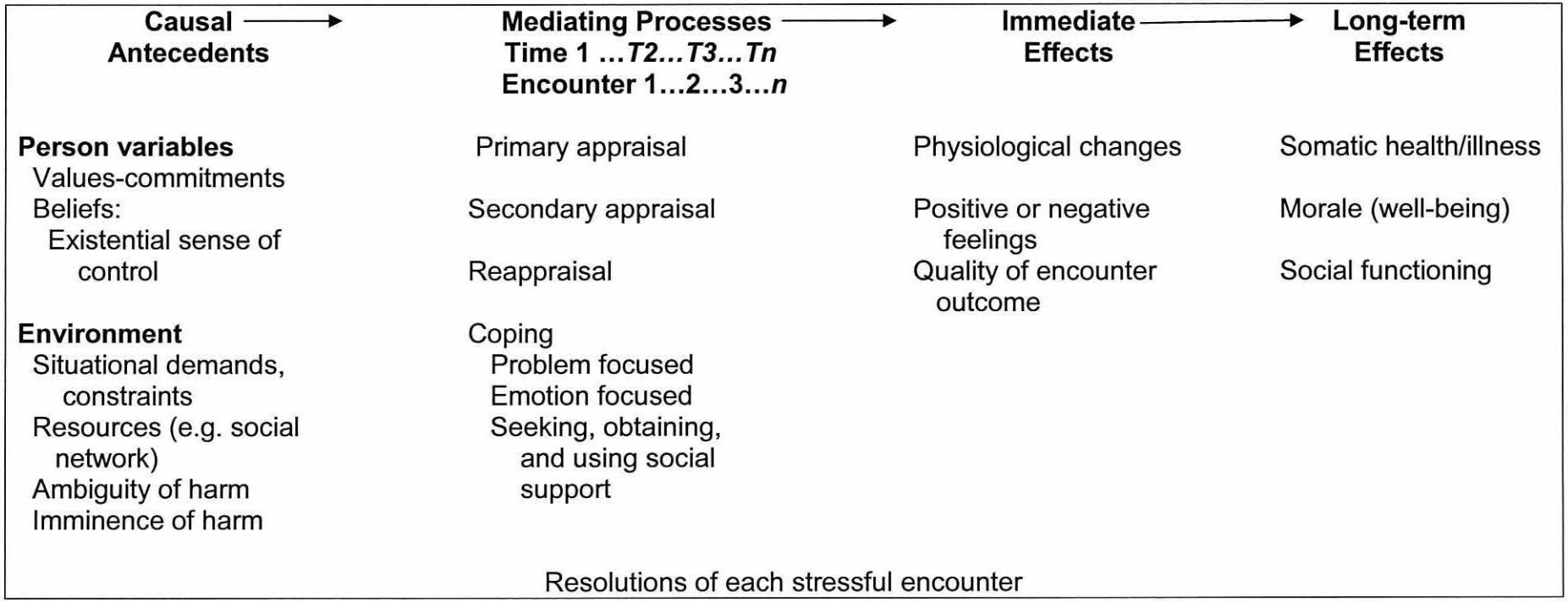

Figure 4.6 Lazarus and Folkman's (1984) theoretical schematization of stress, coping and adaptation (adapted by Lazarus 1999)*

* Lazarus, R.S. (1999) *Stress and Emotion: A New Synthesis*. London: Free Association Books.

Although Lazarus (1999) recently argued for a more subjective, narrative approach in the study of stress and coping, clear, conceptual frameworks for organizing and understanding research in this field are likely to have enduring properties. One such framework is that of the demands-discretion model of strain proposed by Karasek (1979), which has received considerable attention by researchers (*e.g.* de Jonge *et al.* 1999; Mikkelsen 2000; Parkes 1991; Piltch *et al.* 1994; Radmacher & Sheridan 1995; Sauter *et al.*1989).

Karasek's job demand-job discretion model of strain

Karasek's (1979; Karasek & Theorell 1990) model of job strain (see Figure 4.7) predicts high strain will result from a combination of high job demand and low job discretion. The concept *job demand* encompasses workload, conflicting demands, and time pressures, and the concept *job discretion* (or job decision latitude) refers to control over one's work environment and tasks, and opportunities for developing new skills and learning at work. The model also supports the notion that jobs which are highly demanding need not necessarily result in strain, providing the worker has sufficient levels of job discretion (classified as *active jobs*). Such jobs, high on demand and high on job discretion, are hypothesized to lead to increased competence as "the challenges of the situation are matched by the individual's skill or control in dealing with a challenge" (Karasek 1979, p.288). *Passive jobs* have the opposite characteristics of *active jobs*, with low levels of both demand and discretion, but equally are not considered to result in strain. However, they are hypothesized to lead to reduced problem-solving and general activity level. *Low strain jobs* are considered those where job discretion is high and demand low: high job discretion allowing opportunity to deal with any demands that do arise.

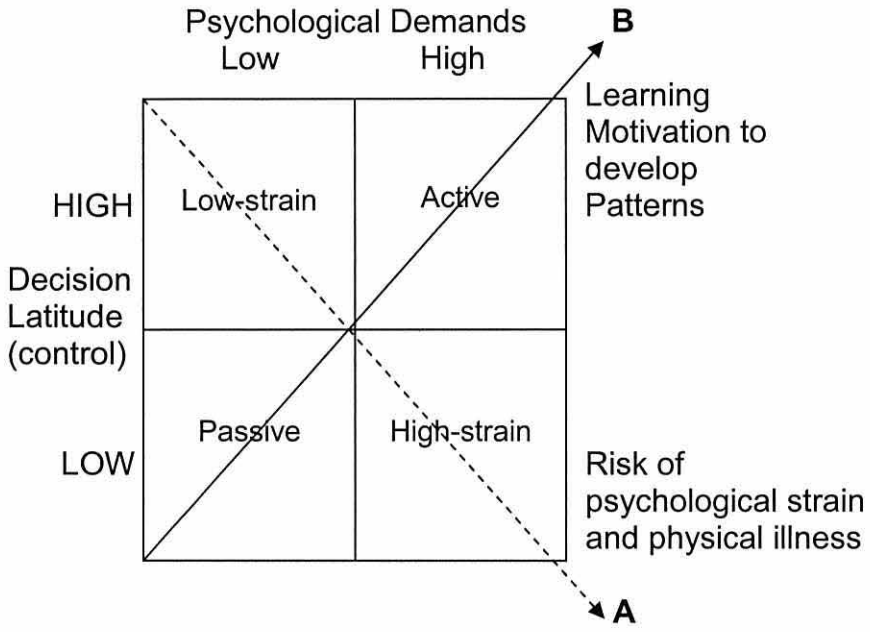

Figure 4.7 Karasek's Demand-Discretion Model of Strain (Karasek & Theorell 1990)*

* Karasek, R. & Theorell, T. (1990) *Healthy Work: Stress, Productivity, and the Reconstruction of Working Life*. New York: Basic Books.

Whilst there has been empirical support for Karasek's model, particularly in prediction of physical health outcomes such as cardiovascular disease (*e.g.* Bromet *et al.* 1988; Freeman & Jucker 1979; Haratani *et al.* 1992; Johnson & Hall 1988; Karasek 1979; Landsbergis *et al.* 1994; Semmer & Frese 1988; Turner 1980), there have also been concerns regarding the reliability of the interaction effect between job demand and job discretion variables (de Jonge *et al.* 1999; Kasl 1989; Parkes 1991; Sauter & Hurrell 1989). Where interactive, rather than additive or non-significant, effects for the two variables have been found these may be explainable by the presence of other mediating variables, especially those pertaining to individual differences (Parkes 1991).

Parkes (1991) investigated the potential mediating effect of locus of control on the demand-discretion interaction. Locus of control is a trait dimension whereby those high on locus of control ('internals') consider themselves able to influence outcomes, whereas those low on locus of control ('externals') believe they have little power to alter circumstances. In the workplace 'internals' tend to be more goal-oriented and determined in their attempt to control their work environment than do 'externals'. Parkes (1991) found three-way demand x discretion x locus of control interactions predicted affective state from cross-sectional data with a sample of civil servants (n=590) and from longitudinal data with a sample of student teachers (n=147). Further analysis revealed demand and discretion variables combined interactively for 'externals', supporting Karasek's model, but only additive findings (where the variables were operating independently) were found for 'internals'.

In a more recent study, de Jonge *et al.* (1999) used different demand concepts (*i.e.* psychological demands, emotional demands and physical demands) and a narrower concept of job discretion (*i.e.* job autonomy) than those applied by Karasek (1979) to predict psychological health in a sample of health and social care professionals (n=212). The aim was to examine the robustness of the Karasek model using a group who were relatively heterogeneous in exposure to potentially strain-provoking stimuli, but

relatively homogeneous in socio-economic status. The *psychological demands* scale used contained items relating to workload, such as working hard, experiencing time pressure and complexity of tasks. The *physical demands* measure included items on constrained standing, carrying heavy weights, carrying at shoulder height, and having to stoop. The *emotional demands* scale consisted of items which referred to having to deal with human suffering, sickness and death, and with social problems or aggressive and awkward clients or patients. *Job autonomy* was assessed using a scale which included items on work goals, pace of work, and work methods. *Psychological health* was measured on scales of job satisfaction, job involvement, psychosomatic health complaints and emotional exhaustion.

Three out of twelve possible interactions were found in the de Jonge *et al.* (1999) study. An interaction was found between psychological demands and job autonomy in the prediction of job satisfaction scores. That is, participants scoring low on job autonomy and high on psychological demands (predicted *high strain* job incumbents) reported low levels of job satisfaction, supporting Karasek's model. However, those high on autonomy were found to report relatively high levels of job satisfaction regardless of psychological demand level (*low strain* and *active job* types).

Another interaction involved physical demands and job autonomy in prediction of job involvement. Participants high on autonomy and high on physical demands (*active job* incumbents) showed relatively higher levels of job involvement than individuals low on autonomy, supporting Karasek's model. However, individual's low on autonomy indicated having lower levels of job involvement regardless of whether physical demand levels were high or low (*high strain* or *passive* types).

A final interaction was found between emotional demands and job autonomy in the prediction of psychosomatic scores. In this interaction participants low on autonomy and low on emotional demands (*passive* types) had the highest level of psychosomatic health complaints, although this level was only slightly higher than when individuals scored high on emotional demands,

regardless of level of job autonomy (*high strain* and *active* types). Such findings do not appear to show the direction of association which would be predicted from Karasek's model. Psychosomatic scores, however, were distinctly lower for individuals low on emotional demands and high on autonomy (*low strain* category), supporting the predictions of Karasek's model.

Since each interaction varied in the degree to which autonomy x discretion combinations fitted with predictions from the Karasek model on 'outcome' scores, they cannot be said to unambiguously support the model. A finding common to other studies examining the reliability of the Karasek model (Kasl 1989). It is interesting to note, however, that all three types of demands (psychological, physical and emotional) in the de Jonge *et al.* (1999) study produced an interaction effect, albeit with different health and job indicators. In regards to these 'differential associations', de Jonge *et al.* (1999) cite Warr's (1990) argument that different job characteristics are more or less important in determining different heath outcomes for workers. This also fits with Parkes (1991) finding that whilst scores on affective distress and anxiety scales were predicted by demand x discretion interactions, other outcome measures, such as absence frequency and social dysfunction were not implicated. Whilst Karasek's model may not withstand rigorous testing of the interaction effect, recurrent evidence of an influencing effect of job demands and job discretion on worker health and well being warrants the use of the Karasek model as a guiding framework for research (and stress management practice) rather than as a precision tool for predicting strain.

Sources, moderators, and manifestations of stress at work

A huge and burgeoning literature on stress in the workplace exists (*e.g.* Beehr 1995; Cooper & Payne 1988; Crandall & Perrewé 1995; Earnshaw & Cooper 1996; Firth-Cozens & Payne 1999; Karasek & Theorell 1990; Kompier & Cooper 1999b; Puryear Keita & Hurrell 1994; Quick *et al.* 1987, 1992; Sauter *et al.* 1989; Sauter & Murphy 1995). Much of this literature

reports research findings directly or summarizes the research of others on sources of occupational stress, moderators of work stress, and manifestations of stress associated with work. Due to economies of space and the sheer quantity of research in these three areas, a comprehensive literature review in each area is not contained here. However, an attempt is made to summarize key findings from the research in the three areas.

Methodological issues in stress research

Prior to outlining the research evidence, it is worth highlighting some of the methodological problems in occupational stress research that can hamper the generalizability of findings and comparison of data between studies. Much of the research is based upon cross-sectional, quantitative, self-report questionnaire designs. Such designs have the advantage of enabling researchers to collect data from large numbers of individuals using standardized scales in a relatively short period of time. However, they are prone to the unreliable memories of individuals, are open to socially favourable reporting by respondents, and impose upon respondents researcher-defined response frameworks. And, whilst standardized measures are used in occupational stress research there is no single measure, or set of measures, thus making comparison across studies difficult (Spielberger & Reheiser 1995). Additionally, the cross-sectional nature of such studies makes it impossible to identify the direction of association (causality) between variables under investigation and offer little insight into the processes involved in stress appraisal and coping.

Whilst longitudinal designs provide the potential to study processes and causality over time, they are not without operational difficulty. For instance, it may be difficult, if not impossible, to establish effective control groups to allow for the control of confounding variables. Although it may be possible to define suitable matching variables for control and study groups, the dynamic nature of organizations mean that the control group is likely to be exposed to stressors during the study period and that these may be different from the study group's stressors. Even where the study group acts as its own control,

as when measures are taken before as well as during or after an event, for example organizational restructuring or company mergers, other events may occur in the interim which have a confounding effect. For instance, an investigation of the impact of restructuring on employees of a public sector organization may well have to take into account the introduction, or imminent introduction, of a new policy or policies during the life span of the study.

Interview designs can be used to help unravel the complexity of relationships between stress/strain variables and the processes involved. Interviewees can be encouraged to recount stressful episodes or general feelings about their work. Whilst they can, consequently, lead to an understanding of stress from the perspective of individuals, it tends to be more costly to interview and the smaller samples achieved make generalizing to the non-study population difficult. Interviews are also susceptible to the same problems of subjectivity as self-report questionnaires.

Some researchers have used behavioural, physiological or medical indicators in their investigations of stress (*e.g.* Hinton *et al.* 2001; Kirschbaum & Hellhammer 1989; Kompier *et al.* 2000; Theorell *et al.* 1990) in an attempt to overcome the difficulties inherent in using subjective methods. Behavioural methods include observation and sifting through archival records, such as sickness absence and accident logs. Physiological indicators include biochemical data on, for instance, changes in hormonal concentrations in blood or urine samples (hormones such as cortisol and testosterone) and ion concentrations in saliva (ions such as potassium and sodium); cardiovascular indicators such as blood pressure and heart rate changes; and, gastrointestinal indicators, such as presence of peptic ulcer (Fried 1988). Medical indicators include tracking incidence of coronary heart disease and cancers. Such 'objective' measures are not, however, without their own methodological problems. For instance, observation can influence the behaviour of those being observed and is time limited (Frese & Zapf 1988); archival data is retrospective in nature and can therefore be unreliable and biased (*e.g.* employees may only notify officials of accidents if they are sufficiently serious); and, only inferences can be made (rather than definite

claims of proof) about causal links between specific stressors and long-term health problems because of the time-lag and the potential for interference from other unmeasured variables.

Fried (1988) describes three main categories of factors, independent of stress factors, that if not controlled for can affect the validity of physiological data. These are *stable or permanent factors* (*e.g.* diet, sex, race, familial or genetic tendencies), which result in differences between individuals and groups in their susceptibility to particular physiological symptoms; *transitory factors*, which are time and situation-specific (*e.g.* room temperature, postural position, time of day, consumption of caffeine, nicotine or other drugs before or during the time of measurement); and *procedural factors*, which are problems associated with measurement procedures (*e.g.* number of times measurements are taken or duration of time between them).

Since there is no single adequate method of studying stress a sensible approach seems to be to use a combination of methods. However, in reality, conducting fieldwork in organizational settings is likely to impose methodological limitations. For instance, employers or employees may be unwilling to have work stopped to enable blood or saliva samples to be taken; it may be inappropriate to use observation methods in instances where employees have to work alone or on a one-to-one basis with clients (although it may be possible to install and use video monitoring equipment, if this is not considered obtrusive). The use of self-report methods is likely to be considered less of an inconvenience, or less interfering, by employers and employees alike and, consequently, these methods appear to be favoured in occupational stress research.

Sources of occupational stress

Research indicates that potential sources of stress differ by occupation, organization, and workgroup or department even within the same organization (Cartwright & Cooper 1996). Nevertheless, there appear to be a number of factors that have repeatedly been found to be associated with

indicators of strain. *Job demands*, such as too little or too much work, high work pace and time pressure, appear to be a particular group of factors that many find stressful. Research linking job demands to worker strain include the large number of studies that have examined Karasek's (1979) Model of Job Strain (see above). Other studies have also provided evidence of an association between job demands and strain. For example, using self-report data from a random population sample in the United Kingdom (n = 820), Fletcher *et al.* (1987) found that workload or job demand factors were among the most common potential stressors. Almost 50% of the sample reported 'much work in bursts', 37% reported having an 'irregular work load', 30% reported 'sudden panics of work', 29% reported having 'no time to relax', 27% that they were 'working too many hours', and 23% that they undertook 'work requiring quick reactions'.

Others, too, have found *job demands* to be potential stressors. For instance, Houtman and Kompier (1995), reporting findings from four surveys of the Dutch working population (n = 5,865), found that 51% of the sample reported 'high work pace' in 1989. An increase in reported incidence of 'high work pace' was apparent at every survey point between 1977 and 1989, with 38% of the sample reporting 'high work pace' in 1977, 42% in 1983 and 47% in 1986. Houtman and Kompier (1995) suggest this may reflect a genuine increase in job demands over time, or increased awareness of stress and the causes of stress in the workplace. Interestingly, professional, health and veterinary services were the industrial branches found to be most at risk of developing health problems from having a high work pace. A study of workers in all European Member States (with surveys in 1991 and 1996) suggests not only that work pace is increasing over time, but that workers in the Netherlands experience the greatest incidence of 'high speed work' (Paoli 1997). However, workers in the United Kingdom appear to have the highest incidence of 'working to tight deadlines', with 63% having tight deadlines 'at least half of the time' and 45% working to tight deadlines 'all the time'.

Role ambiguity and *role conflict* have been commonly studied potential stressors over the last two decades or more (Beehr 1995; Burke 1988; Van der Velde & Class 1995). Beehr (1995) argues that these two factors should be studied separately, although typically they are investigated in the same study and in relation to the same third variable. Beehr (1995) distinguishes between role conflict and role ambiguity in the following way:

> "As stressors or characteristics of the work environment, role ambiguity is deficient or uncertain information in the environment regarding the role behaviors expected of the focal person, and role conflict is the existence of two or more sets of expectations on the focal person (and sent pressures) such that compliance with one makes compliance with the other more difficult." (p.58)

Burke (1988), summarizing the research of others, indicated that role conflict and role ambiguity have been found to be positively correlated with psychological and physical strain, tension, fatigue and anxiety, absenteeism, propensity to leave and leaving the job, and negatively correlated with job satisfaction, job involvement, participation and commitment, task identity, and feedback.

Other work factors found to be associated with indicators of strain include physical work conditions (*e.g.* Houtman & Kompier 1995); relationships with others at work (*e.g.* Beehr 1995); insufficient autonomy or opportunity to learn (*e.g.* Karasek 1979); responsibility (*e.g.* Osipow & Davies 1988); job insecurity (*e.g.* Kuhnert & Vance 1992); threat or incidence of violence against the worker (*e.g.* Greller *et al.* 1992; Balloch *et al.* 1998); negative aspects of organizational structure or climate (*e.g.* Ivancevich & Matteson 1980); and domestic factors (home-work interface) (*e.g.* Collins & Parry-Jones 2000; Wartman *et al.* 1991).

Moderators of stress in the workplace

Moderators (or mediators, as they are also known) of stress in the workplace are factors that interact with potential sources of strain, either ameliorating or worsening their effects. Such factors may actually be considered stressors in

their own right, such as relationships with work colleagues or supervisors, and/or may be aids to coping, such as having sufficient autonomy to solve one's work problems. Moderators may be extrinsic to the individual, such as the gaining of sufficient information to deal with a situation, or be intrinsic to the individual, such as having particular behavioural tendencies (*e.g.* Type A) and personality traits (*e.g.* locus of control). The interactional models of stress described earlier allude to the complexity of the stress process, attempting to take into account the multifaceted nature of interactions between an individual and his/her environment (both internal and external). Moderators interact with stress and coping factors, and they also interact with the interactions. This complexity presents additional challenges to researchers in their attempts to unravel the stress process. There is a need to be explicit about the variables being studied and their potential relationships and to control for or take into account, if possible, confounding variables, the moderators or mediators (Fletcher 1991). However, it is perhaps studying the confounding variables, or the way in which variables interact (the processes involved), which can give the most insight into the stress process.

Fletcher (1991) in his book on the epidemiology of stress, takes the stance that *moderating* or *mediating* variables are:

> "aspects of the individual's personality or environment which change the likelihood that any stressor or constellation of stressors gets translated into strain." (p. 2)

He lists five main groups of mediating or confounding factors that influence life event-illness relationships: *age, sex, personality, cultural factors,* and *socioeconomic status and social support*. Fletcher (1991) cites evidence in support of his listing. Although the theoretical approach to stress at work applied by researchers in the field is typically not a straight forward life events one, the Fletcher framework is useful to begin a discussion of the evidence on moderators and mediators of occupational stress. Firstly, this is because stressful life events are likely to impact on the lives of everyone, regardless of whether they are employed or not employed. Secondly, life

events' lists (for adults of working age) include life events associated with work. And finally, the Fletcher framework is a reasonably comprehensive classification that can be applied to an examination of moderators and mediators of stress in the work place.

Age

In relation to *age* as a moderator, Goldberg and Comstock (1980) found that those aged 65 and over were considerably more likely to report no instances of life events in the previous year than 18-24 year olds, who typically cited four life events in a similar time frame. Fletcher (1991) comments that life event measures are biased towards the type of life events that occur earlier in life (*e.g.* moving house, getting married/divorced). Whilst most people in studies of occupational stress are likely to be under the age of 65, it has been argued that the same life events can have different strain implications for individuals at different points in their lives (Kellam 1984). Age, or an indicator of age (or experience), such as years in an occupation, should therefore be included as a variable in studies of occupational stress.

Sex

Women have been found to report more life events than men (Masuda & Holmes 1978), although other studies provide contradictory evidence (Goldberg & Comstock 1980). Reporting on a meta-analysis of gender differences and occupational stress, Martocchio & O'Leary (1989) found that only 15 (methodologically sound) studies provided evidence of gender differences. They indicated that few studies of occupational stress had actually included women and that more needed to be conducted before conclusions could be drawn as to whether gender differences in occupational stress were typical or not.

In study specifically aiming to examine gender differences in work stress and coping, Trocki and Orioli (1994) found women workers (mainly of professional and administrative grades, from 28 organisations differing in

industry type and size) were more likely than male workers to have higher environmental stressor scores (especially on work pressures/changes and personal pressures/changes scores), higher emotional symptomology scale scores, and lower coping measures scores (except for support seeking and self-care). It was apparent that only some of the variation in symptomology (emotional, behavioural and physical) was due to work factors, some was due to personal and family factors, and the rest of the variance was unexplained. The women respondents seemed to find job demands more distressing than male respondents, the latter finding role ambiguity and a competitive atmosphere more stressful than the former. Due to the different coping strategies that were apparently used by the male and female respondents, Trocki and Orioli (1994) conclude that interventions for stress in the workplace need to take into account gender differences.

Whilst the study adds further to the evidence of gender differences in occupational stress (and coping), the cross-sectional, self-report methods used leave the study open to the usual criticisms of such methodology. Trocki and Orioli (1994) also appeared not to control for income and grade, despite acknowledging that female respondents earned less than male respondents and fewer were in managerial positions. Nevertheless, the weight of evidence suggests that it is important to include gender as a variable in occupational stress research.

Personality

Regarding *personality*, Fletcher (1991) cites evidence that negative affectivity, social conformity and neuroticism (Denny & Frisch 1981; Garrity *et al.* 1977; Watson & Pennebarker 1989) are moderators or mediators of stress. Fletcher (1991) also draws attention to evidence surrounding locus of control as a moderator. The common finding is that those with an external locus of control are more likely than those with an internal locus of control to exhibit signs of distress following reports of negative life events (Johnson & Sarason 1978; Lefcourt 1984). It could be argued that evidence from studies using life events measures are not applicable to studies of stress in the work

place, because most life events typically included in life events scales are those that occur outside of the workplace. However, there is considerable support for the notion that personality influences stressor-strain outcomes. For instance, the Parkes (1991) study described earlier implicates externals as being more likely than internals to suffer adversely from conditions of high job demands and low job discretion. Other studies of locus of control in workers (both cross-sectional and longitudinal) have linked external locus of control with stress or ill-health outcomes (Hurrell & Murphy 1991).

Under the *personality* banner can also be placed evidence surrounding the association between Type A behaviour patterns and adverse health outcomes. Type A individuals typically exhibit impatience, competitiveness, excessive speed, achievement striving, time urgency, hostility and aggressiveness. Research conducted by Rosenman and Friedman and others (summarized by Fletcher 1991) has provided strong evidence for Type A behaviour as a risk factor for coronary heart disease (CHD). Rosenman *et al.* (1966) report, from a longitudinal epidemiological study (the Western Collaborative Group Study), that of men originally in 39-49 and 50-59 age categories, Type A's were found to be almost twice as likely to have developed CHD than Type B's (those having essentially opposite behaviour characteristics) at a 4.5 year follow-up. Eight classes of risk factor had been controlled for including smoking, parental history of CHD, and high systolic and diastolic blood pressure. At 8.5 years follow-up, Rosenman *et al.* (1976) identified only three of 17 'risk' factors to be statistically significant risks: Type A behaviour was one of these, alongside serum cholesterol and smoking behaviour.

Since personality and behaviour characteristics appear to have an influence on indicators of strain, it therefore seems appropriate to consider incorporating personality and/or behaviour measures in studies of occupational stress. Unfortunately, however, there are a multitude of potential personality moderator or mediator factors and a wide range of measurement methods. Since all potential factors and measures could not possibly be included in one study, this leaves the researcher with difficult

selection decisions. If only one, or even no, potential moderating personality factors are included in a study of occupational stress, then perhaps the best course is to acknowledge that personality and behaviour patterns can influence the process and outcomes of stress and that findings cannot reflect the nature of stress in the workplace in its entirety.

Cultural factors

There appear to be cultural differences in the experiencing and perception of life events (Fletcher 1991). However, it is not clear what constitutes these differences. Although cultural differences in emotional experience, in part possibly due to different cultural systems of individualism (Western societies) and collectivism (Asian societies), may partially explain the differences in life events reported by members of different ethnic groups, there is also evidence of no or relatively small cultural differences in emotions and appraisal (see Lazarus 1999).

Studies of occupational stress and coping that have conducted cross-cultural comparisons appear to have had mixed findings too. For instance, Bhagat *et al.* (1994) found 'organizational stress' (a combined measure of role ambiguity, role conflict and work overload) to be predictive of 'psychological strain' (negative affective outcomes) in regression analyses of survey data from all seven of the countries in the study. However, the degree of explained variance differed by country (New Zealand, 16%; USA, 22%; W. Germany, 26%; India and Spain, 27%; Australia, 36%; South Africa, 46%). Decision latitude was found to be a predictor of psychological strain (or the lack of it) in six out of the seven countries (USA excluded). Problem-focused coping was found to be predictive of lower levels of psychological strain in five countries (W. Germany, India, Spain, Australia, and USA). Emotion-focused coping, on the other hand, was not found to be a predictor of psychological strain in any of the countries.

The cross-country findings in the Bhagat *et al.* (1994) study cannot be explained by simple cultural differences, such as the collectivism-

individualism dichotomy. It would seem that a multitude of factors which have not been taken into account in the study are involved. However, stress researchers need to limit the number of variables they investigate in order to attempt to simplify and unravel, piece by piece, the very complex stress (and coping) process. The mixed findings on culture and stress, however, do not clarify for researchers whether cultural differences exist or not, and whether they should be included as one of the main variables in a study of work stress.

Socioeconomic status and social support

The link between low socioeconomic status and poor health is now commonly accepted, with supportive evidence (*e.g.* Macintyre *et al.* 2001; Marmot & Wilkinson 2001; McCulloch 2001; Williams 2001). Liem and Liem (1984) argue that those of lower socioeconomic status are doubly disadvantaged in that they are more likely to both experience greater frequency of adverse life events and have less supportive environments. Thus, socioeconomic status of workers should ideally be taken into account in studies of job stress. However, in investigations of stress in a single occupational group, or in related occupational groups, where the socioeconomic status of study participants is likely to be relatively homogenous, it may be less important to include socioeconomic status indicators.

The buffering effect of social support on stress has been a frequently studied topic (*e.g.* Billings & Moos 1981; Bruhn 1996; Constable & Russell 1986; Cummins 1990; Frone *et al.* 1995; Greller *et al.* 1992; Quick *et al.* 1996). Buffers of stressful events are said to ameliorate their potentially adverse impact (Greller *et al.* 1992). Although the evidence for the buffering effects of social support is by no means clear cut (Frone *et al.* 1995; Greller *et al.* 1992), when social support buffering does occur the most effective social support buffers appear to be of information-giving and esteem-giving types (Cohen & Wills 1985). In the coping literature these tend to be referred to as *instrumental social support* and *emotional social support* (*e.g.* Carver *et al.*

1989). Supervisory support appears to be particularly beneficial (Beehr *et al.* 1990; Constable & Russell 1986; Cummins 1990; Greller *et al.* 1992; Russell *et al.* 1987), although possibly only for those individuals who are relationship-oriented (Cummins 1990). Citing the work of others, Greller *et al.* (1992) explain why supervisory support might be so useful in dealing with stress (or potential stress) in the workplace:

> "The supervisor is uniquely positioned as a source of support. Cohne and Wills (1985) proposed three factors that contribute to buffering: information, support, and esteem. In the work situation, the supervisor can provide all three. Positive feedback from above offers information and fosters esteem. Support may be either material or emotional… Participation in decisions allows greater control over events (Rodin 1986). Supervisor consideration and positive feedback offer the emotional component. Taken together, information, support, and esteem may help the individual alter the stress-producing situation – or at least hold out the possibility of so doing. Support from external sources do not offer such a promise." (p.44)

There is some evidence of gender differences. Women appear to be less responsive to the buffering effects of work place social support than do men, with women seemingly favouring social support external to work (Etzion 1984; Marshall & Barnett 1990). However, women who receive even low levels of social support at work have been found to have significantly lower mortality rates than non-employed women (Hibbard & Pope 1992). In a recent prospective study of women nurses in the USA, Cheng *et al.* (2000) found low work related social support, when combined with high job demands and low job control, to be significantly associated with greater functional health decline over a four year period than for women of higher levels of social support at work. The latter two studies suggest social support in the work place is an important moderator of stress for women, just as it is for men. Consequently, in any study of stress at work the buffering effects of social support should be taken into consideration regardless of whether or not the majority of participants are women (such as in a study of care management practitioners).

Coping

An appropriate addition to the list of moderators and mediators provided by Fletcher (1991) is *coping*. There is a huge literature focused entirely on coping with stress (*e.g.* see Aldwin 1994; Eckenrode 1991; Gottlieb 1997a; Zeidner & Endler 1996) and it is impossible to do justice to it here. However, a little of the research surrounding coping as a mediator of the stressor-strain relationship will be provided in order not to ignore this highly important topic. According to Lazarus and Folkman's (1984) model of stress, coping is an integral part of the stressor-strain process (see Figure 4.6 and earlier discussion, this chapter). After initial appraisal of the stressful situation, coping influences how the stressful encounter is dealt with on an on-going basis until the encounter comes to an end. The coping process is, however, thought to be influenced itself by contextual and dispositional factors precipitating the stressful encounter, by the stressful encounter, and by cognitive appraisal (Holahan *et al.* 1996).

Commonly, investigators have classified coping strategies onto either a *focus of coping* dimension or a *method (or manifestation) of coping* dimension (Holahan *et al.* 1996; Kühlmann 1990). The *focus of coping* dimension distinguishes the target of coping strategies as either *emotion-focused* or *problem-focused*. *Emotion-focused coping* is the attempt to reduce or manage stressor-induced emotional disturbances, whereas *problem-focused coping* is the active seeking of ways of altering the stressful person-environment encounter. *Methods* or *manifestations of coping* are cognitive and behavioural strategies employed to deal with a stressful situation, whereby *cognitive coping* is the mental activity and *behavioural coping* is overt action. Utilizing these distinctions, Kühlmann (1990) provides a definition of, and reason for, coping with stress in the work place:

> "..cognitive and behavioural efforts to alter stress-producing person-environment relationships in the work context and/or to weaken the negative emotional impact of a given transaction." (p.90)

Instruments that have been designed to measure the types of coping strategies used typically identify more than two dimensions. For instance the Ways of Coping Checklist (Folkman & Lazarus 1985) has eight factors: planful problem solving, positive reappraisal; confrontative coping; self-control, distancing, escape/avoidance, accepting responsibility, and seeking social support.

Unfortunately, studies of coping with stress at work have tended not to examine links between specific stressors and use of particular coping strategies (Hepburn *et al.* 1997). Instead, how individuals cope in general with stress at work is studied. Consequently, there is little understanding about what triggers the use of different coping strategies. One study that has attempted to examine different types of coping in relation to different work place environmental stimuli (and personality characteristics) is that of Parkes (1986). In this study of 135 first-year female student nurses, interactions between person, environment and situation variables helped explain variance in scores for direct coping strategies, and interactions between person and situation helped explain suppression (as a coping strategy) score variance. Thus, different coping strategies do appear to be used in different environmental settings. Other research indicates that appraisals of the frequency, intensity and meaning (impact) of stressful episodes influences the type of coping strategy employed by individuals (see Hepburn *et al.* 1997).

Where 'general' work place stress has been studied, more wishful thinking and emotion-focused coping have tended to be found amongst those reporting higher levels of stress as opposed to those reporting lower levels of work stress (Holahan *et al.* 1996). Use of problem-focused coping strategies was not found to differ between participants with high and low stress scores. Others have found high stress levels associated with reduced problem-solving activity (see Hepburn *et al.* 1997). It may be that those experiencing higher levels of stress tried but did not find adequate practical ways of dealing with their sources of stress, so instead attempt to manage the emotional consequences of their continued exposure to stressors.

In terms of having long-term strain outcomes, the evidence of coping as a moderator is mixed (Hepburn *et al.* 1997). For instance, Greenglass and Burke (1991) found preventative coping (*i.e.* planning for the future) and internal control strategies moderated the impact of 'general' stress on depression and anxiety. Bhagat *et al.* (1991) reported that problem-focused coping employed to deal with work 'difficulties' appeared to moderate the relationship between organizational stress and burnout, and organizational stress and illness in teachers. However, Shinn *et al.* (1984) did not find a consistent moderating effect for either problem- or emotion-focused coping in the job stress-strain relationships of professional human service workers. And, Frone *et al.* (1995) also found coping styles did not moderate between 'general' job stress and strain (somatic symptoms and depression) in a general population sample.

Thus, the moderating effects of the use of different coping strategies is still uncertain. Greater methodological and conceptual clarity has been suggested for research in this field (Hepburn et al. 1997). In particular, studies that attempt to link specific stressors to specific coping strategies, and those that make explicit the conceptual differences between coping style (trait) and coping strategy (situation-dependent) have been called for.

Manifestations of stress (strain)

As indicated earlier, strain is the outcome of exposure to stressors, the manifestation of stress. Many types of strain have been recorded in studies of stress in the workplace, and most of these strain types have already been mentioned in the discussion of work stress above. However, here they are brought together using Beehr's (1995) categories of psychological, physical or physiological, and behavioural strain.

Psychological strains

Psychological strains frequently associated with work stressors include depression, anxiety, and job dissatisfaction (Beehr 1995). Whilst job satisfaction/dissatisfaction has been frequently employed as an indicator of work strain, Beehr (1995) suggests that dissatisfaction is less severe than a true strain. The common usage of job satisfaction/ dissatisfaction measures as indicators of strain may have arisen because of conceptual overlap (Decker & Borgen 1993). Locke (1983) defines job satisfaction as:

> "..a pleasurable or positive emotional state resulting from the appraisal of one's job or job experiences." (p.1300)

This quotation suggests that the opposite concept, job dissatisfaction, would be a negative or non-pleasurable emotional state resulting from an appraisal of one's job. If occupational strain is considered to be a negative (psychological) outcome of an appraised imbalance between demands and resources in the workplace, then it is easy to see how conceptual overlap occurs.

Other symptoms of psychological strain are feelings of exhaustion, depersonalization and reduced personal accomplishment, otherwise known as *burnout* (Maslach *et al*. 1996). Burnout can be considered as the outcome of a prolonged imbalance between resources and demands, "a final stage in a breakdown in adaptation" (Schaufeli 1999, p.20). In a review of 16 studies of burnout in care workers and health professionals, Schaufeli and Enzmann (1998) found that job stressors commonly exist in a variety of occupations, such as time pressure, workload and role conflicts, were more highly correlated with burnout than job stressors specific to caring work, such as confrontation with dying and death, contact with terminally or chronically ill patients, and interaction with awkward patients. This suggests that the concept could be applied more widely in studies of occupational stress than it typically has been, moving from studies of health and social care workers to other vocations, such as business or blue collar work. Whilst burnout is

usually found to be associated with depression indicators, Schaufeli (1999) and others (*e.g.* Glass & McKnight 1996) argue that the two represent different, albeit related, syndromes. Schaufeli (1999) explains:

> "..depressive patients are generally overwhelmed by listlessness and lethargy and hold steadfastly to their ideas of guilt, whereas burnout victims present their complaints much more vigorously – they feel disappointed and aggrieved. Furthermore, contrary to depression, burnout tends to be job-related and situation-specific rather than pervasive, at least initially, affecting all other spheres of life. Finally, burnout includes specific dysfunctional attitudes and behaviours that are not typically found in depression. " (p.20-21)

Beehr (1995) includes somatic complaints in his psychological strains category, justifying this by indicating that aches and pains tend to be recorded using self-report measures, rather than by more objective means, and somatic items are frequently used in anxiety scales. However, a definite *psychological strain* classification for somatic complaints is not necessarily applied by different stress investigators. For instance, Greller *et al.* (1992) refer to them as psychosomatic complaints, and Osipow and Davies (1988) label them as physical strain. Using self-report measures, somatic complaints have been found to be associated with job stressors, such as certain shift-work conditions, role ambiguity, and role overload (see Beehr 1995). However, typically the associations are weak (and lower correlations occur with work stressors than the more obvious psychological strains), or non-significant (Beehr 1995).

Physical or physiological strains

Most organizational psychology studies of stress focus on psychological indicators of strain, rather than physiological strains (Beehr 1995). Nevertheless there have been a number of studies that have used physiological measures as indicators of strain in the workplace, typically using some psychological measurement of strain outcome as well (*e.g.* Hinton *et al.* 2001; Kompier *et al.* 2000; Tattersall & Farmer 1995). Types of physiological (or physical) strain indicators used include biochemical change

measures, gastrointestinal indicators and cardiovascular indicators (Fried 1988), as already mentioned. There are problems associated with the use of physiological and physical measures as indicators of strain, as highlighted earlier.

Beehr (1995) asserts that when physiological and psychological indicators have been included in the same study of work stress, the psychological outcomes tend to be more highly correlated with the psychological stressors than do the physiological outcomes (although Beehr provides no evidence in support of this statement). However, there is a relatively new, but rapidly growing research field – psychoneuroimmunology – that has made progress towards linking psychological stressors with malfunctioning of the human immune system (see, for example, Ader *et al.* 1991). Such work fits with the idea that psychological stress can lead to physical illness, such as coronary heart disease and cancer, supporting epidemiological research already conducted into these diseases (see Fletcher 1991).

Behavioural strain

Beehr (1995) argues that for behaviour to be considered a strain, it needs to be deleterious to the individual in some way. Consequently, whilst absenteeism, turnover and poor performance are often cited indicators of stress at work (*e.g.* Carter & West 1999; Kompier *et al.* 2000; Payne 1999; Young & Cooper 1999), they cannot be thought of as behavioural strain outcomes because they are not likely to be harmful to the individual worker. Such outcomes may, however, be considered indirect indicators of strain in the workplace because they may occur as a response by individuals to being under strain. These indicators can more appropriately be classified as organizational outcomes of occupational stress rather than as behavioural strain outcomes (Beehr 1995).

Examples of true behavioural strain indicators could include smoking, drug abuse, alcohol misuse, suicide, risky behaviour (*e.g.* reckless driving), under- or over-eating, and behaviours affecting interpersonal relations (Beehr 1995).

Evidence exists of associations between many of these and psychological stress in the work place. For example, research suggests that farming is very stressful, with farmers having the highest suicide rate of any occupational group in the United Kingdom (Ruralminds/Institute of Rural Health/Mind 1999); alcohol abuse is a commonly found indicator of stress in medical doctors (Firth-Cozens 1999); and, deteriorated relations with managers and peers has been associated with computer performance monitoring systems in clerical workers (see Briner *et al.* 1988).

Occupational stress and individual innovation

Despite the voluminous literature on stress at work, there have been very few published studies that have investigated the relationship between occupational stress (or burnout) and innovation (or creativity) in the work place. Whilst the studies that have been conducted have found associations between innovation (or creativity) and stress (or burnout) (Bunce & West 1994, 1996; Carter & West 1998; Noworol *et al.* 1993; Talbot *et al.* 1992), they do not provide a clear indication of the direction of causality. This is in part due to the fact that almost all the studies conducted in this area are cross-sectional in nature (see Table 4.2).

Table 4.2 summarizes the studies by study type, location, design, sample, methods used, and findings. Four of the studies took place in the United Kingdom (Bunce & West 1994, 1996; Carter & West 1998; Talbot *et al.* 1992), and one in Poland (Noworol *et al.* 1993). Three of the UK studies involved public sector organizations (Bunce & West 1994, 1996; Carter & West 1998), and the other involved a private sector organization (Talbot *et al.* 1992). The Polish study took place in a mixture of private and state-owned organizations.

Table 4.2 Summary of studies exploring relationship between job stress and innovation

Authors /year	Study type	Location	Design	Sample	Methods	Findings
Bunce & West 1994	Investigation of innovation as a stress coping strategy	National Health Service, UK	Cross-sectional postal survey	N = 333 (24% response rate) - community & hospital nurses, clerical workers, & therapists - 95% female	Open-ended questions (stress situation and innovative coping response) and rating scales; independent rater coding	32% reported innovative response to stress
Bunce & West 1996	Innovation promotion as stress management intervention	National Health Service, UK	Comparison of innovation promotion programs (IPP) with traditional stress management programs (SMP) and control group – using self-completion questionnaires	N = 45 attending IPP sessions (n = 20 by final follow-up) N = 62 attending SMP sessions (n = 27 by final follow-up) N = 84 controls at time of sessions (n = 70 by final follow-up)	Pre- and post-intervention data gathering (3 & 12 month follow-up) – self-report measures included psychological well-being/strain measures and innovation scale (number and effectiveness of innovations introduced in workplace)	Indications (at 3 & 12 month follow-up) that both IPP and SMP were effective at improving psychological strain (although only SMP findings significant); innovation improved significantly following IPP at 3 months, with continued improvement at 12 months; innovation declined in SMP group
Carter & West 1998	Investigation of team effectiveness & climate for innovation, reflexivity, and mental health	BBC-TV, UK	Cross-sectional distributed questionnaire, plus performance ratings	N = 19 BBC-TV production teams (57% response rate from individuals)	Questionnaire contained Team Climate Inventory, team reflexivity scale, well-being/strain measures; audience & executive producer ratings	Climate for innovation predicted team member strain; reflexivity predicted team effectiveness, but not team member well-being

Table 4.2 Summary of studies exploring relationship between job stress and innovation (continued)

Authors /year	Study type	Location	Design	Sample	Methods	Findings
Noworol *et al.* 1993	Investigation of relationship between burnout & creativity/ innovation	Private/ state-owned companies (chemical, electronic, construction & steel), Poland	Cross-sectional distributed questionnaire	N = 80 male managers	Questionnaire measures of fluency, flexibility and originality of thinking; Kirton Adaption-Innovation Inventory; burnout inventory	Experience of burnout associated with less creative thinking, and vice versa
Talbot *et al.* 1992	Investigation of relationship between creative climate & occupational stress	UK Service Division, multinational office equipment and systems company	Cross-sectional distributed questionnaire	N = 202, 'mostly male' - operators, supervisors, & three levels of manager	Use of Creative Climate Questionnaire & occupational stress measure	Higher stress levels associated with lower creativity climate scores; the higher the organizational level, the lower the stress and the higher the creative climate

The focus and organizational level of interest varied in the studies. Teams were the unit of analysis in the Carter & West (1998) investigation of team effectiveness, climate for innovation, reflexivity, and mental health in BBC-TV production teams. The Talbot *et al.* (1992) investigation also focused on creative climate (and the association with occupational stress), using the organizational-level unit of analysis. Both the Carter & West (1998) and Talbot *et al.* (1992) studies were investigating the relationship between climate for innovation or creativity and mental health. Individual level analysis was apparent in the Bunce and West (1994) and Noworol *et al.* (1993) studies. These two studies differed in focus, with the Bunce and West (1994) study investigating the use of innovation as a stress coping strategy, and the Noworol *et al.* (1993) study examining the relationship between burnout and creativity. A different tack was taken altogether in the Bunce and West (1996) study, in which groups of individuals attending innovation promotion and stress management intervention programs were compared on measures of psychological strain and the number and effectiveness of self-reported innovations introduced in the workplace (a control group was also included).

Only very tentative conclusions can be drawn from the findings of these five studies of stress and innovation (or creativity) for a number of reasons. Firstly, and as already indicated, most of the studies were cross-sectional in nature. Secondly, they all relied upon self-report data, although the Carter and West (1998) study also included performance ratings by BBC-TV audiences and executive producers. The Bunce and West (1994) study involved independent rater coding, but this was of self-report data rather than of direct observation of study participants' performance. Thirdly, not all the authors reported questionnaire response rate data, making it difficult to estimate how representative the findings were of the populations from which they were drawn. Only Carter and West (1998) and Bunce and West (1994) reported response rates for their surveys, and Bunce and West (1996) reported attrition rates for their intervention study for all measurement points. Whilst Carter and West (1998) reported a reasonably high response rate (57%), making their findings more likely to be generalizable, Bunce and West (1994) reported a poor response rate (of approximately a quarter of their

targeted sample). Attrition rates in the Bunce and West (1996) intervention study (51% for the innovation promotion program group, and 44% for the traditional stress management program group) also indicate that there may be problems generalizing from their findings. Fourthly, the studies had different foci and used different measures. Finally, whilst a mix of public and private sector organizations was achieved across studies, only one study took place in the context of more than one organization (Noworol *et al.* 1993). The latter study was also the only non-UK based study. Also, the insufficient number of studies of individual level, team level, and organizational level innovation (or creativity) make generalizing the findings to individuals, teams/groups, or organizations (other than those studied) difficult.

Despite the limitations of the five studies it is worth describing main findings and (tentative) conclusions because these appear to be the only published examples of studies of occupational stress and innovation and, in their totality, they offer some insight into this relatively uncharted territory. In terms of findings, Bunce and West (1994) report that innovation is used as a method of coping with stress by some individuals (32% of their respondents). Overwork and procedural difficulties appear to be the main sources of stress that trigger innovative coping responses, working procedures being the most likely target of change. Interestingly, in this 1994 study more community nurses (including health visitors and midwives) demonstrated higher levels of innovative coping than hospital nurses and clerical workers (35%, 26% and 26% respectively), although therapists (physiotherapists, speech therapists, and occupational therapists) had the highest levels of innovative coping (47%). However, there was no indication of the perceived level of stress that the various occupational groups were exposed to, so it is difficult to know whether the higher rates of innovative coping by therapists and community nurses were in response to the fact that their work was somehow more stressful than that of hospital nurses or clerical staff. Bunce and West (1994) suggest the group differences might reflect different levels of autonomy in the occupations represented, with higher autonomy associated with greater innovative behaviour (see Chapter 3).

Bunce and West's (1996) intervention study provides some further evidence to support the idea that innovation can be applied as a coping strategy to work place stress. Improvements in psychological well-being from baseline were apparent at the 3 month follow-up, maintained by 12 months. However, these gains were not statistically significant. Therefore, it remains uncertain whether innovation promoting programs alone can reduce occupational stress levels in the medium- and long-term. The findings, however, suggest that the stress-reducing properties of innovation promotion is worthy of more in-depth study. Bunce and West (1996) suggest session processes be examined in future stress intervention research as well as the analysis of outcome indicators.

Noworol *et al.* (1993) were interested in the relationship between burnout and creativity. They measured creativity by including fluency, flexibility and originality of thinking scales in their survey instrument. They also incorporated Kirton's Adaption-Innovation Inventory (KAII), which is a trait measure of creative style (individuals are classified as either innovators or adaptors). Individuals experiencing burnout demonstrated less creative thinking and an adaptive problem-solving style, compared with those not experiencing burnout. The latter demonstrated high levels of creative thinking and were classified as innovators on the KAII. However, the direction of causality between creativity and burnout could not be gleaned from the findings, as noted by Noworol *et al.* (1993) themselves. It could be that adaptors have associated personality tendencies that make them more vulnerable to stress, and then the state of burnout leaves individuals with little creative thinking reserves. Alternatively, those with less creative thinking styles might be less able to devise innovative coping strategies to deal with job stress, thus becoming more prone to burnout syndrome. This latter suggestion fits with the ideas of Bunce and West (1994, 1996) that innovation can be applied as a stress coping strategy. However, Bunce and West (1994, 1996) did not take into account personality predispositions, apparently assuming that study participants were equally capable of being innovative.

The other two studies (Carter & West 1998; Talbot *et al.* 1992) were conducted at team/organizational group level, and consequently the findings are less applicable to studies of individual level innovation and stress. Both these studies also examined climate for innovation/creativity, rather than actual creative thinking or past (self-reported) innovative practice. Climate for innovation/creativity, where found, may well support the innovative practice of individuals (or teams/groups), but it cannot be regarded as a direct indicator of innovative or creative activity. Despite the Carter and West (1998) study including performance measures (audience appreciation ratings and executive producer effectiveness ratings) of what should be highly creative teams, such measures are likely to encompass features other than (or in addition to) creativity or innovation (for example, timeliness, attention to detail, humour). Thus, they cannot be considered direct measures of creativity or innovation. Nevertheless, it was interesting to note that in both studies climate for innovation/creativity was found to be associated with positive mental well-being. Again, it is not clear what the direction of association is. It may be that those who report positive well-being are also more positive in their views of their organization or team. They may feel they are better supported than individuals who are experiencing strain. Alternatively, teams or groups perceiving a climate supportive of innovation or creativity may actually be better supported in other respects, and consequently be more able to deal effectively with stressful situations, regardless of whether they apply innovative or non-innovative coping strategies.

In conclusion, it would appear that there is evidence of a relationship between stress and innovation (or creativity) in the work place, whereby greater innovation (or creativity) is associated with better mental well-being and vice versa. However, the direction of causality is unclear. Many other questions remain unanswered. Does the perception of stress lead to innovative coping strategies, which in turn lowers levels of stress? Does being innovative make one less likely to consider a situation to be stressful in the first place, perhaps perceiving instead a challenging problem to be

overcome? What is the relationship between innovative practice and job stress when the innovative practice is not directly orientated towards stress reduction? What processes and antecedent or moderating factors might underlie the relationship between occupational stress and individual innovation? It seems that this is an area ripe for further empirical consideration.

Since care management practitioners have both the potential to be innovative in their work and are likely to be exposed to numerous stressors, they seem likely candidates for an investigation of innovative practice and occupational stress. Evidence of the stressful nature of the work of care management practitioners is presented next.

Stress and care management practitioners

There has been a burgeoning interest in stress and community care practitioners over the last decade or so. Much of this interest has focused solely on social workers (Bennett *et al.* 1993; Collings & Murray 1996; Gibson *et al.* 1989; Jones *et al.* 1991; Smith & Nursten 1998; Thompson *et al.* 1996) or on social workers in combination with other social care staff, such as managers, residential and domiciliary care workers (*e.g.* Balloch *et al.* 1998; Bradley & Sutherland 1995; Caughey 1996). However, a few studies have examined stress in community nursing (Carson *et al.* 1995; Fielding & Weaver 1994; MacLellan 1990) or community nursing alongside hospital/institutional nursing (*e.g.* Handy 1991; McGrath *et al.* 1989). Both social workers and community nurses (including district nurses, community psychiatric nurses, and community nurses specializing in work with people with learning difficulties) have been found to undertake care management work, although care management work is mainly conducted by social workers (McGrath *et al.* 1996).

Despite the growing literature on stress and community care practitioners, there has been only one explicit study of stress and care management

practitioners in the United Kingdom, the forerunner of the present research (Parry-Jones *et al.* 1998a). And, even though many of the studies on stress and community care practitioners have been published post-implementation of the NHS and Community Care Act 1990 in April 1993, only one is reported to have collected data following the reforms (Balloch *et al.* 1998). There are, however, several studies that may have had data collection points post-reform (with publication acceptance dates from June 1994 onwards), but the authors have not reported the timing of their data collection (Caughey 1996; Collings & Murray 1996; Smith & Nursten 1998; Thompson *et al.* 1996). Whilst high levels of stress have frequently been reported in community care practitioners pre- and post-implementation of the reforms (Balloch *et al.* 1998; Bennett *et al.* 1993; Carson *et al.* 1995; Caughey 1996; Fielding & Weaver 1994; MacLellan 1990; Parry-Jones *et al.* 1998a; Thompson *et al.* 1996), it is only the Parry-Jones *et al.* (1998b) study that reports findings directly about care management practitioners. Nevertheless, the findings of the other studies can provide useful contextual information on sources of stress and dissatisfaction for community care practitioners in general.

Prior to reporting the findings of these studies, it is worth noting that the studies suffer from the same methodological limitations of the vast majority of occupational stress studies outlined earlier. The studies were mainly cross-sectional in nature, although Handy (1991), for instance, involved case study methodology with the collection of data over a period of time (the length of time was not reported). Data were typically of the self-report type, gathered through interviews and/or distributed questionnaire surveys, although Handy (1991) also included observation data and analysis of case notes. Thus, all the studies, with the exception of Handy (1991), used no 'objective' means to cross-validate the self-report findings. Admittedly the response rates of many of the surveys were reasonable, with all achieving a response rate of 55% or above, except for the Parry-Jones *et al.* (1998b) study which achieved only 31% (although it was noted that this was only an approximate response rate because it was not known how many of the targeted sample of community care practitioners were actively practising care management – only care management practitioners were requested to respond). Some caution,

however, needs to be applied in interpreting the findings of all the studies because of the methodology applied and/or response rates achieved.

Sources of stress for community care practitioners

Social workers, community nurses and community psychiatric nurses appear to have some sources of work stress in common. For instance, *insufficient time and resources* and factors associated with these, such as heavy workloads and caseloads, staff shortages and time pressure, are commonly implicated (Bradley & Sutherland 1995; Collings & Murray 1996; Fielding & Weaver 1994; Gibson *et al.* 1991; Jones *et al.* 1991; MacLellan 1990; McGrath *et al.* 1989; Parry-Jones *et al.* 1998a; Thompson *et al.* 1996). Other sources of stress or dissatisfaction in social work, community nursing and community psychiatric nursing commonly reported include *administrative work*, *dealing with awkward service users or patients*, and *relationships with colleagues and managers* (Balloch *et al.* 1998; Bradley & Sutherland 1995; Collings & Murray 1996; Handy 1991; Jones *et al.* 1991; MacLellan 1990; McGrath *et al.* 1989; Parry-Jones *et al.* 1998a; Thompson *et al.* 1996). *Risk of (or having experienced) violence* whilst in the course of one's work and *verbal abuse* have also been reported as stressors, for community psychiatric nurses and social workers in particular (Balloch *et al.* 1998; Carson *et al.* 1995; Jones *et al.* 1991; Smith & Nursten 1998; Thompson *et al.* 1996).

Stress in care management

Parry-Jones *et al.* (1998b) reported finding that care management practitioners such as social workers (n=276), community nurses (n=65) and community psychiatric nurses (n=62) had similar sources of occupational stress and dissatisfaction to their (non-care management or otherwise) counterparts in other studies (see above). However, they also examined predictors of stress level change since the implementation of the community care reforms in April 1993 for the different professional groups through multiple linear regression analyses.

For social work care management practitioners, 33% of the variance in the stress variable was reportedly explained by four factors: sense of personal achievement from work, workload, feeling valued as an employee, and gender (the former two being the most important predictors, explaining 32% of the variance between them). To elaborate, increased stress levels since April 1993 for social work practitioners were associated with a reduced sense of personal achievement from work, increased workload, reduced feelings of being valued as an employee, and being female.

The actual predictors of stress level change since April 1993 for community nurses (district nurses and community nurses working with people with learning difficulties) and community psychiatric nurses with care management roles differed from that of social work care managers. For instance, decreased satisfaction with work conditions, increased administrative work, and reduced time for client contact were found to be predictors of reported increase in stress levels since April 1993 for community nurses (explaining 55% of the variance). For community psychiatric nurses, reduced time for client contact and decreased satisfaction with work conditions were also found to be predictors of increased stress levels. However, increased responsibility, increased quality of communication with managers, and being female were also found to be predictors of increased stress for community psychiatric nurses (42% of the variance was explained in total). Parry-Jones *et al.* (1998b) explain that that the association between increased stress levels and reduced satisfaction with work conditions for the two nursing groups may be more a reflection of changes in the NHS since April 1993, for instance the change to Trust status (Grant *et al.* 1994), rather than the introduction of the care management role.

There are, however, some similarities in the sources of stress identified in the Parry-Jones *et al.* (1998b) study for social workers, community nurses and community psychiatric nurses. Increased *workload* either directly or indirectly appears to be a major stressor. For social work care managers it was found to be a main predictor. Increased administrative work, a specific

type of increased workload, was a predictor for community nurses, and reduced client contact time, implying increased workload, was indicated as a predictor for both nursing groups. Workload was reported as having increased since April 1993 by 90% of the social work and nursing respondents. Although, as mentioned earlier, it is difficult to generalize from the findings of this study (particularly due to the low response rate of the survey), it appears that perceived workload has increased since the introduction of the care management role and that it is a considerable source of stress. Due to the cross-sectional nature of the study, however, it is impossible to know whether introducing care management directly led to the increased workload, or whether the respondents' workloads would have increased anyway. Evidence cited earlier suggests that the job demands of other types of workers have increased over time (Houtman & Kompier 1995), and that 'working to tight deadlines' is a commonplace experience for UK workers (Paoli 1997).

Whilst increased administrative work was only found as a predictor of increased stress levels for community nurses, all groups reported increased administrative work since April 1993 (97% of respondents) (Parry-Jones *et al.* 1998a). Similarly, whilst reduced time for client contact was a predictor of increased stress for the two nursing groups, all groups reported decreased time for client contact since April 1993 (85% of respondents). Consequently, it appears that the administrative workload of community care practitioners has increased and their time for client contact decreased since the introduction of the care management role, and that these factors are associated with increased stress. As concluded by Parry-Jones *et al.* (1998b):

> "It appears that the more intrinsically rewarding aspects of practitioner roles, those that involve direct work with service users and families, are being squeezed by the demands of the new care management."(p.282)

Gender was found to be a predictor of stress level change for social work and community psychiatric nurse respondents, albeit only a minor one

(explaining just two percent of the variance in the social worker stress equation and 7% in the community psychiatric nurse equation). This fits with the findings of others for gender differences in studies of occupational stress (Martocchio & O'Leary 1989; Trocki & Orioli 1994).

However, there also appear to be some rewarding aspects of care management work. In response to an open-ended question within the survey of care management practitioners reported by Parry-Jones *et al.* (1998b), respondents indicated enjoying conducting the stages of care management itself (assessment, arranging, implementing and reviewing care packages, being creative, and being able to offer options). Direct work or contact with service users and carers was also considered to be enjoyable, as was liasing with others and team-working. The rewards of care management practice may counterbalance the negative aspects of the work to a degree, but the increased stress levels since April 1993 reported by a substantial majority of the Parry-Jones *et al.* (1998b) respondents (81%) imply that the demands experienced by care management practitioners far exceed the resources, either personal or organizational, at their disposal.

Stress, innovation and care management: some early conclusions

Whilst care management appears, in theory, to be an ideal vehicle for the introduction of innovation into the care and support of individual vulnerable people in the community, it appears (from Chapter 2) that in reality there are few supports and many constraints to innovative care management practice. Additionally, evidence indicates (this chapter) that community care practitioners who undertake care management work are struggling to cope with the demands of their work and high or increasing stress levels are commonplace. There are multiple implications of this. In the short-term this is likely to lead to reduced practitioner morale and productivity, and the delivery of a poor service to users and carers. In the medium-term community care organisations may have to deal with high rates of sickness absence and staff

turnover, and complaints from service users and carers. In the long-term care management practitioners may suffer poor mental and physical health from exposure to chronic work stressors, and community care organisations may be faced with staff claims for compensation. There are signs that the longer-term implications have already been reached, such as in the case of the social worker/manager who successfully sued his employer for suffering a nervous breakdown as a consequence of stress at work (Walker v. Northumberland County Council [1995] – cited in Earnshaw & Cooper 1996).

Despite frequent reporting of high stress levels amongst community care practitioners, innovative practice in care management may still be possible. Indeed, procedural difficulties and overwork, which appear to typify care management practice, have been cited as major sources of stress associated with innovative coping strategies (see Chapter 3). However, the direction of relationship between work stress and innovation cannot be gleaned from the few empirical studies so far conducted in this area. Whilst innovative practice may be used as a problem-solving approach to coping with stress, individuals who tend to be innovative or creative may simply not perceive situations as stressful in the first place, considering them instead to be 'challenging'.

There appear to be a number of antecedent (or moderating) factors in common to both the stress-strain process and the innovative or creative process (evidence cited in Chapters 3 and 4). These may underlie the apparent relationship between occupational stress and innovative behaviour which has been found. Such factors include age, personality, cultural factors (both internal and external to organisations), and social support. Excessive workload (or time pressure), bureaucracy (or administration), and insufficient resources appear to be both sources of occupational stress and potential inhibitory factors of innovative behaviour. Having sufficient autonomy in one's work appears to be particularly important for both stimulating innovative or creative behaviour and for ameliorating against the impact of stress at work. Thus, both job discretion and job demands are likely to affect both stressor-strain and innovative or creative processes. Karasek's (1979) job demands-

job discretion model of strain may, therefore, be useful for examining the relationship between stress and innovation in care management practitioners.

* * *

The relationship between occupational stress and innovative care management practice is explored more fully through analysis of findings from the second study, the survey of care management practitioners in Wales. Firstly, the methods and findings from a qualitative, exploratory first study of innovative care management practice are reported. Focus is on the characteristics of such practice, and on factors that hinder or facilitate this practice.

PART II

Innovative care management practice: Exploration through case studies

CHAPTER 5 IMPLEMENTING STUDY 1

As indicated in Chapter 1, Study 1 consisted of an exploratory study of the care management practice, innovative or otherwise, of five social work care managers. Case study methodology was employed. One to two cases per care manager (n = 8 in total) were followed from assessment and care planning to first review, making use of observation, case notes, care manager 'case' questionnaires and discussion with the practitioners concerned. Separate interviews were also conducted with each care manager and a questionnaire was sent to the care managers' managers. Thus, a variety of methods were used to gain insight into the care management practice of the five social workers, who specialised in services for older people.

This chapter gives the specific research questions and hypotheses of Study 1 and explains why case study methodology was used. Sample characteristics (of the care managers, their managers, and the 'cases') are provided. It details the methods employed and why they were chosen, with the research procedure and analytical methods outlined separately.

The chapter contains the following sections:

- The research questions
- Hypotheses
- Methodology
- Sample
- Methods
- Procedure
- Analytic methods

The research questions

Study 1 was designed to lead to the achievement of the first two aims of the overall PhD research (given in Chapter 1). To reiterate, these were:

Aim 1 To investigate how innovative practice in care management is characterised and undertaken by practitioners.

Aim 2 To identify which factors facilitate and which constrain innovative care management practice.

Four main research questions arose from these two aims, the first two arising from Aim 1 and the third and fourth from Aim 2. They are:

Question 1 What are the characteristics of innovative and non-innovative packages of care?

Question 2 How do care managers devise and implement innovative and non-innovative care packages, specifically at assessment and problem-solving stages?

Question 3 What factors facilitate or impinge upon the innovative process in the construction of care packages?

Question 4 What are the opinions of social work care managers, and their managers, regarding the feasibility of working in innovative ways?

In order to be able to answer the first three questions it is necessary to be able to distinguish innovative from non-innovative care packages. Whilst identifying the characteristics of innovative and non-innovative care packages is the purpose of the first question, there being no set of criteria previously in existence, there need to be some workable guidelines upon which a distinction between innovative and non-innovative care packages

can be built. *Innovative care packages will be the product of innovative care management practice.* This is the assumption underlying the research aims and the analysis of findings. A working definition of *innovative care management practice* has previously been given (see Chapters 1 and 3).

Although four separate questions are given, the first two are considered to be inextricably linked (arising from Aim 1, as already indicated): the 'characteristics of innovative and non-innovative packages of care' are likely to be determined by the 'underlying processes utilised by care managers in the construction of innovative and non-innovative care packages'. In other words, an innovative care package will be the outcome of a care management process which, in retrospect, can be considered innovative. This fits with West and Farr's (1990) conclusion that definitions of innovation typically include a process element.

Answering the third question, by identifying facilitating and hindering factors of innovative care management practice, will require an understanding of what factors help or hinder care management practice in general, whether innovative or not in outcome. Such factors have been identified through the care management literature presented in Chapter 2: the emphasis placed on assessment, workload, the separation of assessment from provision, budget devolvement, analysis during assessment, multidisciplinary working, and resource availability. It is expected that at least some of these factors will be present and evident as influencing care management practice in the case study research. Other factors, not previously apparent from the literature, may also have an impact on care management practice and data collection will need to be sufficiently open to permit their identification.

One influencing factor that does not appear to have been taken into account before in the care management literature, yet is evident in the research conducted into individual innovation and creativity, is that of personality. Whilst the present study does not attempt to assess the personality of the participant care managers (there being an insufficient number to warrant such an investigation), the fourth research question attempts to gauge the

opinions of care managers and their managers regarding the 'climate' for innovation. Although it will be difficult to estimate whether an innovative climate does indeed exist in the workplace of the care managers, since numbers are small and a validated 'innovative climate' measure is not used, those care managers who indicate it is feasible to be innovative in their work may actually be 'creative types'. They may be individuals who are well motivated to be innovative partly because they have the necessary creative problem solving skills at their disposal.

Hypotheses

Study 1 is intended to be a provisional, exploratory study of the innovative practice of care management practitioners, the first if its kind. The complexity of the subject matter, and its relative newness, warrant an 'open approach' to the research and interpretation of findings. By this is meant that the research is theory-evolving rather than theory-driven and need not, consequently, be limited by a current paradigm relating to the present subject matter. This stance has been taken because the care management literature appears to have no testable theory of how innovation may occur in care management practice, and no single individual innovation or creativity theory in existence is both sufficiently comprehensive and testable for the current purposes. Nevertheless, insights can be gained from both sets of literature (see Chapters 2 and 3) that can help in the interpretation of findings.

Drawing upon the literature, a number of hypotheses have been generated relating to the present study. These are intended as guides to analysis, rather than as a set of definitive, testable statements derived from theory. Indeed, it could be argued that some of them (*e.g.* Hypothesis 1) are not fully testable on conceptual grounds. Finding plausible answers to the research questions, and achieving the research aims, is more important than the testing of these hypotheses.

Hypothesis 1

Innovative care packages will be the product of innovative care management practice.

Hypothesis 2

Greater use of analytical skills and searches for non-routine solutions will be evidenced in assessment and care planning stages during the construction of innovative, rather than non-innovative, care packages.

Hypothesis 3

Factors influencing innovative care management practice will be the same as, or similar to, those that influence care management practice in general.

Hypothesis 4

Workload, bureaucracy, resource availability, practitioner autonomy, team working, manager/supervisor support, and practitioner motivation will influence innovative care management practice.

Methodology

Case study methodology was used in this first study of innovative care management practice. Descriptions of the characteristics of, and reasons for choosing, this methodology follow.

Case study methodology

"Case study is a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of evidence." (Robson 1997, p52)

This definition indicates that case study is an approach or stance which incorporates a variety of methods of data collection (such as interviewing, observation and textual analysis). It involves the thorough investigation of

the circumstances surrounding a specific event, person or place, maintaining the connection between the *phenomenon* and its context. Case studies are, consequently, well suited to unravelling the compound aspects of a phenomenon, whilst still retaining its links with real life, and are commonly used as a research strategy in the social sciences. Yin (1989), in his comprehensive book on case study design and methods, writes:

> "As a research endeavour, the case study contributes uniquely to our knowledge of individual, organizational, social, and political phenomena. Not surprisingly, the case study has been a common research strategy in psychology, sociology, political science, and planning. Case studies are even found in economics... In all of these situations, *the distinctive need for case studies arises out of the desire to understand complex social phenomena*. In brief, the case study allows an investigation to retain the holistic and meaningful characteristics of real-life events – such as individual life cycles, organizational and managerial processes, neighborhood change, international relations, and the maturation of industries." (p.14; italics added for emphasis)

The *social phenomenon* under investigation in Study 1 was care management, with a particular focus on innovative care management practice. Each of the eight 'cases' studied were instances of care management practice. However, they were not treated as independent 'cases', since up to two could be conducted by a single care manager (one of five), and the care managers, at least originally, all worked for the same employer (a single local authority in North Wales).

Typically, case studies are characterised by small numbers of cases because of the intensity of data collection. This has led to criticism of case study research that such studies have difficulty establishing the generalisability of their findings to relevant populations. Yin (1989) argues that a similar criticism could be levelled at experiments, which also typically rely upon small samples. He adds, that 'scientific facts' are usually the outcome of multiple sets of experiments, where the same phenomenon is replicated under different conditions; a similar, though different, approach can be used with multiple-case studies. Yin (1989) concludes that:

> "..case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes. In this sense, the case study, like the experiment, does not represent a "sample" and the investigator's goal is to expand and generalize theories (analytic generalization) and not to enumerate frequencies (statistical generalization)." (p.21)

Thus, the benefit of case studies is the breadth and depth of data gathered about a small number of cases (or a single case) and that this facilitates theory exploration and development. Case study research is, therefore, ideally suited to the investigation of topics where little or no empirical work has been undertaken previously and where theories are either in their infancy or have not yet been conceived. The subject matter under investigation in this thesis falls within these categories, particularly in regards to the process of innovative care management practice and, to a lesser degree, to the processes involved in individual innovation. Therefore, the use of case study methodology was ideal for the first (pilot) study, when theory development and initial exploration of innovative practice within care management was undertaken.

Other approaches are, of course, suitable for exploratory research of the type that leads to theory building. As mentioned above, experiments may be used for this purpose. However, they require control over behavioural events. Whilst it might be possible to alter the environmental and organizational circumstances of care management practitioners to affect outcomes, as in the PSSRU 'quasi-experiments' (see Chapter 2), the intention of the present research was to investigate how practitioners are applying care management in their 'real world' settings and to examine what 'real world' factors influence everyday care management practice. Manipulation was, therefore, inappropriate.

Surveys, historical and archival research are other types of strategy that might have been chosen because they do not require control over behavioural events (Yin 1989). However, historical research would not have achieved the contemporary perspective required for a study of care management practice, nor would it have enabled 'processes', such as the

process of innovative care management, to be explored unless these had been documented in detail previously (which they had not). Archival analysis, involving the examination of records of events, whist it can be contemporary, would be unlikely to permit the in-depth exploration of process in care management and the relationship between process and influencing factors. A survey would have been contemporary and would have helped to determine relationships between factors, but would not easily have enabled process to be studied nor complexity.

Case study strategy, therefore, seemed the most appropriate for meeting the research aims and exploring the research questions associated with Study 1. Yin (1989) points out that one of the main concerns about the use of the case study approach to research is that the investigation can be conducted without sufficient scientific rigor. To counteract this type of criticism a systematic approach was applied to the collection and analysis of data, and methods were adopted that allowed the author to compare her own interpretation of events with those of the social work care managers and their managers. Details of the samples, methods and procedures are outlined below.

Sample

Care manager sample

As previously indicated, the practice of five social work care managers formed the basis of the study. The care managers chosen specialised in care management for older people and were based in three social services area offices, part of a single North Wales county council (there were eight large counties in Wales at the start of the research).

Care managers working with older people were chosen, rather than those working with other client group specialisms, because older people form the largest group of service users of home-based care packages arranged through social services departments. Also, the type of care management

practice undertaken with older people, as well as with people with physical disabilities, was considered (by the author) more likely to reflect models of care management espoused in community care policy and policy guidance than models, used in Wales, of arranging social care for people with learning difficulties or mental health problems.

Of the three social services office sites, one care manager was based at Site A, three at Site B, and one at Site C. Site B was the divisional office with the greatest number of care managers, so the apparent imbalance was not considered to be a concern. One office was based in a rural location (Site C) and the other two were based in urban locations. However, the latter both served outlying rural areas surrounding the towns in which they were based, so potential service users of these offices could live in urban or rural areas. Each care manager has been given a code in order to help achieve anonymity[1]. This code is used throughout the thesis from this point.

- CM1 was based at Site A
- CM2 was based at Site B
- CM3 was based at Site B
- CM4 was based at Site B
- CM5 was based at Site C

Case sample

Ten cases[1] of older people aged 65 or over were to form the basis of the fieldwork, two from each participating care manager's caseload. Only two cases per care manager were to be chosen for two reasons. Firstly, the author wanted to impinge as little as possible upon each care manager's work schedule. Heavy practitioner workloads appeared to be the norm from earlier research in Wales (*e.g.* Parry-Jones et al. 1998b) and the author felt it would be unethical to demand too much time of individual care managers. Also, care managers may have declined from participating in the study if the

[1] Identities of study participants have been disguised as much as possible in order to achieve anonymity. At times this may mean that distinguishing features such as age, gender, specific job titles or locations have been altered from real life in the text.

time implications were too great, with a risk of erosion of precious direct client work time. Secondly, the author wanted to observe a variety of practitioners in their assessment and care management work. Choosing five care managers with two cases each seemed about right in the time available.

Participant care managers were asked (during the initial telephone conversation) to contact the author when *suitable* cases arose. *Suitable* cases consisted of service users referred to care managers for initial assessment who were likely to receive a home-based care package, rather than residential or nursing home placement. Options for having a variety of care arrangements were thought by the author to be greater in the service user's home than in a residential or nursing home, where most (or all) of the care is usually provided by, the residential or nursing home itself. Care received in the service user's own home might come from a number of sources, such as the social services' own home care service, a private, voluntary or not-for-profit independent agency (or a combination of these), a family carer, a neighbour or a member of a religious or other community organisation. It is the variety of resources and the often complex and multiple needs of individuals in their own homes that make innovative practice both possible and, in many instances, probably essential in the setting up and monitoring of home-based care packages.

The achieved case sample was eight and not ten as originally planned. This occurred despite the care managers raising 20 cases (range 1-7 per care manager) as being potentially suitable for the study. In discussion with the care managers, ten of these cases at first seemed suitable (to the author) and the author did observe the assessments of these ten cases. However, only eight turned out to be appropriate for inclusion in the study. Of the two excluded, the observed (continued) assessment of one indicated that care planning was in an advanced stage and a residential placement was being considered by those involved (the care manager had not appeared to understand the case inclusion criteria for the study, but appeared to do so following the post-observation discussion). The second excluded case was a genuine referral for a care manager initial assessment, but it was apparent

early in the assessment that only short-term care arrangements were required (following discharge from hospital) that need not involve a care manager.

The characteristics of the eight achieved cases are described in more detail in the Study 1 findings chapter (Chapter 6). However, the spread of cases by care manager and site is given below.

- CM1 (Site A) - 2 cases
- CM2 (Site B) - 2 cases
- CM3 (Site B) - 1 case
- CM4 (Site B) - 1 case
- CM5 (Site C) - 2 cases

Manager sample

Three managers were surveyed: the overall service manager and two team leaders/managers. Each study site had a team leader/manager and so, potentially, there were three team managers who could have been surveyed. However, one retired early in the fieldwork and the position was temporarily taken over by the service manager.

Methods

As previously indicated, a range of methods were used in Study 1 to investigate prospectively the care management practice of five social work care managers during the assessment, establishment and reviewing of eight care packages. The methods used with regard to the eight 'cases' were:

- Observation of care manager practice during assessments and reviews
- Discussion of assessments, care planning and care arrangements of each case with the relevant care manager
- Examination of care manager case notes relating to the 8 cases
- Care manager questionnaire about the factors influencing the care management practice of the 8 cases

The first three methods were used in an integrated way to build as complete a picture as possible of the circumstances involved in the care planning of each individual case. The fourth method was used to help confirm, or otherwise, the author's views of the factors pertinent in each case.

Two additional methods were used to gain opinions from care managers and their managers regarding care management practice in general, the feasibility of innovative practice and factors influencing such practice. These methods were:

- Semi-structured interviews with individual care managers
- Manager questionnaires

Observation of care manager practice

The intention was to observe initial assessments of cases which were, from referral information, likely to lead to home-based care packages. Initial assessments were sought to be observed because it was considered much of the care planning work would be conducted during such assessments.

Non-participant observation was the method chosen for assessments. There were two main reasons for this. Firstly, observation was chosen at this stage because it was considered that the information gathering and analytic work conducted during assessment would be vitally important in making decisions about how to meet needs. Thus, if needs were to be met in a non-standard, innovative way the innovative process would begin during initial assessment. Observation would provide an opportunity to witness the interaction between service user and care manager, and between the service user or care manager and any others present during assessment, such as family, carers (informal or formal), and other professionals. It was anticipated that much of the early stages of the care management 'process' could be witnessed through the dialogue and interactions of those participating in the assessment. Secondly, non-participant observation was chosen in particular because the author did not want to interfere with the care manager's

practice, nor the interaction between those concerned with developing a suitable care package who were present during assessment.

Prior to the observation, the author gained provisional information about the circumstances of the service user, and their families or carers if appropriate, from the care manager. This was written down by the author at the time the care manager provided the information, which was usually during a telephone conversation between the two when arrangements were made for the author to attend the assessment. Notes were not taken by the author during the visits because this was felt, by the author, to be potentially distracting to the service user, the care manager and any one else attending the assessment. However, notes were made as soon as possible after visits by the author, usually in the car or, sometimes at the care manager's work base.

The notes contained information about the case, such as whether the person lived alone, or was already receiving assistance from informal or formal care networks, and whether assessments or reviews had been conducted before by the care manager or any other practitioners in regards to community care arrangements. The notes also recorded the care manager's style of interaction with the service user and others, such as whether appropriate listening skills were used; how receptive the care manager appeared to be to the information being provided by the user or others; whether the care manager used clear, unambiguous language; and whether he or she seemed to empathise with the user. The overall process was recorded, too, such that changes from assessment (information gathering and analysis) to care planning were noted.

Observations were also made of the work environments of care managers. In particular, the 'office culture' (the way in which colleagues interacted and their morale) and the overall workload of participant care managers were noted.

An open method of recording was used. That is, the note taking used no formal predetermined framework. Instead, the author was guided in what to record by the research questions and by prior knowledge of care management and individual innovation processes. This method was used in order to allow the development of theory directly from the observations and notes. A predetermined framework was thought to limit the opportunity for theory development, since the framework would have had to have been constructed around prior theory and been less adaptable to the recording of information that did not easily fit theory. Also a predetermined framework would, almost certainly, have been unwieldy, given the complexity of the subject matter, or overly simplified in order to make it manageable. A key aspect of note taking, both of the observations and discussions with care managers, was that the author's provisional analysis could be recorded in addition to 'facts'.

Discussion of assessments, care planning and care arrangements

Discussion of cases began prior to the observed visits, immediately after the observation of practice, and at several points thereafter. The final discussion of a case occurred following the establishment and first review of a care package.

Discussion enabled basic information about a case to be gained by the author from the practitioner (the care manager) leading the assessment and planning process. Discussion was thought likely to help provide additional insight (to the observation) into the assessment and care planning processes. It gave the author the opportunity to probe the practitioner about his or her impressions of a case and, in particular, why certain pathways and decisions were made. It also enabled the practitioner to describe his or her thoughts about alternative scenarios, for instance if a family member decided to become involved in care arrangements or not, what the outcomes might be.

Recording of discussions was similar to that of the observations, in that no set framework was applied. The information and insight gained during discussions were actually added to the hand written notes about the observations. Thus, there was one set of notes for each case, built up over time. This integrated approach enabled the author to build what appeared to be a reasonably complete picture of events, processes and factors influencing practice in a chronological order. This chronicle presented its own structure, which in turn facilitated analysis.

To help keep track of contact with care managers, a care manager "Involvement Schedule" (Appendix 1) was used by the author. In this, note was made of dates of visits and discussions regarding particular cases, of the date of the background interview, and details of any further contacts.

Examination of care manager case notes

To help fill in potentially missing aspects of the case 'picture', care manager case notes were examined following the first review of care packages. They included completed (or often uncompleted) assessment documentation and care plans, the latter a formal means of recording care arrangements for each day of the week. They also included information about previous social care assessments or care arrangements, and how these had been altered in the course of assessment or reviewing.

The participant care managers were very busy people and examining the case notes provided the author with the opportunity to check details of cases with little disruption to the work of the care managers. Any additional information arising from the examination of case notes was written into the author's notes of each case.

Care manager questionnaire

Although the observations, discussions and examination of case notes provided the author with 'pictures' of the processes and circumstances surrounding the development and review of care packages, they were the outcome of the author's own interpretation of events. In order to help confirm, or discount, the author's interpretations of the factors involved in the assessment and care management practice, a tick-box questionnaire was devised for self-completion by the participant care managers. One questionnaire per case was to be completed following first review.

The questionnaire (Appendix 2) consisted of a list of factors that might potentially affect needs-assessment and care planning processes, clustered together under group headings. This questionnaire was developed by the author after observing approximately two-thirds of cases. The list of factors were drawn up from the author's impressions of what factors were involved in assessment and care planning from undertaking the case study research up to that point, reading the literature and from undertaking earlier (non-PhD) research on assessment and care management practice (*e.g.* Parry-Jones 1998; Parry-Jones *et al.* 1998). The group heading factors (with examples of sub-factors) were

- communication *e.g.* of client, carer, own team, own manager
- referral aspects - *e.g.* hospital discharge procedure
- time (for undertaking needs-assessment and care planning)
- documents - *e.g.* social care assessment, financial assessment, care plan
- financial - *e.g.* undertaking financial assessment, ceiling on care costs per client
- local resources - *e.g.* Home Care Service, Day Care
- family dynamics
- disability/health problem/behaviour of client - *e.g.* memory impairment, aggression
- specialist knowledge/skills in regards to specific client groups - provided by *e.g.* self, health professional
- other factors

Care managers were asked to distinguish between needs-assessment and care planning processes and to tick whether each (sub-) factor listed appeared to be present, facilitating (positive) or inhibiting (negative) during assessment and/or care planning. Space was also provided for additional information. Care managers were asked to: "Please tick boxes as appropriate". Additional instructions were given within the body of the questionnaire, such as "time for undertaking each process – if negative factor, state reason for lack of time".

Care manager interviews

Interviews were conducted (in English) with each participant care manager in order to gain insight into the opinions care managers held regarding their care management practice (including innovative practice) in general and the factors influencing that practice. An interview schedule was drawn up by the author, informed by the research questions and the earlier research on assessment and care management practice conducted by the author.

The interview schedule (Appendix 3) covered the following areas:

- community care (CC) – whether the main aims were being achieved locally
- assessment and care management (A&CM) – whether key goals were achievable locally
- process – whether assessment and care planning were considered separate processes; description of assessment and care planning process(es); factors facilitating and hindering assessment and care management
- inter-agency/inter-professional working – local situation
- team – supportiveness of colleagues and manager(s); whether colleagues share aspects of their A&CM work with rest of team; team morale/stress levels; expectations about local government reorganisation (LGR)
- innovative practice – whether interviewee considers self to be innovative during A&CM; examples of innovative practice/care packages; advantages/ disadvantages of being innovative; factors facilitating and hindering innovative practice; whether innovative practice helps achieve aims of CC.

Care managers were also asked, during the interview, for some biographical information, such as:

- length of tenure in post/care manager role
- year qualified as social worker
- size of own care management team
- size of caseload
- number of assessments per month.

Each care manager was interviewed once, in a quiet room away from colleagues. The interviews took place during visits by the author to the care managers' work bases. The author briefed each care manager immediately before the interview about the contents of the interview schedule. The care manager was asked his/her permission to tape record the interview. All gave their permission. The interviews were taped to allow the author to fully engage in listening and asking questions of the interviewee without the distraction of note taking. Interviews lasted between 30 and 40 minutes. First impressions were written down as soon as possible after each interview (out of sight of the care manager), and transcripts were made of each interview. Both the transcripts and the 'first impressions' notes were used during analysis.

Manager questionnaires

A postal questionnaire was devised for self-completion by the care managers' managers (n = 3). It was developed towards the end of the fieldwork, informed by a provisional analysis of the findings as well as the author's prior knowledge of assessment and care management practice. The purpose of the questionnaire (Appendix 4) was to seek the opinions of the managers about assessment and care management practice, about the desirability of innovative care management practice in particular, the ways in which they supported such practice, and factors influencing this practice. Since the author considered that the identification of unmet need could lead to innovative practice, managers were additionally asked how unmet need was dealt with in their organisation. The managers' responses helped to

provide additional contextual information to that given by the care managers themselves. In particular, evidence of a 'climate' or 'culture' that supported the innovative practice of care managers was sought.

The questionnaire consisted of five open-ended questions and one pre-coded (yes/no response) question. These were:

- What do you feel are the main factors that appear to facilitate or impinge upon assessment and care management practice?
- What do you consider the main aims and objectives of assessment and care management to be?
- Do you consider innovative thinking and practice is necessary/desirable (please delete as appropriate) to achieve the aims and objectives of assessment and care management? YES/NO
- If "YES", how do you encourage innovative thinking and practice within your team?
- What factors in particular appear to facilitate or impinge upon innovative practice within your team?
- How is the issue of unmet need dealt with by yourself as Team/Service Manager?

Instructions were given for completion at the front of the questionnaire. The instructions indicated that personal experiences and opinions of assessment and care management practice within their own team were sought, from their perspective as a manager. The instructions continued that the questionnaire had been designed with open ended questions "to enable you to express your opinions and experiences without constraint", and that responses of only a few words were required, but that they could elaborate if wanted. A reassurance was included that: "There are no right or wrong answers as it is your opinions and experiences that count". An estimated time of approximately 15-20 minutes for completion was given and respondents were thanked, in writing, for their participation.

Procedure

The fieldwork was conducted between February and May 1996. Before fieldwork could begin, permission was sought (and gained) from the service manager in one area of a North Wales county. Names of five care managers were also sought and these care managers were contacted by letter and by follow-up telephone call. Four care managers agreed to participate and another name was sought from the service manager. A fifth care manager was, consequently, contacted and agreed to participate.

On the lead up to local government reorganisation, in April 1996, permissions were sought from the relevant service managers in the two new unitary authority areas where the five care managers were to have their work bases.

The procedure with care managers was as follows. Participant care managers were asked to contact the author before undertaking initial assessments of cases who appeared, from referral information, to meet the initial inclusion criteria of potentially requiring home-based care. The author explained to participant care managers that she wished to observe initial assessments of cases likely to require home-based care in order to investigate the processes involved in needs assessment and care planning. The author informed care managers that she could attend assessment visits at short notice. The author also explained how she wanted to interview each participant care manager about factors influencing assessment and care management.

Within a fortnight of the initial contact letter being sent to the care managers, one care manager (CM5) had contacted the author with details of a potentially appropriate assessment visit. An appointment was made with CM5 to interview her prior to the assessment visit. All other care managers were interviewed a few weeks after assessment visits. This was due to the short notice given to the author to attend the first assessment visit with each care manager, there being no time beforehand to conduct the interview. All

interviews were undertaken in a similar manner in every other way (described above).

The author was introduced to the service user and any carers or other professionals present and permission to undertake the observation was sought or confirmed. The author had asked care managers to seek permission of the service users and carers (if appropriate) in advance of the visit, but there was not always time for this beforehand. All service users (and carers) whose assessment visits were observed gave their permission. Observations were conducted as described above.

Discussion occurred with care managers before and after observations. Contact was maintained with the care managers over the course of the fieldwork in order to receive up-dates on the progress of cases. Mainly this was by telephone, but additional visits were also made to view case notes. The viewing of case notes was undertaken after the first review of the home-based care package had occurred. A final discussion was held with the care manager concerned following the first review. It was after this discussion and/or the viewing of case notes that the author stopped taking notes relating to a case. However, additional information on the factors influencing the needs-assessment and care planning processes related to each case was sought via the tick box questionnaire, completed by care managers after the first review. The questionnaires and a Freepost envelope (for return of questionnaire) were handed to care managers during the last visit to them at their work bases. A questionnaire was returned for every case in the study.

The managers of care managers were also asked to complete a questionnaire (see above). Agreement from the managers that they would complete and return the questionnaires was gained prior to their distribution, which was towards the end of the fieldwork with the care managers. They were contacted by telephone about the questionnaire and then sent one, and a Freepost envelope, by post. All three managers returned completed questionnaires.

Analytic methods

Yin (1989) argues that case study researchers should make explicit their general (overall) analytic strategy and the particular analytic techniques they use. A 'general analytic strategy' indicates what should be analysed and why, and an 'analytic technique' is the method chosen for bringing meaning to the data. With reference to Yin (1989), both the general analytic strategy and the analytic techniques of the study are described below. The analytic procedure is then given.

General analytic strategy

Yin (1989) indicates there are two general analytic strategies for case study research: *relying on theoretical propositions* and *developing a case description*. In regards to the latter, he states that:

> "The first and more preferred strategy is to follow the theoretical propositions that led to the case study. The original objectives and design of the case study presumably were based on such propositions, which in turn reflected a set of research questions, reviews of the literature, and new insights. ..the proposition helps to focus attention on certain data and to ignore other data. ..The proposition also helps to organize the entire case study and to define alternative explanations to be examined. Theoretical propositions about causal relations – answers to 'how' and 'why' questions – can be very useful in guiding case study analysis in this manner." (p.106-107)

Yin (1989) suggests that *developing a case description* is a useful analytic strategy if theoretical propositions are not present. He indicates that this strategy is appropriate where the original aim is solely to describe a case, such as to provide insight into the characteristics of a city and its population. However, he also states that even where the main objective of the research is not to provide a case description, the strategy may be adopted to "help identify the appropriate causal links to be analyzed – even quantitatively" (p.108).

The general analytic strategy used in the present case study research was mainly that of the first kind, being based on theoretical propositions (stated earlier). However, cases were also described, both in terms of the characteristics of service users and their situations, and the step by step process of events that constituted the assessment and care planning of each case. This proved useful, as Yin (1989) suggested, in helping to illuminate "causal links", especially between process and influencing factors. In regards to the present research, *developing a case description*, proved to be more of an analytic technique than a general analytic strategy.

Analytic techniques

There are three dominant analytic techniques for case study research, according to Yin (1989): *pattern matching*, *explanation-building*, and *time series*.

Pattern matching involves drawing comparison between empirically-derived patterns and predicted patterns. Yin (1989) suggests that if "patterns coincide, the results can help a case study to strengthen its internal validity" (p.109). In other words, achieving pattern matching would assist supporting the notion that the way in which the study was designed and conducted was suitable for the type of research questions posed.
Explanation-building is a complex form of the pattern-matching technique. Yin (1989) states that 'explaining' a phenomenon "is to stipulate a set of causal links about it" (p.113). He suggests that the final explanation is the outcome of a succession of iterations:

- an initial case is compared with an initial theoretical proposition or statement, which is consequently modified;
- other aspects of the case are compared with the revised formulation, leading to further modification;
- the modified proposition or statement is then compared with other cases, and repeatedly modified;
- the process is repeated for as long as need be.

Yin explains (1989) further about the explanation-building technique:

> "In this sense, the final explanation may not have been fully stipulated at the beginning of a study and therefore differs in this respect from the [other] pattern-matching approaches... Rather, the case study evidence is examined, theoretical propositions are revised, and the evidence is examined once again from a new perspective, in this iterative mode." (p.115)

Such a technique was found to be particularly well suited to the care management case study. Here, initial hypotheses were based on a provisional theoretical stand point, there being no definite theory of innovation in care management practice prior to the study. Exploration of the case data permitted hypothesis development and testing, allowing a tentative theory of innovative practice in care management to be devised.

Time-series analysis is similar to that conducted in experimental and quasi-experimental studies, and can be either simple or complex. The simplest time-series analysis involves examination of data from time points relating to one particular variable. Where the function of more than one variable is of interest, and the interactions between variables, time-series analysis becomes more complex. Time-series analysis is also complex when one is investigating "not merely rising or declining trends, but some rise followed by some decline within the same case" (Yin 1989, p.118). Yin (1989) argues that complex time-series analysis is preferable to simple time-series analysis, since it leads to a more elaborate set of findings (trends), and that matches found between predictions and empirical findings "will produce strong evidence for an initial theoretical proposition" (p.118).

One particular type of time-series analysis is the *analysis of chronologies*. According to Yin (1989), this form of analysis enables the researcher to ascertain causality "because the basic sequence of a cause and its effect cannot be temporally inverted" (p.119). That is, the order of events and their outcomes can be investigated as they actually happen. Through analysis, explanations can be developed for why particular outcomes arose, with processes and influencing factors revealed. This type of (complex) time-

series analysis was used with the present study's data, the research having been designed to enable investigation of the care management process (innovative and non-innovative) and its influencing factors.

Analytic procedure

Analysis was on-going throughout the fieldwork. It began in decisions of selection regarding the type of information that was documented in the field notes, and the way in which this information was recorded. Although a basic format for recording field notes developed early on, the type of questions asked by the author, both to herself during observation and to care managers during discussions, varied by stage of care management process, type of case, and how well the data were answering the research questions. Thus, the procedure involved making sure enough data, in terms of quality and quantity, were collected at the various stages in order to address the research questions, and modifying the underlying explanatory theory in light of the on-going analysis. Consequently, notes contained not only 'factual' information about a case but early interpretations of events.

Provisional analysis of two-thirds of the cases led to development of the care manager 'case' questionnaire, as indicated above. Identification of this as a suitable method for verifying the author's interpretations arose out of the on-going analysis work. The manager's questionnaire was devised toward the end of fieldwork, with items developed directly from the early analytic work.

Following completion of field notes and return of care manager and manager questionnaires, further analysis was undertaken and a summary report written (Appendix 5). This report was sent to study participants for feedback and comment. The idea of requesting comments was to further validate, or otherwise, the author's impressions of the assessment, care management and innovative practice surrounding the eight cases. Comments were only received from one participant, the Service Manager (see copy of letter in Appendix 6). The letter from the Service Manager with the comments indicated it had been circulated to the two Team Managers who had been

surveyed. It was not clear whether they were consulted before the letter was written. The author wrote a letter of response to the comments and queries raised in the letter (see Appendix 7). Writing both the report and the letter of response helped the analytic process of comparison of the findings against the research propositions and the development of explanatory theory.

More in-depth analysis was undertaken during the writing of this thesis. The care management process outlined in the official practitioners' guide (Social Services Inspectorate 1991a) was used as a framework to help guide the analysis of the care management process apparent in the case studies. Factors identified as influencing care management practice (including innovative practice) arose (as categories) out of the analysis of case notes and the questionnaire responses. Similar analytic work was conducted to identify the characteristics of innovative and non-innovative practice. These analyses were informed by the relevant literatures and the author's own insights.

* * *

The next chapter (Chapter 6) describes the care management cases and presents the author's interpretations of the case study data, based on the analytic work. Provisional conclusions from Study 1 are drawn in the following chapter (Chapter 7).

CHAPTER 6 CARE MANAGEMENT AND INNOVATIVE PRACTICE: CHARACTERISTICS AND INFLUENCING FACTORS

Study 1's findings are presented in this chapter in two main ways. Firstly, the characteristics of the cases are described, case-by-case. The case descriptions are drawn from the case notes (written following observations, discussion of individual cases and examination of case documentation) and the responses on the care manager questionnaires about factors influencing individual cases. Secondly, the outcome of the in-depth analysis of the case study data, informed by the findings from all methods used in Study 1, is reported. In regards to the latter, the data were examined in an attempt to answer the four research questions of Study 1, detailed in the previous chapter (Chapter 5). The findings are presented under the following headings:

- Case descriptions
- Assessment and care planning practice
- Innovative practice: facilitating and hindering factors
- Characteristics of innovative and non-innovative practice

Case descriptions

Each case description consists of a summary of the biographical and circumstantial data of that case. The care management process is also outlined for each case. The anonymity of individuals associated with cases is preserved through use of case codes, and the giving of fictional names to service users and their relatives. The author has altered some biographical details of service users and their carers, such as gender, age, health complaints and disabilities, in order to help preserve anonymity[1]. The order

[1] Whilst some of these variables, such as gender, may influence the care planning process, they did not appear to unduly do so for the cases presented. The need to maintain anonymity was considered to be of vital importance and took precedent over an analysis of the care planning process by gender.

in which cases are presented does not necessarily reflect the chronological order in which they occurred.

Case CM1a

'Huw' was a man in his late 70s who had chronic arthritis. He had become a wheel chair user some 15 years earlier and was unable to do many daily living tasks for himself, due to the severity of his impairment. He lived alone in a single storey dwelling with no family nearby, but had a kindly neighbour whom he could call upon in times of need. The house had been adapted for wheel chair use.

Prior to the care manager's assessment, he had already been receiving home care from the local authority's Home Care Service for several years following assessment and care planning by a home care organiser. The service provided included preparation of meals, and help with washing, dressing and undressing. There were three calls a day during the week and two on a weekend. The referral had come for care manager assessment because the Home Care Service could not undertake the additional calls that Huw was requesting.

Table 6.1 Care management procedure for case CM1a

Element/stage	Details
Referral from Home care organiser (HCM)	Package of care already in place; referral due to need for care at time of day when Home Care Service could not cover – private care needed to be purchased
Assessment/review of care package/care planning*	First visit by Care Manager (CM) in client's home; assessment of changing needs and care planning based on extension of original care package – initial assessment document and modified care plan completed following visit; financial aspects of care discussed
Assessment/review of care package*	Second visit by CM; joint review/care planning with the referring home care organiser; occurred following deterioration in health of client; financial aspects of care discussed
OUTCOME (3 weeks after last author visit)	Continued heavy care package with no signs of being able to reduce it

* author present at visits

Table 6.1 presents the care management process, step-by-step, that appeared to occur in this case as conducted by the care manager, CM1. The first visit by the care manager, the 'initial assessment', contained three elements: an assessment of current need, review of the original care package, and care planning. The care planning, in this instance, was tied to the review of the current care package, in that it was a modification of that care package, rather than a completely new set of arrangements.

Review and assessment elements contained information gathering from Huw. The care manager used probing questions during this information gathering stage. However, Huw appeared to want to talk about his problems in his own way, not responding appropriately to the questions asked. For instance, he was asked directly whether his meals were prepared and cooked in his own kitchen or brought in as frozen 'ready meals' to be reheated. Huw responded that he had been unable to eat his midday meals because of a recent change in medication. When the question was put to him again, he repeated this response. Later, when the author asked the care manager about Huw's inappropriate responding, she appeared not to have noticed it. However, the care manager was clearly not well on the day of the initial assessment and may not have been as attentive to detail as she might usually have been.

When the care planning stage was reached, the care manager noticeably switched from this information gathering mode to making suggestions for how the care arrangements could be altered to suit Huw's requirements. The care manager explained that a private agency could be bought in to deliver a cooked meal in the evening, but that the midday Home Care Service call would then cease, although sandwiches could be prepared for lunchtime during the morning call. Financial aspects were discussed, these appearing to influence, in part, the drop of the midday call in exchange for the evening meal call. Huw was already making a contribution to the cost of his care arrangements through the local authorities charging policy. A further call in the day would have meant increased cost to Huw. The care manager

appeared to be particularly concerned about the potential extra costs to Huw, although he did not.

Despite agreeing to the alteration of the care plan, Huw requested that no change be made for a week or two to his present care package, claiming that his change of medication was putting him off his food and so he would not benefit from the altered care arrangements. The care manager indicated she would contact him the following week to see when he would like the new arrangements to begin. An initial assessment document and a modified care plan were completed by the care manager following the visit.

A month later a second visit to Huw occurred, after a deterioration in his health. The author observed this visit, which was attended by the Home care organiser as well as the care manager. In response to his urgent need for greater help (he could no longer transfer himself from the wheelchair to the toilet or his bed, due to loss of strength in his legs), the Home care organiser had put in additional care a week previously. This second visit by the care manager involved reassessment of need and review of the newly changed care package. A hoist had been brought in to help home care assistants to transfer Huw, and 'sleep-ins'[2] occurred every night in addition to the three daily calls provided by the Home Care Service. A district nurse also attended every morning.

Once the new arrangements were clear to the care manager, through discussion with Huw and the Home care organiser, finances were again raised by the care manager. Indeed, both the care manager and the Home care organiser seemed concerned to reduce the cost of the care package and much of the discussion revolved around ways to reduce costs. The care package was over the £300 a week ceiling which the local authority would fund. Huw was paying nearly £100 a week himself, although part of this was made up of an Attendance Allowance payment. Despite suggestions by the

[2] 'Sleep-ins' involve a care assistant staying overnight in a service user's house in order to provide night time assistance, for instance with toileting. The care assistant can sleep when assistance is not required.

care manager and Home care organiser to drop the 'sleep-ins' (Huw only occasionally needed assistance at night), Huw appeared less concerned than they did about the costs (he was paying the extra costs, over and above the £300 ceiling) and indicated he would like the 'sleep-ins' to continue. Since Huw appeared happy with the present arrangements, the care manager and Home care organiser agreed for them to continue. It was left to Huw to contact them again for any further alterations.

Three weeks after the second visit the same care package was in place. The care manager described it as a "heavy package of care", suggesting there was more to it than the 'average' care package. She also expressed the belief that the care package would probably not be reduced in the near future, indicating it was down to Huw, since he was paying the extra costs. She added that she felt the care package was easy to deal with because Huw could clearly articulate his own needs.

Case CM1b

'Glyn' and 'Sara' were a married couple living in a two storey house. 'Glyn', who was in his late 70s, was hospitalised following a stroke. Prior to the stroke he had not been well and, where they used to share household tasks previously, Sara (in her early 80s) now did everything, except the cleaning. The couple had arranged for, and paid, a private agency to clean the house once a week. There were no other formal care or support arrangements.

Referral was made for a care manager assessment by a ward nurse. Initial assessment and care planning had begun during a case conference three days before the assessment visit attended by the author[3]. As Table 6.2 shows, the case conference involved a ward nurse (the referrer), a hospital

[3] The care manager attended the case conference prior to contacting the author to indicate she had found a suitable case for the study. She said she had had very little referral information and it was only when she attended the case conference that it became clear that a home-based package of care was required. She indicated that she tended to arrange residential or nursing home placements more frequently than home-based care packages for individuals returning to the community following a stroke.

occupational therapist and the care manager. Neither Glyn nor his wife were present. The care manager described the case conference as "initial discussions", yet some care equipment, such as a special bed and a hoist, had already been ordered and were soon to arrive at Glyn's house, ready for his discharge. The care management assessment visit was arranged for another day so that Glyn's wife, Sara, would be present.

Table 6.2 Care management procedure for case CM1b

Element	Details
Referral	Hospital discharge case
Assessment/care planning	Multidisciplinary case conference in hospital – care manager (CM), ward nurse and occupational therapist (OT) present
Training of carer pre-care plan implementation	Wife received training in 2-handed hoist useage by OT – to gain skill and assess whether wife physically capable of doing this aspect of care
Continued assessment/care planning*	Visit to service user (wife present) in hospital; discussions also held separately with nursing staff and OT (user, wife and author not present); assessment form and care plan completed following visit
Implementation of care plan	In service user's home following discharge from hospital
Monitoring/alteration of care plan	Monitoring visit a few days after care package begun; agency of paid home care workers contacted CM re. increasing input of care workers (from single-handed to two-handed evening call for hoisting client) – CM consulted with OT re. hoisting - care plan altered temporarily (care package now over weekly budget allowed)
Implementation of altered care plan	
Review	Carer (wife) able to hoist single-handedly in afternoon, so reducing need for one paid carer visit (cost now within budget limit)
Implementation of altered care plan	
OUTCOME (5 weeks after author visit)	As above

* author present at visit

Upon her arrival on the ward the second time, the care manager spoke with the ward nurse who had been present at the case conference. The nurse indicated that all of the care equipment would be delivered to Glyn's house the next day, except for a special mattress where there was going to be a delay of several days. This would hold up Glyn's discharge. The nurse also mentioned that the district nurse who would be involved in Glyn's care when he returned home, had indicated to her that she would like to have a case conference prior to his return home to help decide how best to integrate care. It sounded as though the district nurse would have liked to have been invited to the first case conference, but the ward nurse and the care manager appeared to collude with one another, saying that her presence was not necessary then because of the early nature of discussions.

The visit attended by the author, therefore, appeared to be a 'continued assessment' in a multidisciplinary assessment process, rather than a care manager 'initial assessment'. During the case conference visit, nursing staff had indicated that two-handed calls from home care assistants were, in their opinion, needed to help Glyn out of bed in the morning and back to bed in the evening. When the care manager spoke with Glyn and Sara about these needs, Sara mentioned having had some training with the occupational therapist in how to use the hoist and felt she could manage (with further practice) to transfer Glyn using the equipment with a home care assistant. The care manager indicated that if she was able to do this it would help, since apparently the local authority's Home Care Service would have been unable to provide two care assistants for a morning call. Bringing in a private agency would have increased costs, since they only work in one hour blocks of time.

Nursing staff had also apparently suggested that Glyn go to bed for a couple of hours in the afternoon, although the reasons for this were not clear (the care manager did not follow this up with the nursing staff). There seemed to be an assumption that this was for rest, but both Glyn and Sara indicated that they thought Glyn could rest on a chair or on the sofa. By the end of the assessment visit it was not clear, to the author at least, whether Glyn was

going to go to bed or not during the afternoon. There seemed to be no hurry for a decision because of the anticipated wait of 1 - 1.5 weeks for the special mattress and, anyway, there may have been alterations to the care arrangements when the district nurse became more involved.

Although Glyn's speech had been affected by the stroke he was, nevertheless, able to communicate his preferences. Despite Sara doing most of the talking on behalf of the couple, both Sara and the care manager asked Glyn directly whether he agreed to the care arrangements.

Immediately following the assessment visit, the care manager indicated to the author having reservations about Sara's ability to help with the hoist lifts. She expressed concern that Sara may be putting herself at risk since she was over 80.

Later discussions with the care manager, plus examination of case notes, revealed that assessment and care plan documents were completed shortly after the visit. Glyn had gone home 8 days after the assessment visit with a care package that incorporated three calls a day (to include the afternoon bed transfer). Double-handed morning and evening calls were made possible by combining Home Care Service and private agency home care. Sara had not felt sufficiently competent to conduct the hoisting (with assistance) at these times because both dressing and using the equipment was involved, and had been feeling exhausted from trying (discovered during early monitoring visit by care manager). The care manager indicated that the care package now cost over and above the newly reduced ceiling for home-based care packages of £220, and so only temporary arrangements had been made for the extra care assistant help morning and evening.

The formal first review of the care package was conducted 2.5 weeks after the care package began. It was then deemed possible to remove the afternoon call, but the two-handed morning and evening calls remained. The cost of the care package now came in at just under the local authority's financial ceiling. The care manager expressed an opinion that if Sara was

unable to continue do the shopping, food preparation and other general care of Glyn, then the care package would not be affordable. She felt that it was her involvement as a carer that was really helping to keep Glyn in his own home.

Case CM2a

'Megan' was in her mid 60s and had suffered a stroke two years earlier, which left her with weakness to her left side. She lived at home in a two storey house with her teenage son, but was presently in hospital after a planned amputation of several toes on her right foot, a complication of a lifetime of diabetes. Prior to the hospitalisation she had been in receipt of home care twice a day, for help with getting up, going to bed, and meal preparation. Megan's son and her brother, who lived 16 miles away, did the food shopping and cleaned the house. Whilst the care manager had set up the original care package, it had been monitored by a home care organiser and the case had been closed by the care manager. The referral had come from the Home care organiser, indicating that the Home Care Service would be unable to make the anticipated extra care visits following discharge.

Following a first assessment visit by the care manager to Megan in hospital, a home visit was conducted by the care manager and an occupational therapist (see Table 6.3). The eldest son was present. Whilst Megan had been using a wheelchair since the stroke, wheelchair access around the house was found to be limited. It was thought that Megan's bed would need to be moved downstairs, since she would be unable to walk upstairs. The coal fire would also need to be prepared and lit every morning. The eldest son agreed to do both these things. He also indicated he would check up on his mother every evening. (The youngest son was soon leaving for university and so would not be able to help with regular tasks.) Additional home care calls were required to help with toileting during the day (Megan had difficulty transferring herself because of the amputation and weakness from her stroke). A private agency was approached, and agreed, to provide the additional home care assistance required.

The observed visit by the author was originally planned to be a first review visit to see how well the home-based care package was operating a few days after Megan's discharge. However, the visit observed by the author turned out to be a continued assessment visit at the hospital. Megan had not been discharged because her foot had not been healing properly, some 6 weeks after treatment.

Table 6.3 Care management procedure for case CM2a

Element	Details
Assessment/care planning	"First" visit to client (in hospital); care package was to be extension of one prior to hospital admission 2 months before –service user already known to care manager (CM) (previously involved in setting up care arrangements in home); multidisciplinary assessment input (*e.g.* hospital consultant)
Continued assessment	Home visit by CM and occupational therapist; son present.
Continued assessment/care planning*	This visit was planned as a first review, but health of client did not improve sufficiently to be discharged from hospital; changed circumstances meant reconsideration of needs/care plan - suggestion now of temporary residential care by CM (as opposed to domiciliary care); financial assessment (in part) undertaken; CM practice focused more on pursuading service user to take up offer of temporary residential care than on assessing needs
OUTCOME 1 (2 weeks after author visit)	CM continued to assess circumstances of service user and to consult with medical staff (especially, the consultant) re. appropriateness of residential care - temporary residential care placement resulted; if health improves further, then may get sheltered housing (own house deemed unsuitable by CM) – sheltered housing applied for by CM
OUTCOME 2 (2 months after author visit)	Service user back in hospital as health condition not improving; after further treatment client has expressed wish to return to residential care temporarily; CM still trying to secure sheltered accomodation

* author present at visit

The care manager had spoken recently with the medical consultant in charge, who had expressed the opinion that Megan would not be safe left alone at home at night. In addition to her physical complaints, Megan appeared not to fully appreciate the implications of her current situation and the consultant thought she posed a risk to herself. She was now unable to

stand unassisted yet, whilst in hospital, had repeatedly attempted to so, falling on two occasions. If she needed to go to the toilet during the night, the consultant was concerned that she would fall without assistance. The consultant had said that residential care, at least temporarily whilst her foot continued to heal, would be the best option.

During the assessment, the care manager suggested to Megan that temporary residential care would be a suitable temporary arrangement following discharge from hospital. She explained the financial implications of the local authority's charging policy (that Megan would have to pay full or partial costs, dependent on whether she had savings of over £8,000). Megan seemed to listen to the care manager, but appeared less than keen to discuss her financial situation and became visibly distressed. This may have been because she could not remember her present state of finances, because she was not keen on the idea of residential care and on using her own finances (if she had savings), or because she didn't like the thought of anybody knowing her personal financial situation (the care manager or, indeed, the author). The care manager later described Megan as "awkward" in a discussion with the author. However, it appeared, to the author, that Megan was feeling 'cornered', that is, that she had little option but to accept the residential placement at her own cost.

The care manager did, briefly, talk about the implications of returning home with Megan. However, she did so in a way that presented problems, with very little, if any, mention of solutions. Although the author has classified the visit as continued assessment (with care planning), there was little sign of the assessment of Megan's needs. The care manager, armed with medical opinion, instead spent much effort trying to persuade Megan to go down the residential placement route. Since agreement was clearly not forthcoming from Megan, the care manager indicated she would return the following week.

Follow-up discussions with the care manager by the author indicated that she had continued to seek medical opinion regarding Megan's health, and

that Megan had gone into temporary residential care. Megan had apparently agreed to the temporary placement on the understanding that if the foot healed she could either go home or to sheltered housing. The care manager only at this stage indicated that she had put Megan on a waiting list for sheltered accommodation (with her consent) several months prior to the hospital treatment. Megan had had to self-fund the residential placement because of having substantial savings and, if it became permanent, would have to sell her house to finance the care. However, moving to sheltered housing would not require her to sell her house.

Two months after the author's visit, Megan had returned to hospital as her foot was still not healing. She had expressed a desire to return to residential care temporarily following further treatment. The care manager was continuing to try to secure sheltered housing for Megan.

Case CM2b

'Eileen' and 'Philip' were a married couple living in their own home, with a daughter some 25 miles away. Eileen, who was in her mid 70s, had had a stroke 18 months before. She was unable to speak clearly and physically weak. Philip was in his mid-80s and was finding looking after his wife too much. The care manager had previously arranged a home-based care package for both of them, but prior to implementation of the care package, Philip suddenly became ill and was admitted to hospital by the GP. The GP also admitted Eileen to a GP respite bed in a hospital. Philip was diagnosed as having had a mild stroke. Since their admission, the care manager had visited Eileen, who indicated a desire to return home.

The visit observed by the author (see Table 6.4) was both a continued care manager assessment (the care manager having been involved pre-hospital admission) and a 'new' assessment (the service users' circumstances having changed considerably). Care planning was involved, too, with discussion focusing on how the original (unimplemented) care plan could be modified to take into account the couple's new needs. The original care plan had

Table 6.4 Care management procedure for case CM2b

Element	Details
Assessment/care planning	Visit to home of married couple (both requiring assessment/care arrangements); care manager (CM) discussed circumstances/care planning and financial implications of care arrangements with husband and daughter (wife/mother unable to speak clearly); clients known to CM – CM had set up temporary residential care placement afew years earlier; new package was for joint assistance; daughter signed domiciliary care contract/care plan
Emergency assessment/care planning	Prior to implementation of care plan, husband taken suddenly ill – CM contacted, and arranged temporary care of wife (home care) – GP arrived and referred husband to hospital for medical assessment and wife to GP respite bed in hospital
Assessment	Visit to wife in respite hospital bed – wanted to return home
Continued assessment/new assessment/ care planning*	Visit to husband in hospital to discuss the couple's care arrangements for returning home – daughter appeared no longer involved in assessment/care planning (had not visited either parent since been admitted to hospital); financial implications of care arrangements discussed; CM discussed discharge date and care arrangements with ward staff (not in presence of client); focus of CM discussion with client was on how originally agreed care arrangements might be altered in the light of changed circumstances; original domiciliary care contract signed by daughter was discussed briefly with husband (no further signing needed)
Information giving	Visit to wife in hospital to inform her of new/modified care plan agreed with husband (immediately post-visit to husband)
Implementation of care package	After husband and wife returned home
First review	CM considered care package was working well
OUTCOME (approx. 6 weeks after author visit)	As above

* author present at visit

involved three calls from the Home Care Service, morning, afternoon and early evening, for food preparation, helping Eileen to get washed and dressed, and some household cleaning. During the observed visit the care manager suggested to Philip that a late evening call would be appropriate, to help Eileen to bed. Philip immediately agreed, and the care manager booked a date for review of the care package in her diary, even though neither Philip nor herself knew the actual discharge date. The care manager indicated that she thought it would be in about a week's time.

The care manager went through the entire care arrangements and explained the cost implications (it appeared that the local authority's charging policy had been explained previously). The extra half hour call would apparently cost the couple no extra, since they had already agreed to pay the maximum charge incurred on their last care plan. It was at this point that the care manager left, briefly, in search of a nurse to ask about the discharge date. The care manager mentioned to Philip, upon her return, that no discharge date had been set and that nursing staff were concerned about night cover at home. Should anything happen to Philip, Eileen would not be able to phone for assistance. She suggested installing a Care Line, so that Eileen, or Philip, would be able to call for assistance merely by pressing a button. It was explained that this would cost £2.00 a week. Philip seemed reassured by the idea and agreed to it. The care manager explained she would arrange for someone from the Care Line service to come and discuss the system in detail.

After asking Philip to sign a consent form that permitted those involved in the care to see a copy, the care manager indicated she would go immediately and visit Eileen to tell her what was happening. She also said she would call the hospital in a few days to get a discharge date. The entire observed 'assessment' seemed, to the author, to be more of a care planning and information giving session than an assessment of service user need.

Although Philip and Eileen's daughter had been involved in the assessment for the original care package, and had been responsible for contacting the

care manager after finding her father had become ill, the daughter had not responded to the care manager's recorded phone messages. The daughter had also not visited either parent since their admission to hospital. After the observed assessment, the care manager expressed the opinion to the author that there might be family dynamics problems. She indicated it was safest to assume that the daughter did not want to be involved in the care arrangements in any way. It occurred to the author, however, that the daughter might merely be away on holiday or on a course.

On follow-up, the author found that both Eileen and Philip had been discharged home shortly after the assessment visit and the care package initiated. First review revealed the care package was working well. The care manager even mentioned how she thought that the relationship between husband and wife had improved (previously neither would sit in the same room together, but now they did), with both seemingly happy with the care arrangements.

Case CM3a

'Jane' was in her early 70s and had a history of alcohol dependency and self-neglect. She had been in temporary residential care for the past 12 months. She had moved there after a brief hospital stay following an incident in which she had been found unconscious at her home. She would not wash or look after herself whilst in hospital, but apparently had improved during her residential placement. She had indicated to staff that she wanted to return home and they had made a referral for a care manager assessment.

The care manager first visited Jane in the residential home and then took her on a home visit as part of the assessment process (see Table 6.5). She discovered that Jane's house was in an unsafe condition due to the fact that Jane did not clear anything up. She secured funding to clean the house. A care plan was devised and agreed to by Jane, which included three calls a day by a private home care agency for food preparation and domestic hygiene (*i.e.* household cleaning and laundry service). The care manager

considered, however, that Jane had unmet therapeutic or emotional support needs. Her son had died two years earlier in mysterious circumstances and this appeared to have compounded Jane's alcohol dependency problem. The care manager, however, had been unsuccessful in securing the services of a counselling service.

Table 6.5 Care management procedure for case CM3a

Element	Details
Assessment/ care planning	Service user in temporary residential care (1 year) and wanted to return home; care manager (CM) assessed service user both in residential home and on home visit; prior to service user returning home house was cleaned (was in unsafe condition); some unmet needs identified (CM unable to secure therapeutic/ emotional support); care package devised
Implementation of care plan	Service user able to return home
Continued assessment/monitoring/first review	Due to service user being identified as at high risk, monitoring/continual assessment visits occurred daily over first five weeks after returning home
Review/continued assessment**	Service user refused to let CM and author into house for visit; service user had refused to let home care workers into house previously (earlier that day and during previous day); if home carers denied access for three consecutive days care package would be terminated (in original care plan)
OUTCOME (3 weeks after planned visit by author)	Care plan terminated because of continued refused access of home carers; CM calls at service user's house every now and then to attempt visit – access denied every time; CM to continue to attempt to visit to monitor service user

** author planned visit

Since the care manager was concerned that Jane would be unable to look after herself when back at home, even with the care arrangements, she arranged to conduct monitoring and continued assessment for five weeks following her return home. The care manager was going to visit Jane every

day at first, to see how things went. The planned observed visit was to be one of these review/continued assessment visits[4]. Unfortunately, Jane did not respond to the care manager's requests to open the door. A care assistant arrived at that point and mentioned having access problems yesterday, although Jane had let her in in the late afternoon. She had apparently reverted to her previous binge drinking, was not eating the food prepared for her and was still wearing the same clothes she had been in when she left the residential care home six days earlier. The care manager asked the care assistant to contact her later on, if she could still not get in.

The care manager had had a suspicion something like this might happen and had included a statement on the care plan (which Jane had agreed to) that if care assistants were refused access on three consecutive days then the care package would be terminated. The care manager explained that the local authority cannot afford to pay the private agency for not providing care. She also mentioned not wanting to get in a position where the agency want out of the contract, since it may be difficult to get another agency to agree to do the work. She pointed out that there were no extra financial incentives for agencies to work with difficult clients.

Three weeks after the failed visit, contact with the care manager revealed that the care package had indeed been terminated. However, the care manager indicated that she would personally continue to attempt to visit Jane, but thought that the most likely outcome was some sort of crisis that may lead to sectioning under the Mental Health Act by a psychiatrist.

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[4] This care manager had struggled to find what she considered to be suitable cases for the author's research. During one telephone conversation, the care manager mentioned 'Jane' as a possible case. She indicated she had already done the initial assessment some time ago, but that the care package was shortly to begin and an observed early review/continued assessment visit would be feasible. Since this care manager offered no other suitable cases and the period of fieldwork was nearly at an end, the author decided to include this case.

Case CM4a

'David' was in his mid 80s and had dementia. He had been admitted to hospital following a fall. During the course of his hospital stay his wife, 'Mavis', had moved in with her daughter (David's step-daughter), who lived 12 miles away. Mavis had been David's main carer, but Mavis's daughter was concerned about her mother's health and did not want her to continue to care for David. Mavis suffered from angina and high blood pressure.

The referral had come from another care manager, who had arranged a care package at short notice for an imminent discharge (the Monday following a Friday referral). The case had been passed to the participant care manager because she was the specialist care manager in her team for care management for older people with mental health problems. In discussion with the author, she indicated there was no time to conduct an assessment prior to discharge or to write a care plan. She had to focus on making sure a care package was in place on the day of discharge and made arrangements with a private home care agency following the suggested care plan of her colleague.

The care package included 'sleep-ins' for the first few days, as well as calls during the day, in order to help David adjust to being on his own and to provide more insight into David's needs. The care manager was to meet with the agency care organiser for a first review/continued assessment visit two days after David returned home (see Table 6.6).

The care organiser arrived at David's house prior to the care manager and author. As David had complained of not feeling well, the care organiser had rung his GP. Since David was not feeling well, he had remained in bed, but was sitting upright. The assessment/review took place in David's bedroom, with care manager, care organiser and author present (a care assistant was also in the house, preparing food in the kitchen). The GP arrived towards the end of the visit.

Table 6.6 Care management procedure for case CM4a

Element	Details
Referral	Hospital discharge case – referred on a Friday for a Monday discharge by another care manager (CM)
Care planning	No time for study CM to assess service user prior to discharge, to write up documents (*e.g.* care plan) or get them signed; assessment document written by original CM; care plan arranged with service user and private home care agency prior to discharge
Implementation of care plan	Service user returns home; care put in place for support and continued assessment purposes
Continued assessment/first review*	Visit to service user 2 days post-discharge; agency care organiser present during review with CM; needs/care arrangements discussed with client, but decision making done by CM and care organiser; GP visited for health check during CM visit – care arrangements briefly discussed with GP; service user signed key/access and agency contract documents; visit to wife (carer prior to hospital admission), (step-) daughter and son-in-law at different house (wife being cared for by daughter) to discuss service user's care arrangements and seek information re. financial assessment – carer's section on assessment form completed during visit
Continued implementation of care plan	Included continued assessment element
Revision of care package	Service user found to be at high risk (had fallen/not eaten) – moved to residential care temporarily (family informed)
OUTCOME (3 weeks after author visit)	As above

* author present at visits

During the first 24 hours, the care arrangements had worked as arranged. However, on the second evening the care assistant could not gain access to the house. It appeared that David had gone to bed and was already asleep. The care manager mentioned the problem to David and asked if he would agree to a spare key being made available to the care assistant. The care

manager quickly wrote a statement to that effect for David to sign. However, when she went through the words, David seemed to have forgotten what it was about and so the care manager reminded him. On several more occasions she had to remind him of what was happening. She seemed attuned to David's need for constant reassurance about the situation.

David appeared agitated when the care manager mentioned needing to undertake a financial assessment and wanting to speak to Mavis about this. David appeared to distrust Mavis's family. However, since Mavis had been David's main carer, care arrangements and financial implications would need to be discussed with her. The care manager (and the care organiser) continued to give David reassurances. The care manager seemed particularly skilful in her conversations with David. She appeared caring and interested, yet kept to the matter at hand, moving from reminders and reassurances to discussions of the care arrangements and the financial assessment. The care organiser too appeared caring and conscientious but, in contrast, tended to talk directly to the care manager rather than to David.

When the GP arrived, the care manager and care organiser moved to the lounge to continue their discussions. The care plan was completed there. 'Sleep-ins' were to continue for a further two nights to help with the continued assessment, and three calls a day. On the third day there were to be four calls, with the 'sleep-ins' dropped. However, the care manager explained she would call the care organiser to find out if there were any problems. After the GP had examined David, she said that she had given him painkillers for his knee, and indicated she would call again in a few days time. When the care manager explained that care assistants would be calling on a regular basis, the GP indicated she would not call back unless a request came to do so.

A second stage of the assessment occurred in Mavis's daughter's house, shortly after the visit to David. Present were Mavis, her daughter, her son-in-law, the care manager and the author. It was clear that Mavis's daughter and son-in-law wanted to keep Mavis with them, and that they did not want her to return to her caring role with David. The care manager explained the need to

conduct a financial assessment and to have access to David's pension (which Mavis had been keeping, since she used to collect his pension). The money from the pension would be needed to buy food for David and pay household bills. David's care arrangements were also explained.

The care manager agreed with the family that a small amount of the pension would be left for David as pocket money, and that the rest would be kept in a safe place to pay for bills. The family had indicated that David was prone to giving money away or losing it.

Mavis expressed concern on several occasions for David's wellbeing, but also added that she felt her own health prevented her from caring any longer. The care manager appeared effective at reassuring Mavis that regular and appropriate care arrangements had been made.

On follow-up it appeared that there had been problems. David had been leaving his key in the lock on the inside of the door, meaning the care assistants could not get in using their key. On the first night that David was on his own, he had apparently left the gas cooker on all night and was feeling very ill in the morning when the care assistant came. He had been found on the floor on several occasions and had been incontinent. He was not always eating meals left for him and had been found in a distressed, confused state both during the day and at night, apparently looking for Mavis. He was admitted temporarily, with consent, to the residential home that had been supplying the home care. The family were informed.

Case CM5a

'Gwenda' was in her late 70s and lived alone. She had been in hospital with a chest infection. She was referred to the care manager by another care manager because Gwenda had reported memory problems and confusion (the participant care manager was a specialist care manager of older people with mental health problems). By the time the care manager received the referral Gwenda was already back home.

The participating care manager conducted a first visit to Gwenda three days after she returned home. A community psychiatric nurse, whom she frequently worked with, met her there so that a joint assessment could be undertaken (see Table 6.7). Previously Gwenda had been having a (private) home care assistant to undertake household cleaning (paid for and arranged by Gwenda), and the care assistant was also present. Gwenda and the care assistant agreed that more frequent (twice daily) calls would be made by the care assistant, to help with tasks such as food preparation and lighting the fire. The care manager was to call back in a few days time to see how things were going.

Before the care manager managed a return visit, the care assistant had phoned her, expressing concern over an apparent excessive use of painkillers by Gwenda. A phone call was also received from a concerned neighbour who had, up until a recent argument, been helping out. He expressed the opinion that Gwenda should not be left alone for so long during the day (the care assistant would leave at 1.00pm and not return until the next morning).

The second visit by the care manager was observed by the author[5]. This was a continued assessment visit that involved care planning (modification of the existing care arrangements). The care assistant was present during much of the discussions. The care manager explored issues with Gwenda, such as her current health and consumption of tablets, the arrangement with the care assistant, what she did in between the carer afternoon and morning calls, and what social contacts and activities she had. Gwenda mentioned taking water tablets on a regular basis, saying she used painkillers only very rarely. (The care manager had asked the care assistant to check her use of painkillers every day following their telephone conversation. She indicated to

[5] The care manager did not invite the author to the first visit because she did not want too many people to be present at the initial assessment in Gwenda's home. She had already arranged for the community psychiatric nurse and the care assistant to attend and did not know how confused Gwenda would be by the presence of yet another person (the author).

Table 6.7 Care management procedure for case CM5a

Element	Details
Referral	Referral from another care manager (CM) due to reported memory loss/some confusion (study CM deals with EMI); initial referral to colleague CM was as hospital discharge case
Assessment/care planning	Joint visit by CM and community psychiatric nurse (CPN) 3 days after service user returned home from hospital; service user and paid (private) home carer involved in discussions; service user receiving home care service (self-funded and arranged) prior to hospital admission – additional calls by home carer to be made; financial assessment undertaken
Implementation of modified care plan	
Monitoring	Phone call from a neighbour concerned over length of time during day when service user alone; phone call from paid home carer re. concern over medication useage
Continued assessment/care planning*	Second visit by CM, in response to monitoring phone calls (see above); service user and paid carer involved in discussions; most of discussion appeared to be on identifying needs – some information giving (re. benefits, SSD charging policy) and some discussion on care/suport possibilities (*e.g.* befriending scheme); no alteration to care plan, but CM to call again (continued assessment)
Implementation of care plan/continued assessment	CM and Housing Officer visit to install Care Line for service user (part of orignal care plan) 2 days after previous visit; CM used visit for continued assessment purposes; further continued assessment visits planned by CM
OUTCOME (7-8 weeks after author visit)	Confusional state of client passed (CM put original confusion as down to an infection, which was treated in hospital); care package reduced; CM considering closing case

* author present at visit

the author that people with dementia can be more confused in the evening and at night than during the rest of the day, and that she would call one afternoon or evening to continue the assessment.) The care manager asked Gwenda exactly how she managed with the coal fire, and she indicated the way in which she looked after it when the care assistant was gone. (Later, the care manager expressed concern to the author that Gwenda was at risk of falling into the fire, since she was unstable at times on her feet.) The care manager asked about family, but none were living anywhere nearby, and about what she did with her time. Gwenda indicated that prior to her hospital admission she used to go to Women's Institute meetings on a regular basis, but she had not driven since her return and so was now unable to go.

The conversation then switched to what help or support Gwenda might like, the care manager tactfully prompting her to consider the time in the afternoon and evening when the care assistant was not around. Despite being referred to the care manager because of confusion and memory problems, most of the time Gwenda appeared to respond appropriately. She mentioned being lonely and how she enjoyed the company of the care assistant and her neighbour, when he came. She said the only problem was that they didn't have enough time to stay for long. The care manager indicated that any further care arrangements would cost more money and that a financial assessment would have to be conducted, unless she was prepared to continue to self-fund and/or her savings were over £8,000. Benefits were discussed, and the care manager asked to look at Gwenda's pension book to see if she was in receipt of Attendance Allowance (she didn't seem to know if she was). She said she would bring the relevant benefit forms on her next visit. She indicated that she would call one afternoon, saying it would help break up the day.

Later, the care manager mentioned to the author that she considered a Befriending Scheme would be appropriate, but that none existed locally. She thought she would approach the local Women's Institute, since Gwenda was known there, but would need Gwenda's approval.

Two days after the observed visit, the care manager returned to visit Gwenda in the morning, this time with a Housing Officer. A Care Line was to be installed, part of the original care plan. The care manager indicated she took the opportunity to continue her assessment, observing that Gwenda presented well, as she had done before, but that she was still in her dressing gown late morning. The care manager indicated to the author that she would visit again, and possibly several times, before the assessment was complete. The assessment appeared to be a drawn out process, necessary both to identify unfolding needs and to plan suitable care arrangements.

Seven to eight weeks after the author's visit, the care manager indicated that Gwenda had stopped showing signs of confusion and the care package had been reduced. Gwenda was even driving her car again. She suggested the confusion could have arisen from the infection that Gwenda had received treatment for in hospital. Lacking pre-admission information on Gwenda's mental state, the care manager had only Gwenda's present state to go on. She indicated that she was thinking of closing the case and reiterated the importance of the continued assessment process.

Case CM5b

'John' was in his early 80s and lived alone in a small block of flats. He had dementia and was prone to wandering. His daughter, 'Jolene' lived two streets away and led her own busy life, with young children and a part-time job, but increasingly found her father knocking on the door or calling to her in the street from very early in the morning to late at night. She contacted social services because she felt that outside assistance was needed to help manage the situation with her father.

A provisional visit to Jolene and her father at Jolene's house (see Table 6.8), led the care manager to organise early morning calls by a care assistant to John's flat. These calls were to check John was alright and to encourage him to attend a day centre, just 10 minutes walk away. The aim was partly to ensure that he was cared for (could wash, take a bath, and have meals in the

day centre), and to give Jolene respite from her father during the day. The care manager expressed the view to the author that it would not be long before John would benefit from a residential home placement, but at present John seemed to be coping and strongly objected to the idea of a residential placement.

Table 6.8 Care management procedure for case CM5b

Element	Details
Assessment/care planning	Needs of service user and carer (daughter) taken into account; financial assessment undertaken (with daughter, who looks after service user's finances); benefits advice given (to daughter)
Implementation of care plan	Early morning call by paid home carer to encourage client to attend day care
First review*	Review held at daughter's home (client doesn't always remember appointments); care manager (CM), community psychiatric nurse (CPN), home care organiser, social work student, daughter present (service user arrives part way through discussion); care plan had appeared to be working better than had been expected; need for daily monitoring of client identified – daily log to be completed in day care centre; CPN to monitor/visit client every fortnight; information giving to daughter by CM re. benefits form and characteristics of dementia
Continued implementation of care plan	Monitoring key element of care plan
OUTCOME (2 weeks after author visit)	CM considered care arrangements were working extremely well – long term prediction that service user would end up in residential care (same venue as day care)

* author present at visit

The planned observation visit was a first review of the care package[6]. It took place in Jolene's house because John does not always remember to keep appointments. There were a number of people present: the care manager and author, a community psychiatric nurse, a home care organiser, and a social work student. Despite the large number of people, neither Jolene nor John (when he arrived, mid way through discussions) appeared unsettled.

The care package had been working better than expected. It only took one visit by the care assistant and a lift to the day care centre to start John on a daily pattern of walking to the day care centre. Much of the time John had already got himself up and left for the day centre prior to the care assistant's visit. Since John liked to walk, he often did not stay all day at the day centre, preferring instead to leave after lunch and walk back home. Usually he would call with his daughter on his return walk, and had never, since the care package began, disturbed his daughter early in the morning. More and more frequently he was walking back to the day centre in the evening and staying overnight (it was also a residential home).

The care manager asked John if he would like to move permanently to the care home. Whilst he seemed confused during the other stages of the discussion, he was clear that he did not want to do this. It was agreed that a flexible Care Plan would be produced, which would allow John to continue to go to the centre during the day and to stay at night when he so wished. He would be charged only for the nights he stayed. A daily log would be kept by the centre/care home staff of his attendance, to build a pattern of his movements. The community psychiatric nurse said he would visit every fortnight to monitor John's needs. After the main discussion, the care manager spoke on her own with Jolene to go through benefit forms and provide information about dementia.

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[6] The care manager indicated to the author that the first review would involve an assessment element. She had not invited the author to the initial assessment because she had thought it was going to lead to a residential home placement and not a home-based package of care.

During the review visit the care manager seemed in charge of the discussion, taking it through a series of stages, from talking about the current arrangements, to John's present needs, and the alteration of the care plan. She engaged each participant (bar the author) in the discussion, asking them their opinions, listening and responding appropriately. Jolene was a key participant, who provided information and asked questions about what would happen next. However, John's contribution was limited. Although the care manager asked him directly about his opinion or experiences, on several occasions, he mostly appeared confused by what he was being asked. The care manager did not dwell on his obvious problems, and instead sought information from the other participants. She did, however, attempt to engage John in the dialogue whenever she could.

Later, the care manager indicated to the author that she thought John was probably unaware that there was a care plan. She also mentioned that she found that Jolene did not seem to easily take on board the information she was providing, especially about the characteristics of dementia, and commented that this aspect was hard work.

Two weeks after the review visit, it appeared that the care arrangements, including the monitoring by care staff, were working well. The care manager foresaw that a permanent placement in the residential home would occur.

Assessment and care planning practice

In order to place the innovative (or non-innovative) practice of care managers in context, it is first necessary to gain an understanding of assessment and care management practice in general, and the factors that influence that practice. Findings from all methods used in Study 1 inform this section, which is divided into the following sub-headings:

- assessment and care planning procedure
- factors affecting assessment and care planning practice

Assessment and care planning procedure

This section is informed by the observations, discussions of individual cases and the reviewing of case records. Assessment and care planning procedure refers to the pattern of use of the various tasks of care management by the care managers. In the official practitioners' guide (Social Services Inspectorate 1991a) the care management process includes the following stages or tasks:

- determining the level of assessment (following referral)
- assessing need
- care planning
- implementing the care plan
- monitoring
- reviewing.

The first of these tasks (determining level of assessment) was to begin the process, followed by assessing need. A cyclical process of assessing need, care planning, implementing the care plan, monitoring, reviewing and back to assessing need was to occur. All tasks were observed and/or discussed during the case study research, although not all tasks were observed with every case. The basic cyclical process seems to be a simplification of what actually happens in practice, as evidenced in the processes of each case above. A far more complex procedure appears to occur, with backward loops occurring at various points along the basic cycle and blurred distinctions between core tasks.

The first stage, determining the level of assessment, had typically already been undertaken before referral to the care managers. Referral to a care manager meant a decision had already been made about the need for a care manager assessment, a decision frequently made by duty social workers, hospital social workers or home care organisers. Care managers in the study sites at the time of the fieldwork assessed (or were only supposed to assess) "complex" cases, where client dependency was assumed to be high and a comprehensive package of care likely. A "comprehensive" care package may

involve more than one service provider. Care managers had access to a budget for purchasing independent sector provision and so could purchase and coordinate multi-provider care packages. More straightforward cases, where dependency was viewed as lower, were usually referred directly to the social services Home Care Service. Hospital social workers could also act as "care managers", being able to access a budget to purchase care, but could only arrange packages of care that were due to last a few weeks following discharge from hospital. If longer term packages of care were considered likely, then hospital social workers were supposed to refer to care managers based in area offices.

Thus, due to the screening procedures in place, care managers were unlikely to be the ones making decisions about level of assessment. Indeed, in two of the cases initial assessments were made by either a home care organiser or another care manager pre-referral to the study care managers. In one instance, it appeared to be this assessment (or, rather, a care package review by the home care organiser) that had led to the care manager referral. The case involving referral from another care manager had occurred because the original care manager was leaving the area.

It was not necessarily clear when initial assessments of need had been made. Many cases were already known to the care managers, or to fellow care managers, hospital social workers or home care organisers, and care packages were already in place (or were on hold while the client was in hospital). Referral to the study care managers had occurred because of the recognition (on the part of the referrer) that needs had changed and new or modified (or more complex) care packages were likely to be required. The study care managers would complete assessment documentation as though the client had never been assessed before, but, where care plans had previously been established (four cases), care planning appeared to arise out of the previous care plan rather than out of a complete reassessment of need. Established care arrangements were, thus, built upon and modified in the light of discussion about changed or changing needs and this constituted

the care manager assessment. Assessment of need was, as a consequence, inextricably intertwined with the care planning stage of care management.

Many of the assessment visits observed as part of the study could be classified as "continued assessment visits", whereby assessment of need was combined with monitoring of care packages within the first few days of the client returning home from hospital or residential care. Assessment of need in these instances was also intertwined with care planning, with care plans being "fine tuned", informed through the continued assessment process of identifying less obvious or emerging needs. The distinction between assessment of need and formally reviewing care packages was observed to be blurred during visits to two service users. In one case, care planning had been hasty due to an imminent hospital discharge following referral. The care plan was based upon the referring social worker's initial assessment. The first review of this care package occurred two days following discharge and included a "continued assessment" element. In the other case, the review of a long established care package was combined with the completion of an initial assessment document, in acknowledgement of changing needs and the change over from home care organiser to care manager "management" of the care package.

Factors affecting assessment and care planning practice

The findings from all methods used in Study 1 informed this section. Seven key factor areas influencing assessment and care planning practice were identified:

- care manager assessment and care planning style
- administrative work
- workload and time
- multidisciplinary work
- finances and resources
- service users and carers
- manager, administrative and peer support

Care manager assessment and care planning style

The assessment and care planning style of the five care managers varied considerably. Most seemed very competent at structuring interviews with service users and their relatives or neighbours and in making interviews as brief as possible. They were all experienced practitioners with many years practice behind them, so this was as could have been expected. However, one had a very brief assessment style (possibly due to caseload pressures, though this was not clear) and tended to overlook instances when further probing questions seemed appropriate. Her assessments appeared 'incomplete', in that she did not always pursue a line of questioning begun to gain information she needed for care planning purposes.

The manner in which most of the care managers conducted interviews was generally considerate of the circumstances and wishes of interviewees. Service users and family members were asked their opinions about potential care arrangements. Two practitioners worked with older people with mental health problems and they appeared very skilled at engaging their clients in relevant conversation, reminding and reassuring them of what was going on. Another care manager appeared to be less considerate of users' opinions. Whilst she seemed to want to put together a 'suitable' care package for her clients, she also appeared strongly influenced by her own views of users and their families and, thus, her assessments appeared biased. In one case, she clearly did not agree with the user's wish to go home from hospital and appeared to collude with hospital staff in this respect. She mentioned to the author, following the interview with her client, that she did not want to see the client's son being placed into a position of caring for his relative, despite the fact that he had willingly stated he would undertake some of the care tasks. The user concerned ended up going to a residential home.

Administrative work

Administrative work appears to both facilitate and hinder assessment and care planning. Documents requiring completion by care managers included

social care assessment forms, care plans, financial assessment forms, benefits forms, and contractual documents (between the local authority, agencies and service users or carers). The actual social care assessment and care plan documents, in regard to the individual cases, were seen as a help to assessment and care planning processes by the care managers. They focused the practitioner's mind on key areas, provided a place for structured comment, and formalised agreement between care managers, service users and their families, care assistants and care organisers.

Assessment and care plan forms, however, were not viewed as appropriate in their entirety for all service users. For instance, the structure of the assessment form did not provide sufficient space to record all aspects of cases where individuals had mental health problems, nor was it sufficiently flexible to adapt to new information gathered over a period of time. During interview, one care manager was asked how useful the standard assessment documents were for her particular client group. She replied:

> "Not very, really. We can use certain boxes to actually write, because a lot of work with my clients is judgemental as well, you know is, in my opinion, based on what you can see but you are actually making assumptions on their abilities because there is no other way around it and very often you will see somebody who is functioning extremely well on the surface but you know that underneath there are minor things there which are actually meaning that there is a lot more going on under the surface. That is hard to record."

She continued by explaining the difficulties of sharing the contents of assessment documents with her clients with confusion.

> "It is hard to record anyway because putting things down about people, you are supposed to be filling that document in together but that person says I am perfectly fine, there is nothing wrong with me, or they might actually agree that their memory is not as good as it used to be, but trying to put that degree of impairment in where they actually see it is quite distressing for them and it is a very difficult question really, how to actually do it sensitively and convey the difficulties that you have got."

Completing financial assessment documents and discussion of charging policy appeared to be a barrier to the construction of care plans with users and their families. Although some users and families (case studies) appeared to understand the financial constraints placed upon social services and were willing to supplement care charges, others appeared to feel they had little choice. One service user, a stroke case, became very distressed during discussions that were, presumably, not conducive to her health.

Above all, though, the volume of documents to be completed as part of the care management process was viewed as a major constraint to practice. One care manager commented:

> "..I wish the paperwork was being cut down rather than increasing. That just seems to be increasing all the time, the paperwork that is demanded from us."

Another care manager complained about insufficient time to complete all necessary paperwork:

> "Paperwork. It has been a real headache for me because I just don't have time to do paperwork. I am continually chasing my tail and getting [financial] assessors, relatives, homes, etc., saying we haven't had our money through and whatever because I don't have time to do my paperwork."

Administrative demands and their impact on clients and care managers were acknowledged by all three managers in response to a questionnaire item about what factors facilitated or impinged upon assessment and care management practice. For example:

> "Paperwork impinges on what is often a major life decision."

And:

> "Too much emphasis on financial implications – collection of data, feedback and liaison with financial agencies which impinge on time SW/CM's believe should be spent with clients. Administrative

demands of working to an admin system, a computer system and a financial system that do not seem to 'talk' to each other!"

Workload and time

Insufficient time in general appeared to be a major constraining factor. There were two main sources of time pressure. These were from heavy workloads and having insufficient time for setting up care packages. In regard to the latter, one care manager explained:

> "The thing that's most helpful is if it's going to be care management, if you have the case early on so that you've got time to discuss with the people concerned, to get all the other professionals' opinions and help as well. The worst scenario is when you get referrals, say from [name of hospital], and they want discharging in two days' time and you don't feel you've got the written stuff, you don't present the care plans at the right time, you're rushing phone calls, things like that. The time is important really. The sooner you're involved with somebody who needs a care package the easier it is and the better you feel you've done the job at the end of it."

This care manager continued by commenting about how this makes her and the service user feel:

> "You probably end up with the same sort of care in the end, you just feel hassled and you feel that perhaps the client is hassled. I mean it's nice to be able to actually present them with the care plan before it actually happens so that they've got a timetable of who's coming in when and if you've had to rush it then you haven't had time to do that. I mean the care is probably there and you've probably told them over the phone or something what's happening. Also if you've got time they can usually meet the [home] carers beforehand which is quite important, particularly if it's somebody living by themselves. But again, if you're rushed, you don't have time to do that. You just have to get the care in there and hope for the best."

Several of the care managers during fieldwork mentioned the crisis nature of much of their work, high referral rates and caseloads and about feeling stressed from time pressures. Observations at the care managers' work bases supported this view. They were dealing with cases most of the time the author was around, answering and making phone calls, responding to

requests for information from other care managers and administrative colleagues, and being so busy that it was often difficult for the author to ask questions about cases. One of the care managers visibly looked like she was under considerable strain.

All three of the care managers' managers, when asked what they considered to be the main factors facilitating or impinging upon assessment and care management practice, made comments on their questionnaires about time pressures and high caseloads. For instance:

> "Impinge (*i.e.* problems): High caseloads – no time for lateral thinking. Rushed hospital discharges – pressure on beds."

And:

> "Speed with which assessment/care plans have to be put in place – good locality working can prevent this to a degree but hospital discharges cause concern with regard to appropriate and constructive assessment of need re the time available to do this in. Large caseloads."

Multidisciplinary work

Multidisciplinary work is any joint work between practitioners from different disciplines who may be employed by the same or different organisations. In terms of the case studies, liaison between the care managers and health personnel occurred as part of the assessment and care planning process for the majority of cases and was regarded by care managers as mainly facilitative. Community psychiatric nurses, district nurses, occupational therapists, ward nurses and one general practitioner provided specialist knowledge and assessment skills to enable a more holistic picture of the circumstances of clients to be formed. There seemed to be a sharing of values between the health professionals and the care managers, which facilitated the collaborative climate. However, with three of the cases this sharing of values did not appear to have taken place, resulting in unsatisfactory practice for the care managers concerned.

Two cases involved hasty hospital discharge, leaving the care managers involved little notice to assess and set up care arrangements. In these instances, communication with ward staff was considered by care managers to be more negative than positive.

With an alcohol dependency case, the care manager experienced difficulties in establishing the involvement of a community psychiatric nurse despite the fact that one had been allocated by name to the case. The care manager expressed a belief that the nature of such cases, often typified by aggressive behaviour and/or an unwillingness to progress therapeutically, made them less of a priority than conventional cases of older people with mental health problems (*i.e.* those with dementia). Unfortunately, the domiciliary care arrangements broke down shortly after the person concerned returned from residential care. It is uncertain whether the involvement of a community psychiatric nurse would have therapeutically benefited this person, but perhaps a community psychiatric nurse could have monitored the person's mental health and reinforced the benefits of the care plan.

During interview, though, most of the care managers indicated that multidisciplinary team working was highly valuable. One explained:

> "It's helpful when you work well with other parts of the department, particularly the occupational therapists, if they're working with you. Or the CPNs, if they're working with you I think you work out a better care package than if you're struggling along by yourself. Because they've got a different input, haven't they, which we can't put in and it just makes a better all-round package I think."

Interestingly, none of the care managers' managers picked up on the positive role multidisciplinary working has to assessment and care management practice in their questionnaire responses.

Finances and resources

The type and nature of social care provision varied across cases. In a number of instances, social services domiciliary and respite care facilities were utilised. Generally, the communication and responsiveness to need of staff within these services was regarded favourably by care managers. However, there were instances where their involvement hindered assessment and care planning work. In one particular case some respite care staff failed to either observe or communicate specifics of client behaviour which might have facilitated the fine tuning of care arrangements at an early stage. Perhaps they were not aware of the monitoring potential of their role, or perhaps their knowledge was insufficient to spot possible difficulties before they arose.

There appeared to be a lack of flexibility in meeting needs at particular times of day by the social services own home care service in certain areas. Most care managers overcame this lack of flexibility by combining social services with private agency domiciliary care.

Discussions with private agency care organisers, their responsiveness to crises and their flexibility in meeting needs were regarded highly by care managers. The specialist knowledge of agency care staff dealing with a particular case (individual with dementia) was praised as invaluable during the initial assessment and implementation of the care package. Their identification and rapid communication of problems shortly after the client was discharged home from hospital dramatically reduced risk to the client in the opinion of the care manager.

There was little evidence of use of the voluntary sector. However, voluntary sector support was investigated for an alcohol dependency case but, the care manager indicated, the local organisation that offers alcohol counselling only worked with people under 65.

Other forms of community resources, such as the church, were not evidenced in the care planning of any of the cases. In one instance, however, a neighbour provided information at the assessment stage. Care managers seemed to employ two strategies regarding the potential of community resources: firstly they would only investigate not-for-profit community resources (excluding family members, friends or neighbours who were already providing a degree of support) if the for-profit care sector could not meet all assessed needs; secondly they would only spend a limited amount of time inquiring into not-for-profit community resources. As time is a precious commodity to care managers with heavy caseloads such strategies are understandable, but do not facilitate imaginative and individualised care packaging.

Financing individual packages of care was mentioned as a factor hindering assessment and care planning practice by care managers during interview. One indicated:

> "It is choices, and money, you know, it's getting the funding. ..it's an expensive do really, it really does cost a lot when you start coming into needing care."

She went on to explain the process of going above the ceiling for a care package, which was £300 per week at the time:

> "..we..have to take it back to the manager and discuss it and the reasons why and get sanction from above really.."

Another care manager indicated concern over an anticipated reduction in the ceiling for individual care packages:

> "..if we're going to be limited to at most just over £200, then it cuts out a lot of night care, it cuts out perhaps prolonged periods of care during the day. For example, I've got one lady who needs her husband at home to help her again with going to the toilet. She's wheelchair bound but he needs to get out because he's beginning to get dementia and he needs to go to [name of facility] because that gives him a day out and some sort of stimulation for him. So we have to have the [home] carer in for several hours at a time for the wife. That

> sort of thing is going to be more difficult to do if we're going to be limited to a couple of hundred pounds."

The care managers' managers appeared well aware of the influence on practice, both positive and negative, of finances. For instance:

> "Impinge (*i.e.* problems): Budget never adequate. Complicated charging – DSS and SSD applications should be merged."

And:

> "Social workers having access to budgets and control of purchasing – facilitate."

Service users and carers

Ease of communication with clients and their families appeared to be a particularly important factor in assessment and care planning work. It varied between cases and seemed dependent upon the type of disability or health problem as well as family dynamics. For instance, clients with confusion and/or memory dysfunction, two stroke cases and an alcohol dependency case, appeared to be the least able to communicate effectively about their needs and often seemed unaware of their conditions and the risks to which they exposed themselves. Care managers attempts to involve such clients in assessment and care planning presented them with a dilemma. On the one hand practitioners wished to enable clients to make their own care choices, empowerment being congruous with social work practice and the needs-led approach. On the other hand, policy requires them to take the leading role in decision-making to minimise risk and keep care costs within budgetary ceilings. During interview, one care manager commented:

> "Well my assessments are a little bit different to other people's because of the client group. Other care managers, you know, if I was going to somebody who wasn't an EMI client group person I would give the client choice as far as I could and an informed choice, but because my clients can't have an informed choice because they are not able to, I have to be far more prescriptive than I would if I had clients with generic illnesses and I have to rely a lot on health service recommendations and assessments, etc., and what I am looking at is a lot of the safety aspects because that is paramount in my assessments because quite a lot of my clients say, oh I want to go home, but they are not safe at home.."

Another care manager indicated the difficulties of dealing with families and decisions around how care is financed:

> "I think you have got the practical, the purely practical can and can't do bits of it [assessment and care management] but I think the family dynamics, for instance, and the finances, all these sort of things. ..The finances relating to those relatives who pay, or they are wanting to pay, people who don't pay for services, even if they get the Attendance Allowance.. ..and when you get a case like, when there has been a lot of in-fighting in the family and they don't get on and they have their children and don't want to cooperate with each other then it's more difficult."

Only one of the managers recorded that families and carers influence assessment and care management practice, although she did not provide an illustration of how:

> "Relatives/carers – can impinge or facilitate."

Manager, administrative and peer support

In several cases care managers sought support from their line managers, which was always regarded by the practitioners as facilitating assessment and care planning practice. Administrative staff were acknowledged as helping with the voluminous paperwork, particularly in regard to financial assessment, and with accessing computers, which care managers found time consuming. However, one care manager indicated during interview that there was insufficient administrative support:

> "..I find that we write everything about three times and we have to put stuff on computers, and admin request it in a certain way so you have to go through everything.. ..which we have put on the machines which takes more time. If you had your own admin assistant who knew the processes and had more time they would be able to look through the cases and do a lot of the letters for you, a lot of the forms for you and could take this off you but there is not the admin backup."

In regard to the particular cases studied, no care manager recorded communications with other care managers as being influential in their assessment and care planning work. However, during visits to the work bases of care managers the researcher observed informal discussions between care managers regarding their active cases. These discussions appeared to provide a forum for venting frustrations brought about through direct client work and care planning. Thus, emotional rather than instrumental social support appears to have been sought from colleagues.

None of the care managers' managers, in response to the questionnaire item about what factors facilitated or hindered assessment and care management practice, indicated that support from themselves was important. However, having certain operational arrangements was implied as being beneficial by all of the managers. For instance, one reported:

> "Facilitate: Budget devolved – flexibility. Locality based – knowing resources and other agencies. Team whose main focus is care management with one client group."

Innovative practice: facilitating and hindering factors

The care managers were asked during their individual interviews whether they considered innovative practice feasible in their care management practice and what factors influenced their ability to undertake (or not undertake) innovative practice. Their managers, through a postal questionnaire, were asked (i) about the necessity of innovative thinking and practice to assessment and care management; (ii) how they personally encourage innovative practice and thinking within their team; and (iii) what

factors facilitate or impinge upon innovative practice in their team. Interview and questionnaire responses inform this section.

The following factors appear to influence innovative practice:

- perceptions about feasibility/appropriateness of innovative practice
- time, workload and pressure
- bureaucracy
- community care budgets, resource availability and flexibility of provision
- knowledge, experience and training
- management support and team working

Perceptions about feasibility and appropriateness of innovative practice

Differences of opinion were apparent amongst care managers as to whether innovative practice was feasible and appropriate for them to undertake. Most indicated that they undertook innovative practice, albeit within a climate of various constraints (mainly time, finances and resources). One care manager took the slant that innovative practice referred to service development and that this was not part of the care manager's role. She indicated that another team of social workers in the area were responsible for this:

> "I don't think we have any time at all to develop things like that [innovative practice]. It's supposed to be the work of the community team…
> ..I suppose it's not really in our role, is it? I mean our job is to devise packages of care for people and that's the priority. I suppose, yes, if we had all the time in the world and you could look further. As I say, I don't think you can tag it onto the end of a care management job. I think it needs more organisation and more effort put into organising those sort of services."

Despite this assertion this care manager reflected, when asked to think about responding to individual client needs, that:

> "..it might make us think laterally a bit and tap into what's there, say like making use of church societies or something, which isn't actually within our social services remit, is it?"

Another care manager indicated that innovative practice was impossible because of time constraints:

> "Not really, no. I mean if I had the time to spend with this one [visually impaired] client now that he has got so much that he needs doing, I could spend the next three weeks basically on him and looking and really exploring what I could do with him and I would love to do that but there is no way that you would have that amount of time to spend with one client. Because I always feel that when you come up with these problems there are ways round them, there must be, but unless things are really quite obvious you don't have the time to explore further, if you like, no you don't."

However, in discussing her care management practice regarding a different client (one of the case study clients) it was clear that she thought creatively about how to meet the needs of her clients. Whether she was able to implement her innovative ideas was another matter.

All three managers indicated that they considered innovative thinking and practice to be necessary to achieve the aims and objectives of assessment and care management. When asked what were the aims and objectives of assessment and care management, the managers' lists included:

- that the needs of individuals be identified and responded to according to priority, with reference to eligibility criteria and "to explore their real potential"
- "making good things happen for the client" (such as "independence, secure environment, respect, food, warmth, shelter, etc." or "keeping up neighbourhood links and a 'normal' social environment")
- to plan care "in an agreed and specific manner"
- to work with other agencies to achieve "a joint perspective"
- "ensuring that limited resources are used fairly and consistently and imaginatively", and "to those with greatest need"
- "extending choice and creating new services"
- supporting and developing communities
- "ensuring that SSD is accountable for decisions".

Thus, it is clear that managers believed innovative thinking and practice was an essential element of care management and that even "creating new services" was the (partial) responsibility of care managers (in direct contradiction to a belief held by one of the care managers, as indicated above). Managers acknowledged, however, that care managers would have to operate within the confines of prioritisation policies and limited finances.

Time, workload and felt press*u*re

Time is a factor that influences assessment and care planning practice in general, as reported earlier. In particular it appears to affect the ability of care managers to work innovatively in meeting the needs of their clients. Three of the care managers mentioned this in particular. It appeared to be one of the major barriers to innovative practice. As one of the three put it:

> "It always comes down to time. You do need time to do it and you also need time to think, rather than your day being full and go off and do something. When a thought comes, yes that is a good idea, you need time to actually develop that and that's a bit risky. You don't always have it. It depends on your caseload and the pressures within the existing cases, so it would be nice to have a few more days in a week, but you do your best within that."

Within the above comment the link between time, caseload demand and felt pressure is apparent. This is reinforced by the comments of another care manager:

> "..we have gone through periods up until about nine months ago where we would have periods that we were absolutely rushed off our feet, but then they would be followed by a slack period that would give you some time to gather yourself together again and sort of take stock of what you were doing and perhaps look at things like this [working innovatively with a particular client's support arrangements], but I would say for the last nine months we just haven't had one of those breathing spaces. Now why, none of us can fathom out. I just don't know. And without them the pressure starts to build up then because you just don't feel you get – you just feel you are on a conveyor belt, you are a machine churning out these care plans. I mean I don't feel I am doing a good job at the moment. We are getting bogged down.."

Having insufficient time or, rather, having a lack of respite from caseload demands (over long periods, in the above care manger's opinion) appears to lead to both perceptions of being under pressure and an inability to conduct quality work ("doing a good job"). Thus, the effect of experiencing a heavy workload is twofold: reduced perceived performance and an awareness of felt pressure (stress). The long term impact is described succinctly in the iteration - "We are getting bogged down".

All three managers acknowledged, in their responses to an open-ended item in their questionnaire, that time constraint and high caseloads impinged upon innovative practise within their team. One manager wrote:

> "The time factor. If you have no time then you cannot listen and get to know what a person's needs are. At the heart of the process is listening."

Another commented:

> "1. High caseloads. 2. Having to focus on those with greatest need – not enough scope/money for preventative approach. Too much 'fire fighting'."

This same manager when asked, "How do you encourage innovative thinking within your team?", responded:

> "Trying to manage caseloads to give space for creative work.."

Adding..

> "..(usually not achievable)."

Whilst the managers recognised that time constraints limited the ability of practitioners to be innovative, they did not link felt pressure (or being under stress) with reduced (innovative) performance. Comparing manager and care manager findings suggests that high workload and insufficient time restrict innovative practice. Felt pressure (or stress) may be considered an additional

outcome of unrelenting heavy work demands, rather than as a factor that directly impinges upon innovative performance. However, since neither managers nor care managers were asked to discuss the relationship between perceived stress and innovative practice, the possibility remains that innovative practice could be limited by feelings of stressfulness.

Bureaucracy

Dealing with bureaucracy and undertaking administrative tasks appear to be major constraints, as indicated above, to assessment and care management practice in general. Such activity, in particular, appears to hinder the innovative potential of care managers. Time spent in bureaucratic endeavour meant reduced time for tapping into unconventional or underdeveloped community support for clients. One care manager commented, when asked about innovative or imaginative care management:

> "I think we will all say it's the written work that is the bane of our lives, there is so much of it and now you really need to have it up to date, everything needs to be done, so the pressures of getting that done as well as the pressures of actually doing it [putting together a package of care], they don't always sit easy together, and you are reading such scary things about if it isn't done, the consequences of that, or if you have forgotten to say something or forgotten to do it in a certain way, that you could be laying yourself wide open for a law suit or something, so there are those pressures. I think we have all tended to push them to the back but they are still quite heavy. For instance, the care plan, how that is written up, and the assessment sheet, having all those documents actually completed, so there are different types of tensions within the job. If they are all sort of pulling nicely together and you are balanced in the middle, fine, but if one keeps coming back you've had it and are hung, drawn and quartered."

The reasons for having to record assessments and their outcomes (in the care plan) are clear. Care managers take accountability seriously for fear of legal repercussions. In the above quotation it is also interesting to note that 'tensions' and 'pressure' are referred to again in relation to care management work. Getting the paperwork completed and implementing care arrangements appear to be in conflict. Thus, time constraint appears to impinge again and lead to perceived 'pressure' or 'tension'.

Another care manager described an instance where she and her colleagues worked in an innovative way to provide a piece of needed equipment in a hurry for a client, but were reprimanded for not following local authority procedure.

Only one of the managers purposely mentioned administrative work and bureaucracy as impinging upon innovative practice within the team. A key inhibiting factor was, again, time as well as the inherent nature of bureaucratic systems:

> "Time spent on administrative tasks. Frustration with the complexities of the system – especially finances (*e.g.* explaining to the client and family the joint DSS/SSD funding and the application to two separate agencies for support)."

Community care budgets, resource availability and flexibility of provision

Finances and the adequacy and responsiveness of resources were indicated earlier as influencing assessment and care planning in general. Three care managers commented that limited finances and resources mitigated against innovation in care management. One stated:

> "..I think it is very difficult in an organisation to provide, and in a financial climate which is tightening all the time, to be too innovative."

One of the other care managers described the difficulties of meeting individual needs with a budget that has to be spread over many people, and the consequences for individual service users:

> "It's very difficult because we haven't got the resources that we need. It is actually balancing the resources that you've got with the need that's out there.. The ideal is to see what people actually need and to then try to meet that need. Hopefully we are trying to build up resources that reflect the different kinds of needs, but when it comes down to money, which it always does, if you like, that are going to get left out every time. For instance, in this area, if somebody wanted to

> remain at home but needed twenty-four hour care, they just can't because we don't have the facilities for night care at home and the cost is quite prohibitive to actually develop that so we are looking at then that really permanent care is the only way round it."

The same care manager went on by mentioning the difficulties of developing or maintaining sufficient resources for individuals living in (low population) rural areas:

> "We have also got the problem here of such a large rural patch, that to deliver a service to two or three is much more expensive than to deliver to fifty in a town. Travel costs here are a major consideration whereas you wouldn't think about it so much in a town, so that's a very big problem."

Two of the managers reported that innovative practice within their teams was hindered by insufficient finances and resources. For instance:

> "Budget restrictions – no money ring-fenced within team for 'ideas'."

The same manager indicated the particular problems of catering for needs in rural areas:

> "Rural area – not much variety of provision."

Despite the agreement about negative aspects of restricted finances, some care managers also explained that having limited finances was beneficial for innovative practice. They acknowledged that having budgetary ceilings of a certain level (it was £300 per service user/week at the time) helped focus the mind on priority needs and economical and innovative means of meeting them. For example:

> "..with the ceiling [for individual care packages] you do tend to prioritise and to target the need if you have got to work within that certain budget and you do tend to use things like day care which is cheaper. You have to be a bit more imaginative in your package and use other things that are perhaps cheaper than one to one all the time."

However, the wider issue of insufficient finances to develop community services was regarded as impeding innovative practice. Thus, the way in which the overall budget is split appears to favour care planning for some individuals at the expense of developing services for groups of clients or carers.

Some private agency providers of care were praised as being flexible and responsive to need. One care manager stated:

> "Agencies have expanded tremendously now and most of them are quite responsive in terms of what you want to do.."

One manager indicated that they encourage innovative practice by supporting their staff to work in conjunction with voluntary providers, in recognition of the inability of the local authority to meet all needs:

> "Encouraging work with voluntary organisations to meet the needs we can't provide for."

Knowledge, experience and training

One care manager and two managers linked the need to be adequately trained and experienced to innovative practice. The care manager and one of the managers made negative comments, reporting that personal or team training and experience was insufficient.

> "Team members – lack of experience and training in 'community' approach."

> "..I didn't think it [a service user's care arrangements] through obviously because I haven't had enough training with people who are visually impaired."

The other manager was more positive, indicating in their response to the question, "How do you encourage innovative thinking and practice within your team?":

> "To encourage team to complete each assessment on an individual basis – expanding their knowledge base as appropriate and developing a relationship with the client that helps to identify needs specific to them as individuals – a care plan should be a 'partnership' document. Develop a good knowledge of locality and resources available and to be innovative with service provision (budget permitting). On-going support and training to develop SW [social worker] skills in complex area of work."

Building up knowledge of the individual client, of the resources available locally and the skills of social workers in general were recognised as important for innovative practice by this manager.

Management support and team working

Management support and team working, as reported earlier, appeared to facilitate assessment and care planning practice in general. These factors appeared to particularly influence innovative care management practice. The importance of having a work climate or culture which supported innovative practice was apparent from the comments of two of the care managers and all three managers. One manager wrote:

> "Facilitate – A 'why not' culture for the practice. If SWs [social workers] are given lots of reasons why things should not happen, rather than a culture where effort is put into trying to make things happen, then at least you have the chance of innovation."

A care manager mentioned:

> "I find management is very helpful with that [being able to creative] because you are allowed to be innovative in your job whereas in some counties you are not. So I think a supportive management team.. you can just do things that you think, well, that is going to fit that person.."

Another care manager advocated that team working helped innovative practice. She commented about the multidisciplinary team she works with:

> "..in this area we're quite lucky, we seem to work quite well together. We all know that we have got ownership of certain parts of our job that is exclusively ours but there are lots of areas where we can link in, so

> we are not really precious about things. I don't mind going to somebody else and asking, 'Is there anything that you have got that will help what I am doing?', or the other way round, and that is working well."

One manager mentioned encouraging innovative practice through the support of a social work group:

> "'Practice issues' group of SW's [social workers] meet regularly"

Overall, as indicated previously, all three managers appeared supportive of innovative practice in care management. Whilst three of the care managers reported the existence of factors that facilitated innovative practice, all care managers indicated there were great difficulties in undertaking innovative work. Perhaps this indicates that overall there is little scope for innovative practice in contemporary care management, mainly due to the climate of resource restrictions, heavy caseloads, high administrative demands and resultant insufficient time.

Characteristics of innovative and non-innovative practice

Characteristics of innovative practice, as described here, refer to the distinctive elements of the process or processes of innovative care management practice. These are elements which appear to distinguish innovative from non-innovative practice. However, it should be noted that some aspects of innovative care management practice are similar to those of 'non-innovative' care management practice. Attempts will be made to distinguish between 'innovative' and 'non-innovative' care management practice where appropriate.

All care managers, when interviewed, gave examples of what they classified as innovative practice. In addition, the author classified the observed 'cases' as either examples of mainly innovative or mainly non-innovative practice. These examples will be used to illustrate the characteristics of innovative (and non-innovative) practice. The comments of care managers' managers

are also used as sources of evidence about the characteristics of innovative and non-innovative care management practice.

The following structure is used in this section in line with the author's view of the innovative care management process, which emerged from analysis of the fieldwork:

- identification of needs
- identification of unmet needs
- finding alternatives and implementing ideas
- concluding the innovative process.

Identification of needs

As indicated above (in *Assessment and care planning procedure*), there appears to be a blurring of the core tasks of the care management process when conducted in practice. This fuzziness ought to make it difficult to distinguish the key elements of innovative practice. Despite this, though, the accurate assessment of need can be identified as crucial for innovative practice to occur. Indeed, one reason why care management practice could be deemed to be "non-innovative" is if the assessment of need is incomplete or inaccurate. Two of the managers (of the care managers) highlighted the importance of assessing need to innovative practice. One stated:

> "In my view, people's needs are so diverse that if you are identifying needs your practice is inevitably and necessarily innovative."

The other manager indicated that she encouraged team members, in support of innovative thinking and practice, to assess each service user individually. She stressed the importance of building relationships with service users in order to identify the specific needs of individuals.

The assessment of need during innovative care management practice can be likened to the problem finding, problem recognition or *perceived need for change* elements that have been theorized as spearheading individual innovative practice (Farr & Ford 1990).

The importance of listening to an individual's needs, and the priority an individual places on different needs, is illustrated by the following example of innovative practice given by a care manager during interview with the author.

> "For instance I had this lady last week.. ..she doesn't understand why she can't go home [from hospital], she is not really able to go home physically and her mental problems are over-riding this. ..what she was saying actually was that she wanted to go home because she has got a dog she wanted to go home to and this was the main thing, it was the thrust to go home, so I found a nursing home who will take the dog. She arrived on Thursday, so she is in the nursing home with the dog and she seems quite settled there at the moment.."

Thorough assessment of need, therefore, is not only vital for innovative practice but for "good" care management practice too. This was highlighted by one of the managers:

> "A client has a great love of classical music: one of his needs was to be given the space in a residential setting to listen. This went into a care plan and happened. Is this innovative or just good practice?"

Identification of unmet needs

As indicated above, accurately identifying needs is essential for innovative care management practice. However, prior to finding an alternative idea or option (from standard) for a care plan, a decision must be made that conventional (menu) options do not fully meet the needs of the assessed individual. This decision, in care management terms, can be regarded as the identification of unmet needs. It should be noted, however, that if the care manager finds a satisfactory solution to the identified problem then he/she may not consider that an unmet need ever existed.

There is an added dimension to the identification of needs and unmet needs. As care managers have to work within a climate of resource constraints and eligibility criteria there may be justifiable reasons, in the sense of their employing local authority, of not meeting some identified needs or, indeed, of not identifying them as needs in the first place. They will, thus, not be

considered as *unmet*. The difficulty of identifying what can be considered a *need* or an *unmet need* can be considerably challenging to social care practitioners (Parry-Jones & Soulsby 2001). However, despite this most of the participant care managers indicated, when asked, that they could identify unmet needs. One care manager when questioned about the existence of unmet needs described how she conceptualises a need:

> "It isn't necessarily a need, it may be a want. You have got to differentiate between a need and a want. That is a want rather than a need, isn't it. 'I want to be as I was twenty years ago.' If it is a need, what you need is to be safe, to have a meal in the day, to have.. patients supervised. That kind of thing is the need."

When asked again to consider whether unmet needs existed this same care manager responded:

> "I can deal with most of them."

Another care manager, during discussions about one of the case study cases, mentioned the ideas she had generated in order to meet the needs of the client, but that she was unable to operationalize some of these. She described a process of searching for alternative options, but to no avail. She went on by stating that she had written in the care plan document that some identified needs had been left unmet. During interview, a different care manager described her recording of unmet need information on the care plan document:

> "The back page is all about unmet needs and unmet need may be because the client wants twenty-four hour care at home, you may not think it's necessary or you may not be able to provide it so there's either a difference of opinion or the fact that the service doesn't exist, so that would go down."

The role that unmet need identification plays in the process of innovation is apparent from the comments (below) of one care manager and one of the managers. The care manager indirectly expressed the link between the identification of unmet needs and the decision that innovative practice was

necessary (although she did not consider that it was in her role to undertake the latter):

> "..we can identify them [unmet needs] and I think we've all identified this social isolation as being quite crucial. Also, there is nowhere for younger people suffering from senile dementia but then I think it's for somebody else to take that up to develop because it needs a lot of.. it's a lot of hard work really."

A manager also made this link in response to a question about how unmet need is dealt with:

> "Very unsatisfactory – we have a section within the Care Plan for unmet needs to be logged. They seldom are [recorded] because of uncertainty about the definition of "unmet need" and lack of time to think innovatively. IT system not yet fully operational to use unmet need info and this is not being logged there. Supervision [is] used to tease out unmet need with discussion about suggested solutions."

Finding alternatives and implementing ideas

Once a need (or an unmet need) has been identified and a decision made that conventional care arrangements will be insufficient to meet the need, the search for alternative options may or may not be pursued. If, for instance, the practitioner is feeling time pressured and considers that the majority of the most important needs have been met by conventional provision, he/she may decide that the care plan (for the time being) is sufficient. A non-innovative care package will result and he or she may record the *unmet need* in the appropriate section of the care plan document. If, on the other hand, the practitioner thinks that alternatives must be found to meet important needs, then the innovative process will continue.

One care manager in discussing her innovative practice, indicated that it was important to consider options that will be agreeable to the service user concerned:

> "..so that seems to be the thing you tend to look at, to see if you can find alternatives which are acceptable to the person."

Indeed, once ideas or possible solutions have been generated, the innovative process continues with the practitioner deciding upon the likelihood of those ideas being put into practice. The acceptability and apparent degree of benefit to the service user are, therefore, likely to influence decisions about whether to consider implementing the generated solution. Financial, resource and time implications are also likely to affect such decision making, as are impressions of risk (to service user, carer, practitioner and care staff), and other factors mentioned earlier.

The following is an example of the development and implementation of an innovative care package, one of the case studies (CM5b). It repeats some of the detail provided under the *Case descriptions* section above and provides some additional insights. A more complete picture of circumstances and events is given here to provide a clear illustration of the development and implementation of an innovative care package.

> John was a service user with dementia. He was prone to wandering at any time of the day or night, an occupation that could be considered risky for someone with dementia. He stated he did not want to live in residential care. The care package consisted of a morning call by a home care assistant to check whether John was at home and, if so, to encourage him to attend the nearby day centre. After a few days of this arrangement John started to take himself, unprompted, to the day centre. The home care assistant, finding John not at home, contacted the day centre to find out whether he had made it there. Sometimes he would wander at night to the day centre, which was also a residential home, and stay the night. A flexible arrangement was made, as part of the Care Plan, to allow John to continue to do this. He would be charged an additional fee per week dependent on the number of overnight stays. A daily log of John's patterns of attendance at the centre was completed by staff, to provide further checks of his whereabouts. The local police were given a description of John and who to contact (day centre/residential home staff) should he be found wandering. This was also written into the Care Plan. Thus, John could maintain his place in the community, for the time being, whilst allowing for a degree of (supervised) risk taking. The whole package was developed by the care manager in consultation with the service user (who, the care manager said, had little sense of awareness of his own condition), a close family member (carer) and a community psychiatric nurse.

The practice of another care manager showed signs of being innovative, during one of the case studies, but was thwarted by lack of resources (and a degree of unwillingness on the part of the service user).

> Jane, a client with alcohol dependency, had possibly not come to terms with the death of a close relative. The care manager conceived a mixture of alcohol and bereavement counselling was appropriate. There were no voluntary agencies locally that would undertake such counselling with someone like Jane because she was aged over 65. A community psychiatric nurse had been assigned to her but had not been in touch since Jane's return home from residential care. The care manager indicated she would have liked to have included a (social services) project worker as part of Jane's care package, to provide daily support to her, but such workers were only available for clients under 65 years of age. Jane had been a practising Christian, and the care manager suggested to her that the local priest come and visit her, to talk things over. Unfortunately, there had been a change in priest during her temporary stay in a residential home and she did not want to see the new priest.

Concluding the innovative process

After a care package, whether innovative or not, has been implemented, monitoring and reviewing are important for deciding whether the care package is meeting identified needs and, indeed, whether any further needs warrant attention. It could be said that the innovative process concludes at the point of implementation of innovative solutions, since monitoring and reviewing are elements of care management practice which, in theory, occur with all care packages irrespective of whether they are *innovative* or *non-innovative*. However, the innovative practitioner, during monitoring and review processes, will continue to develop innovative ideas to meet emerging needs. So long as a care package requires overseeing, the innovative practitioner will continue to assess (identify needs/unmet needs), generate ideas and implement them as appropriate. Thus, the innovative process is cyclical, as is the standard model of care management.

CHAPTER 7 INNOVATIVE CARE MANAGEMENT PRACTICE: CONCLUSIONS FROM STUDY 1

There are several main conclusions that can be drawn from Study 1's findings. These have been organised under the following three headings:

- Methodology
- Care management: process and influencing factors in everyday practice
- Innovative care management practice

Methodology

Although the number of cases used in the study is relatively small, they provide a rich and varied source of data and a suitable means of studying the care management process. The methods used specifically for collecting data about the eight cases – the observations, discussions with care managers, examination of case notes, and responses to care manager questionnaires – all served their intended purpose and proved to be complementary in the development of pictures of the circumstances of service users, their carers, and the various stages of assessment and care management. The other methods used – the care manager interviews and questionnaires to managers – helped to develop insight into the factors influencing care management practice, both in general and in relation to innovative practice, and to the opinions held by practitioners and managers about innovative care management practice. The combination of all six methods provided data that enabled the author to draw out and explain the process of innovative care management practice.

Consequently, case study methodology appeared to be both appropriate and successful in eliciting data to explore Study 1's research questions and aims (listed in Chapter 5). However, a number of difficulties were encountered in using the approach in this piece of research. Firstly, meeting the original case study inclusion criteria (where initial assessments of home-based care

packages could be observed) proved to be extremely difficult to apply in practice. Many of the care managers appeared to be conducting assessments with very short notice, or on a crisis basis. Responding quickly meant they frequently did not contact the author before the initial assessment, instead contacting her for a 'continued assessment' visit, or even a first review, when there was more time to organise the visit. Where assessments were observed, these did not necessarily lead to the outcome of a home-based package of care during the course of the fieldwork (as in Case CM2a). Also, early in the fieldwork it became clear that the care managers were not contacting the author with 'suitable' cases, because they were finding it difficult to decide in advance whether a home-based package of care would be required. This was, after all, part of the reason for conducting comprehensive assessments. As a consequence, the author slackened the inclusion criteria (and informed the care managers): continued assessments or review/reassessments were considered to be appropriate, rather than just initial assessments. However, packages of care were still to be anticipated as being home-based. This change to the inclusion criteria enabled more cases to be included in the study, yet, even so, only eight cases were included in the study, rather than the proposed ten. (If the fieldwork had continued for a longer period it was anticipated a further two cases could have been achieved.)

A second difficulty with conducting the study appeared to be the reluctance, on the part of at least one care manager (CM5), to invite the author to the initial assessment of an older person with suspected dementia. The care manager, who appeared very considerate of her clients during observation, indicated not wanting to disturb 'Gwenda' by having a large number of strange people descend on her house (the community psychiatric nurse, a care assistant and the care manager were already planned to be present). However, this same care manager invited an even larger number of people to a first review of a care package of a different individual with dementia, and the individual concerned did not seem distressed at all. This was a slightly different situation, though, since the care manager was already known to the service user and his daughter (the carer).

A disappointment, rather than a difficulty, occurred during the feedback of the study findings to participant care managers and managers – only one person, the most senior manager, responded. It would have helped to test the internal validity of the findings if the care managers, in particular, had provided a response. Their non-response can have any number of meanings. Firstly, they may have known the senior manager was responding and assumed that she would respond for all of them — a sort of 'corporate response'. Secondly, they may have agreed with the findings and did not have any constructive comments to make. Thirdly, they may not have agreed with all the findings yet had insufficient time to respond — their busy work schedules determining other priorities in need of attention.

Ethical issues are important to consider. Although every effort has been made to maintain anonymity in the reporting of findings, due to the small number of participants and the localised nature of the case study research, those participating in the study will possibly be able to identify other participants and findings pertaining to them. Being able to report and reflect on the intricacies of the phenomenon under study is one of the benefits of undertaking case study research. It would be unscientific, and indeed unethical, to report only positive findings. Therefore, what might be considered 'negative' findings are reported also. However, it is important to ensure there will be no negative implications following the reporting of findings for individual participants. Care needs to be taken, in particular, where there is a likely power imbalance between participants, for example practitioners versus line managers or service users versus social services staff as in the present study. Thus, there is potential conflict between reporting findings as found and protecting the interests of participants. It is uncertain whether the right balance was struck in the present study. The lack of participant care manager response to the summary report may have occurred because some of them were unhappy with the potential identification of negative aspects of their practice to management. Future case study research needs to consider ways of providing feedback to participants so that adequate confidentiality is maintained.

Care management: process and influencing factors in everyday practice

Despite the methodological difficulties, the findings appeared to reveal much about everyday care management practice and the factors influencing that practice. These aspects were explored in order to enable comparison between everyday and innovative practice, and between those factors that appear to affect everyday practice and those that the managers and care managers considered affected innovative care management practice.

Whilst the care management procedure conducted during the eight cases by the five participant care managers differed, a pattern of events or stages was discerned across the cases: assessing need, care planning, implementing the care plan, monitoring and reviewing. This appeared to support the care management process model given in the official practitioners' guide (Social Services Inspectorate 1991a). However, the practitioners' guide stage 'determining the level of assessment' appeared to have been conducted by those who made referrals to the care managers, rather than by the care managers themselves. Also, the procedure applied in everyday practice appeared to involve the blurring of boundaries between the key stages. The practitioners' guide model incorporates a cyclical procedure whereby reviewing can lead to an assessment of need to restart the process. Although an overall cyclical procedure was discerned in the cases, feedback loops appear to be present at each stage, indicating the reflexive nature of care management practice. Thus, the everyday care management practice studied was more complex in nature than the official guidance suggests.

Factors appearing to influence everyday care management practice included the volume and nature of administrative work; workload and time pressure; multidisciplinary work; finances and resources; service user and carer characteristics (especially their ability to communicate and understand presenting circumstances); manager and colleague support; and the style or

approach that care managers used to conduct assessments and care planning. The diversity of factors, and the variety of ways in which they can influence practice (for example, administrative documents can both facilitate and hinder practice), appear to present practitioners with an ever changing environment in which they conduct their practice. This may, in part, explain why the care management procedure is not a straightforward process, with an array of factors supporting or mitigating against progress towards the end goal: a finely-tuned care package which meets the user's needs whilst remaining within available resources. The impact of resources upon process and outcome cannot be understated.

Innovative care management practice

Many of the factors that influence everyday care management practice appear also to affect innovative care management practice. Factors in common include time, workload and felt pressure; bureaucracy; finances and resource availability; and management support and team working. Factors that were particularly noted as affecting innovative practice included perceptions of the feasibility or appropriateness of innovative practice; having sufficient knowledge, experience and training (or skills); and flexibility of provision. Considering whether innovative practice is feasible may be a reflection of the perception of a number of elements, namely that the organisational climate is supportive and that being innovative is part of the care management practitioner's role. It may also be the consequence of the practitioner having an underlying disposition towards creativity and innovation. This, in turn, may influence the style or approach a care manager takes during the care management process.

It, therefore, appears that the factors influencing innovative care management practice were the same, or similar, to those that influence care management practice in general, albeit that some differences exist. This finding helps to provide support for the third hypothesis given in Chapter 5: *factors influencing innovative care management practice will be the same as,*

or similar to, those that influence care management practice in general. However, the hypothesis was very general in nature, and did not predict that some differences would be found. As indicated earlier (in Chapter 5), though, the hypotheses were only intended to be guides to analysis. The fact that some differences were found helps to provide evidence for the existence of innovative care management practice, as well as giving insight into the factors influencing such practice.

In regards to specific influencing factors, it was hypothesised that workload, bureaucracy, resource availability, manager/supervisor support, and practitioner motivation, would influence innovative care management practice (Hypothesis 4). Whilst practitioner motivation was not explicitly noted as an influencing factor, all other factors were considered influencers of innovative practice by managers and care managers.

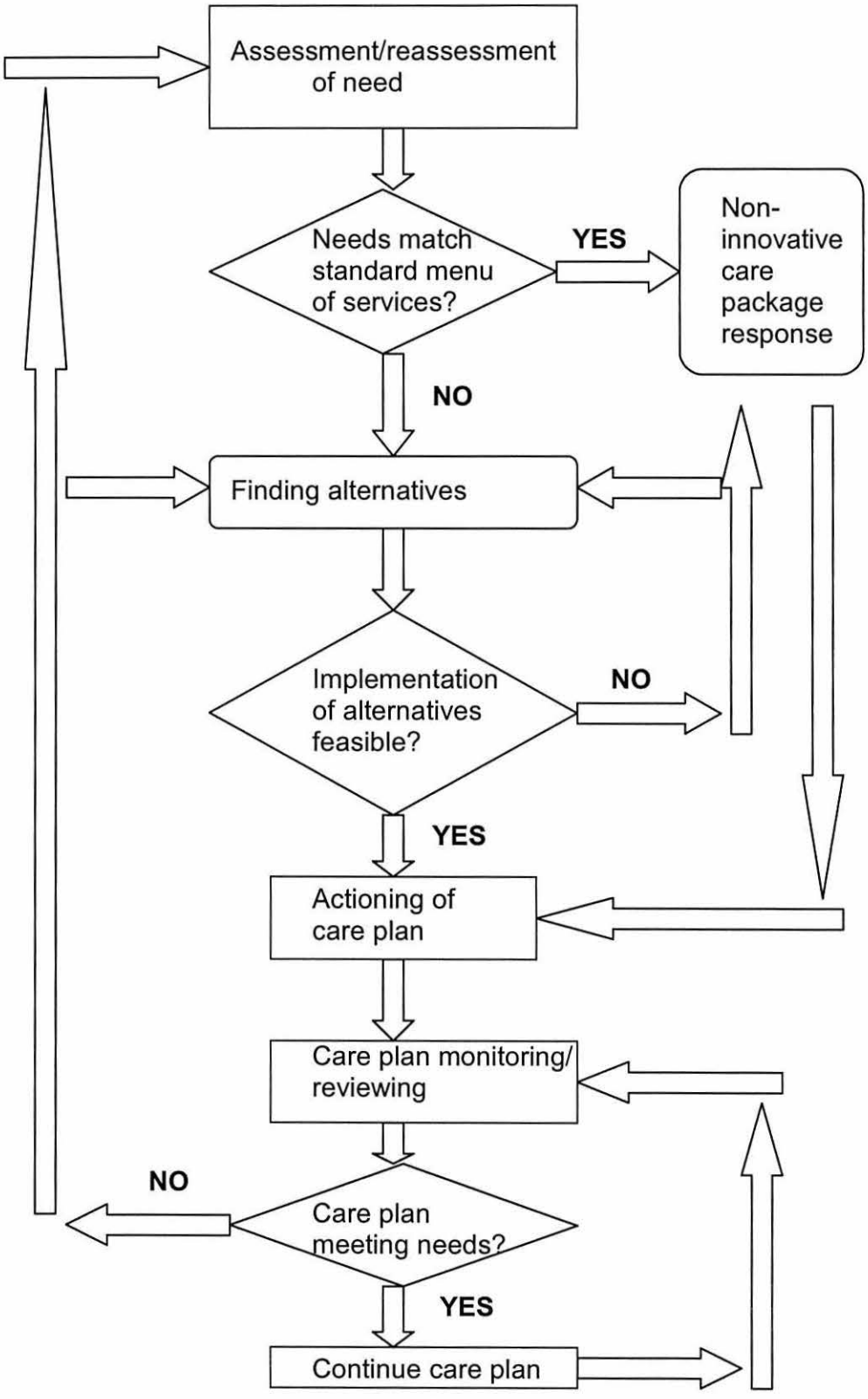
In respect of Hypothesis 1, that innovative care packages would be the product of innovative care management practice, too few of the cases appeared to be innovative to support or discount this hypothesis. Only two of the cases (Case CM3a and Case CM5b) showed signs of innovative practice. Case CM5b (involving 'John') appeared to be an innovative care package and, as such, it necessarily evolved from innovative care management practice. However, Case CM3a (involving 'Jane') showed signs of innovative practice, but resulted in thwarted attempts to implement the innovative solutions. The resulting care package, with home care calls for assistance with food preparation and hygiene, could hardly be considered innovative. Yet, had the innovative solutions (the community counselling and support) been secured, the care package could have been labelled innovative. This case appears to provide evidence of the difficulties of applying an innovative approach to the practice of care management under constraints, such as the lack of appropriate resources.

Whilst only two of the eight cases showed signs of innovative care management practice, the fact that any innovation was observed is, perhaps, remarkable given the small number of cases and the apparent large number of inhibitory factors.

The outcome of the analysis of the process of innovative care management practice appears to provide support for the final hypothesis (Hypothesis 2). This hypothesis asserted that *greater use of analytical skills and searches for non-routine solutions will be evidenced in the assessment and care planning stages during the construction of innovative, rather than non-innovative, care packages*. Analysis was clearly necessary for assessment and care planning, guiding decision making regarding whether needs could be meet by a standard menu of service options or required a search for non-routine solutions.

A flow chart model of the innovative care management process, developed from analysis of Study 1's findings, is presented in Figure 7.1. Assessment (or reassessment) of need begins the process and is followed by a decision about whether standard *menu* service options can adequately meet the assessed needs. If so, a non-innovative care package response will occur, otherwise a search for alternative options begins. This is the first of two crucial stages in the development of innovative care packages. The second crucial stage is deciding whether identified alternatives are feasible. To be feasible an alternative must operate within resource constraints (those of the local authority, the service user or carer, and any care provider or other agency involved), be agreeable to the service user and/or carer, and begin in a reasonable time frame. If an alternative is not feasible, then other alternative options may be sought, or a non-innovative care package response may result. Unmet needs may or may not be recorded.

Figure 7.1 Innovative care management process



Whether care arrangements are deemed to be innovative or not, the next stage in the model is the actioning of the care plan. Monitoring and reviewing follow and lead to a decision regarding whether assessed needs are being adequately met by the care plan. If they are, the care plan continues unmodified (reviewed at a later date), otherwise alternative care arrangements are sought or a reassessment of need occurs. The innovative care management process is, therefore, cyclical with numerous feedback loops. One of the strengths of the model is that it permits both innovative and non-innovative care package responses to result from the innovative care management process. It is also specific about the individual elements of the care management process and how they relate to one another, making it potentially more useful to practitioners and future researchers than more general frameworks of *good* care management, such as that of Orme and Glastonbury (1993; see Chapter 2). However, it does not indicate what factors help to initiate, maintain or hinder innovative (or non-innovative) care management practice.

In summary, innovative practice appears to be the consequence of the interaction of three main elements: the application of a particular procedure (*the innovative process*); the degree of existence of certain potentially influencing factors; and the perception of the feasibility and appropriateness of innovative practice. The latter is particularly important. If a practitioner perceives innovative practice to be unnecessary or the role of someone else, then innovative practice is unlikely to occur. However, care managers have to weigh up the benefits of spending time finding alternative solutions with the fact that a standard, *menu* option may be sufficient to meet the (priority) needs of a service user or carer. If too long is spent pursuing innovative solutions, then the initiation of a care package may be delayed, potentially impacting on the quality of life of the service user or carer concerned. The care arrangements for other service users may be held up, too, if too much time is spent on one particular care package. Therefore, an innovative care package may not necessarily be *good* care management practice. It will only be *good* care management practice if a service user's (or carer's) needs are

appropriately identified and met in an individualised care package that is delivered within a befitting time frame.

* * *

The findings in Study 1 were only ever intended to be a first, exploratory step into the use of individual innovation in care management. Whilst they provide insight into the innovative care management process, and the factors influencing that process, they only do so with a very small number of cases, in one particular region of Wales. In order to further explore the issues and provide evidence that can be more readily generalised to other care management practitioners, another study was conducted – the survey of care management practitioners in Wales. The research questions, hypothesis, methodology and findings of this study, Study 2, are presented in the next part of the thesis.

In particular, Study 2 addresses the frequency of innovative practice in the care management practitioner population; the characteristics of innovative care packages will be investigated further; and, practitioner strain will be explored through perceived stress levels, degree of job discretion and job demand. The relationship between strain and innovative practice will also be examined.

PART III

Occupational Stress, innovative practice and care management: A practitioner survey

CHAPTER 8 IMPLEMENTING STUDY 2

Study 2, as previously mentioned, consisted of a postal survey of care management practitioners in seven unitary authorities across Wales. This was a further exploratory study, building upon and expanding the findings from Study 1.

This chapter presents the research questions and links these to the overall research aims. It is followed by a description of Study 2's hypotheses. The methodology is explored in two ways: the pros and cons of using surveys, and the quantitative-qualitative dimension. Details of the survey sample and instrument, procedure and analytic methods then follow. The section headings used are:

- Research aims, questions and hypotheses
- Methodology
- Survey instrument
- Sample
- Procedure
- Analytic methods

Research aims, questions and hypotheses

The research aims

The objective of Study 2 was to help achieve all three aims of the overall PhD research. These aims were originally given in Chapter 1, but are repeated here to enable the links between them and Study 2's research questions to be clearly discerned. The relationship between Study 1 and 2 is given through a brief discussion of the aims. The aims are:

Aim 1 To investigate how innovative practice in care management is characterised and undertaken by practitioners.

Aim 2 To identify which factors facilitate and which factors constrain innovative practice.

Aim 3 To investigate the relationship between innovative practice and occupational stress.

Whilst the first and second aims had already been explored in Study 1, they were done so with a small number of cases and an even smaller number of care management practitioners. Using a much larger, and more diverse, sample of care management practitioners in Study 2, permitted further exploration of the characteristics of innovative care management practice and the factors which influence that practice. If similar characteristics and influencing factors could be found in Study 2 this would help to provide support for the findings of Study 1. And, whatever was found in Study 2 would be more readily generalizable to the care management practitioner population than the findings of Study 1. However, because Study 2 was a postal survey, the findings would be far less in-depth than Study 1. In particular, case study methodology could lend itself to the investigation of the process of innovative care management practice, whereas the postal survey could not. However, the frequency of innovative practice in a sample of the care management population could be explored with the postal survey, but not with the case studies.

The two studies were, therefore, complementary in regards to the achievement of Aims 1 and 2. However, the second study also aimed to progress empirically-derived knowledge of individual innovative behaviour through an investigation of the relationship between innovative practice and occupational stress (Aim 3). The high levels of occupational stress previously reported in the practitioner groups undertaking care management, led the author to conclude that job stress, as well as innovative practice, could be studied in a care management practitioner sample. In Study 1 there were certainly signs that stress was a factor influencing the work lives of the participant care managers. Indeed, many of the factors which were found, in

Study 1, to hinder innovative care management practice, were factors which have been found elsewhere (see Chapter 4) to be stressful (or strain inducing).

The research questions

The three research aims led to four main research questions for Study 2. The first two questions arose from *Aim 1*, the third question from *Aim 2*, and fourth question from *Aim 3*.

Question 1 How frequently are care management practitioners innovative in their assessment, care planning, monitoring or review work with service users and carers?

Question 2 What do care management practitioners consider to be innovative in their work with service users and carers?

Question 3 What factors facilitate and what hinder innovative practice by care management practitioners?

Question 4 Is there a relationship between occupational stress and innovative practice in care management and, if so, what factors underlie the relationship?

In order to help place innovative care management practice in context, it seems sensible to seek an indication of the frequency of innovative, as opposed to non-innovative, care management practice. This is the initial reason for having *Question 1*. However, having an innovative practice frequency variable can, additionally, assist in the examination of the relationship between innovative practice and occupational stress. To conduct the latter, by using statistical methods, it is necessary to have a quantifiable innovative practice variable. Other aspects of innovative practice, such as degree of innovativeness of examples of innovative care management

practice, are less easily quantifiable (see Chapters 10 and 11 for relevant findings and a discussion).

In Study 1 the author provided, and used, a definition of innovative care management practice based on an understanding of the literature and assumptions about who should benefit from such practice, namely service users and carers (see Chapter 5). *Question 2* was asked in an attempt to discern the characteristics of innovative care management practice from the perspective of care management practitioners themselves. Their responses would help to reinforce, or otherwise, the definition of innovative care management practice applied by the author in Study 1. The practitioners' responses would, therefore, assist in the building of a knowledge base on what can be considered innovative care management practice. This, in turn, may be useful in considering whether the intentions of the community care reforms, such as the meeting of individual service user (and carer) needs, and the promotion of individual choice and self-determination, have come to fruition.

As indicated above, securing further insight into the factors that facilitate or hinder innovative practice (in response to *Question 3*), will help to strengthen the evidence base begun in Study 1. Since the community care reforms, in part, depended on the successful implementation of care management, identifying the influencing factors could assist community care strategy development, both locally and nationally.

In regards to *Question 4*, the rationale for studying the relationship between innovative practice and occupational stress has been given earlier. However, little has been said about how the relationship will be studied. It is intended to do this through the collection and analysis of quantitative data. Variables identified through the literature as affecting both stress levels and individual innovation will be studied and their relationships with reported stress level change and innovation (frequency) examined. For instance, levels of job demands and job discretion (freedom to undertake one's work) in care management and their influence on both reported stress level change and

individual innovation will be investigated. Job demands and job discretion variables are key components of Karasek's (1979) Model of Strain (see Chapter 4). Whilst discretion (freedom of time and decision making) and demands at work have been associated with individual innovation or creativity (or a lack of it, in the case of too many demands and too little discretion), a systematic examination of their relationship with individual innovation does not appear to have occurred (see Chapter 3).

Hypotheses

Study 1 was a provisional, exploratory investigation of innovative care management practice. A 'bottom-up' theory-evolving approach was taken whereby the findings, through analysis, led to the building of theory about the process of innovative care management practice and the factors influencing that practice. The stance taken in Study 2 was somewhat different. Whilst Study 2 was intended to be a further exploration of innovative care management practice, building upon the findings and theoretical work of Study 1, both a 'bottom-up' and a 'top-down' approach were taken. The 'bottom-up' approach involved further gathering of qualitative data about the factors that influence innovative care management practice. Thus, practitioners were to be asked directly about what hindered and what helped their innovative practice (reasons given above). However, since information about influencing factors already existed (from Study 1 and the research literature), pre-coded variables were introduced and used to test theory.

The hypotheses listed below stem out of an appreciation of the current state of relevant theory and knowledge. They also involve a degree of speculation on the part of the author. They are intended to be theory-testing.

Hypothesis 1

Innovative care management practice will be less frequent than non-innovative care management practice.

Hypothesis 2

Reported increased stress levels will be associated with reported low frequency of innovative practice, and vice versa.

Hypothesis 3

The following factors will be associated with reported innovative care management practice: job demands (including workload and administrative work/bureaucracy); job discretion; finances and resource availability/ flexibility; manager and colleague support; knowledge, experience and training. Similar factors will be associated with reported stress level change.

Hypothesis 4

Both increased stress levels and low frequency of innovative practice will be associated with high job demands and low job discretion.

Underlying *Hypothesis 1* are two assumptions. The first assumption is that innovative care management practice is difficult because of the overall constraining nature of the organizational and political environment in which care management practitioners work. The second assumption is that innovation in care management is not always warranted, since the (priority) needs of some service users and their carers are likely to be adequately met by using routine solutions.

Empirical findings underlie the second, third and fourth hypotheses, albeit that these are relatively few and far between (except in regards to occupational stress and its relationship to job demands and job discretion variables, where a considerable amount of empirical research has already been conducted). *Hypothesis 2* tests out findings from the research of others who have attempted to examine the relationship between occupational stress and individual innovation or creativity (see Chapter 4). *Hypothesis 3* directly tests out the findings from Study 1 using a larger and more diverse sample. It also draws upon the job stress literature, where similar variables appear to be associated with job stress as with innovative practice (in care

management). *Hypothesis 4* is both a test of Karasek's (1979) Model of Strain (in regards to the occupational stress variable) and a test of the speculation of the author regarding associations between job demands, job discretion and innovation practice. If associations are found with job demand and job discretion in the predicted direction for both stress level change and innovation frequency variables, then it may be that such variables underlie the relationship (if found) between stress level change and innovation frequency.

Methodology

As already indicated, a postal survey of care management practitioners was conducted. The survey questionnaire used a mixture of qualitative and quantitative means to address the research questions. The characteristics of, and reasons for choosing, survey methodology are described. The use of qualitative and quantitative methodologies is also explained.

Survey methodology

A survey is an approach used to gather usually standardised information from a distinct population or a representative or random sample of that population. Methods typically employed are questionnaires and structured interviews. The aim is commonly to produce profiles which can be generalised to the population as a whole. Therefore, in contrast to case study methodology, the focus tends to be away from the individual towards populations. In so doing, however, the context within which the individual responses were given is often sacrificed.

Surveys are favoured in studies that seek to describe the quantities of people, situations or things that fall within categories of interest. The categories may be known in advance and help formulate the contents of closed questions. Closed questions are questions that ask for a specific response, such as 'yes' or 'no', or the rating of an item on a scale.

Alternatively, categories may arise from the responses to open questions via the technique known as content analysis[1]. Open questions allow respondents to respond freely to the question posed, with the only constraints being time and/or available space on a questionnaire.

Quantification is not necessarily the sole objective of surveys. They can be employed to explore issues, in order to develop theories, or to generate data to test (a priori) hypotheses.

The benefits and pitfalls of using different survey methods were considered. Common survey methods are face-to-face interviews, telephone interviews and postal questionnaires. Benefits of using interviews include being able to secure the sample size. For instance, if 50 people are to be interviewed then more than 50 people can potentially be asked to participate, only stopping when the agreement of 50 people has been gained. With postal surveys, typically, the agreement of potential participants is not sought prior to distributing questionnaires. The method used, rather, is one of sending out a set number of questionnaires, say 200, and leaving it up to targeted individuals to respond or not. Thus, the response rate of postal surveys is frequently low, with under 50% return common (Baruch 1999; Hall & Hall 1996). Also, depending on the subject matter, people may prefer giving verbal responses to a "known" individual, rather than written responses to an "unknown" individual or group, so may be more likely to agree to participate to an interview than to complete a written questionnaire. However, where subject matter may be sensitive in nature, anonymous postal questionnaires may be most appropriate and more likely to secure responses.

Other benefits of interview methods include the fact that both interviewees and interviewers can seek clarification during the exchange of dialogue. If postal questionnaire items are worded ambiguously or are unclear in any way, then the reliability of responses is questionable because respondents

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[1] Content analysis is a method employed to code and quantify qualitative data (further details are provided within the *Analytic methods* section below).

cannot secure clarification of meaning and have to make their own judgements about meaning. However, the time and cost implications of the interview method are usually greater than for postal surveys. Interviews typically require the interviewer to travel to the location of the interviewee and are often lengthy to conduct. Several interviewers may need to be employed to undertake the fieldwork in a short period of time, with resultant salary and training costs. If several interviewers are required it may be difficult to achieve a standard approach to the interviewing, standardising being needed in order to achieve data that can meaningfully be compared. Surveying by interview can, therefore, lead to high research costs and may be impractical if sufficient quality interviewers are not available.

Postal questionnaire surveys, on the other hand, are convenient because they are self-administered. Other than the time and financial costs incurred in preparing for and distributing the questionnaires, little time is spent undertaking the 'fieldwork' and no team of interviewers is required. The data is often easier and less time consuming to analyse, because it is usually limited to the available space on the questionnaire itself. Whilst this may be true, also, for interviews that are based on a standardised questionnaire format, for less structured forms of interviewing analysis work can be immensely time consuming.

A postal questionnaire design was chosen for Phase II of the study (survey of care management practitioners) because of the desire to gather fairly standardised data from a large sample over a short period of time. Whilst it was recognised that a high response rate would be difficult to achieve, given the already time pressured nature of care management (McGrath *et al.* 1997), the offer of anonymity of response and the potential benefits to the respondents in terms of being able to influence policy and practice in Wales was thought sufficient to motivate people to respond.

The qualitative-quantitative dimension

In Study 1, as already mentioned, a qualitative approach to data collection and analysis was taken. In Study 2 both qualitative and quantitative methodologies were employed. Much has been written about the benefits and disadvantages of using either quantitative or qualitative methodologies, and about the different interpretive stances that lie behind, and give reason to, them (*e.g.* Cassell & Symon 1997a; Denzin & Lincoln 1994a; Palys 1997). One of the most contentious issues is whether qualitative research can be used for 'scientific' investigation, which has fuelled a debate in psychology, in particular, for some time (*e.g.* Cooper & Stevenson 1998; Morgan 1998). The debate revolves around whether the use of 'objective' methods ('objective' being associated with quantitative methods only) is necessary for research to claim to be 'scientific'. The natural sciences, such as physics, rely on the standardisation of methods to measure the subject under investigation in order to be able to meet the 'scientific' criteria of reliability (replication). However, philosophers of science (*e.g.* Kuhn 1964) argue that scientists who use such an approach, the positivist tradition, are subjective at the point when they make decisions over whether or not to accept or reject evidence.

Within the social sciences, such as social anthropology and sociology, phenomenological (qualitative) approaches are used and accepted. The phenomenological researcher is concerned with the study of social phenomena and typically takes a constructivist approach, whereby theory is generated (or 'constructed') directly from the data, emerging over the course of the research (Cassell & Symon 1997b). Such an approach requires a degree of 'reflexivity', whereby the researcher is aware of how he/she influences the gaining and interpretation of findings. Fryer (1991) suggests that:

> "Qualitative researchers are characteristically concerned in their research with attempting to accurately describe, decode and interpret the precise meanings to persons of phenomena occurring in their normal social contexts and are typically preoccupied with complexity, authenticity, contextualization, shared subjectivity of researcher and researched and minimization of illusion." (p.3)

Study 1 took a phenomenological, constructivist approach to data collection and interpretation. Whilst Study 2 also involved the collection of qualitative data, and a degree of phenomenological interpretation, the limited contextual information of the individual survey respondents made this type of approach more difficult. However, since the qualitative survey data was building upon the evidence and theory generated in Study 1, the method is valid. However, quantitative data were also collected in the survey. These data were used to test theory and, consequently, a positivist approach was taken. Combining different methods within a single study is known as 'triangulation', and has the benefit of balancing the strengths and weaknesses of the various individual methods and of generating an in-depth understanding of the phenomenon under investigation (Denzin & Lincoln 1994b).

Survey instrument

The questionnaire items that made up Study 2's survey instrument formed part of a larger questionnaire on the assessment and care management practice of care management practitioners (see Appendix 8). The questionnaire was designed as a follow-up to an earlier postal questionnaire distributed to care management practitioners two years earlier (Grant *et al.* 1997; Parry-Jones *et al.* 1998b). Much of the structuring and content of the later questionnaire arose directly from the structure and content of the earlier questionnaire, with some modifications due to (i) knowledge gained from the use of items/areas in the first questionnaire and (ii) the need to focus on specific areas in the second questionnaire. Some of the items used in Study 2 were developed as part of the general assessment and care management study (*e.g.* stress, satisfaction and practice change items). Others were

included specifically for Study 2 of the author's research (*e.g.* the innovative practice and work activities items).

The questionnaire sections used for the present study were:

- demography
- demands and resources for services
- stress level, job satisfaction and practice change
- innovative practice
- work activities

The content and structure of these sections is described in detail below. Most questionnaire items were pre-coded with rating scales. A few items were open ended.

Demography

The following areas of demography (pages 1, 16 & 17 of questionnaire) were used in Study 2's analysis:

- main client group worked with (Item 1)
- full-time/part-time working (Item 3(i))
- caseload size (Item 3(ii))
- profession (Item 27)
- gender (Item 30)
- number of years since qualifying (Item 32)
- employing organisation (item 35)

These items were included in order to help contextualize the other findings of Study 2. They were also used in statistical analyses to ascertain whether differences on main variables (*e.g.* frequency of innovation and stress level change) could be explained in part by biographical variation.

In regards to *main client group*, respondents were asked to indicate the client group or groups that they spend most time with. They were given the following choices:

- Elderly people
- Elderly mentally ill people
- Physically disabled people under 65 years
- Hearing impaired people
- People with terminal illness
- Visually impaired people
- People in hospital
- People with mental health problems
- Adults and/or children with learning disability
- People affected by HIV/AIDS
- Chronically sick people
- People affected by substance misuse

The *caseload size* item was worded as follows:

"For approximately how many cases are you currently responsible?"

The items which asked respondents to indicate their *profession* and the *number of years since receiving their basic professional qualification* used open response boxes. Responses to the *profession* item were coded according to professional group categories *e.g.* social worker, community psychiatric nurse, community nurse, mental handicap nurse, occupational therapist, physiotherapist, home care organiser/manager, other/non-classified.

The items about *gender*, *full-time/part-time working*, and *employing organisation* had specified response categories: "M/F"; "full-time/part-time"; and, "Local authority/NHS Trust/Voluntary agency/Other (please specify)", respectively. There was a sub-question of the *full-time/part-time working* item, which asked those who were part-time to indicate the number of hours they work per week.

Demands and resources for services

Questions 19 and 20 in the questionnaire asked respondents to consider (separately) whether available resources and demands for services had decreased, stayed the same, or increased over the last 12 months. These items were included to gain respondents' impressions of the balance (or imbalance) between demands and resources for service provision during the last year.

An overall view of increasing demands and decreasing (or stable) levels of resources was considered likely given the general trend towards an increasing older population and frozen community care budgets. Whilst responses to the demands and resources items could only reflect the opinions of respondent practitioners and may not, therefore, represent accurately the state of budgets and demand trends, such opinions might influence innovative care management practice. For instance, if demands for care management services are increasing, care management practitioners would, as a consequence, find their time dealing with each case decreasing. Time needed for innovative thinking and implementation may, as a result, be squeezed, and less time consuming menu-driven forms of care planning would then be used more frequently. If, however, increasing demands were matched by increasing resources, then more care management practitioners could be employed. The demand impact on each practitioner would then be lessened and there would be time for innovative practice again.

The availability of resources may also influence innovative practice directly. Having sufficient community care services, or the finances to develop such provision, may enable care management practitioners to think imaginatively in their use of these resources.

Stress level, job satisfaction and practice change

The stress level, job satisfaction and practice change section (pages 14 & 15 in the questionnaire) was based on a similar set of pre-coded items used in a study of hospital and community nurses in North Wales (Nolan *et al.* 1995). It was used in the 1995 care management practitioner survey and again in the present research.

The stress level, job satisfaction and practice change section (present study) consisted of fourteen items all using the same five-point scale. Respondents were required to indicate the degree to which each item had changed over the previous 12 months using the scale:

(1) "decreased a lot"
(2) "decreased a little"
(3) "stayed the same"
(4) "increased a little"
(5) "increased a lot"

The item areas were:

- level of responsibility
- job satisfaction
- workload
- ability to manage workload
- morale of colleagues
- stress level
- feeling valued as an employee
- quality of service able to give
- satisfaction with overall working conditions
- amount of administrative work
- amount of time for direct client contact
- sense of personal achievement gained from work
- confidence in future of community care
- quality of communication with managers

The rating scale and items were identical to those used in the 1995 *Assessment and Care Management Project* questionnaire, although

respondents in 1995 were required to indicate change since the implementation of the community care reforms in April 1993 as opposed to the previous 12 months (Parry-Jones *et al.*1998b). The scale and items were included in the 1997 questionnaire because they had been found useful in the analysis of the 1995 survey data as indicators of stress level, job satisfaction and practice change (see Parry-Jones *et al.* 1998a).

Alongside the stress level change item, the job satisfaction item was considered to provide an approximate indication of strain. The practice change items were included to give an indication of the ways in which practice had changed, in the view of the respondents, over the previous year. Associations between practice change, stress level and job satisfaction change could also be investigated.

Innovative practice

The innovative practice section combined pre-coded and open-ended items which were designed specifically for the present research. The innovative practice section (pages 6 & 7) consisted of six items, half pre-coded and half open-ended.

The first item in the section asked:

> "In your opinion is being innovative a necessary function of your care manager role? Yes/No/Not sure"

This item was included to gauge whether individual care management practitioners held a belief about the necessity of innovative practice to their role. It was included to provide an indication of how important practitioners thought innovative practice was to their daily work. The assumption was that if they held the belief then they would be more likely to claim to be innovative in their work than if they did not. Responses to this item were also considered to give an indication of how care management practitioners interpreted policy and policy guidance on care management. Whilst policy and guidance clearly linked creative or imaginative thinking with care

planning (see Chapter 2), it was not previously known whether care management practitioners had taken this on board.

The second question in the innovative practice section was a frequency item:

> "Approximately how frequently are you able to be innovative whilst planning, implementing or evaluating individual care packages? (please ring appropriate response)
>
> Never
> Occasionally (at least 1 in 50 cases)
> Sometimes (at least 1 in 20 cases)
> Often (at least 1 in 5 cases)
> Always"

Clarification of what "occasionally", "sometimes" and "often" meant in relation to practice was included in brackets in order to help with the reliability of responses across respondents and make the data more meaningful.

The third innovative practice section item was open-ended. A large box was provided for responses to the following request:

> "Please give one example below of your innovative practice whilst planning, implementing or evaluating an individual care package?"

Examples of respondents' innovative practice during care package planning and reviewing were sought to provide insight into the types of practice that respondents themselves viewed as innovative. These examples were also subject to expert ratings of their degree of imaginativeness in an attempt to objectify (through quantification) the amount of imaginativeness employed.

The fourth and fifth innovative practice section items were connected. Respondents were asked:

> "Do you undertake service development work?" Yes/No
>
> "If yes, please give one example."

A large response box was provided for the latter item. The service development items were included because (i) it was not certain how many care management practitioners have a service development remit and (ii) to gain insight into another potential area of innovative practice from the respondent's perspective.

The final item in this section was open-ended and asked:

> "What helps or hinders your innovative practice?"

A large response box was provided which included prompts to provide information on both what "helps" and what "hinders". This item was included because one of the aims of the study was to find out what factors facilitate and what hinder innovative practice.

Work activities

The work activities section (page 13 of the questionnaire) consisted of Karasek's (1979) Activities Descriptions (job demands and job discretion) items and scale. The Activities Descriptions Questionnaire was included because it is a validated measure of perceived job discretion and job demand (see Karasek 1979 for development and validation of the measure). The questionnaire is based on Karasek's job strain model, a model that predicts that job strain occurs when demands are high and discretion is low. The questionnaire has been commonly used in studies of occupational stress (see Sauter *et al.* 1989) and associations have been reported between job discretion and innovative practice (see Chapter 3).

The Activities Descriptions Questionnaire consists of seven job discretion items and seven job demand items and a four-point scale. Respondents are asked to:

> "Please indicate how well each of the descriptions below characterise your daily work activities (please ring as appropriate)
>
> (1) not at all; (2) to some extent; (3) quite a lot; (4) very much indeed".

The scale point "not at all" is given a value of "1"; "to some extent" is given a value of "2"; "quite a lot" has a value of "3"; and "very much indeed" has a value of "4". An overall job discretion score is attained by summing the scores obtained on the seven job discretion items. Similarly, an overall job demand score is achieved by adding the scores obtained on the seven job demand items.

The job discretion items are:

- Allows opportunity to learn new things
- Allows you to make your own decisions
- Creative
- Allows freedom
- Allows you to participate in decision making
- Work requires a high level of skill
- Allows you to have a say in what you do

The job demand items are:

- Have to work very hard
- Lack of time to finish tasks
- Lots of work
- Work gives rise to conflicting demands
- Have to work fast
- Not enough time to do the work
- Excessive amount of time [*i.e.* having too much time]

Sample

All care management practitioners in seven participating unitary authority areas were targeted (N=606). The choice of unitary authority was based on gaining a mix of urban-rural and territorial differences (North, South and Mid Wales). A sample of unitary authorities was chosen, rather than an all-Wales approach, because it was felt to be more realistically achievable and the sample size was considered likely to be sufficient for statistical analyses of the type used with survey data.

Team managers were approached to provide information on the numbers of practitioners they considered to be undertaking an assessment or care management function under the auspices of the NHS and Community Care Act 1990. However, it was ultimately down to the practitioners themselves to decide whether they fulfilled the following criteria, which were located on the inside front cover of the questionnaire:

> "This questionnaire is intended for completion by practitioners with responsibility for any of the following:
>
> (i) comprehensive/full assessments under the NHS and Community Care Act
> (ii) coordinating specialist assessments
> (iii) arranging care packages
> (iv) monitoring care packages
>
> Please note: We acknowledge variation in the meaning of the terms "care management" and "care manager" across Wales. These terms are used in this questionnaire to refer to people involved in "care management", "case management" or "key working"."

One hundred and eighty-one practitioners returned questionnaires, a 30% response rate. The number and proportion of respondents by professional group are shown in Table 8.1.

Table 8.1 Number and proportion of respondents by profession

Profession	Number of respondents	Proportion of respondents (%)
Social workers	112	62
Nurses	44	24
Therapists	8	4
Other/non-classified	17	9

N = 181

Social workers formed by far the largest group (62% of the sample). Nurses formed the next largest group (24%), followed by therapists (4%). The nurse group consisted of community nurses/community mental handicap nurses (n=21) and community psychiatric nurses (n=23). The therapists group consisted of occupational therapists and physiotherapists. Nine percent of the sample were non-professionals (*e.g.* home care officer) or did not provide a response. Similar proportions of these practitioner groups were found in an earlier (1995) survey of care management practitioners in Wales (Grant *et al.* 1997), suggesting the proportions reflect a genuine trend.

All social workers and most of the 'other/non-classified' group (n=15) worked for local authorities. The majority of nurses (93%) worked for NHS trusts, with the remaining (n=3) employed by local authorities. Therapists were approximately evenly distributed in their employer between NHS trusts (n=4) and local authorities (n=3).

The numbers and proportions of male and female respondents by professional group are given in Table 8.2. Proportionally more social workers (77%) than nurses (60%) were female (x^2=4.1, d.f.=1, $p<0.05$). All therapists, and the majority of other/non-classified practitioners, were female.

Table 8.2 Profession by gender

Profession	Males n (%)	Females n (%)
Social workers[a]	26 (23)	86 (77)
Nurses[b]	17 (40)	26 (60)
Therapists[c]	0 (0)	8 (100)
Other/non-classified[d]	3 (20)	12 (80)

[a] N = 112
[b] N = 43
[c] N = 8
[d] N = 15

Procedure

The fieldwork for Study 2 was undertaken between January and December 1997. The early part of the year consisted of the development and piloting of the questionnaire and the gaining of appropriate permissions. Distribution of the questionnaire and follow-up letters occurred during the summer months. Completed questionnaires were received as late as December.

The questionnaire was piloted with a dozen care management practitioners from several unitary authority areas that were not participating in the main survey.

Permission to conduct the full survey in the seven unitary authorities was sought and secured from Directors of Social Services. The Directors of Social Services were asked to provide the name of someone within their department who would facilitate distribution of the questionnaires, which were produced in Welsh and English. Lists of names and contact details of team managers of care management practitioners in adult services[2] were gained from the local authority representative. These team managers were then contacted and asked for information on the number of care management practitioners under their line management. They were asked to distribute the questionnaires. Details of care management practitioners

[2] Only care management practitioners working with adults were surveyed because children and family services did not practice care management at that time.

working in multidisciplinary teams (mental health and learning disabilities fields) were also sought. Team managers were also asked to approach the manager of relevant health service practitioners, with which they appeared to work closely, to see if it would be appropriate and acceptable to distribute questionnaires to those practitioners also.

A small number of team managers declined from distributing questionnaires, despite being notified that permission to survey care management practitioners had been granted from the relevant Director of Social Services. Some indicated their staff were already under high workloads and needed to prioritise their work over the completion of research questionnaires. Others mentioned that they and their staff were dealing with crises and were too busy at that point to become involved in the study. Most team managers did agree to distribute questionnaires, although some did so reservedly, indicating they would be surprised if practitioners within their teams would have the time to complete the questionnaires.

Having gained information about the numbers of care management practitioners to which team managers could distribute questionnaires, the relevant number plus a couple of spare questionnaires were sent to them. Each questionnaire, enclosed within an A4 envelope, was accompanied by a covering letter and a Freepost envelope for the anonymous return of the questionnaire. The covering letter (Appendix 9) explained the aims of the study and the anonymous nature of completing and returning the questionnaire. A follow-up letter was distributed via team managers approximately 4-6 weeks after the questionnaires were first sent out.

Analytic methods

The quantitative and qualitative survey data were coded and analysed using different methods, according to the analytic strategy.

Analytic strategy

The purpose of the analytic strategy was to ensure that analyses were conducted to meet the aims of the study and enable hypotheses to be tested. There were two parts to the overall analytic strategy: a descriptive analytic strategy and a hypothesis testing strategy.

Descriptive analytic strategy

The descriptive analytic strategy involved the use of statistical and qualitative methods to describe the data of relevance to the three aims (and four main research questions) of Study 2. Data were explored in a way that permitted both the characteristics of respondents and their innovative practice and the context in which they conducted their care management practice to become evident. Many demographic and structural variables were subsequently used during hypothesis testing. However, since Study 2 was designed to further explore innovative care management practice (following on from Study 1), some variables were subject to the descriptive analytic strategy only and not involved in hypothesis testing. For example, the examples of innovative practice reported by respondents were described by use of category codes and expert ratings of degree of imaginativeness.

Particular attention was paid to exploring how innovative care management practice appeared to be characterised and undertaken by survey respondents (in fulfilment of *Aim 1*); to identifying respondents' perceptions of the factors that facilitate and constrain their innovative practice (in part fulfilment of *Aim 2*); and to describing occupational stress and innovative practice variables and other variables that potentially influence stress and

innovation outcomes (in part fulfilment of *Aims 2 and 3*). To examine whether there were any major differences in responding between care management practitioners with different professional backgrounds, data were described and compared by main professional group (social work, nursing, occupational/physiotherapy, other) as well as for respondents as a whole.

Hypothesis testing strategy

The hypothesis testing strategy involved the use of any analytic methods that facilitated conclusions to be reached about whether hypotheses were supported or not by the data. Thus, a strict statistical testing of significance model was not always employed.

Testing *Hypothesis 1* involved examination of the frequencies of responses to the innovation frequency item. Since the vast majority of respondents (88%) replied that they were innovative whilst planning implementing or evaluating care packages infrequently (less than one in five cases), the hypothesis that innovative care management practice will be less frequent than non-innovative care management practice was clearly supported. Thus, there was no need to investigate statistical significance.

Regarding *Hypothesis 2*, a correlation coefficient was obtained to test whether reported increased stress levels were indeed associated, and to what degree, with reported low frequency of innovative practice.

Support for *Hypothesis* 3 was examined in a number of ways. Correlation coefficients were obtained for innovation frequency and stress level change variables with job demands and job discretion variables, in partial fulfilment of *Hypotheses 3* (and *Hypothesis 4* – see below). *Multiple* linear regression analyses were also conducted to examine whether these or other factors (demographic and structural/practice/satisfaction change variables) were predictive, and therefore the most associative, of innovation frequency and stress level change. Regression results for the innovation frequency and stress level change variables were compared descriptively. Exploration of

qualitative data (responses to the open-ended item about what factors helped and hindered innovative practice) also provided evidence for *Hypothesis 3*.

Hypothesis 4 was investigated, firstly, through correlation analyses in order to ascertain whether increased stress levels and low innovation frequency were both associated with high job demands and low job discretion. Secondly, the utility of applying Karasek's (1979) Model of Strain to both stress level change and innovation frequency variables was tested by conducting analysis of variance tests using computed job demands-job discretion quadrant data.

Details of the quantitative and qualitative analytic techniques used in pursuing the overall analytic strategy are outlined next.

Quantitative data analysis

The following questionnaire items were coded as quantitative data:

- Demographic (*i.e.* client group, hours of working, caseload size, profession, gender, number of years since qualifying, employing organisation)
- Demand and resource change
- Stress level, job satisfaction and practice change
- Innovation necessary part of care manager role
- Innovation frequency
- Undertake service development work

Responses to all of these items were given numerical scores. A coding sheet was used to help transfer the coded data from questionnaires to an SPSS computer database. Quantitative analyses were then conducted using SPSS Version 9.0. The quantitative data were analysed using a variety of methods:

- descriptive techniques
- statistical comparison of means
- correlation
- multiple linear regression

Descriptive techniques

All the quantitative survey data of interest were described first as frequencies, that is, as the number and percentage of respondents who provided specific responses. Means, medians and standard deviations of item responses were also given where it seemed appropriate to provide such measures of central tendency.

Crosstabulations of frequency data (and means and standard deviations) were given where responses to a particular item were being compared across another variable of interest. For instance, the frequencies (and central tendencies) of responses to specific items, such as gender, number of years since qualifying, innovation frequency and stress level change, were described according to the professional group of respondents.

Statistical comparison of means

The independent sample t-test was conducted only once: to examine whether respondents who reported undertaking service development work were the most frequent care management innovators.

Several one-way analysis of variance tests were conducted. Differences in mean job demands and job discretion scores between professional groups were tested for statistical significance. One-way analysis of variance was also used to test whether the main variables of interest, *stress level change* and *innovation frequency*, varied across respondents in different job demand-job discretion 'quadrants'. These 'quadrants' related to the four possible types of job demand-job discretion scoring in Karasek's (1979) Model of Job Strain: high demand combined with high discretion; high demand combined with low discretion; low demand combined with low discretion; and, low demand combined with high discretion.

Where statistical comparison of means was undertaken, the following three (parametric) assumptions were made about the data:

> "1. The independent variable is categorical and contains two levels; that is, you have two mutually exclusive groups of subjects. Mutually exclusive means that a subject can contribute just one score to one of the two groups. This is the assumption of independence.
>
> 2. The distribution of the dependent variable is normal.
>
> 3. The variances of the dependent variable for the two groups are similar. This is related to the assumption implied by the null hypothesis that the groups are from a single population. The assumption is called the requirement of homogeneity of variance." (Munro 2001, p.125-126)

Correlation

Pearson Product Moment correlation coefficients were calculated to help investigate the relationships between two variables, that is, whether the variation in responding to one variable appeared to correspond with variation in responding to the other variable.

In using the Pearson correlation analysis, the parametric assumptions of homogeneity of variance and normal distribution of correlated variables were made. Most of the variables used in the correlation analyses were either continuous or categorical, where equal distance was assumed between categorical points. One categorical variable was treated as not having equal distance between categorical points: *innovation frequency*.

The *innovation frequency* scale points were given the following values:

'Never'	= 0.01
'Occasionally'	= 0.015
'Sometimes'	= 0.075
'Often'	= 0.40
'Always'	= 1.00

The values given were the calculated estimates of the interpretation of each scale point by respondents. These values were the mid-way value between the possible values of two adjoining scale points (except for 'always', which was given the value '1.00' in accordance with the meaning 'in every case'). Thus, 'often', which had the meaning 'at least 1 in 5 cases', was calculated as the mid-point between the interpretation of '1 in 5 cases' (*i.e.* 0.20) and 'in every case' (*i.e.* 1.00):

$$\frac{1 - 0.2}{2} = 0.4$$

In a similar manner, 'sometimes', which had the meaning 'at least 1 in 20 cases', was calculated as the mid-point between '1 in 20 cases' (*i.e.* 0.05) and '1 in 5 cases' (*i.e.* 0.20):

$$\frac{0.2 - 0.05}{2} = 0.075$$

And, 'occasionally', which had the meaning 'at least 1 in 50 cases', was calculated as the mid-point between '1 in 50 cases' (*i.e.* 0.02) and '1 in 20 cases' (*i.e.* 0.05):

$$\frac{0.05 - 0.02}{2} = 0.015$$

'Never' was calculated as the mid-point between 'no cases' (*i.e.* 0.00) and '1 in 50 cases' (*i.e.* 0.02):

$$\frac{0.02 - 0.00}{2} = 0.01$$

Multiple linear regression

Multiple linear regression analyses were conducted to identify predictors of the two main variables of interest: *innovation frequency* and *stress level change*. 'Predictors' are independent variables that are found (through regression analysis) to be able to explain a proportion of the variance in the

dependent variable. Thus, in the present study, predictors were sought for the dependent variables, *innovation frequency* and *stress level change*. The purpose of regression has been explained as:

> "..to establish a prediction equation in which the independent variables are each assigned a weight based on their relationship to the dependent variable. ..Regression is a useful technique that allows us to predict outcomes and explain the interrelationships among variables." (Munro 2001, p.245-246)

The assumptions underlying regression are the same as those for correlation analyses (see above).

Qualitative data analysis

Qualitative data analysis was conducted on responses to open-ended questionnaire items:

- Examples of innovative care management practice
- Examples of service development
- Factors that help or hinder innovative practice

The open-ended item responses were first typed onto a word processor. A template was set up on the word processor to enable responses to be placed under item headings. This arrangement facilitated the later transference of the qualitative data onto a QSR NUD*IST 4.0 computer database. The author then categorised responses under relevant item headings using the NUD*IST 4.0 software. NUD*IST stands for Non-numerical, Unstructured Data Indexing, Searching and Theorizing. The user's guide states:

> "QSR NUD*IST is a computer package designed to aid users in handling Non-numerical and Unstructured Data in qualitative analysis, by supporting processes of coding data in an Index System, Searching text or searching patterns of coding and Theorizing about the data." (Qualitative Solutions and Research Pty Ltd 1997, p. 2)

There were two main analytical techniques that were applied to the qualitative data:

- Content analysis
- Expert ratings (and Kappa calculations)

Content analysis

Content analysis was the main method used for analysing the responses to the open-ended items in the questionnaire. This method involved categorising the responses to each item using a classification system that developed from an examination of the data itself. The following procedure was used.

All the responses to one particular item were provisionally examined to develop an initial classification system. The categories, and links between categories, were saved as an index system ('tree') on the NUD*IST 4 data management system. Each response was then re-examined and a code applied, where each code represented a 'node' (category) on the index system. In many instances the response of an individual respondent appeared to relate to several categories and, where this occurred, several codes were applied to the response. Sometimes, in the course of the coding work, another category or sub-category would emerge. New nodes would then be added to the index tree and the previously coded responses would be re-examined to see if the new codes were applicable.

Once the coding was complete for all responses to a particular item, the author would leave the analysis for a week or so and then return to recheck the coding. The idea behind this was to see if the same codes appeared applicable after a few days away from the task, to help test the internal (content) validity of the classification system.

Expert ratings (and Kappa calculations)

Expert ratings were gained for the *innovative practice examples*. This method was used in order to ascertain whether quality ratings could be meaningfully applied to the *innovative practice examples*. Five 'experts' provided independent ratings of the degree of imaginativeness (*i.e.* innovativeness) of each innovative practice example (n = 89).

Kappa calculations were conducted to test the degree of inter-rater agreement (*i.e.* the consistency of scoring between raters). This was done in order to examine the robustness of the degree of imaginativeness rating scale. Fleiss (1981) describes the reason for examining inter-rater agreement:

> "To assess the extent to which a given characterization of a subject is reliable, it is clear that we must have a number of subjects classified more than once, for example by more than one rater. The degree of agreement among raters provides no more than an upper bound on the degree of accuracy in the ratings, however. If agreement among the raters is high, then there is a possibility, but by no means a guarantee, that the ratings do in fact reflect the dimension they are purported to reflect. If their agreement is low, on the other hand, then the usefulness of the ratings is severely limited, for it is meaningless to ask what is associated with the variable being rated when one cannot even trust those ratings to begin with." (p.212)

The author originally intended to investigate associations between degree of imaginativeness ratings and other main (quantitative) variables of interest, such as *innovation frequency* and *stress level change*. Thus, reflecting on Fleiss's comments, it was important to ascertain that the rating scale had construct validity (*i.e.* that it measured what it was supposed to measure). However, as will be shown in Chapter 10, inter-rater agreement was found to be low and, consequently, quantitative analyses using the rating scale were not conducted.

* * *

The findings from Study 2 are presented in the following two chapters.

CHAPTER 9 STRESS, DEMANDS AND DISCRETION IN CARE MANAGEMENT

This chapter and the next contain findings from the care management survey. Within this chapter, the background demographic data are presented, followed by findings on stress level, job satisfaction and practice change, and on perceived job demands and job discretion. The relationship between stress, job demands, job discretion and other variables is explored through correlation and regression analyses, and the Karasek (1979) Model of Strain is tested via analysis of variance (ANOVA). The headings used are:

- Demography – profiling of respondents
- Demands and resources for services
- Job demands and job discretion
- Stress, job satisfaction and practice change
- Stress, job satisfaction, job demands and job discretion: correlations
- Job demand – job discretion quadrants and stress level change: testing Karasek's model
- Predictors of stress

Descriptive techniques are used to introduce the findings in each section, with frequencies, means and standard deviations commonly used. Other analytic methods are then used as appropriate, such as analysis of variance, bivariate Pearson Product Moment Correlation and multiple linear regression. The data analysed within this chapter are all quantitative in nature.

Demography – profiling of respondents

The number and proportion of respondents by professional group and gender were reported previously as sample characteristics (Chapter 8). More detailed respondent demography is provided below, specifically in terms of:

- number of years qualified
- main client group
- hours of working
- caseload size.

Number of years qualified

As shown in Table 9.1, therapist respondents had, on average, worked more years since qualifying (mean = 17.3 years, S.D. = 9.7 years) than respondents from any of the other professional groups. Nurse respondents had the next highest mean number of years since qualifying (mean = 14.9 years, S.D. = 7.9). Social work respondents had worked, on average, the least number of years since qualifying (mean = 10.5, S.D. = 8.1).

Table 9.1 Profession by number of years qualified

Profession	Mean number of years qualified	Standard deviation (years)
Social workers	10.5	8.1
Nurses	14.9	7.9
Therapists	17.3	9.7
Other/non-classified	11.9	8.3

Main client group

Respondents were asked in the questionnaire: "With which client group/s do you spend most time?" A selection of categories were provided and respondents asked to tick the appropriate box/es. An "other (please specify)" box was also included. As can be seen from Table 9.2, the main client groups worked with were elderly people (43% of respondents), people with physical or sensory impairment (30% of respondents) and people with mental health problems (30% of respondents). Other major client groups served by practitioners were elderly mentally infirm people, people in hospital and people with learning disabilities (26%, 25% and 19% of respondents

respectively). Ten percent of respondents worked with people with drug or alcohol related problems, and 4% worked with other types of clients.

Social workers worked across the full range of client groups (Table 9.2), but most worked with elderly people, people with physical or sensory impairment and people in hospital (53%, 39% and 38% respectively). The majority of nurses (61%) worked with people with mental health problems. Approximately a third also worked with people with learning disabilities and almost a fifth worked with elderly mentally infirm people. Of the eight therapists, half worked in mental health, three worked in the elderly field and 3 in the physical/sensory impairment field. Those who formed the "other/non-classified" professional group worked mainly with elderly people (n=14), people with physical or sensory disability (n=7) and elderly mentally infirm people (n=6).

Table 9.2 Number and proportion of respondents by profession and main user group

	Professional group				
Main user group	**social workers n (%)**	**nurses n (%)**	**therapists n (%)**	**other n (%)**	**Total[a] n (%)**
elderly	59 (53%)	2 (5%)	3 (38%)	14 (82%)	78 (43%)
physical/sensory impairment	44 (39%)	1 (2%)	3 (38%)	7 (41%)	55 (30%)
elderly mentally infirm	30 (27%)	8 (18%)	2 (25%)	6 (35%)	46 (26%)
mental health	23 (21%)	27 (61%)	4 (50%)	1 (6%)	55 (30%)
learning disability	17 (15%)	14 (32%)	2 (25%)	2 (12%)	35 (19%)
hospital	42 (38%)	1 (2%)	0 (0%)	2 (12%)	45 (25%)
drug/alcohol	13 (12%)	5(11%)	0 (0%)	0 (0%)	18 (10%)
hiv/aids/other	5 (5%)	1 (2%)	0 (0%)	1 (6%)	7 (4%)

[a] Number of people who responded to main user group item, N = 181. Since respondents could indicate working with more than one main user group, the numbers in this column add to more than 181.

Hours of working

Eighty-three percent of respondents reported working full-time (n=150). Of the 16% (n=28) who worked part-time, 64% (n=18) worked 8-21 hours and the remaining 36% (n=10) worked 21-30 hours. Seventeen social workers (15% of all social work respondents) worked part-time, as did five nurses (11% of nurse respondents), four therapists (50% of therapist respondents), and two other/non-classified practitioners (12% of other/non-classified respondents). Thus, other than therapists, all other professional groups had similar proportions of those who worked part-time.

Caseload size

Practitioners were asked to indicate the number of cases they were responsible for. Caseload size ranged from 8 to 250, with a mean of 44.14 cases (standard deviation = 34.45 cases) and a median of 35.50 cases. Table 9.3 shows the number and proportions of each professional group that have different caseload size classifications. Only social workers and those in the 'other' practitioner category had respondents with caseload sizes across the range. The majority of nurse and therapist respondents (n = 30, 75%; and n = 6, 75% respectively) indicated they had 39 or fewer cases that they were responsible for, and all nurse and therapist respondents claimed to have 79 or fewer cases. The majority of social workers (n = 68, 75%) reported caseload sizes of at least 59, with almost a fifth (n = 17, 19%) indicating they were responsible for between 60 and 99 cases, and the remaining six social worker respondents reporting caseload sizes between 100 and 250. Thus, social workers appear to typically have larger caseload sizes than nurses or therapists. Those in the 'other' practitioner category also showed a tendency towards higher caseload sizes.

The relatively small caseload size of therapists might, in part, reflect the fact that half of the 8 therapist respondents worked part-time. Both the therapist and 'other' practitioner categories had few respondents, so it is difficult to make any generalizations regarding these groups (and because the 'other'

category was not a homogenous group). However, there appeared to be considerable differences in the caseload sizes of nurse and social work respondents, with the latter typically having over 30% more cases than the former (social worker mean = 46.70 cases, S.D. = 31.67 cases; nurse mean = 32.23 cases, S.D. = 14.59 cases).

Table 9.3 Frequency and percentage of respondents by professional group and caseload size

Caseload size[a]	Social workers, n[b] (%)	Nurses, n[c] (%)	Therapists, n[d] (%)	Other, n[e] (%)
8 - 19	12 (13)	9 (23)	2 (25)	1 (6)
20 - 39	31 (34)	21 (53)	4 (50)	4 (7)
40 - 59	25 (28)	7 (18)	1 (13)	4 (25)
60 - 79	13 (14)	3 (8)	1 (13)	3 (19)
80 - 99	4 (4)	0 (0)	0 (0)	2 (13)
100 - 250	6 (7)	0 (0)	0 (0)	2 (13)
Mean[f]	46.70	32.23	33.63	63.87
Standard deviation[f]	31.67	14.59	17.74	54.89

[a] Caseload size was a continuous variable, but is shown as categories for clarity.
[b] N = 91
[c] N = 40
[d] N = 8
[e] N = 16
[f] Mean and standard deviation figures given are for number of cases

Caseload size data were also examined by the main user group specified by respondents. Table 9.4 shows the crosstabulation of main user group and caseload size. It also shows the mean and standard deviation caseload size for the different main user groups. Examining means, it is clear that respondents working with older people and/or people with physical or sensory impairments typically had the largest caseloads (mean = 58.04 cases, S.D. = 40.72 cases). Those working with older people with mental health problems ('elderly mentally infirm') had the next largest mean caseload size (mean = 50.08 cases, S.D. = 27.05 cases). Respondents with the lowest mean caseload sizes worked with people with mental health problems (including people with drug and alcohol problems) and with people

with learning difficulties (mean $_{\text{mental health}}$ = 35.38 cases, S.D. = 22.17 cases; mean $_{\text{learning difficulties}}$ = 35.21 cases, S.D. = 20.27).

Table 9.4 Number and percentage of respondents by main user group and caseload size

	Main user group					
Caseload size[a]	**Elderly/physical or sensory impairment, n[b] (%)**	**Elderly mentally infirm, n[c] (%)**	**Mental health, n[d] (%)**	**Learning disability, n[e] (%)**	**Hospital, n[f] (%)**	**Other, n[g] (%)**
8 – 19	8 (12)	6 (16)	14 (25)	5 (16)	6 (18)	0 (0)
20 – 39	14 (20)	11 (29)	25 (45)	17 (53)	12 (35)	3 (50)
40 – 59	21 (30)	6 (16)	8 (14)	8 (25)	7 (21)	1 (17)
60 – 79	12 (17)	8 (21)	6 (11)	1 (3)	5 (15)	1 (17)
80 – 99	6 (9)	5 (13)	2 (4)	0 (0)	2 (6)	1 (17)
100 - 250	8 (12)	2 (5)	1 (2)	1 (3)	2 (6)	0 (0)
Mean[h]	58.04	50.08	35.38	35.21	42.56	44.17
Standard deviation[h]	40.72	27.05	22.17	20.27	26.83	23.33

[a] Caseload size was a continuous variable, but is shown as categories for clarity
[b] N = 69
[c] N = 38
[d] N = 56; includes respondents who indicated they worked with people with drug or alcolhol problems
[e] N = 32
[f] N = 34
[g] N = 6; included respondents who indicated they work with people with HIV/AIDS
[h] Mean and standard deviation figures given are for number of cases

The majority of respondents working with older people and/or people with physical or sensory impairment (n = 55, 80%) and those working with older people with mental health problems (n = 31, 82%) were responsible for up to 79 cases. The majority of those working with people with mental health problems (n = 47, 84%) and those working with people with learning difficulties (n = 30, 94%) were responsible for up to 59 cases. These figures further illustrate the differences in caseload size for respondents working with mainly older people (including older people with mental health problems)/people with physical or sensory impairment and respondents working mainly with people with learning difficulties or mental health problems. Such differences may help to explain the differences in typical caseload size for social workers and nurses, the latter working mainly with people with mental health problems and learning difficulties and the former

working mainly with older people and people with physical or sensory impairment (see Table 9.2).

Demands and resources for services

Table 9.5 shows the number and percentage of respondents who indicated a change, or no change, in available resources and demands for services. The majority of respondents (69%) reported that demands for services had increased during the past 12 months. A similar proportion (66%) reported a decrease in resource availability. However, just over a quarter (27%) specified there was no change in the availability of resources during the past year. A similar proportion (27%) indicated demands had stayed the same. Seven percent reported that resource availability had increased. Only one percent specified that demands for services had decreased.

Table 9.5 Number and percentage of respondents indicating change in available resources and demands for services

	Number, n, and percentage (%) of respondents by type of change over past 12 months		
Change indicator	**Decreased**	**No change**	**Increased**
Resources[a]	114 (66.3)	46 (26.7)	12 (7.0)
Demands for services[b]	2 (1.2)	46 (26.6)	125 (69.1)

[a] N = 172 [b] N = 173

The response profiles of the different professional groups to the resource availability and demand change questions were examined (Tables 9.6 and 9.7, respectively). Other than therapist respondents, the majority of respondents belonging to the other professional groups indicated that resource availability had decreased over the preceding 12 months (68% of social workers, 63% of nurses, and 80% of other/non-classified practitioners). However, almost as many therapists indicated resource availability had decreased as had stayed the same (n = 3, 38%, and n = 4, 50%, respectively).

Table 9.6 Number and percentage of respondents by professional group indicating change in availability of resources

Change in resource availiability[a]	Social workers, n[b] (%)	Nurses, n[c] (%)	Therapists, n[d] (%)	Other, n[e] (%)
Decreased	73 (68)	26 (63)	3 (38)	12 (80)
No change	29 (27)	11 (27)	4 (50)	2 (13)
Increased	6 (6)	4 (10)	1 (13)	1 (7)

[a] Change in resource availability over the last 12 months
[b] N = 108
[c] N = 41
[d] N = 8
[e] N = 15

The majority of those in all professional group categories reported that demand for services had increased over the last 12 months (86% of nurses, 75% of therapists, 69% of social workers, and 53% of other/non-classified practitioners).

Table 9.7 Number and percentage of respondents by professional group indicating change in demand for services

Change in demand for services[a]	Social workers, n[b] (%)	Nurses, n[c] (%)	Therapists, n[d] (%)	Other, n[e] (%)
Decreased	1 (1)	0 (0)	0 (0)	1 (7)
No change	32 (30)	6 (14)	2 (25)	6 (40)
Increased	75 (69)	36 (86)	6 (75)	8 (53)

[a] Change in demand for services over the last 12 months
[b] N = 108
[c] N = 42
[d] N = 8
[e] N = 15

Job demands and job discretion

This section examines responses to the Work Activities part of the questionnaire. As indicated in Chapter 4, Karasek's Job Strain Model is based on predicting what will occur from paired job demands - job discretion scores. For instance, high demand-low discretion scores should, according to the model, predict high levels of stress; high demand-high discretion scores and low demand-low discretion scores should predict moderate levels

of stress; and, low demand-high discretion should be associated with minimal stress.

In order to ascertain the main demand-discretion 'quadrant' of Karasek's model for care management practitioners in the current study, job demand and job discretion scores were calculated for each respondent. The means and standard deviations of job discretion and job demands scores are given in Table 9.8. Since the possible range of scores was 7 (low demands/discretion) to 28 (high demands/discretion), the mid-point is 17.5. The mean job discretion score was 18.59, approximately one point higher than the mid-point. On average, then, the job discretion of respondents was on the high side of 'middling'. The mean job demands score of 21.75 was 4.25 points above the mid-point and can be considered well within the 'high' range. Thus, in terms of the current sample, care management appears to be high on job demands and middling on job discretion.

Table 9.8 Mean and standard deviation of job demands and job discretion scores

Variable	Mean	Std. deviation	N
Job discretion[a]	18.59	3.60	180
Job demands[a]	21.75	4.38	181

[a] Job demands/job discretion scale: 1 = "not at all", 2 = "to some extent", 3 = "quite a lot", 4 = "very much indeed"

A correlation coefficient was calculated to examine the degree of variance between job demands and job discretion scores. A statistically significant association was not found between these two variables (Pearson correlation coefficient $r = 0.10$; $p = 0.17$). Thus, in terms of the current study, job demands and job discretion scores appear to be reasonably independent of each other.

Table 9.9 Mean and standard deviation of job demands and job discretion scores for each professional group

Profession	Job discretion: mean (S.D.)	Job demands: mean (S.D.)	Number of respondents, n[a]
Social workers	18.21 (3.67)	21.77 (4.39)	112
Nurses	19.05 (3.46)	21.82 (4.09)	43-44
Therapists	19.88 (2.90)	23.38 (3.62)	8
Other	19.35 (3.60)	20.71 (5.37)	17

[a] N = 163-164

The mean job demands and job discretion scores for each professional group are given in Table 9.9. It appears that social work respondents typically have the lowest job discretion scores and that therapist respondents typically have the highest job discretion scores ($mean_{social\ workers}$ = 18.21, S.D. = 3.67; $mean_{therapists}$ = 19.88, S.D. = 2.90). However, social workers have the largest variation in job discretion scores of all professional groups. Additionally, it is difficult to interpret the meaning of the therapist respondent data given their small sample size. A one-way analysis of variance (ANOVA) was conducted with professional group as the independent variable (factor) and job discretion as the dependent variable to ascertain if the between group differences were significant. A non-significant result occurred (F = 1.26; d.f. = 176, 3; p = 0.29).

Whilst therapist respondents had the highest mean job demands score and those in the other/non-classified practitioner group the lowest (mean therapists = 23.38, S.D. = 3.62; mean other = 20.71, S.D. = 5.37), a one-way ANOVA result indicated there were no significant between group differences (F = 0.69; d.f. = 17, 3; p = 0.56).

Job demand-job discretion quadrants

Respondents were classified according to whether they were high or low on demand and high or low on discretion, *i.e.* high demands-high discretion, high demands-low discretion, low demands-high discretion, low demands-low discretion. The number of respondents, mean and standard deviations

for each 'quadrant', and the inclusion criteria, are given in Table 9.10. These quadrants were used in further analyses, presented elsewhere.

Table 9.10 Means, standard deviations, respondent frequencies and inclusion criteria of job demand-job discretion quadrants

Quadrant	Mean score	Standard deviation	Number of respondents n[a] (%)	Inclusion criteria[b]
Low demands-high discretion	36.47	4.17	15 (8.3)	demands 17 discretion >17
Low demands-low discretion	30.06	3.02	18 (10.0)	demands 17 discretion 17
High demands-high discretion	44.16	4.41	90 (50.0)	demands >17 discretion >17
High demands-low discretion	38.54	3.23	57 (31.7)	demands >17 discretion 17

[a] N = 180

[b] The mid-point of the demands/discretion range is 17.5 (possible range of scores = 7 – 28), but 17 was chosen as the cut-off point in the inclusion criteria because a score of 17.5 is not possible (only whole numbers are possible).

Less than a fifth of the sample (18%; n = 33) appeared to have low perceived work demands, with approximately 8% falling within the *low demands-high discretion* quadrant and 10% falling within the *low demands-low discretion* quadrant. Those in the former quadrant would be predicted to have low levels of stress and those in the latter quadrant, moderate levels of stress.

The large majority of respondents, more than four-fifths (82%; n = 147), indicated having high work demands. Half of all respondents gave responses consistent with the *high demands-high discretion* quadrant, which predicts moderate levels of stress. Close to a third of respondents (32%) fell within the high strain quadrant of *high demands-low discretion*. In terms of job discretion, almost three-fifths of respondents (58.3%; n = 105) indicated having high levels of discretion and approximately two-fifths (41.7%; n = 75) appeared to have low levels of discretion.

Table 9.11 Number and percentage of respondents by professional group in the different job demand-job discretion quadrants

Quadrant	Social workers, n[a] (%)	Nurses, n[b] (%)	Therapists, n[c] (%)	Other, n[d] (%)
Low demands-high discretion	9 (8)	4 (9)	0 (0)	2 (12)
Low demands-low discretion	13 (12)	3 (7)	0 (0)	2 (12)
High demands-high discretion	53 (47)	23 (53)	5 (63)	9 (53)
High demands-low discretion	37 (33)	13 (30)	3 (38)	4 (24)

[a] N = 112
[b] N = 43
[c] N = 8
[d] N = 17

Table 9.11 shows the number and percentage of respondents whose job demands and job discretion scores fell within the different demand-discretion quadrants by professional group. The high demands-high discretion quadrant contained the largest proportions of respondents from each professional group (63% of therapists, 53% of nurses, 53% of other/non-classified practitioners, and 47% of social workers). Approximately a third of nurses, social workers and therapists (30%, 33%, and 38% respectively) and a quarter of other/non-classified practitioners (24%) had job demands and job discretion scores that fell into the high demands-low discretion quadrant. The similarities in job demands-job discretion quadrant proportions across professional groups reflect the similarities in mean job demands and job discretion scores by professional group indicated in Table 9.9.

Stress, job satisfaction and practice change

Tables 9.12 and 9.13 present the proportion of respondents who indicated whether, and in what way, their stress level and job satisfaction (Table 9.12) or practice (Table 9.13) had changed over the preceding 12 months (*i.e.* between mid-1996 and mid-1997).

Stress level and job satisfaction change

Table 9.12 Stress and satisfaction indicators: mean score and proportion of respondents indicating type of change by variable

Stress & satisfaction indicators	Number and percentage of respondents[a] indicating type of change over past 12 months[b]			Mean score[c] (& SD)
	Decreased, n (%)	No change, n (%)	Increased, n (%)	
Stress level	14 (8)	43 (24)	122 (68)	3.8 (0.9)
Job satisfaction	87 (49)	53 (30)	39 (22)	2.6 (1.1)
Sense of achievement	95 (53)	58 (32)	27 (15)	2.4 (1.0)
Feeling valued	96 (53)	55 (31)	29 (16)	2.5 (1.0)
Satisfaction with working conditions	97 (54)	58 (32)	24 (13)	2.4 (1.0)
Confidence in community care	121 (67)	42 (23)	17 (9)	2.1 (1.0)
Morale of colleagues	131 (73)	36 (20)	12 (7)	2.1 (0.9)

[a] N = 179 - 180
[b] A three-point scale has been used, as opposed to the original 5-point scale, for visual clarity.
[c] The original 5-point scale applies to the mean and standard deviation scores *i.e.* 1 = "decreased a lot", 2 = "decreased a little", 3 = "stayed the same", 4 = "increased a little", 5 = "increased a lot".

Stress level change was considered to be the main indicator of strain in the questionnaire. More than two-thirds of respondents (68%) reported increased *stress levels* over the previous 12 months (see Table 9.10). Approximately a quarter (24%) indicated there was no change in stress levels and 8% that there had been a decrease. Those who indicated 'no change' in stress level may have continued to experience stress at high, low or moderate levels over the 12 month period. A *morale of colleagues* variable was included in the questionnaire because it was considered to provide an indication of the perception of strain in the work environment of respondents. The findings indicated that close to three-quarters of respondents (73%) reported that the *morale of colleagues* had reduced over the preceding 12 months.

Almost half the sample (49%) reported a reduction in *job satisfaction* over the past 12 months. However, more than a fifth indicated improved job satisfaction over the same period. The *job satisfaction* indicator was included in the questionnaire as an approximate measure of strain, albeit a much weaker one than that of the *stress level change* or *morale of colleagues* indicators.

Reduced *sense of achievement*, *feeling valued* and *satisfaction with overall working conditions*, other job satisfaction indicators, were noted by more than half the respondents (53-54%). Considerably less than a fifth (13-16%) reported enhancement in these areas. Just over two-thirds of respondents (67%) reported having a decrease in their level of *confidence in community care*, an overall indication of respondents' dissatisfaction with the implementation of community care reforms.

Since stress level change was one of the main variables of interest in the study, reported change was examined by professional group. As Table 9.13 indicates, the proportions of respondents who reported their stress levels to have increased, decreased or stayed the same was similar across professional groups.

Table 9.13 Number and percentage of respondents in each professional group reporting change in stress level

Stress level has...[a]	Social workers, N[b] (%)	Nurses, N[c] (%)	Therapists, N[d] (%)	Other, N[e] (%)
decreased	9 (9)	4 (9)	1 (13)	0 (0)
stayed the same	26 (25)	8 (19)	1 (13)	6 (38)
increased	70 (67)	31 (72)	6 (75)	10 (63)

[a] Original 5-point scale reduced to 3-point scale in table for visual clarity
[b] N = 105
[c] N = 43
[d] N = 8
[e] N = 16

Change in job satisfaction, as a weak indicator of strain, was also examined by professional group. As shown in Table 9.14, more social workers than other professionals reported reduced job satisfaction (55%, as opposed to

44% of nurses, 35% of other/non-classified practitioners, and 25% of therapists). However, similar proportions of social workers, nurses and other/non-classified practitioners indicated that their job satisfaction had increased (22%, 23%, and 24% respectively). Whilst only one therapist (13%) reported an increase in job satisfaction, the small number of therapist respondents mean that if just one more had reported an increase therapists would have a similar response pattern to the other professional groups. Thus, overall the pattern of responding to the job satisfaction item appears similar across professional groups.

Table 9.14 Number and percentage of respondents in each professional group reporting change in job satisfaction

Job satisfaction has...[a]	Social workers, N[b] (%)	Nurses, N[c] (%)	Therapists, N[d] (%)	Other, N[e] (%)
decreased	57 (55)	19 (44)	2 (25)	6 (35)
stayed the same	24 (23)	14 (33)	5 (63)	7 (41)
increased	23 (22)	10 (23)	1 (13)	4 (24)

[a] Original 5-point scale reduced to 3-point scale in table for visual clarity
[b] N = 104
[c] N = 43
[d] N = 8
[e] N = 17

Practice change

Explanations for increased stress and lowered satisfaction in care management work may, partly, be found in the findings presented in Table 9.15. For instance, *paperwork* and *workload* in general were considered to have increased by the vast majority of respondents (86% and 74% respectively) over the previous 12 months. Large proportions of respondents also reported increased *responsibility* and reduced time for *client contact* (60% and 65% respectively). A reduction in client contact time, in particular, might reduce job satisfaction, since it is likely that practitioners view their main role as one of helping clients directly. The reported increase in paperwork may explain the reduction in client contact time. Increased paperwork, workload in general and responsibility may increase the pressure

care management practitioners feel themselves under, and partly explain the apparently raised stress levels.

Table 9.15 Practice change indicators: mean score and proportion of respondents indicating type of change by variable

Practice change indicators	Number[a] and percentage of respondents indicating type of change over past 12 months[b]			Mean score[c] (& SD)
	Decreased, n (%)	No change, n (%)	Increased, n (%)	
Paperwork	3 (2)	22 (12)	155 (86)	4.3 (0.8)
Workload	9 (5)	37 (21)	134 (74)	4.1 (0.9)
Responsibility	11 (6)	61 (34)	107 (60)	3.8 (0.9)
Contact with managers	62 (34)	66 (37)	52 (29)	2.9 (1.1)
Coping with workload	57 (32)	70 (39)	53 (29)	3.0 (1.0)
Service quality	90 (50)	53 (29)	37 (21)	2.6 (1.0)
Client contact	117 (65)	52 (29)	11 (6)	2.2 (0.9)

[a] N = 180
[b] A 3-point scale has been used, as opposed to the original 5-point scale, for visual clarity.
[c] The original 5-point scale applies to the mean and standard deviation scores *i.e.* 1 = "decreased a lot", 2 = "decreased a little", 3 = "stayed the same", 4 = "increased a little", 5 = "increased a lot".

Those who feel that their ability for *coping with workload* has decreased and who have reduced quality of *contact with managers*, 32% and 34% of respondents respectively, may be more likely to report increased stress levels. Half the respondents reported a decrease in the *service quality* they felt able to give. This finding may also explain the general apparent malaise of the sample.

Stress, job satisfaction, job demands and job discretion: correlations

Pearson Product Moment correlation coefficients were calculated between stress level change, job satisfaction change, job demands and job discretion variable scores. These were conducted in order to examine strain, satisfaction and demand/discretion relationships. Table 9.16 shows the results.

Table 9.16 Correlation coefficients, r, between reported stress level change, job satisfaction change, job demands and job discretion variables

	Stress level change	Job satisfaction change	Job demands	Job discretion
Stress level change	1.00	-0.31**	0.38**	-0.19**
Job satisfaction change	-0.31**	1.00	-0.14	0.37**
Job demands	0.38**	-0.14	1.00	0.10
Job discretion	-0.19**	0.37**	0.10	1.00

** Correlation coefficient is significant at the 0.01 level (1-tailed)
N = 178 - 180

Significant correlations (at the 1% level) were found between stress level change and the three other main variables: job satisfaction change, job demands, and job discretion. The stress and job satisfaction variables produced a negative correlation (r = -0.31), meaning respondents reporting increased stress levels also tended to report reduced job satisfaction over the same 12 month period. The correlation also indicates that the stress level and job satisfaction change variables exhibited a degree of similarity in the variation of scores, suggesting a common underlying factor. This could be psychological strain. The intended purpose of the job satisfaction change variable was as an alternative indicator of strain, in keeping with past research (see Chapter 4).

Reported increased stress levels were also associated with perceived high job demands and low job discretion (r = 0.38 and –0.19 respectively). The latter correlations appear to provide support for Karasek's (1979) Model of Strain, and to be supportive of Hypothesis 4 (or, rather, part of Hypothesis 4, *i.e.* that high job demands and low job discretion will be associated with increased stress levels – see Chapter 8). However, the correlation coefficient between the stress and job discretion variables was small, despite being significant, and so it can only be said that there was weak support for the Karasek (1979) model (and Hypothesis 4) using these data.

Interestingly, the job satisfaction variable correlated significantly with job discretion, but not the job demands variable (r = 0.37 and –0.14 respectively). Thus, high job discretion was associated with reported increased job satisfaction. Therefore, a different result was obtained than for the stress level change variable, suggesting that job satisfaction is, to a degree, conceptually different from stress (strain).

Job demand-job discretion quadrants and stress level change: testing Karasek's model

Although correlation coefficients of stress level change, job demands and job discretion go some way towards examining the theoretical underpinnings of Karasek's (1979) model, in terms of relationships between key variables, they do not test the model. Consequently, a one-way ANOVA was conducted to test the hypothesis that increased stress levels would be associated with high job demands and low job discretion (Hypothesis 4). Karasek's model also predicts that high demands combined with high discretion, and low demands combined with low discretion, will lead to moderate symptoms of strain, and low demands-high discretion will lead to low levels of strain. Thus, for Karasek's model to be supported evidence of such associations also need to be found.

Table 9.17 ANOVA result for comparison of stress level change by job demand-job discretion quadrant

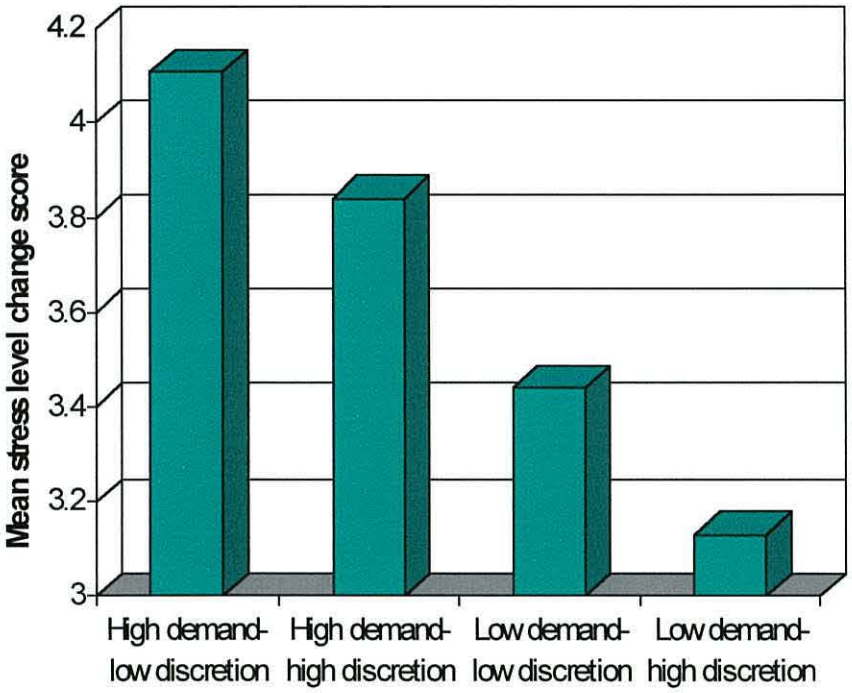
	Sum of squares	df	Mean square	F	Sig. (p)
Between Groups	14.082	3	4.694	5.882	.001
Within Groups	138.861	174	0.798		
Total	152.99	177			

Note Five-point scale used for stress level change variable in ANOVA procedure, where 1 = "decreased a lot", 2 = "decreased a little", 3 = "stayed the same", 4 = "increased a little", 5 = "increased a lot".

As indicated by the ANOVA result (Table 9.17), mean stress level change scores differed significantly across job demand-job discretion quadrants. The bar chart in Figure 9.1 shows that respondents reporting high demands and low discretion reported the greatest increase in stress level change over the past 12 months (mean = 4.11, S.D. = 0.92; n = 57). Those reporting the next greatest increase in stress level change were those reporting high demands and high discretion (mean = 3.84, S.D. = 0.92; n = 90) and those reporting low demands and low discretion (mean = 3.44, S.D. = 0.51; n = 16). Respondents reporting low demands and high discretion had the lowest mean stress level change score (mean = 3.13, S.D. = 0.92; n = 15).

Whilst a measure of *stress level change* cannot be regarded as equivalent to a measure of *stress level* (or *strain*) as usually used to test Karasek's model, the trends shown in Figure 9.1 approximate to those predicted by the model. Although caution needs to be applied to the quadrants with few respondents (*i.e.* low demands-low discretion and low demands-high discretion), the part of Hypothesis 4 relating to finding an association between high job demands and low job discretion with increased stress level change appears to have been supported.

Figure 9.1 Mean stress level change scores by demand-discretion quadrant



Predictors of stress

One final series of analyses were undertaken with the stress level change variable as the main variable of interest. Multiple linear regression analyses were conducted with the stress level change variable as the dependent variable in order to find the predictors[1] of stress. The 'independent' variables entered during analysis were gender, years since qualifying, caseload size, service demand change, change in resources, job demands, job discretion, satisfaction and practice change variables, innovation frequency[2] and service development[3]. Part of the reason for conducting these regression analyses was to be able to compare the results with those of similar regression analyses conducted with innovation frequency as the dependent variable. The latter are reported in Chapter 10.

Table 9.18 presents the results of a regression analysis using the stepwise method of entering and removing independent variables (where F-to-enter = 0.05, and F-to-remove = 0.10). The results indicate that decreased morale of colleagues, increased workload, and reduced ability to cope were predictive of reported increased stress levels. Together, these variables explained nearly 44% of the variance in the stress level change responses (R^2 = 0.438). Even when adjusted for error, 42% of the variance in the stress responses was explained by these three predictors (Adjusted R^2 = 0.424).

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[11] 'Predictors' is the term used in reporting regression results to mean those variables that have scores which can be used to calculate the scores on the dependent variable (using the regression equation). Use of the term with cross-sectional data does not indicate an actual cause-and-effect relationship, although it is implied.

[2] Statistics surrounding the innovation frequency variable are explored in the next chapter, but the variable is included in the stress regression analysis since one of the aims of the research was to investigate the relationship between innovative practice and occupational stress.

[3] Service development is one of the 'innovation' variables and is described in the next chapter.

Table 9.18 Stress level change regression analysis outcome: stepwise method 1 (F-to-enter = 0.05, F-to-remove = 0.10)

Variables	Unstandardized coefficients		Standardized coefficients	t	Sig
	B	Std Error	Beta		
(constant)	4.058	0.444		9.139	0.000
Morale of colleagues	-0.357	0.084	-0.325	-4.254	0.000
Workload	0.338	0.078	0.317	4.332	0.000
Ability to manage workload	-0.280	0.073	-0.289	-3.812	0.000

$R = 0.662$ $R^2 = 0.438$ Adjusted $R^2 = 0.424$ Std. Error of the Estimate = 0.74

In order to investigate how robust this regression model was the regression analysis was repeated using both forward and backward methods. The forward method (F-to-enter = 0.05) produced an identical result to the original stepwise method. However, the backward method (F-to-remove = 0.05) included job satisfaction change and contact with management change variables as predictors of stress level change alongside the original three variables. Thus, decreased job satisfaction and increased contact with managers in combination with increased workload, reduced ability to manage one's workload, and decreased morale of colleagues, were predictive of increased stress using the backward method. Only a slightly larger proportion of the variance in the stress level change variable was explained by this new regression model (45% as opposed to 42%; Adjusted $R^2_{\text{backward method}} = 0.450$).

Exploring the data further, a stepwise regression was conducted with less restrictive entry/removal criteria into the regression equation (F-to-enter = 0.10, F-to-remove = 0.15). Table 9.19 shows the results. The three variables (morale of colleagues, workload, and ability to manage workload) were found, again, to be the main predictors. Other predictors in the model included job satisfaction, contact (or, rather, communication) with managers, and resources changed. All six variables were able to explain almost half the variance in the stress level change variable ($R^2 = 0.489$). Corrected for error, they still explained 46% of the variance in the stress variable (Adjusted $R^2 = 0.461$).

Table 9.19 Stress level change regression analysis outcome: stepwise method 2 (F-to-enter = 0.10, F-to-remove = 0.15)

Variables	Unstandardized coefficients		Standardized coefficients		
	B	Std Error	Beta	t	Sig
(constant)	3.865	0.443		8.717	0.000
Morale of colleagues	-0.388	0.094	-0.353	-4.103	0.000
Workload	0.333	0.076	0.312	4.391	0.000
Ability to manage workload	-0.243	0.077	-0.250	-3.172	0.002
Job satisfaction	-0.195	0.082	-0.203	-2.384	0.019
Contact with managers	0.136	0.068	0.164	2.012	0.047
Resources changed	0.194	0.108	0.126	1.791	0.076

$R = 0.699$ $R^2 = 0.489$ Adjusted $R^2 = 0.461$ Std. Error of the Estimate = 0.72

Thus, reported reduced morale of colleagues, decreased ability to manage workload, reduced job satisfaction, and increased workload, increased communication with managers, and raised resources, were predictive of increased stress levels over the past 12 months.

Whilst the direction of association between the stress variable and most of the variables in the regression equation appear to make sense (*i.e.* reduced morale of colleagues, increased workload, reduced ability to manage one's workload, and decreased satisfaction with one's job and work conditions are predictive of increased stress levels), there appear to be two anomalies in the regression equation: increased stress being associated with increased communication with managers and with increased resources. However, greater communication with one's manager may be a sign of being less able to cope with one's workload alone. Care management practitioners with increased stress levels may be actively seeking support and guidance from their managers as a way of attempting to cope.

Explaining the association between increased stress levels and increased resources is less easy, since it would make more sense that an increase in resources would assist one's care management practice. Looking at the

relationship from the opposite perspective, that reduced stress levels are associated with decreased resources, may provide a better indication of why the direction of association is the way it is. Decreased resources could lead to a tightening of service eligibility criteria and a reduction in workload (*i.e.* if fewer potential users meet the eligibility criteria for services, there may well be fewer referrals to care management practitioners in the first place and, even when users have been referred, fewer will be eligible for care packages, or the care packages may be less complicated because resources are limited). The resultant reduction in workload may lead to a greater ability to be able to manage one's workload and the experiencing of less stress.

The three regression models that arose from the use of stepwise, forward and backward methods (at 5% and 10% levels of probability) all have in common three variables: morale of colleagues, workload, and ability to manage one's workload. These variables could explain 42% of the variance in the stress level change variable. Only an additional 4% of the variance could be explained by including the additional variables, job satisfaction change, contact with managers change, and resources change variables in the regression model. Consequently, morale of colleagues, workload, and ability to manage one's workload appear to be the main predictors of stress level change.

The predictors found for the stress level change variable in part support Hypothesis 3 (see Chapter 8). Stress level change was associated with workload and ability to manage workload, both being an indication of job demands. Stress level change was also associated with resource availability and manager contact or communication (aka support). However, job discretion was not found to be a predictor of stress level change, even in the regression model with more lenient entry and removal criteria.

In regards to Hypothesis 2, reported frequency of innovative practice was not found to be predictive of stress level change. Even though innovation frequency lacked predictive power in regards to stress level change, this does not mean that these variables were not associated, merely that the

variance in the stress level change variable could be better explained by variance in other factors. The relationship between stress level change and innovative care management practice is, therefore, explored further in the following chapter.

CHAPTER 10 INNOVATIVE PRACTICE AND OCCUPATIONAL STRESS IN CARE MANAGEMENT

This chapter is the second to present findings from the survey of care management practitioners. It contains the innovative practice findings, both quantitative and qualitative, and examines the relationship between innovative practice and occupational stress in care management through correlation and regression analyses. The relationship between innovative practice and job demands/job discretion is explored through the application and testing of the Karasek Model of Strain (via analysis of variance). Innovative practice examples are subjected to expert ratings. The section headings used within this chapter are:

- innovative practice – quantitative data
- innovative practice, job demands, job discretion and stress: correlations
- job demand-job discretion quadrants and innovation frequency: applying and testing Karasek's model
- predictors of innovation frequency
- innovative practice – qualitative data
- expert ratings of the innovative practice examples.

Innovative practice – quantitative data

There were three pre-coded (quantitative) innovative practice items in the questionnaire. One asked respondents to indicate whether being innovative was a necessary function of the care manager role (Question 6). Another item required respondents to specify the frequency of their innovative practice *whilst planning, implementing or evaluating individual care packages* (Question 7). The third item asked respondents whether they undertook service development work (Question 9(i)).

Is innovative practice necessary?

A large majority of the sample (n = 152, 84%) indicated that they thought being innovative was a necessary aspect of care manager work. Six

respondents (3%) indicated the opposite, that they considered being innovative was unnecessary. Fifteen respondents (8%) reported being unsure, and eight (4%) did not provide a response. Therefore, it appears that most respondents considered innovative practice vital for care management.

How frequent is innovative care management practice?

One hundred and sixty-six respondents (92% of the sample) appeared able to estimate the frequency of their individual innovative practice. Table 10.1 shows the numbers and percentages of respondents who reported being never, occasionally, sometimes, often, or always innovative whilst planning, implementing or evaluating individual care packages.

Table 10.1 Number and percentage of respondents indicating different innovation frequencies

Innovation frequency	Number of respondents (n)	Percentage of respondents (%)
Never	10	6.0
Occasionally	59	35.5
Sometimes	77	46.4
Often	18	10.8
Always	2	1.2

N = 166

Only six percent (n = 10) of those who responded to the frequency of innovation item reported not being innovative whilst planning, implementing or evaluating individual care packages. All other respondents of this item (n = 156, 94%) reported being innovative at least *occasionally*. More than a third of respondents (36%) reported being innovative with care packages *occasionally* (deemed to be at least one in 50 cases). Forty-six percent specified they were *sometimes* innovative (occurring at least one in 20 cases). Approximately a tenth of respondents (11%) reported being innovative *often* (*i.e.* one in five cases), and only two respondents (1%) indicated they were *always* innovative when dealing with individual care packages. Thus, innovative care management practice appears to have

been far less frequent than non-innovative care management practice, supporting Hypothesis 1 (Chapter 8).

Table 10.2 Frequency of innovativeness by "Is innovative practice necessary?"

How often innovate?	"Is innovative practice necessary?"		
	Yes n (%)	No n (%)	Not sure n (%)
Never	8 (5)	1 (1)	1 (1)
Occasionally	47 (29)	2 (1)	9 (6)
Sometimes	71 (43)	2 (1)	3 (2)
Often	17 (10)	1 (1)	0 (0)
Always	2 (1)	0 (0)	0 (0)

N = 164

Table 10.2 shows the number and percentage of respondents who responded to both the innovative frequency and "Is innovative practice necessary?" items, scale point by scale point. The majority of respondents who considered innovative practice to be a necessary function of the care manager role claimed to be innovative at least *occasionally* (n = 137, 94%). Of those who were uncertain whether innovative practice was necessary in care management (n = 13), all but one individual reported being innovative during planning, implementing or evaluating individual care packages at least *occasionally*. Even those who considered innovative practice not to be a necessary care manager function (n = 6), tended to report having been innovative as a care manager (n = 5). Interestingly, there were eight respondents who considered innovative practice was necessary for care management, yet reported *never* being innovative whilst planning, implementing or evaluating a care package.

Table 10.3 presents the number and proportion of social worker, nurse, therapist, and other/non-classified respondents who reported different frequencies of innovative care management practice. All therapists and almost all other/non-classified practitioners reported being innovative as a care manager only *occasionally* (at least one in 50 cases) or *sometimes* (at least one in 20 cases). Whilst the majority of social workers and nurses (84%

and 71%, respectively) reported being innovative as a care manager only *occasionally* or *sometimes*, a minority (11% of social workers, 14% of nurses) reported being innovative at least one in five cases (*i.e. often*). Two nurses (5%) reported being innovative whilst acting as a care manager *always*. Indeed, nurses appeared to be the most frequent care management innovators, with 19% indicating they were innovative either *often* or *always*, as opposed to 11% of social workers, 1% of other/non-classified practitioners, and 0% of therapists. However, nurses had the highest proportion of within profession respondents to report *never* being innovative as a care manager (10%, as opposed to 6% of social workers and no therapists or other/non-classified practitioners).

Table 10.3 Number and percentage of respondents by professional group indicating frequency of innovation

Frequency of innovative practice[a]	Social workers, n[b] (%)	Nurses, n[c] (%)	Therapists, n[d] (%)	Other, n[e] (%)
Never	6 (6)	4 (10)	0 (0)	0 (0)
Occasionally	38 (37)	12 (29)	5 (63)	4 (33)
Sometimes	49 (47)	18 (43)	3 (38)	7 (58)
Often	11 (11)	6 (14)	0 (0)	1 (8)
Always	0 (0)	2 (5)	0 (0)	0 (0)

[a] Frequency of being innovative whilst planning, implementing or evaluating individual care packages
[b] N = 104
[c] N = 42
[d] N = 8
[e] N = 12

Do care management practitioners undertake service development work?

Respondents were asked to specify whether they undertook service development work. This type of innovative practice was considered (by the author) to refer to population level work, whereby services would be developed for groups of service users rather than for individuals alone. Only the latter (the individual level work) can be considered part of the care management model of practice. However, the service development item was

included in the questionnaire to see what other ways, if any, care management practitioners considered they were being innovative.

Of the 165 respondents (91% of the sample) who responded to the service development item, just under half (n = 78, 47%) reported undertaking service development work. The remainder of those who responded (n = 87, 53%) indicated they did not undertake service development. Sixteen failed to respond to the item, their non-response indicating, perhaps, their lack of involvement in service development work.

Table 10.4 Number and percentages of respondents who indicated innovation frequency and undertaking, or not undertaking, service development work

Innovation frequency	Undertake service development work	
	No n (%)	Yes n (%)
Never	7 (5)	1 (1)
Occasionally	34 (22)	23 (15)
Sometimes	37 (24)	35 (22)
Often	4 (3)	13 (8)
Always	0 (0)	2 (1)
Mean[a]	0.06	0.14
Standard deviation[a]	0.08	0.20

[a] Mean (and standard deviation) innovation frequency score for service developer and non-service developer respondents. Innovation frequency scale values: "Never" = 0.01; "Occasionally" = 0.02; "Sometimes" = 0.08; "Often" = 0.40; and "Always" = 1.00.
N = 156

A comparison was made between the innovation frequency and service development items to explore whether those who claimed to be more frequent care package innovators were also the ones who tended to be service developers. Table 10.4 combines (care package) innovation frequency and undertake service development data. Of those who indicated undertaking development work, all except one indicated being an innovative care manager in at least one in every 50 cases (*i.e. occasionally*). Just seven respondents reported both not undertaking service development work and *never* being innovative as a care manager.

Conducting an independent samples t-test revealed that the mean innovation frequency score of service developers was significantly higher than that of non-service developers ($Mean_{service\ developers}$ = 0.14, $S.D._{service\ developers}$ = 0.20; $Mean_{non\text{-}service\ developers}$ = 0.06, $S.D._{non\text{-}service\ developers}$ = 0.08; t = -3.220, d.f. = 154, p = 0.00). Thus, those who reported undertaking service development work tended to be more frequent care package innovators than those who indicated they did not undertake service development work.

Table 10.5 Number and percentage of respondents by professional group indicating if undertake service development work

Undertake service development work	Social workers, n[a] (%)	Nurses, n[b] (%)	Therapists, n[c] (%)	Other, n[d] (%)
No	58 (56)	20 (48)	3 (38)	6 (50)
Yes	45 (44)	22 (52)	5 (63)	6 (50)

[a] N = 103
[b] N = 42
[c] N = 8
[d] N = 12

Table 10.5 shows the number and percentage (within profession) of social workers, nurses, therapists, and other/non-classified practitioners who reported either undertaking or not undertaking service development work. Approximately half of respondents in each practitioner group reported undertaking service development work. However, social work respondents appeared the least likely to report undertaking service development work (44%, as opposed to 52% of nurses, 63% of therapists, and 50% of other/non-classified respondents).

Innovative practice, job demands, job discretion and stress: correlations

Table 10.6 shows the Pearson Product Moment correlation coefficients for innovation frequency with stress level change, job demands, and job discretion variables. The relationships between these variables were

explored in a first attempt to support, or discount, Hypotheses 2 and 4 (see Chapter 8).

Table 10.6 Correlation coefficients, r, between innovation frequency, stress level change, job demands, job discretion and job satisfaction variables

	Innovation frequency[a]
Stress level change[b]	-0.16*
Job demands[c]	0.01
Job discretion[c]	0.29**

* Correlation is significant at the 0.05 level (1-tailed)
** Correlation is significant at the 0.01 level (1-tailed)
N = 165 - 166
[a] Innovation frequency scale: 0.01 = "never", 0.015 = "occasionally", 0.075 = "sometimes", 0.40 = "often", 1 = "always".
[b] Stress level change scale: 1 = "decreased a lot", 2 = "decreased a little", 3 = "stayed the same", 4 = "increased a little", 5 = "increased a lot".
[c] Job demands/job discretion scale: 1 = "not at all", 2 = "to some extent", 3 = "quite a lot", 4 = "very much indeed".

A significant, though weak, negative association between *innovation frequency* and *stress level change* was found ($r = -0.16$, $p <= 0.05$). The direction of the relationship indicates that increased stress levels are associated with reduced frequency for (care package) innovation frequency, and vice versa, in line with Hypothesis 2. However, the correlation coefficient between these two variables is so small that little weight can be given to this finding. Therefore, the evidence for a definite association between occupational stress and innovative care management practice using the present data is exceedingly weak.

A stronger (positive) relationship was found between innovation frequency and job discretion variables ($r = 0.29$, $p <= 0.01$). Thus, those with higher job discretion scores also tended to report more frequent innovative care management practice. Likewise, those with low levels of job discretion typically reported less frequent innovative practice. Although Hypothesis 4 predicted high job demands, as well as low job discretion, would be associated with low frequency of innovative practice, no relationship was found between innovation frequency and job demands variables.

Job demand-job discretion quadrants and innovation frequency: applying and testing Karasek's model

To explore whether combinations of the job demands-job discretion variables — the quadrants of Karasek's Model of Job Strain — were associated with variation in innovation frequency scores, a one-way analysis of variance (ANOVA) was conducted[1]. Hypothesis 4 predicted that high job demands and low job discretion would be associated with low innovation frequency. In addition to this association, if Karasek's model could be applied to the prediction of innovation (frequency), low demands combined with low discretion, and high demands combined with high discretion, should lead to moderate levels of innovation frequency, and low demands-high discretion should lead to high levels of innovation frequency[2].

Table 10.7 ANOVA results for innovation frequency by job demand-job discretion quadrant

	Sum of squares	df	Mean square	F	Sig. (p)
Between Groups	0.138	3	0.046	4.034	0.111
Within Groups	3.65	161	0.023		
Total	3.79	164			

Note Innovation frequency scale: 0.01 = "never", 0.015 = "occasionally", 0.075 = "sometimes", 0.40 = "often", 1 = "always".

As shown in Table 10.7, the results of the ANOVA were insignificant. Thus, there appeared to be no real difference in the mean innovation frequency scores of respondents across job demand-job discretion quadrants. However, the bar chart in Figure 10.1 suggests that there were some tendencies. For instance, respondents reporting low job demands and high job discretion reported the highest frequency of innovative practice (mean =

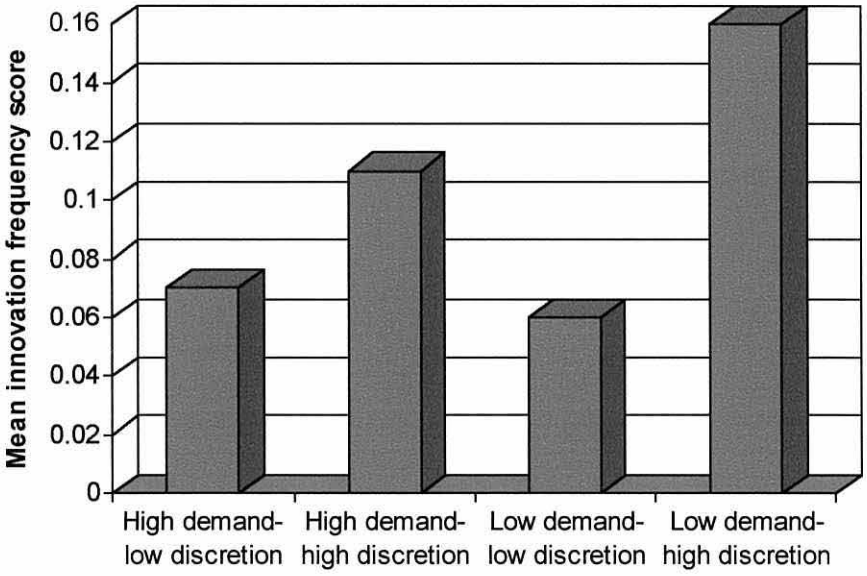
[1] This was the same type of analysis conducted with the job demands-job discretion quadrants and stress level change variable in Chapter 9, used to test Karasek's model.

[2] Whilst the analysis of cross-sectional data cannot provide results indicating functional variability of one variable by another variable (or combinations of variables), the degree of equivalence of variability in two or more variables can be examined.

0.16, S.D. = 0.26; n = 15). Those reporting low job demands with low job discretion, and high job demands with low job discretion, reported the lowest levels of innovation frequency ($mean_{low\ demand\text{-}low\ discrtetion\ group}$ = 0.06, S.D. = 0.10, n = 14; $mean_{high\ demand\text{-}low\ discrection\ group}$ = 0.07, S.D. 0.10, n = 53). Those reporting high job demands with high discretion reported middling levels of innovation frequency compared with other groups (mean = 0.11, S.D. = 0.16, n = 83).

The lack of statistical significance found through the ANOVA may have occurred because of the almost floor levels of innovation frequency apparent with the majority of respondents. Even though there may have been a floor effect, there was still a noticeable tendency for high job demands and low job discretion to be associated with low frequency of innovative practice, in accordance with Hypothesis 4. Since the opposite occurred with low demands and high discretion, that is an association with higher frequency of innovative practice, there was a degree of support (albeit non-significant) for the application of the Karasek (1979) model for predicting individual innovative practice.

Figure 10.1 Mean innovation frequency scores by demand-discretion quadrant



Predictors of innovation frequency

Similar to the exploration of the stress level change variable, a series of multiple linear regression analyses were conducted with the innovation frequency variable as the dependent variable. Variables included in the regression analyses were: stress level change, job discretion, job demand, service development work, gender, years since qualifying, caseload size, service demand change, change in resources, and satisfaction and practice change variables. These were the same (independent) variables used in the stress level change regression analyses, except that stress level change was now included as an independent variable and innovation frequency as the dependent variable.

Table 10.8 Frequency of innovativeness linear regression analysis: Stepwise method 1 (F-to-enter = 0.05; F-to-remove = 0.10)

Variables	Unstandardized coefficients		Standardized coefficients	t	Sig
	B	Std Error	Beta		
(constant)	-9.943E-02	0.069		-1.432	0.155
Job discretion	9.486E-03	0.004	0.228	2.506	0.014
Service development work	6.261E-02	0.028	0.206	2.264	0.025

R = 0.344 R^2 = 0.118 Adjusted R^2 = 0.103 Std. Error of the Estimate = 0.145

Table 10.8 presents the results of a stepwise regression analysis (where F-to-enter = 0.05, and F-to-remove = 0.10). Just two variables were found to be predictive of innovation frequency: job discretion and service development work. Thus, high job discretion and doing service development work were predictive of greater frequency of innovation. However, only just 12% of the variance in the innovation frequency variable could be explained by job discretion and service development variable scores (R^2 = 0.118). And, when adjusted for error only 10% of the variance in the innovation frequency variable could be explained by the regression equation (Adjusted R^2 = 0.103). Therefore, 90% of the variation in innovation frequency scores was

left unaccounted for, despite the large number of variables processed during the regression analysis.

To test the robustness of the regression model, the same independent variables were used in further regression analyses using different methods. Forward and backward methods produced exactly the same regression model as the stepwise method (where F-to-enter = 0.05 for the forward method, and F-to-remove = 0.05 for the backward method). Whilst the original regression model was found to be the best fitting model of the data at the 5% probability level, the small amount of explained variance suggests that other factors not included in the analyses may be better predictors of innovation frequency.

In order to ascertain whether any of the originally excluded (independent) variables could help to explain more of the variance in innovation frequency, more lenient criteria were applied for entry and removal of independent variables using the stepwise method (F-to-enter = 0.10, F-to-remove = 0.15). However, the same regression result occurred, suggesting that of the variables entered into the different regression analyses only job discretion and service development variables reliably predicted (a proportion of variance in) innovation frequency.

The innovation frequency regression analyses produced only weak support for Hypothesis 3. Whilst the majority of factors considered likely to be associated with innovative care management practice (such as job demands, resources, and manager support) were not found to be predictive of innovation frequency, job discretion was. Although not named as a factor potentially associated with innovative care management practice in Hypothesis 3, undertaking service development work was, additionally, found to be partly predictive of innovation frequency. Thus, underlying personality (or motivational) differences, as well as degree of job discretion, appear to be influential in the frequency of care package innovation.

Hypothesis 2, that reported stress level change and innovation frequency would be associated, was not supported by the regression analyses.

Innovative practice – qualitative data

Responses to the open ended questions in the Innovative Practice section of the questionnaire, regarding factors affecting innovative practice and respondent produced examples of innovative practice, are examined here.

Factors which help or hinder innovative practice

Respondents were asked: "What helps or hinders your innovative practice?" One hundred and one practitioners gave 'helps' responses and 125 gave 'hinders' responses (56% and 69% of survey respondents, respectively). Of those who gave 'helps' responses, 63% were social workers, 25% were nurses, 6% were therapists, and 6% were 'other/non-classified' practitioners. An almost identical responding pattern was found in regards to the 'hinders' responses, where 63% were social workers, 24% were nurses, 6% were therapists, and 6% were 'other/non-classified' practitioners. The figures are comparable with those for overall responding to the survey by the different professional groups (62% for social workers, 24% for nurses, 4% for therapists, and 9% for 'other/non-classified' respondents).

Helps innovative practice

Table 10.9 lists the 'Helps innovative practice' category headings generated from responses, and the number and proportion of responses per category.

Table 10.9 "Helps innovative practice" categories and response numbers

Category	Number of respondents giving response	Proportion of respondents (N=101) giving response (%)
Team working	44	44%
Manager support	29	29%
Knowledge	15	15%
Autonomy	15	15%
Flexibility of providers	8	8%
Finances	7	7%
Attitude of self	5	5%
Experience	5	5%
Other	12	12%

The most frequently mentioned factor that helps innovative practice for care management practitioners is ***team working*** (44% of respondents who gave a "helps" response, n = 44). Various sub-categories of responses became apparent under the umbrella "team working" category. These were as follows, with examples:

Exchange of information between colleagues (20 respondents commented) For instance:

> "Discussing situations with colleagues." (Social worker)
>
> "Hearing about other workers innovative practice." (Social worker)

Multidisciplinary team working (12 respondents commented). For example:

> "MD [multidisciplinary]/collaborative working." (Social worker)

Or, combining this category and the *Exchange of information* category:

> "Use of reflective practice. Liaison/discussions with MDT [Multidisciplinary Team] and other colleagues." (Nurse)
>
> "Multidisciplinary team. Having colleagues from other professions to discuss and plan." (Other/non-classified practitioner)

Colleague support (12 respondents provided responses), such as:.

> "Encouragement from others." (Social worker)
>
> "Good multidisciplinary practice and shared values about patient care. Excellent support from team." (Social worker).

The *Attitude of others* (11 respondents) category included, for instance:

> "Enthusiastic co-workers." (Social worker)
>
> "Open-minded team members. Flexible working practice." (Social worker)

Manager support was the second most frequently reported type of response (29% of respondents, n = 29). Examples of this category of response are:

> "My team manager is supportive towards promoting innovative practice." (Social worker)
>
> "Very supportive manager who allows us to try different things." (Social worker)
>
> "Support, discussion, positive supervision." (Nurse)
>
> "Having an understanding budget holder." (Nurse)
>
> "Management backing/appreciation." (Other/non-classified practitioner)
>
> "Praise and encouragement. Recognition/value of role and ideas. Being given opportunities to take part in appropriate forum." (Nurse)

One respondent appeared to have difficulty giving a positive response to the request for factors that help innovative practice, but indicated that supportive management would most likely facilitate such practice:

> "Hard to say that anything does, but a more imaginative approach from management would be helpful, although I understand they work under a constraining system." (Social worker)

Having colleague and manager support were both clearly linked in the minds of many respondents as being helpful to their innovative practice, as the following example indicates:

> "Supportive management who are committed to the development of new services. Enthusiastic colleagues who encourage and help out when they are able." (Social worker)

Knowledge and knowledge acquisition were also reported as important facilitators of innovative practice (15% of respondents). For example,

> "Knowledge of local community." (Nurse)
>
> "Training opportunities. Keeping abreast of new developments/ equipment." (Therapist)

Having management support was recorded as being a necessary precursor for some types of knowledge acquisition, as indicated by the following:

> "Backing for training and consultation." (Social worker)

Autonomy was considered helpful for innovative practice (15% of respondents). For instance:

> "A degree of freedom and flexibility within the role. My ability to stand alone
> with other professionals." (Social worker)
>
> "Being in a GP practice and being my own boss! to an extent!" (Social worker)
>
> "Freedom to develop my own ideas." (Social worker)

Flexibility of providers, availability of ***finances***, having a certain ***attitude*** oneself and past ***experience*** were other factors noted by a few respondents. Examples of responses included:

> "Agencies being prepared to be flexible." (Social worker)
>
> "Access to resources." (Social worker)
>
> "Being willing to invest one's own time/effort." (Social worker)
>
> "Initiative, experience and contacts. Development of working relationships with *e.g.* private sector homes, community based nursing staff." (Social worker)

Hinders innovative practice

Eight main category headings were generated from the "Hinders innovative practice" responses. Table 10.10 gives the number and proportion of respondents who supplied responses falling under the different headings.

Table 10.10 "Hinders innovative practice" categories and response numbers

Category	Number of respondents giving response	Proportion of respondents (N=125) giving response (%)
Lack of resources	61	49
Lack of time	48	38
Lack of support	21	17
Attitudes	18	14
Bureaucracy	12	10
Nature of work	11	9
Inflexible providers	8	6
Local policy	7	6
Other	7	6

The most frequently reported 'hinders' factor was ***lack of resources***, with nearly half the respondents (n = 61) who gave a response noting its importance in this respect. Some respondents stated it very simply:

> "Budgets" (Social worker)
>
> "Resource limitation." (Social worker)

Others spelled it out a little fuller:

> "Lack of resources – human and financial" (Nurse)
>
> "Working in a rural area where services can be difficult to secure." (Social worker)
>
> "Services unable to respond to need because of lack of funding" (Other/non-classified practitioner)
>
> "We have to take what we can get." (Nurse)

Whilst some of the 'hinders' responses were clearly the opposite of the factors given which help innovative practice, many responses were not. Of particular note was ***lack of time***, which nearly two-fifths of respondents (38%, n = 48) indicated hindered their innovative practice. Having a sufficiency of time was reported by only a single respondent as helpful for innovative practice: "Time to think out outcomes, discussions with colleagues." Examples of responses of the *lack of time* category include:

> "Lack of time - pressure of work." (Social worker)
>
> "Too busy – crisis driven." (Social worker)
>
> "Lack of own creativity due to pressure of work." (Therapist)
>
> "Lack of time to follow up research and lack of time for brainstorming new ideas". (Nurse)

A number of respondents explicitly linked their lack of time for innovative practice to high referrals and caseloads:

> "Increasing caseload and care management responsibilities require more
> time, thus limiting options." (Social worker)
>
> "Not enough time. High number of referrals." (Social worker)
>
> "Lack of time/high caseload." (Social worker)

Others made more indirect associations between insufficient time and caseload or workload size:

> "Too large a caseload." (Nurse)
>
> "Too heavy a workload." (Social worker)

Many jointly made reference to lack of time and insufficient resources:

> "Lack of time and resources." (Nurse)
>
> "Finite resources. Lack of time." (Therapist)

"Time. Other duties. Financial limitations. Caseload priorities. Request for speed re. hospital discharge." (Social worker)

Lack of support and ***attitudes*** of others were considered hindering factors by 17% (n = 21) and 14% (n = 18) of respondents, respectively. Managers appeared to be the biggest culprits of being non-supportive, and boundary problems between agencies were also noted as hindering innovative practice. Responses included the following:

"Management inertia." (Other/non-classified practitioner)

"Management do not pick up suggestions because they are threatened by them. Power struggles. Unclear thinking." (Social worker)

"SSD vs Health Authority boundaries/mentality." (Social worker)

"Departmental middle management, lack of joint working policies with health, lack of shared perspectives with Housing." (Social worker)

"Lack of feedback from SSD management. Limited communication. Reluctance of NH Trust to fund cooperative ventures." (Social worker)

"Dogma." (Nurse)

"Cynicism, lack of support, high caseload." (Nurse)

"Stereotypical attitudes. (Social worker)

Colleagues and clients were also reported as being non-supportive or being negative about innovation. For example:

"Lack of support from other staff members." (Social worker)

"Negative attitudes of co-workers."(Social worker)

"Resistance to change by certain staff." (Nurse)

"Clients not willing to cooperate." (Social worker)

Providers were also accused (by several respondents) of being unsupportive or, rather, of being ***inflexible***. For instance:

"Inflexibility of service providers." (Social worker)

"Keeping 'tabs' with service – and getting service to be flexible." (Social worker)

One practitioner gave a clear indication of why this might be so:

"Services unable to respond to need because of a lack of funding. Little or no
incentive for no/low cost services to provide for service users." (Other/non-classified practitioner)

Bureaucracy and the ***nature of practitioners' work*** were noted as hindering innovation by approximately 10% of respondents. Noted by a small number, ***local policy*** was also apparently disabling. The fact that local authorities, in particular, are bureaucratic organisations, designed for implementing certain legislation, appeared to be a key reason why some (social worker) practitioners experienced difficulties in being innovative. Examples of the categories are:

"Bureaucracy, getting past senior management." (Social worker)

"Bureaucracy from HQ." (Social worker)

"Volume of assessments which usually require that the client will go into L.T. nursing or residential care – *i.e.* the bulk of the work requires routine solutions." (Social worker)

"Perhaps we're conscious that we work in a local authority department which is directed by statutory acts and operates in the usual 'bureaucratic' way *i.e.* the systems we operate etc." (Social worker)

"Local policy." (Social worker)

"Legislation." (Social worker)

Some respondents indicated that it was care management itself that hindered their innovative practice. Their comments appear to reflect an erosion of the more traditional, provider roles of nurses and social workers, and a lack of flexibility of the care manager role in meeting the needs of all clients:

"Care management and lack of understanding from managers." (Nurse)

"Carrying out care management. Too many clients." (Nurse)

"Constraints on what is regarded as the role of the social worker." (Social worker)

"Defined roles." (Social worker)

"Care managing cases." (Social worker)

Examples of innovative practice

Respondents were asked to give one example of their innovative practice "whilst planning, implementing or evaluating an individual care package". One hundred and eighteen practitioners, 65% of the survey respondents, responded to the question. All responses were first checked to see whether they were valid or not, that is, whether they appeared appropriate to the question asked. Eighty-nine valid responses were given and 38 invalid responses. Four respondents had given two examples in response to Question 8, which required only one. The first of their examples were counted as "valid" and the second as "invalid". Other invalid responses were those that lacked sufficient information to be categorised, were too vague or did not make any sense. A few related to service development rather than care packaging and three respondents indicated that innovative practice was impossible at that time.

Sixty-seven percent of the 89 respondents who provided valid examples were social workers (n = 60), 24% were nurses (n = 21), 5% were therapists (n = 4), and 5% were 'other' practitioners (n = 4). Since social workers formed the largest respondent group in the overall survey (62%), it is to be expected that they would also provide the greatest number of innovative care management practice examples. However, the proportion of social worker innovative practice responses was slightly higher, compared with the other professional groups, than their proportion in the overall survey (67% as

opposed to 62%). Nurses and therapists responding to the innovative practice example exhibited similar proportions to their responding proportions in the overall survey (the latter being 24% for nurses and 4% for therapists). The proportion of other/non-classified practitioners was lower in the innovative practice example than it was in the overall survey (5% as opposed to 9%).

The valid examples of innovative practice were treated to two different analysis methods. The first was to categorise the responses under headings that emerged from the data; a summary of the findings are presented, with example responses of each category (see Appendix 10 for all valid examples and their category codes). The second method was to get experts to rate the degree of 'innovativeness' (imaginativeness) of the examples. A description of the method and findings is given in the last section of this chapter.

The diversity involved in the innovative practice of the 89 respondents who gave valid examples is indicated by the breadth and number (14) of category headings, as shown in Table 10.11. Some of the innovative practice examples fitted more than one category, whereas others fitted only one. A description of each category follows with a sample of relevant examples. When considering the examples given below, it should be remembered that the qualification of these as *innovative practice* was given by the practitioner respondent him- or herself. Only the practitioner can truly know whether, and to what degree, the example given is innovative in the light of their previous practice. Thus, some of the examples may not seem innovative to the reader.

Table 10.11 Valid innovative practice examples: categories and response numbers

Category	Number of respondents giving response	Proportion of respondents (N=89) giving response (%)
Institutional setting	18	20
Aid to health	18	20
Finances mentioned	16	18
Community/voluntary agency involvement	14	16
User empowerment	13	15
Mixed agency care	11	12
Vocational/educational	10	11
Leisure	9	10
Eating arrangements	7	8
Support worker	6	7
Carer benefit	5	6
Increased service flexibility	4	4
Equipment	4	4
Other	6	7

The innovative care management practice examples of a fifth of respondents who provided an example (n = 18) fell under the ***institutional setting*** heading. This category represented examples of innovative practice involving day, residential or respite care. For instance:

> "The provision of day care at a residential home coupled with regular respite that hopefully will lead to long term placement there." (Nurse)
>
> "Use of shared care bed facilities. Client home with main carer part of a week – residential or hospital care rest of week." (Social worker)
>
> "Arranging SSD/voluntary day care for hospital in-patient in order to promote psychological welfare." (Social worker)

A fifth of respondents (n = 18) provided examples which were classified as an ***aid to health***. Such examples involved reference to enhancement of service user wellbeing as a consequence or rationale of the innovation. Such examples were:

> "Arrange a care package for the children so the mother can attend physiotherapy at the hospital." (Social worker)

"Recommending use of tandem for adult with autistic tendencies with lots of energy." (Nurse)

"Confused, agitated man in residential care, searching for his wife constantly. Use of smell (lavender oil) for relaxation and reassurance (she used to grow lavender) rather than tranquillisers." (Nurse)

The ***finances mentioned*** category includes innovative practice examples which made reference to finances. The examples of close to a fifth of respondents (18%, n = 16) fell into this category. For instance:

"OT work. Client falls with MS regularly. Finds it easiest to get up by crawling to stairs. Paid builder to make two steps – carpet covered. Kept in bedroom for just such occasions." (Other/non-classified practitioner)

"A person wanted to go on holiday. This man had Parkinson's disease – the cost of an escorted holiday – the escort part was cheaper than his care package so funding was agreed." (Social worker)

"Working out an intensive care package, from a variety of sources – health, voluntary and family, to ensure adequate support. The financial limit currently imposed by our authority would not have allowed an adequate package." (Social worker)

Those innovative practice examples which indicated community or voluntary agency involvement in care arrangements were classified by the ***community/voluntary agency involvement*** category. Sixteen percent of respondents (n = 14) provided such examples as:

"Using a voluntary agency (which supports carers) to provide a volunteer for a stroke damaged client to practice her speech and writing because speech therapy from health sector has been withdrawn and the client is very motivated towards regaining these skills." (Social worker)

"Involving a Mencap representative in the initial assessment meeting provided a link to the local resource centre and a face to remember from the beginning." (Social worker)

"Asking a local shop to call in to a housebound couple while they were without a phone or neighbours were away." (Social worker)

Examples under the ***user empowerment*** heading included those that clearly encouraged service users to make decisions for themselves and get their voice heard (15% of respondents; n = 13). For instance:

> "Evaluation of a care package. Asking clients to look at care plans and discuss what they thought would happen? How well the package worked? If their objectives were met, if not how could they be and then drawing up a new care plan." (Social worker)

> "To encourage/introduce community integration/activities which is user led. These are monitored monthly during club meetings. Users encouraged to participate on committees etc. in order to improve services – increase choice according to need." (Therapist)

The *user empowerment* category also included examples of the setting up of self-help schemes, such as:

> "I have helped a client to set up a user led self-help group for clients suffering with depression." (Nurse)

> "'Skills matching' among clients. Arrange meeting in neutral venue to discuss and negotiate what skills exchange could be achieved e.g. one client repairs clothes in exchange for hedge being trimmed." (Therapist)

Twelve percent of respondents (n = 11) gave examples of innovative practice which involved mixed or multi-agency care, included in the ***mixed agency care*** category. For instance:

> "Case management of dual diagnosis client with HIV. Good example of inter-agency cooperation to provide a comprehensive package of care which incorporated 8-10 agencies." (Social worker)

> "Persuading the LA that a stroke/brain damaged victim could spend the nights in residence and go home at times during the day working towards rehabilitation [at] home and have H/C [Home Care] to help at home at the same time." (Social worker)

> "Use of a private care agency in combination with statutory services and health professionals to ensure total care at home for a terminally ill patient." (Social worker)

Vocational/educational responses were examples of innovative practice that made reference to developing or introducing work, education or training opportunities for service users (and their family carers). Eleven percent of respondents (n = 10) provided such examples as:

> "Introducing client with mental health problems to work with horses which he had requested. Persuading employer/owner of racing stable to employ client." (Social worker)
>
> "Introducing voluntary work as a form of respite for both patient and family." (Nurse)
>
> "Extending care to more detailed training with patients and carers, e.g. individual packages for assertiveness/communication/relationships or anger management." (Nurse)

Examples provided by a tenth of respondents (n = 9) fell into the ***leisure*** category, and made reference to leisure activities and holidays. For instance:

> "Accessing a tailor made holiday for a client to suit her needs perfectly." (Social worker)
>
> "Arranged evening social activities with other people with learning disabilities using community facilities." (Social worker)
>
> "Using e.g. education authority to arrange divisional [diversional?] activity (pottery class)." (Nurse)

Eating arrangements examples consisted of innovative practice which focused on novel ways of providing meals for service users. The use of pubs for providing meals was mentioned by six out of seven practitioners whose responses fell within this category. All six were based in the same county which is suggestive of the sharing of good practice. The seventh practitioner made reference to meals at a luncheon club. Examples are:

> "Arranged for a local pub to deliver a cooked lunch on a daily basis to an adult with learning disability who wanted to remain in his own home after the death of a carer. This was an interim measure while he underwent a process of independent living skills training." (Social worker)

"Using community resources such as good neighbour scheme to ensure someone attended a luncheon club as they did not want MOWs [Meals on Wheels]." (Social worker)

Support worker, ***carer benefit***, ***increased service flexibility*** and ***equipment*** categories included the examples of six or fewer respondents. Examples included:

"Introducing a group of students to one sheltered housing complex and arranging that they call to get to know individuals to undertake tasks such as shopping, transporting elderly person to visit brother 20 miles away or just generally sitting down for a chat. Supporting group on a monthly basis." (Other/non-classified practitioner)

"Allowing time for a carer to undertake a social activity." (Social worker)

"Ability to use a support service provided by Age Concern in a more flexible way – with full backup and encouragement of Age Concern. The client's needs were regarded as more important than a rigid adherence to the service provision." (Social worker)

"Using community care funding to install a safety isolation gas switch for a confused elderly lady." (Social worker)

The examples of six respondents fell into the ***other*** category. These were mainly one-off examples or were too general to classify. For instance:

"Exploring changing package [of] personnel to meet client's needs. Yes this is possible if the contracts are set up positively." (Nurse)

"Arranging trial at home without services." (Social worker)

Service development examples

Respondents were asked to provide one example of service development work, if they undertook this type of work. As indicated previously, service development work was viewed as another possible avenue for the innovative practice of care management practitioners. Eighty respondents provided examples. However, three of these stated that they were not involved in service development work (one indicated there was a service development

team responsible for this, and the other two reported that they used to do it but now no longer had the time), and four provided insufficient information to make a service development classification. Thus, there were 73 valid service development examples, representing 40% of all survey respondents.

Sixty-three percent of those who provided a valid service development example were social workers (n = 46), 23% were nurses (n = 17), 7% were therapists (n = 5), and 7% were 'other' practitioners (n = 5). Responding from the different professional groups for the service development example item, therefore, represents similar proportions to overall responding to the questionnaire (62% for social workers, 24% for nurses, 4% for therapists, and 9% for other/non-classified respondents)

Three main categories of service development examples emerged, as shown in Table 10.12a. Almost all of those who gave a valid service development example (n = 71, 97%) specified *service development type or method*. Just over three-fifths of the respondents (n = 45, 62%) indicated the type of service in which the service development work was conducted, the *target service*. Just over half the respondents (n = 38, 52%) mentioned a *target group* (service users or carers). The characteristics of, and examples from, these main categories are given below.

Table 10.12a Service development examples: categories and response numbers

Category	Number of respondents giving response	Proportion of respondents (N=73) giving response (%)
Service development type or method	71	97
Target service	45	62
Target group	38	52

Service development type or method

Table 10.12b presents the sub-categories that come under the *service development type or method* main category heading.

Table 10.12b Service development type or method sub-categories and response numbers

Sub-category	Number of respondents giving response	Proportion of respondents (N = 71) giving response (%)
Implementation stage	27	38
Planning stage	24	34
Service development groups or meetings	22	31
Multi-agency/multi-disciplinary	14	20
Training	11	15
Evaluation	8	11
Policy or practice development	7	10
Other	2	3

Almost two-fifths of those who provided a service development type or method example (n = 27, 38%) indicated they had been involved in the ***implementation stage*** of a service development. In these instances it was not always clear whether the individuals concerned had been the originators of the service development idea. For instance:

> "I work on practice based projects such as the 75 plus health checks. Social care needs are now included along with health care needs in the assessment. Letters are sent on by both the practice nurses and myself to all over 75s. This involves me in some preventative work." (Social worker)

> "Development of a 'hiring service' *i.e.* getting 'hired' workers to support and assist clients to work following a period of mental illness." (Social worker)

> "Introducing Red Cross into our service control stores *i.e.* equipment loaned for aids and adaptations. Red Cross now fit 80% approx. of equipment assessment for client." (Social worker)

"Introducing an out of hours on-call service." (Nurse)

However, according to West and Farr's (1989) definition of innovation (see Chapter 3), innovation need only involve "intentional introduction" or "application" of "ideas, processes, products or procedures, new to the relevant unit of adoption". Thus, service development examples which indicate the respondent was involved in implementation can appropriately be classified as innovative, providing the 'innovation' was "new to the relevant unit of adoption".

Just over a third of respondents who gave a service development type or method example (n = 24, 34%) appeared to have been involved in the ***planning stage*** of a service development. Some of these examples are:

> "Involved in planning future services specifically for women." (Social worker)
>
> "I am on a steering group developing specialist residential care for drug users." (Social worker)
>
> "Much of my recent development work has been in conjunction with Housing Association, special needs housing officers and day care and respite services. I am currently working with a group of people employed in a newly developed respite centre to look at how it can be best utilised. We are, at this point, looking at short term intensive rehab. With a view to 'move on' to a more independent setting, *e.g.* housing with support." (Social worker)

Several respondents provided examples that indicated that they were involved in both the *planning stage* and *implementation stage* of service development work. For instance:

> "The setting up of a specialist workshop within an ATC [Adult Training Centre] setting. Being involved in the transformation of ATC to resource centre." (Nurse)
>
> "Involved in local planning team as well as starting new services within team." (Nurse)

> "I have been involved in developing and co-ordinating an intensive support team which offers high level of input to clients to avoid admission to hospital." (Nurse)

Almost a third of respondents (n = 22, 31%) provided service development type or method examples which fell into the sub-category ***service development groups or meetings***. These were examples which specified the type of forum in which service developments were planned or implemented. For instance:

> "Attempting to set up a meeting with the local drug and alcohol agencies in the hospital so that hospital staff can hear what can/cannot be arranged for service users on discharge." (Social worker)

> "I attend co-ordination of care meetings for HIV/AIDS services to develop local services." (Social worker)

> "Meetings with health, grants department, other offices." (Therapist)

A fifth of respondents who provided service development type or method examples mentioned their involvement in ***multi-agency or multidisciplinary*** service development work (n = 14, 20%), such as:

> "Closer working arrangements with Area Health." (Social worker)

> "Set up joint meetings with district nurses working on the patch. Also care management patch meetings with home care supervisors." (Social worker)

> "Co-opted as advisor to local mental health agency committee." (Social worker)

Eleven respondents (15%) gave examples which specified a ***training*** element to their service development work. For example:

> "Planning and implementing training workshops." (Social worker)

> "Sexuality policy and training." (Social worker)

Eight respondents (11%) mentioned ***evaluation*** or reviewing as an aspect of their service development work. For instance:

"Recently reviewed provision of home shopping service provided by private agency to evaluate service and provide basis for future service planning and delivery." (Social worker)

"Recent review of service has led to extra staffing which will result in development in rehabilitation aspect of work." (Therapist)

The examples of seven respondents (10%) indicated they were involved in ***policy or practice development***. For instance:

"Recently completed county policy and practice documents for displacement of nearest relative under Mental Health Act normally required in elder abuse cases." (Social worker)

"Looking at criteria for orange badges, MOW [Meals on Wheels] direct payment scheme." (Social worker)

The ***other*** service development type or method sub-category included two examples which had unique aspects. One respondent mentioned undertaking service development with users:

"Setting up club for leisure pursuits in conjunction with voluntary bodies and user." (Therapist)

The other respondent whose example fell in the *other* sub-category indicated how he/she had to be persistent in order to change service delivery:

"Constantly make suggestions at Hosp and LA [local authority] meetings about inaproved [inappropriate/unapproved?] methods of doing things." (Social worker)

Target service

Table 10.12c Target service sub-categories and response numbers

Sub-category	Number of respondents giving response	Proportion of respondents (N = 45) giving response (%)
Health care	9	20
Residential or respite	8	18
Leisure or transport	7	16
Social care	7	16
Assessment	5	11
Support workers	2	4
Rehabilitation	2	4
Prevention	2	4
Other	15	33

Table 10.12c indicates the type of target service evident from the examples of the 45 respondents whose examples fell into this sub-category. The most frequently cited service targets were ***health care*** (n = 9), ***residential or respite*** (n = 8), ***leisure or transport*** (n = 7), and ***social care***. Examples of the *health care* sub-category are:

> "As well as a care manager I am also a manager and practitioner. Managing health workers means I am responsible for the development of health care services particularly in meeting health gain targets." (Other/non-classified practitioner)

> "I have sat on Steering Committee for Hospital Discharge Policy." (Social worker)

Examples of the *residential or respite* sub-category are:

> "When the local planning group was still in existence it provided a useful forum and contact with the Mental Health Development group. New developments at this time included the provision of a support bed unit." (Therapist)

> "Future development/planning of 'time out' beds." (Nurse)

Examples of sub-category *leisure or transport* are:

"At present setting up a library. Arranging training sessions." (Nurse)
"Organising a circus skills workshop for clients." (Nurse)

Social care sub-category examples include:

"The development of a holistic social work service for dialysis patients as part of a new development at this hospital." (Social worker)

"Working with staff to identify over 75's and then contacting SW's [social workers] and following up those known to SSD [social services department]. Project still on-going." (Social worker)

Less frequently mentioned as a service target was ***assessment*** (five examples). This sub-category included:

"I have been a part of a group which developed an initial assessment for our clients." (Nurse)

Sub-categories which had the examples of just two respondents each included ***support workers***, ***rehabilitation***, and ***prevention***. Examples with a unique element were included in the ***other*** sub-category.

Target group

As mentioned above, thirty-eight respondents gave examples that fell under the *target group* main heading. Of these the most frequently mentioned target group were ***people with physical disability*** (7 examples), followed by ***older people***, ***people with mental health problems***, and ***hospital patients*** (five examples each). Four examples of service development were apparent for people with ***hearing or visual impairment***, ***substance misuse*** and ***learning disabilities*** (see Table 10.12d). Just two respondents gave examples which could fall under each of the following sub-categories: ***HIV/AIDS***, ***children***, and ***carers***. Nine individual respondents mentioned target groups which were unique to their example.

Table 10.12d Target group sub-categories and response numbers

Sub-category	Number of respondents giving response	Proportion of respondents (N = 38) giving response (%)
People with physical disability	7	18
Older people	5	13
People with mental health problems	5	13
Hospital patients	5	13
Hearing or visual impairment	4	11
Substance misuse	4	11
People with learning disabilities	4	11
HIV/AIDS	2	5
Children	2	5
Carers	2	5
Other	9	24

Examples falling under the *target group* main heading include:

> "Liaison role with day centre for the physically disabled. Main project at present trying to devise strategies for those reaching upper age limit." (Social worker)

> "Through the Service Managers Monitoring and Development Group (i) Elders and (ii) Disability." (Social worker)

> "Lithium clinic, mood stabilisation groups." (Nurse)

> "Obtaining funding from Welsh Office to develop and manage interpreting service." (Social worker)

> "Establishing numbers of deaf-blind people in the area and categorising them to show service deficiencies." (Social worker)

> "Looking at support needs of parents with learning disabilities." (Social worker)

> "I am part of a group working towards implementing individual goal planning meetings for all patients on admission." (Social worker)

> "Development of specialist service for people with epilepsy." Nurse)

Expert ratings of the innovative practice examples

The author wanted to know whether it would be possible to get individual 'experts' to decide upon the degree of 'innovativeness' (imaginativeness) of the innovative practice (valid) examples and whether a degree of consensus could be achieved. By definition, an innovation has to be "new to the unit of adoption" (see Chapter 3). Therefore, when the innovation is at the individual practitioner level, judgements of self-innovativeness will be relative to the practitioner's own past experience and knowledge. Consequently, the degree of 'innovativeness' of a practitioner's practice can only truly be gauged by the practitioner him- or herself. This was made clear to the experts in their instructions (Appendix 11). They were, thus, asked to consider innovativeness as akin to imaginativeness or creativity. Theoretically, judgements of imaginativeness and creativity can be made by persons other than those who carried out and originally classified their practice as "innovative".

Survey respondents were given the following simplified definition of innovative practice:

> "Being innovative refers to introducing something as new or making changes within your work role."

Strictly speaking creativity relies on absolute novelty and originality whereas innovation does not – innovation may, simply, involve the introduction of something into a context in which it has not been used before.

In the process of rating examples of innovative practice in the way described, a quantification dimension was introduced to this qualitative data. Of interest to the author was how useful the quantification of this qualitative data could be in the examination of the relationship between innovative practice and occupational stress. Relationships between average degree of innovativeness (imaginativeness) ratings and other factors, such as frequency of innovative practice, stress level change, job control and job

demand, would be possible using SPSS. However, it would first be necessary to ensure that the degree of innovativeness rating scale was being applied reasonably consistently across experts, that is, that the scale had construct validity.

Six "experts" were approached in total. They consisted of the four core researchers (including the author) of the *Assessment and Care Management Project*, of which the survey was a part. They were chosen because of their understanding of care management and the factors influencing care management practice. Two care management practitioners (social work care managers), chosen from the five who participated in the first phase of the PhD study (the case study research), were also asked to be expert raters. They were two practitioners who indicated they conducted innovative practice on a regular basis. The practitioners were contacted by letter with follow up telephone calls and were informed that they could claim £10.00 for their time spent rating the 89 examples, which was estimated to take about an hour. They both agreed to undertake the task. However, only one practitioner completed and returned the rating task. All four researchers completed the rating exercise. The author undertook the task prior to examining any of the other "expert" ratings.

The experts were asked (on paper):

> "To what extent do you think each example is innovative (imaginative)? Using the rating scale below please place appropriate number in the box on the right-hand side of each example."
>
> "Can't decide" "Not at all" "To some extent" "Quite a lot" "Very much indeed"
> 0 1 2 3 4

All 89 innovative practice (valid) examples were then listed, with a box on the right-hand side of each example for recording the rating.

Two of the researcher experts provided written notes of how they had undertaken the task and the issues it raised for them. The author had also made notes, prior to distributing the rating sheets, about the potential

difficulties that the experts might encounter in undertaking the ratings. The main issues were as follows:

- knowledge of the roles of care management practitioners, what is not expected as standard practice (and may, therefore, be considered creative) is needed, yet no guidelines or empirical evidence exists on this – thus, decisions on what is standard and what creative practice is subjective and reliant on the "experts" personal knowledge;
- many of the examples of innovative practice given by respondents appeared to be what could be considered as standard practice;
- rating the imaginativeness/creativity of examples involved comparison between the examples, rather than judging the imaginativeness of each example separately against some notion of "ideal" innovative practice;
- some examples may have been more meaningfully rated if they gave an indication of why the practice described was undertaken, especially in relation to the relative benefit to service users and/or their carers;
- some examples just did not give enough information to allow for meaningful rating.

Inter-rater agreement

The expert codings were entered by case number onto the SPSS file containing the other quantitative data. The rating spread by rater was examined first, that is, each rater's frequency of usage of each point on the scale was compared with such usage by the other raters. Rating spread of each rater is indicated in Figure 10.2. As can be seen, the four researchers (Experts 1-4) show a similar pattern in their frequency of usage of the 5 points of the scale, with most examples (n = 52-69; 58-78%) given an innovative practice rating of 2 or 3 ("To some extent" or "Quite a lot"). The sole practitioner expert (Expert 5), however, scored the majority of examples (n = 74; 83%) with the number 1, equivalent to "Not at all" innovative (imaginative). There are several possible explanations for this difference. The practitioner rater may not have understood the task or may have interpreted the points on the scale in a different way to the researchers. Alternatively, she may hold a different model of innovative care management practice in her mind. She may be so innovative and imaginative herself that she considered the majority of responses given by other practitioners to

equate to her view of standard or normative care management practice and, thus, did not consider them to be innovative (imaginative).

Kappa calculations

Although there appears to be a reasonable amount of agreement between the four researcher experts in the use of the degree of innovativeness scale, as depicted in Figure 10.2, inter-rater agreement statistics were sought to examine agreement in scale usage case by case. A number of Kappa calculations were subsequently conducted.

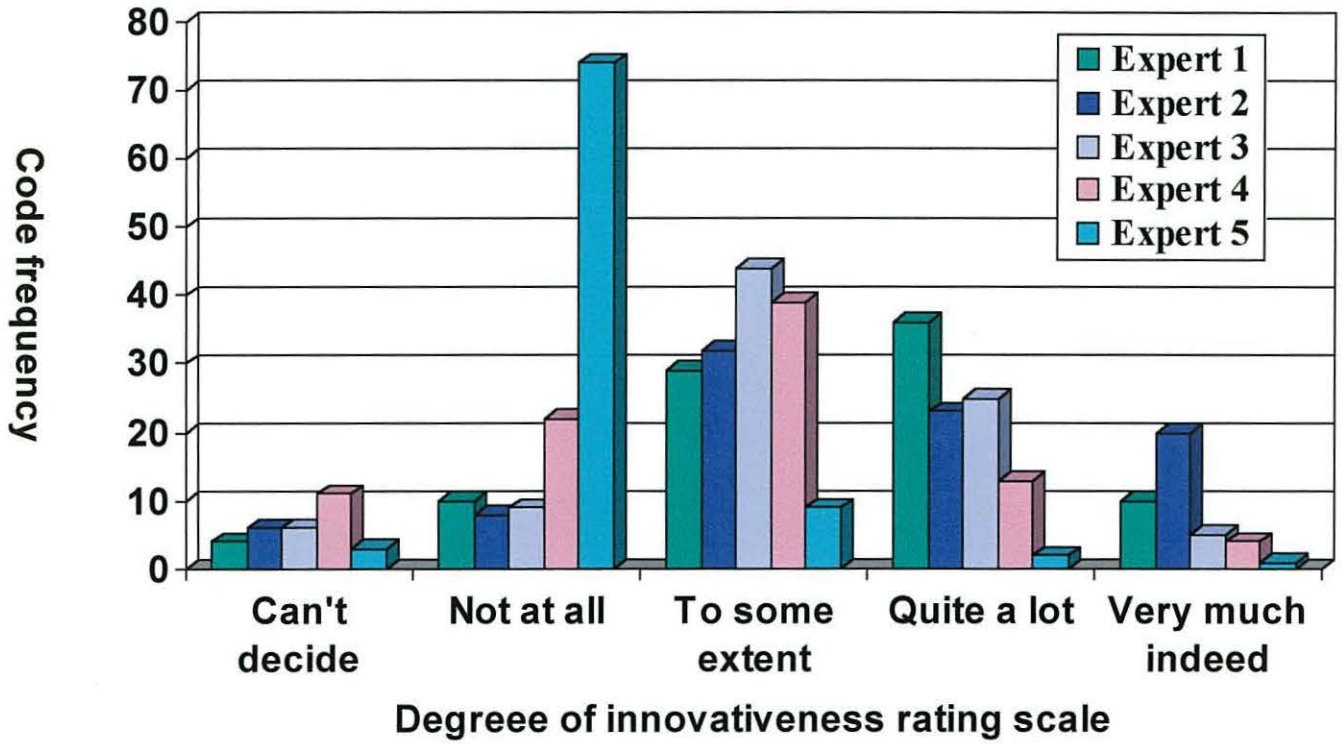
The first Kappa calculations were conducted across all five experts, and then the 4 researcher experts, for each scale point separately. Thus, what was being examined was the degree of agreement across experts in the use of a specific scale point, case by case. Table 10.13 shows the results.

Table 10.13 Kappas[a] for each degree of innovativeness scale point[b] by number/type of experts

Number/type of experts	Point '0' Kappa	Point '1' Kappa	Point '2' Kappa	Point '3' Kappa	Point '4' Kappa
All 5	0.18	-0.04	-0.00	0.06	0.08
4 researcher	0.24	0.06	0.07	0.13	0.09

[a] The larger the Kappa the more inter-rater agreement exists. Kappas usually go from zero to one in value, with values close to zero indicating inter-rater agreement is at chance levels. Negative Kappa values indicate inter-rater agreemnt is worse than chance.
[b] Where '0' = 'Can't decide'; '1' = 'Not at all'; '2' = 'To some extent'; '3' = 'Quite a lot'; '4' = 'Very much indeed'.

Figure 10.2 Frequency of use of degree of innovativeness rating scale points by expert



As indicated in Table 10.13, there is little or no inter-rater agreement across the five points on the degree of innovativeness scale, irrespective of whether the data of all five or just the researcher experts were included in the calculations. Only the '0' scale point, the 'Can't decide' rating, shows some signs of inter-rater agreement, reaching the 'fair' strength of agreement interpretation of Landis and Koch (1977) for the four researcher experts (Kappa = 0.24). Despite the overall poor strength of agreement exhibited across the other scale points, a trend of improved inter-rater agreement is apparent for the four researcher experts' data as opposed to the data of all five experts. This confirms the tendency witnessed in Figure 10.1, where the practitioner expert's use of the rating scale appears to be different from that of the four researcher experts.

Calculating Kappas for all points on the rating scale separately involves the application of rather harsh criteria on this type of data. The five-point rating scale used gave the raters a large degree of response choice. Examining inter-rater agreement point-by-point does not reflect this degree of choice, nor the difficult nature of the task, that of rating the degree of innovativeness (imaginativeness). Consequently, the next step of the exploration of the rating scale data involved Kappa calculations across all scale points for pairs of raters[3]. As can be seen in Table 10.14, there was very little inter-rater agreement in use of the degree of innovativeness rating scale. The majority of Kappa values reflect poor or no agreement, that is, they are more or less equivalent to chance levels of agreement. Only Experts 1 and 4 exhibit some agreement, although this is only 'fair'. Altman (1991) suggests that in practice Kappa values below 0.5 should be interpreted as indicative of poor inter-rater agreement. Thus, the rating scale appears to have been used differently by all raters. Expert 5, the practitioner expert, appears in particular to agree less in scale usage than the other experts, with Kappas around zero when this expert's ratings are compared with those of each of the other experts.

[3] The SPSS software only included Kappa analysis for pairs of raters.

Table 10.14 Kappas for pairs of expert raters for degree of innovativeness scale

Rater pairing[a]	Kappa	Level of agreement[b]
Expert 1 x Expert 2	0.15	Poor
Expert 1 x Expert 3	0.04	None/poor
Expert 1 x Expert 4	0.20	Fair
Expert 1 x Expert 5	0.01	None
Expert 2 x Expert 3	0.10	Poor
Expert 2 x Expert 4	0.06	None/poor
Expert 2 x Expert 5	-0.02	None
Expert 3 x Expert 4	0.13	Poor
Expert 3 x Expert 5	0.00	None
Expert 4 x Expert 5	0.03	None/poor

[a] Experts 1 – 4 = Researcher experts; Expert 5 = Practitioner expert
[b] Level agreement interpretation adapted from Landis & Koch (1977)

The apparent lack of inter-rater agreement in use of the scale is suggestive that it was an inappropriate tool for measuring degree of innovativeness (imaginativeness). It may have been that the scale was too sensitive, that is, it offered too much response choice. The different scoring between experts, case by case, may have occurred because the task of rating degree of innovativeness was very conceptually difficult. A simple 'yes, it's innovative'/'no, it's not innovative' scale may have been more appropriate. To test whether a simplified scale would have been more appropriate, the five-point scale was reduced to a binary scale and Kappa calculations calculated again across pairs of raters. Firstly, points '0', '1' and '2' (*i.e.* 'Can't decide', 'Not at all', and 'To some extent') were recoded and given the value '0', to signify meaning 'Not innovative'; points '3' and '4' (*i.e.* 'Quite a lot' and 'Very much indeed') were recoded as '1', to signify meaning 'Innovative'. Table 10.15 reveals considerably higher Kappa values were found for the expert pairings using the binary scale than previously, when the full five-point scale was used. All but one of the Kappas for Experts 1 – 4 pairings were 'fair', the other being 'poor'. One of these Kappas was close to an interpretation of 'moderate' inter-rater agreement (Expert 1 x Expert 2, $k = 0.39$). However, all the Kappa values were below 0.5, indicative of insufficient levels of agreement for practical purposes (Altman 1991). Kappa values for rater pairings involving Expert 5, the practitioner expert, were all close to zero,

reflecting the difference of agreement found between this expert and the others in previous Kappa calculations.

Table 10.15 Kappas for pairs of expert raters for first binary innovativeness scale[a]

Rater pairing[b]	Kappa	Level of agreement[c]
Expert 1 x Expert 2	0.39	Fair
Expert 1 x Expert 3	0.24	Fair
Expert 1 x Expert 4	0.19	Poor
Expert 1 x Expert 5	0.02	None
Expert 2 x Expert 3	0.21	Fair
Expert 2 x Expert 4	0.27	Fair
Expert 2 x Expert 5	0.07	None/poor
Expert 3 x Expert 4	0.30	Fair
Expert 3 x Expert 5	0.06	None/poor
Expert 4 x Expert 5	0.05	None/poor

[a] Where original degree of innovativeness scale points '0', '1' and '2' were given the value of '0', meaning 'Not innovative', and the original points '3' and '4' were given the value '1', meaning 'Innovative'.
[b] Experts 1 – 4 = Researcher experts; Expert 5 = Practitioner expert
[c] Level agreement interpretation adapted from Landis & Koch (1977)

Whilst the Kappa values were still fairly low for the binary scale, they reflected far higher levels of inter-rater agreement than when the degree of innovativeness scale was applied. Therefore, it appears that the degree of innovativeness scale was too sensitive or, rather, that the task of rating degree of innovativeness was too difficult for these particular 'experts'. Perhaps the raters were not expert enough in care management innovation, or there were too few examples of truly innovative care management for a degree of innovativeness scale to be applicable. Alternatively, there may have been insufficient information given by the survey respondents in their innovativeness examples to permit meaningful interpretation of the levels of innovation or, indeed, whether innovation was present at all.

One final series of Kappa calculations were conducted. These involved recoding scale points '0' and '1' (*i.e.* 'Can't decide' and 'Not at all') as '0' (meaning 'Not innovative'), and points '2', '3' and '4' ('To some extent', 'Quite a lot', and 'Very much indeed') as '1' (meaning 'Innovative'), on a binary scale. This was done because it could be argued that use of the point '2' ('To

some extent') originally meant that the rater considered there to be some signs, albeit weak ones, that the example given was innovative. Thus, this may be a more meaningful way of splitting the data up, when recoding into a binary scale. The resultant Kappa values are shown in Table 10.16.

Table 10.16 Kappas for pairs of expert raters for second binary innovativeness scale[a]

Rater pairing[b]	Kappa	Level of agreement[c]
Expert 1 x Expert 2	0.32	Fair
Expert 1 x Expert 3	0.22	Fair
Expert 1 x Expert 4	0.32	Fair
Expert 1 x Expert 5	0.03	None/poor
Expert 2 x Expert 3	0.05	None/poor
Expert 2 x Expert 4	0.10	Poor
Expert 2 x Expert 5	0.03	None/poor
Expert 3 x Expert 4	0.24	Fair
Expert 3 x Expert 5	0.06	None/poor
Expert 4 x Expert 5	0.09	Poor

[a] Where original degree of innovativeness scale points '0' and '1' were given the value of '0', meaning 'Not innovative', and the original points '2', '3' and '4' were given the value '1', meaning 'Innovative'.
[b] Experts 1 – 4 = Researcher experts; Expert 5 = Practitioner expert
[c] Level agreement interpretation adapted from Landis & Koch (1977)

Table 10.16 shows that only four of the ten rater pairing Kappas reached the 'fair' level of inter-rater agreement using the second binary scale. This is fewer, by one rater pairing, than the first binary rating scale (see Table 10.15). It could be argued, then, that the first binary scale was the most appropriate of all the scales applied during the analysis of inter-rater agreement. If the Kappa results of rater pairings including the practitioner expert, Expert 5, are removed, due to the clearly different scoring of this rater, the first binary scale produces five 'fair' inter-rater agreement Kappa values out of a possible six. Thus, the researcher experts, typically, exhibit a 'fair' degree of inter-rater agreement when the first binary scale is applied. However, even these experts are clearly scoring the innovative practice examples differently, as witnessed in Table 10.17, which shows the probability of giving the equivalent of a '1' score (*i.e.* an 'Innovative', as opposed to a 'Not innovative' rating) rater by rater. Whilst Experts 1 and 2 are giving 'Innovativeness' ratings to examples approximately half the time,

for Expert 3 this is only a third of the time, and for Expert 4 this is approximately a fifth of the time. Thus, Experts 3 and 4 appear to have applied more restrictive criteria of what can be regarded as innovative care management practice, than Experts 1 and 2. The probability of Expert 5 giving an 'Innovative' rating to an example is less than four in a thousand, providing further evidence of the very restrictive criteria applied by the practitioner expert.

Table 10.17 Probability of each expert scoring an innovative practice example as 'Innovative'

Rater[a]	Probability of scoring an innovative practice example as 'Innovative'[a]
Expert 1	0.52
Expert 2	0.48
Expert 3	0.34
Expert 4	0.19
Expert 5	3.37E-02

[a] Experts 1 – 4 = Researcher experts; Expert 5 = Practitioner expert
[b] Applies to use of first binary scale, where original degree of innovativeness scale points '0', '1' and '2' were given the value of '0', meaning 'Not innovative', and the original points '3' and '4' were given the value '1', meaning 'Innovative'.

Due to the relatively low levels of inter-rater agreement observed using the original five-point scale, the mean expert ratings were not used in analyses with other survey variables, such as the frequency of innovation and stress level change variables. However, the first binary innovativeness scale scores are included alongside the innovative practice examples in Appendix 10, in order to give readers an indication of the types of examples that were considered innovative or not innovative by the expert raters.

* * *

Conclusions from Study 2's findings follow in the next chapter.

CHAPTER 11 OCCUPATIONAL STRESS, INNOVATIVE PRACTICE AND CARE MANAGEMENT: CONCLUSIONS FROM STUDY 2

Conclusions from Study 2 are considered under five main headings:

- Methodology
- Characteristics of care management practitioners
- The experience of being a care management practitioner: demands, discretion and stress
- Characteristics of innovative practice
- Job stress and innovative practice

Methodology

Issues surrounding the application of survey methodology and the use of expert ratings (as an analytic method) in Study 2 arose. The type of survey methodology used gave a large number of community health and social care practitioners in Wales (n = 181) the opportunity to report their experiences and opinions of a particular form of practice: care management. The type and size of the dataset gives weight to the findings, both quantitative and qualitative, since they apply to a large number of care management practitioners in health and social care. Despite the large number of respondents, however, they represented only 30% of those targeted for the survey. The low response rate, consequently, makes it difficult to generalise the findings to other care management practitioners than the survey respondents.

Although non-response data was not systematically gathered, there are three main suspected reasons why the response rate was so low. Firstly, not all targeted practitioners may have received questionnaires. Whilst arranging distribution by team managers appeared to be the quickest and easiest method of distributing questionnaires, there was no guarantee that the

managers distributed all the questionnaires they were sent. Secondly, some practitioners who received questionnaires (who were counted as potential respondents) may not have considered themselves to be *care management practitioners* (see Chapter 8 for self-selection criteria), and choose not to respond. Thirdly, there were undoubtedly care management practitioners who decided not to respond. This may have been for any number of reasons, such as: feeling time pressured and considering questionnaire completion to be low on the priority list; feeling that they already had enough paperwork to deal with without any more; that they had recently completed a questionnaire for another study and couldn't see the point in filling out yet another questionnaire; feeling that participating in studies was a waste of time because policy makers never pay any heed to research findings; forgetting to respond, or to return a completed questionnaire, by the deadline given (or, even, not receiving the questionnaire until after the deadline for return).

To investigate how innovative, or rather how imaginative, the innovative practice examples cited by respondents were five experts rated each valid example. There was anticipated 'added value' to using the expert rating method, that is, it would provide information not generated by other means about the relative quality of innovativeness in the examples of care management practice. The lack of consistency in rating between the raters, however, meant that this additional information could not be considered reliable. On the positive side, though, this raised further research questions, with implications for future research in this area.

The finding that so-called experts could not agree on how to apply an innovativeness (imaginativeness) rating scale to the examples is intriguing. Were the 'experts' insufficiently expert in what can be considered innovative care management practice? Was insufficient information available to the 'experts' to undertake the task? Is rating degree of innovativeness an impossible task? Prior to the present study there had been no known empirical work on characteristics of innovative care management practice.

Therefore, the 'experts' may well have had very different schemas in their minds about what constituted innovative care management practice, informed by their own experiences and prior knowledge of 'typical' care management practice. Three of the experts actually recorded how difficult a task it was to decide what counted as innovative practice and what not. They suggested (independently) that many of the examples seemed to represent what could be construed as standard practice, and that examples could have been more meaningfully rated if more information was provided, such as the relative benefit to service users and carers.

It may be that *innovative practice* is too subjective a concept for objective 'measurement'. In other words, only the respondents themselves knew how innovative their individual examples were, since only they had insight into their 'standard' as opposed to 'innovative' practice. The expert raters were not able to access this information, information which would have enabled them to make a judgement on the relative innovativeness of each example compared with the 'standard' practice of each respondent. Perhaps getting line managers to rate the degree of innovativeness of their (respondent) care management practitioners would have been a more relevant means of obtaining 'objective' ratings of innovativeness, since such managers should have insight into the standard and novel practice of their supervisees. However, it would not have been possible to obtain such ratings and maintain the anonymity of respondents. Removing anonymity may have reduced the response rate that was achieved, or altered the type of information that respondents so readily gave.

Characteristics of care management practitioners

Care management practitioner respondents of the present survey were, typically, female (74% of respondents), social workers or nurses by profession (62% of the sample being social workers, 24% being nurses, 4% being therapists, and 9% being other/non-classified practitioners), and worked full-time (83% of sample). Nurse and therapist respondents had

worked the longest since qualifying (between 15 and 17 years, on average), whilst social workers had worked for the shortest period since qualifying (approximately 11 years, on average).

The main client group worked with varied by profession. Whilst social work respondents worked with a large number of client groups, the majority worked with older people, people with physical or sensory impairment, and people in hospital. Most nurse respondents, on the other hand, worked with people with mental health problems, and people with learning difficulties. The therapist respondents (of which there were only eight) were split between mental health and older adults/physical and sensory disability fields. Those in the other/non-classified practitioner group worked mainly with older people, people with physical or sensory impairment, and people with mental health problems.

Whilst the average caseload size of respondents was around 44 cases, there was a large degree of variability (standard deviation = 34 cases). Social workers typically had 30% larger caseloads than nurses (47 cases and 32 cases on average, respectively). The differences in caseload size between nurses and social workers may reflect the different practitioner roles of these groups. Nurses are likely to retain more of a provider role than social workers, since despite being care management practitioners, theoretically they are more likely to get involved in cases because there is a clinical reason for using the skills and knowledge of a nurse. Social workers, on the other hand, are likely to be referred cases in fulfilment of the statutory requirement of local authorities to conduct needs assessments. Consequently, their workload may have more of an assessment and care management function than a provider function. Additionally, the provider aspect of local authorities was actually discouraged in policy and policy guidance documents (Department of Health 1989, 1990).

Caseload size also varied by main client group worked with. Caseload sizes were largest for respondents working with older people and/or people with

physical or sensory impairment (average of 58 cases), and for those working with older people with mental health problems (50 cases on average). The lowest caseloads were reported by respondents working mainly with people with mental health problems or with people with learning difficulties (35 cases on average in each specialism).

These large differences in average caseload size may be the result of a number of factors. Firstly, they may reflect a genuinely greater need for assessment and care management services by older people and people with physical or sensory impairment. This may be, in part, due to the larger numbers of older people and people with physical or sensory impairments in society than people with mental health problems or learning difficulties. However, it may also be a sign that care management is more appropriate for older people and people with physical/sensory impairment, than people with mental health problems or learning difficulties. This latter point fits with the second possible reason for the difference in average caseload size, that people with learning difficulties or mental health problems require a greater degree of 'provider' input by their 'key worker' practitioner than older service users or those with physical or sensory impairment. Care management practitioners who maintain a 'provider' role (*e.g.* counselling, therapy, or support worker roles) are likely to spend a greater proportion of their time with each client than practitioners who do not have (or do not practice) a direct provider role. Consequently, the former will not be able to case manage as many cases as the latter.

A third possible reason for the differences in average caseload size is related to the purchaser-provider issue. Community care policy propounded that assessment and care management should be separated from provision, and local authorities, in particular, should move from being providers to being purchasers and enablers of provision. Since the majority of respondents who reported older people or people with a physical or sensory impairment as their main client group were social workers, and all social workers are employed by local authorities, these service user groups are

less likely to receive direct provision from their care management practitioners than service user groups who are more readily served by health practitioners (*i.e.* people with learning difficulties, and people with mental health problems). Related to this issue, community care policy specifically identifies that mental health and learning disability service users may need to have 'key workers' with both care management and provider roles.

There is also a fourth possible reason for the discrepancies in caseload size. Services for older people and people with physical or sensory impairments may be underfunded in comparison to services for people with mental health or learning difficulties. If so, there would be fewer care management practitioners per older or physically/sensory disabled service user than per mental health or learning disabled service user. Thus, practitioners working mainly with older people or people with physical/sensory impairment would have to deal with larger numbers of service users than those working in the other two fields. This may have implications for the innovative practice of care management practitioners: those who have less time for each case (taken to be those with the largest caseloads, that is, in older adult and physical/sensory disability fields) may be less likely to be innovative.

The experience of being a care management practitioner: demands, discretion, and stress

Demands and resources

The majority of respondents in all professional groups reported an increase in demands for services over the past 12 months. Whilst significantly more nurses than social workers reported increased demand for services (86% and 69% respectively), a large proportion of social workers indicated there was no change in demand for services over the past year. Demand could already have been at high levels as perceived by these social workers, and continued to be high. Thus, the actual level of perceived demand for services could have been similar for social workers and nurses. Similar (and

large) proportions of social workers and nurses indicated that resource availability had reduced over the past 12 months.

In regards to Karasek's (1979) job demands and job discretion dimensions, respondents reported high job demands (mean = 21.8, S.D. = 4.4) and middling levels of job discretion (mean = 18.6, S.D. = 3.6). No significant differences were found on either dimension by professional group. Close to a third of respondents reported high demands and low discretion. According to Karasek's (1979) Model of Strain, this group would have high levels of stress. Thus, a large number of care management practitioners may well find their work stressful. However, half the respondents reported high discretion alongside high demands. Karasek's model would predict this group to have moderate levels of strain and, additionally, be the most likely group to actively learn and develop in their jobs.

Stress, satisfaction and demands

Over two-thirds of respondents indicated experiencing an increase in stress over the past 12 months. Close to a quarter reported no change in stress level. The latter may have already been experiencing high levels of stress, although they could equally have been experiencing low or middling levels of stress. Almost half of respondents reported reduced job satisfaction over the last 12 months (30% reported no change). Response to the job satisfaction and stress level change items was similar for all professions. Thus it appears that, typically, stress levels of care management practitioners had risen and job satisfaction had reduced over the same period of time that demands for services had increased and resource availability had decreased. Indeed, the majority of respondents indicated that workload, paperwork and responsibility had increased and time for client contact and service quality had decreased for the same 12-month period. Close to a third of respondents also reported reduced ability to manage their workload, a clear indication of strain.

Demands, discretion and stress

Correlation analyses indicated that reported increased stress was associated with lowered job satisfaction and high job demands ($r = -0.31$ and $r = 0.38$, respectively; $p = 0.01$). Reduced job satisfaction was associated with low levels of job discretion ($r = 0.37$, $p = 0.01$). A significant, though small, negative correlation was found between stress level change and job discretion ($r = -0.19$, $p = 0.01$). Although no causal relationship is implied, it may be that high job demands combined with low job discretion lead to both heightened stress and reduced job satisfaction. Analysis of variance further revealed a relationship between reported increased stress and high demands combined with low discretion. This is as predicted by Karasek's model and in line with Hypothesis 4 (see Chapter 8).

In order to explore what were the main predictors of stress level change, multiple regression analyses were conducted with stress level change as the dependent variable. Decreased morale of colleagues, increased workload and reduced ability to manage one's workload were found to be the main predictors of reported increased stress, and were able to explain 42% of the variance in the stress variable. A further 4% of the variance could be explained by job satisfaction, communication with managers, and resource change variables. Thus, approaching half the variance in the stress variable (46%) could be predicted from the responses to these six variables.

Interestingly, although job demands and job discretion variables were included as independent variables in the regression analyses, neither was implicated in the final regression model. However, the workload (change) variable may be viewed as akin to the job demands variable, except that the former represents change over a period of time whereas the latter represents a current state. Since the stress level (change) variable also represents change over time (and the same period of time as the workload variable), it makes sense that the stress level change variable was more closely related to the workload change variable as opposed to the job

demands variable. Reduced ability to manage one's workload may well be related to feelings of reduced control over one's work, control being akin to job discretion. Again, however, the fact that the ability to manage workload variable operates on a change over time basis, in line with the stress level change variable, may help to explain the greater association between ability to manage workload (change) and stress level change.

Characteristics of innovative practice

Frequency and type of innovative practice

Despite the majority of respondents (84%) reporting that innovative practice was a necessary aspect of their care manager work, only 12% indicated being able to be innovative whilst planning, implementing or evaluating care packages *always* or *often* (at least one in every five cases). More commonly respondents (82% of the sample) reported being innovative whilst planning, initiating or reviewing care packages *sometimes* (*i.e.* at least one in 20 cases, but less than one in five cases) or *occasionally* (*i.e.* at least one in 50 cases, but less than one in 20 cases). Therefore, it is evident that innovative care management is much less frequent than non-innovative care management practice, according to practitioners. This supports the prediction of Hypothesis 1 (see Chapter 8).

A larger proportion of nurses reported being more frequently innovative during care packaging than social workers, with 19% of nurses indicating they were *often* or *always* innovative as compared with 11% of social workers. The difference may in part be due to the smaller average caseload size of nurses (see above), which may enable them to spend a greater proportion of their time with each service user than social workers. Nurses may also have greater opportunity for innovative practice with planning, implementing or evaluating care packages because of their provider role. Such a role would enable them to get to know their clients well, and to tailor care arrangements to emerging needs. Thus, time and the ability to assess

and monitor care arrangements closely appear to be underlying factors that influence frequency of innovative care management practice.

Another avenue for innovative practice for care management practitioners is the undertaking of service development work. When asked, just under half of respondents (47%) indicated they undertook service development work. Typically, such individuals were more frequent care package innovators than those who indicated they did not undertake service development work (*e.g.* 20% of service developers indicated they were innovative whilst care packaging *often* or *always*, as opposed to just 5% of non-service developers). Social workers appeared to be the least likely professional group to report undertaking service development work (44%, as compared with 50-63% of nurses, therapists and other/non-classified practitioners). This may be explained, again, in terms of the relatively high caseload sizes of social workers as opposed to other practitioner groups. They may, simply, have less time to engage in service development or any other innovative work. Alternatively, or additionally, fewer social workers may have reported undertaking service development than other practitioner groups because some social workers may believe that service development is not part of their role as care management practitioners. Such a belief appeared to have been held by at least one of the five social work care managers who participated in Study 1.

Influencing factors of innovative practice

Respondents were asked in an open-ended question to indicate what factors help and what factors hinder their innovative practice. Fifty-six percent of survey respondents gave facilitating factors and 69% gave hindering factors. The main facilitating factors reported were team working, manager support, having and acquiring knowledge, and autonomy. Facilitating factors less frequently mentioned were flexibility of providers, availability of finances, having a certain attitude oneself, and past experience. The main factors reported as hindering innovative practice were lack of resources and lack of

time, followed by insufficient support (particularly by managers and agencies) and the attitudes of others. Bureaucracy, the nature of the work, inflexible providers, and local policy were other hindering factors, mentioned less frequently.

Whilst many of the hindering factors reported were opposites of the facilitating factors, lack of time stands out as a barrier to innovative practice that had no definite opposite in the facilitating factors list. It may be that time is only noticed as a factor when it is in short supply. When there is a sufficiency of time, time becomes less of an issue and, hence, other factors are perceived as facilitating factors.

The fact that almost half of respondents (49%) gave *lack of resources* as a hindering factor suggests the significant part that resources play in the innovative practice of those involved in organising and providing community care at the front-line. *Resources* represent the finances needed for purchasing individual care arrangements and developing new services, the types of provision available in a locality, and the statutory and non-statutory staff that are required to oil the cogs of the community care industry. Inadequate staff resources, particularly in the care management practitioner's own organisation, will inevitably lead to time pressures for all grades of staff. This may result in larger numbers of referrals for each practitioner that is available, making insufficiency of time a direct hindrance on innovative practice. It may also result in overworked and frustrated managers and administrative staff, who then have less time, and possibly the inclination, to be supportive of the work of practitioners. The support and attitudes of others were clearly implicated as influencing factors of the innovative practice of respondents.

Personal attributes were apparent as facilitating factors of innovative practice: having a certain attitude oneself, and knowledge and experience were all listed. Structural aspects of a practitioner's work also appeared to be important influencers of innovative practice: autonomy was reported as a

facilitating factor; bureaucracy and the nature of one's work were implicated as hindrances. Local policy, listed as a hindering factor, may influence both the structure of a practitioner's work and the resources available to support that work.

Innovative care management practice examples

Sixty-five percent of respondents provided examples of their innovative practice whilst planning, implementing or evaluating care packages. Examples were classified according to characteristics that emerged through analysis of the examples. There was great diversity in the types of characteristics that were identified (14 different categories in all). The most frequently found characteristics of innovations were that they took place in an institutional (day, residential or respite care) setting; that they appeared to have the aim of enhancing service user well being; that a reference to finances was made; and, that there was community or voluntary agency involvement.

Other characteristics of innovations identified were that there was an element of user empowerment; that a number of agencies were involved in assessments or care arrangements; that there was an educational or vocational element for service users (viewed as beneficial to users, families, and society); and, that a leisure activity was arranged for a service user. Other, less frequently identified, characteristics of innovative practice examples included: being innovative in the way meals were provided to service users; arranging novel support worker methods for users; that there was carer benefit in the arrangements; that service provision was encouraged to be more flexible in meeting user needs; and, that special aids and equipment were provided to users in novel ways.

It is not known how innovative respondents considered their individual innovative practice examples were. Presumably each respondent believed his or her example was innovative to at least a small degree, by the very fact

that the example was given in response to a request for an example of innovative care management practice. Given the difficulty the 'experts' had in rating the degree of imaginativeness of the examples, future research should consider more reliable means of obtaining degree of innovativeness ratings, such as from the practitioners themselves.

Service development examples

Respondents who indicated they undertook service development work were asked to give one example of such practice. As mentioned earlier, the undertaking of service development work was viewed as another possible way in which care management practitioners could be innovative. Forty percent of all respondents provided valid service development examples. Service development examples were characterised in three main ways: by the service development type or method; the target service; and, the target group.

Under the *service development type or method* category, the most frequently apparent characteristics were that service development took place during implementation or planning stages, or in service development groups or meetings. Multi-agency or multidisciplinary involvement was apparent in many service development examples. Training, service evaluation, and policy or practice development were found as types of service development in several examples.

The *target service* of examples varied considerably. In different examples the following were apparent target services: health or social care; residential or respite care; leisure or transport; assessment; rehabilitation; prevention; and, support workers. Numerous *target groups* were mentioned in service development examples from older people/people with physical or sensory impairment to people with mental health problems (including substance misuse populations), people with learning difficulties, and hospital patients.

Job stress and innovative practice

A number of different statistical methods were used to examine the relationship between, and underlying common factors of, innovative practice and occupational stress in care management respondents. These were correlations, analysis of variance, and multiple regression analyses.

Innovation frequency and stress level change were found to be significantly (and negatively) correlated. However, the size of the correlation coefficient ($r = -0.16$) indicates that the relationship between innovation frequency and stress level change was weak. There may have been a number of reasons for this. Firstly, the low correlation may have reflected a genuine lack of relatedness between job stress and innovative practice concepts (in care management). Secondly, those who did not respond to the survey may have been both more highly stressed and less frequently innovative (due to, say, time pressures) than those who did respond to the survey. Data from such practitioners may have strengthened the degree of association.

Thirdly, and very importantly, the two variables may not have been the most effective indicators of innovative practice and occupational stress in care management. The stress level change item required respondents to make a judgement about degree of variation in stress level over a (long) period of time, rather than current level of stress (*i.e.* there is no indication of whether those who indicated stress levels had increased were experiencing high, medium or low levels of stress during the time of the survey). Whilst the innovative frequency variable was likely to have reasonably accurately represented the innovative practice frequency of respondents (due in part to the clarification of meaning attached to each frequency scale point), it is not apparent how innovative each incident of innovative practice was (judging from the examples of innovative practice a large proportion of what respondents claimed to be innovative may well have been viewed as standard practice by others).

Although the correlation between the stress level change and innovative frequency variables was weak, it was in the predicted direction. That is, less frequent innovation was associated with increased stress. Thus, in part, Hypothesis 2 was supported, but only just.

Correlation analyses were also conducted between innovation frequency and job demands/job discretion variables, since the latter were viewed as potentially common underlying influencing factors of stress level change and innovation frequency. Only job discretion was found to correlate significantly (and positively) with innovation frequency ($r = 0.29$). Thus, high perceived job discretion tended to be reported alongside greater frequency of innovative care management practice. The lack of correlation with the job demands variable is surprising, since it was presumed that high job demands would reduce time available for innovative care management practice. However, since some of what respondents counted as innovative care management practice in their innovation frequency response may have been a minor adjustment to a care package that took little time, time pressure may not have adversely affected such practice. Additionally, high levels of job demand may actually have been experienced as challenging, encouraging innovative-minded practitioners to consider time- or resource-saving care planning methods or arrangements.

As noted above, stress level change was correlated with job demands and job discretion (albeit weakly with the latter), where high job demands and low job discretion were associated with increased stress levels. This is as predicted by Karasek's model. However, only job discretion appears to be associated with innovation frequency. Thus, whilst it appeared to make sense that high demands and low discretion would be associated with both increased stress and low frequency of innovative practice (Hypothesis 4). This did not appear to be the case from the correlation analyses.

However, to examine further the potential link between the quadrants of Karasek's model and innovation frequency, an analysis of variance test was

conducted. The analysis of variance result was not significant, suggesting that respondents with scores in the different job demands-job discretion quadrants reported similar levels of innovation frequency. However, trends were visibly discernible from a bar chart of innovation frequency mean scores per job demand-job discretion quadrant. It appeared that low job demands and high job discretion in combination were associated with the highest levels of innovation frequency. Whilst high job demands and low job discretion were associated with some of the lowest reported levels of innovation frequency, so were low job demands and low job discretion. Thus, it appears that Hypothesis 4 (the part implying that low innovation frequency would be associated with high demands and low discretion) was weakly supported. A floor effect on the innovation frequency variable was apparent and may explain the insignificant analysis of variance result. The tendencies revealed by the bar chart, however, indicate that Karasek's (1979) model may well be a useful means of conceptualising inter-relationships between job demands, job discretion and individual innovation. Further research is needed to test the utility of the model in this respect.

Regression analyses revealed job discretion and undertaking service development work to be the main predictors of innovation frequency. However, only 10% of the variance in the innovation frequency variable could be explained by these two variables. Nevertheless, it appears that job discretion is an important variable in the individual innovative practice of care management practitioners. The relationship with the service development variable could be due, in part, to autonomy in one's work: care management practitioners who reported being able to undertake service development work must have been relatively autonomous in order to undertake this practice in addition to their care management work. However, undertaking service development work in addition to innovative care management work may reflect 'innovative mindedness', an underlying desire or motivation to be creative in one's work for the benefit of others (namely service users and carers).

Taking into account the factors that respondents indicated helped or hindered their innovative practice, combined with the predictors of innovation frequency from the regression analyses, it appears that job discretion or autonomy is an important influencer of the innovative practice of care management practitioners. However, there are many other factors that seem to be equally or even more important, such as time and resources, the support and attitudes of others, the nature of one's work and employing organisation, and personal factors. Whilst most of these factors were implicated in Hypothesis 3, job demands is the most noticeable variable not to be clearly associated with the innovative practice of the survey respondents.

The innovation frequency and stress level change shared very few underlying factors in common. Those that appeared to be in common related to support from others (communication with managers re the stress level change variable) and resources (resource change re stress level change). Whilst ability to manage workload (a predictor of stress level change) might be linked to both time pressure and insufficient control of one's work (aka autonomy), job discretion was not implicated as a predictor of the stress level change variable but was with the innovation frequency variable. Thus, there appears to be little in the way of either a direct relationship (correlation) between stress level change and innovation frequency, or underlying (potential) influencing factors.

* * *

The next chapter discusses both Study 1 and Study 2 findings and relates them to the occupational stress, innovative practice and care management literature.

PART IV

Discussion and implications

CHAPTER 12 DISCUSSION AND IMPLICATIONS

The research presented in this thesis represents the first two studies ever conducted into the individual innovative practice of care management practitioners. Study 1 used case study methodology to gain insight into the processes and influencing factors of innovative (and non-innovative) practice of five care management practitioners. Study 2 was a postal survey of care management practitioners, designed to investigate influential factors (further), frequency and examples of innovative practice, and the relationship between innovation frequency and perceptions of stress, job demands and job discretion.

Study 1 was unique in using a naturalistic, qualitative approach to study the individual innovation process. Study 2 was one of only a small number of studies that have attempted to examine the relationship between occupational stress and individual innovation, and the first to investigate such a relationship through use of Karasek's (1979) job demands-job discretion model. Thus, whilst drawing upon relevant literatures (see Chapters 2, 3 and 4), both studies were essentially exploratory in nature.

The objectives of this final chapter are to:

(i) summarize and pull together the main conclusions from Studies 1 and 2;
(ii) compare the present findings with those of earlier research;
(iii) indicate how the two studies have progressed understanding in the areas of care management, individual innovation and occupational stress;
(iv) make suggestions for further research; and
(v) specify implications for policy and practice.

Methodological issues will be briefly addressed (detailed consideration having been given in previous chapters) and achievement of the main aims

of the research (described in Chapter 1) acknowledged. The following structure will be used in this chapter:

- Methodological issues
- Characteristics of innovative care management practice
- Stress and innovation in care management
- Implications for policy and practice

Methodological issues

The small sample size in the case study research (Study 1) and the low response rate of the survey of care management practitioners (Study 2) make it difficult to estimate the representativeness of the samples and, consequently, place limitations on the generalisability of the findings to other care manager populations. However, such generalisability was not a key aim of Study 1: gaining an understanding of innovative and non-innovative care management processes and influencing factors was. The multi-method qualitative approach adopted in Study 1 enabled a detailed exploratory study of the practice of five care managers and the environment in which they operate to be undertaken. The observations, reviewing of case documentation and discussion with care managers about individual cases, plus the confirmation of influencing factors in each case through the care manager questionnaires, complemented each other as methods to help build a picture of the circumstances and processes involved in the care planning of each case. Whilst there was a degree of overlap in the information gained from using these methods, the repeated emergence of details helped validate the individual case findings. The added value of using interviews with care managers and questionnaires with line managers was that general opinions and beliefs about care management practice (including innovative care management practice) could be gleaned to add further context to the individual case findings.

Generalisability was an aim for Study 2. Whilst the response rate to the survey was only 30%, respondents (n = 181) were from all seven unitary

authority areas targeted and included both health and social care practitioners. Thus, there was a degree of representativeness. A similar response rate had occurred in an earlier survey of care management practitioners in Wales (31%; Parry-Jones *et al.* 1998a). Low response rates are fairly typical of postal surveys (Baruch 1999; Hall & Hall 1996). Since questionnaire distribution was by third parties in both the current and earlier care management practitioner research, recruitment of respondents in future surveys may be improved by using more direct distribution, such as by researchers at team meetings. Not only would a definite distribution figure be obtained instead of estimates, but researchers could explain the research, answer any queries, and provide a 'face' for the research. This more personalised approach should help potential respondents to differentiate the research from any other concurrent studies and to gain an understanding of the benefits of participating. Such an approach was used by West (1989) in a questionnaire study of innovative practice in health visitors and resulted in a 90% response rate. However, the latter was conducted in only one health authority area, whereas the care management practitioner survey was undertaken in seven unitary authority areas across Wales. Having researchers attend team meetings in every area would have been time consuming and costly, given that there were numerous teams in different specialities in each area and that the geography of Wales imposes travel constraints.

Recruitment issues arose also in Study 1, although these were in relation to the recruitment of 'cases' rather than care manager practitioners. The difficulty appeared to be due to the inclusion criteria of initial assessments of home-based care packages. Negotiation between participant care managers and the author during the study led to a slackening of these criteria, with continued assessment or reassessment/reviews subsequently allowed. Whilst the author had not anticipated such modifications, changing the inclusion criteria in this way reflected the responsiveness of case study methodology to the phenomena under study. Future use of case study methodology in practitioner or individual innovation research can be recommended, particularly where processes are to be investigated.

However, consideration should be given early on to discussion with participants, since they are likely to be able to provide information regarding the feasibility of study methods.

Characteristics of innovative care management practice

Two of the three overarching research aims were *to investigate how innovative practice is characterised and undertaken by practitioners* and *to investigate which factors facilitate and which constrain innovative care management practice*. Bearing in mind the limitations of the two studies, details of the innovative care management process, influencing factors, frequency and types of innovative care management practice now exist because of this research. A working definition of innovative care management practice has also been developed (see Chapters 1 and 3).

The innovative care management process

Although community care policy and guidance (*e.g.* Social Services Inspectorate 1991a) encouraged practitioners to be creative, innovative or imaginative in care management, little advice was given as to how to assess need and develop individually-based packages of care. Noticeably absent was information on what constituted *being innovative* or creative during care management and how practitioners could achieve an innovative or creative approach. The message that being innovative or creative during care management is appropriate appears to have been received, since four out of five of the care managers in Study 1 and 84% of survey respondents in Study 2 expressed such a belief. However, the insufficiency of guidance may in part explain why innovative care management practice appears to be infrequent – only two of the eight cases studied seemed to involve innovative practice, and the majority of survey respondents (82%) reported being innovative whilst planning, initiating or reviewing care packages either less than one in five or less than one in twenty cases.

The prospective, multi-method case study approach used in Study 1 facilitated close examination of the procedures employed by the five care managers during assessment, care planning and reviewing work. This led, firstly, to insights regarding the stages involved in everyday care management practice and, secondly, to the development of a process model of innovative care management practice.

The practitioners' guide (Social Services Inspectorate 1991a) specified a care management process model. This was used as a starting point from which to explore how the five care managers conducted their practice during the care management of the eight cases. According to the practitioners' guide model, determining level of assessment was to spearhead the process, followed by a cyclical path of assessing need, planning care, implementing the care plan, monitoring, and reviewing. Whilst the model appears to approximate what happens, in reality a more complex, reflexive procedure seems to operate. The core tasks do not occur in isolated and progressive steps. Instead, task boundaries are blurred and feedback loops operate throughout the basic cycle. The task of assessment, in particular, appears to operate in most stages, with comparison of needs against available resources occurring during assessment of need, care planning, monitoring and reviewing.

The innovative care management process model devised by the author (see Chapters 6 and 7) arose out of a consideration of Study 1's findings, particularly in respect of how innovative and non-innovative care management practice seemed to differ, and the relevant literature (see Chapters 2 and 3). The model builds on and extends the general care management process model outlined above, but gives more detailed consideration to care planning and implementation stages. There appear to be two crucial decision-making stages: deciding whether identified needs can be met by standard *menu* services, and deciding whether alternatives to standard provision can feasibly be implemented. If standard services can meet identified needs then there would be little point in spending time and effort devising alternative arrangements. The criteria for *good* care

management practice, of meeting needs for the benefit of service users and/or carers (as indicated in Chapters 2 and 3), would have been met. However, if standard provision cannot meet all identified needs, then generating alternatives is an appropriate next step. But, even when alternative ideas for meeting needs have been generated their implementation may be hampered. Perhaps agreement to provide a particular service by an agency cannot be elicited because of existing eligibility criteria or lack of suitable staff or finances. Or, perhaps the service user or carer does not want to try something that is different or untested, or there is simply not enough time. Thus, non-innovative care packages may result despite innovative behaviour on the part of the practitioner.

The innovative care management process model is, undoubtedly, a simplification of what happens in everyday practice. However, building upon earlier models of *good* care management (*e.g.* Orme and Galstonbury 1993), it has the potential to be used as a practical procedural framework for care management practice and as a theoretical starting point for researchers investigating individual innovation in health and social care delivery.

The innovative process model has much in common with general problem solving models. It contains the three typical phases of such models (see Kaufman 1988), such as problem identification and understanding, generating a variety of alternative solutions, and deciding upon the best solution, as well as a fourth phase (suggested by Simon 1977), of reviewing implemented solutions. However, the innovative practice model contains more detailed stages and includes decision-making points that can differentiate innovative from non-innovative problem solving practice. The innovative process model does, however, fit with the school of thought that creativity (or individual innovation) can occur from a combination of logical problem solving and sufficient domain knowledge, rather than being a specialised problem solving process (see Kaufman 1988; King & Anderson 1995).

In terms of contemporary models of individual innovation (as summarized in Chapter 3), the innovative care management process model appears to have little in common. Most of the former either relate only to role innovation or focus on antecedent and maintaining factors (*e.g.* Farr & Ford 1990; West & Farr 1989), rather than the processes involved in producing innovative behaviour. Whilst Scott and Bruce's (1994) social interactionist model of individual innovative behaviour includes process elements, the model is too general to bear much resemblance to the specifics of the innovative care management model. Since types of individual innovation at work are multi-various, it is perhaps unlikely that any model can represent individual innovation as a universal concept. Future research and theory building into individual innovation should move away from this generalistic approach and, instead, focus on defining and investigating particular types of individual innovation. Much has been gained in the area of role innovation from taking such a stance.

The present research has focused on a particular form of practitioner innovation. Other types of individual innovation include how managers deal with their responsibilities towards employees and their organisation, and how teachers, trainers and lecturers operate when devising new learning packages and programs. Specific models are likely to apply in these work contexts, too. Regarding the model of innovative care management developed here, further research is needed to empirically test the robustness of the model. Exactly where and how the different factors (identified in both studies) influence the various stages of the care management process, whether innovative or non-innovative, needs further investigation. It would also be of value to examine the outcomes for service users and carers, such as quality of care or quality of life, of innovative and non-innovative care management practice. Just because innovative practice has occurred, does not necessarily mean 'good' outcomes will result.

There has been an over-reliance on cross-sectional quantitative methodology in individual innovation research. The majority of studies have relied on self-report questionnaires administered at a single time point (*e.g.*

Scott & Bruce 1994; Unsworth & West 1998). Whilst providing useful information regarding respondent perceptions of influencing factors, such methods cannot examine the processes involved in individual innovation. The prospective, qualitative multi-method case study approach, as used in the present research, has much to offer in this respect. Future individual innovation process research should, therefore, consider such an approach.

Factors influencing innovative care management practice

Numerous factors were identified as influencing innovative care management practice during the case study research (Study 1): time and resources; felt pressure; bureaucracy; team working and manager support; having sufficient knowledge, experience and skills; and perceptions of the feasibility or appropriateness of innovative practice. Many of these factors were also identified through the survey of care management practitioners (Study 2), providing internal validation of the research findings. Survey respondents were asked to specify in an open-ended question what factors helped and what factors hindered their innovative practice. Commonly reported facilitating factors were team working, having manager support, knowledge and knowledge acquisition, and autonomy. Less commonly reported were flexibility of providers, availability of finances, having a certain attitude oneself, and previous experience. The main barriers to innovative practice reported were insufficient time and resources, unsupportive managers and agencies, and the attitudes of others in general. Other barriers cited less frequently were bureaucracy, the nature of care management work, inflexible providers, and local policies. Whilst care management practitioners clearly have many obstacles in their way hindering innovative practice, the fact that facilitative factors were identified suggests that innovative care management is indeed possible given appropriate support.

Access to resources

As highlighted in Chapter 2, both the care management literature and official documentation alluded to the benefits of devolving budgets to practitioners

as enabling them to unleash their creative potential in pursuit of meeting the needs of individuals (Davies *et al.* 1996; Department of Health 1989, 1990, 1993a; Lewis & Glennerster 1996; Social Services Inspectorate 1991a, b). Although it is not clear from Study 2's findings whether budgets were devolved sufficiently, and indeed there was likely to be variation across the unitary authorities surveyed in this respect (see McGrath *et al.* 1996), the availability of finances and resource issues were clearly implicated as influencing innovative practice.

From Study 1, there were indications that budgets had been devolved to a degree in the participant local authority areas, with care managers having access to a certain level of finances per client per week. Whilst having a set budget appeared to give care managers a concrete means of figuring out the amount of (funded) care that could be included in a care package, both practitioners and their managers indicated budget levels were inadequate and, consequentially, limited choice for service users. Devolved, though restricted, budgets should have served to encourage care managers to seek cost-effective alternatives to standard domiciliary care provision. However, there was little evidence of use of voluntary or community resources, though this may have been because they were unsuitable or unresponsive or not agreeable to the service user (as in the case of 'Jane'). Closer working between local authorities and voluntary and community organisations are needed if services are to develop to meet the needs of the communities they are supposed to support. Whilst care managers have a role to play in identifying and recording unmet needs, they are unlikely to have sufficient time to devote to population level service development.

Policy published since data collection for the present research (*e.g.* Department of Health 1998; Department of the Environment, Transport and the Regions 1998; Welsh Office 1999a) stipulates local authorities are to make alliances with the voluntary sector in order to address population level needs. The onus, therefore, is on local authority management to implement a workable service development system. Research into community care service development systems is appropriate.

Time constraints

Time was implicated as a major influencing factor of innovative care management in both studies. Insufficient time is likely to hamper thorough assessment of need, the generation of alternatives to standard provision, consideration of the feasibility of alternative care arrangements, as well as monitoring and reviewing stages of the innovative care management process. Since caseload size across all client specialisms (Study 2) was on average greater than those of the original PSSRU case management experiments, it is unsurprising that time was reported as a hindrance to innovative care management practice.

Caseload sizes of between 20 and 30 cases were typical in the PSSRU studies (Davies & Challis 1986; Challis *et al.* 1988, 1989, 1990), yet in the present research they were more than double (average of 64 cases) in practitioners working with older people or people with physical disabilities. The average caseload size of practitioners specialising in services for older people with mental health problems, one of the most vulnerable groups of people in society, was 50 cases, considerably higher than the PSSRU studies' figures. The average caseload sizes of practitioners working with people with mental health problems or learning difficulties were typically lower and nearer in size to those of the PSSRU studies (34 and 32 cases on average, respectively). Whilst it can be argued that a provider role is rightly maintained by practitioners in the latter two specialisms, limiting caseload size, it would appear that older people and people with physical disabilities are having their emotional and support needs neglected. Older people with mental health problems appear to be particularly disadvantaged, simply because they are over 65 years of age.

One of the principles of the National Service Framework for older people is that ageism will "not be tolerated in the NHS, with the elimination of any arbitrary policies based on age alone" (Department of Health 2000, paragraph 15.6). Local authorities should also work to ensure that ageism is

banished. However, in the NHS and local government this is likely to prove difficult given the constraints on the public purse and the ever-growing older population. The challenge to care management practice will be the reintroduction of 'provider' elements (*i.e.* counselling, therapy and emotional support) into services for older people and people with physical disabilities to ensure equity of service provision with people with learning difficulties and mental health problems. The resource implications are huge.

Time constraints are likely to come not just from high caseloads, however, but from other aspects of practitioners' workloads. Administration, overall workload and demands for services were reported as increasing over the past 12 months by the majority of survey respondents (Study 2). Such factors were recognized as influencing everyday care management practice by the care managers in Study 1. The emphasis placed on assessment (Department of Health 1993a; McGrath *et al.* 1996, 1997; Parry-Jones & Soulsby 1999; Ramcharan *et al.* 1999), appears to have limited time for innovative care management. Unless increasing demands for services are matched by increasing resources, time for innovative practice will become ever more limited. The signs are bleak. Survey respondents reported a reduction in the availability of resources over the past 12 months and, around the same time as the survey, Singleton *et al.* (1999) estimated a £95M shortfall in social care provision for older people in Wales. Research investigating the qualitative differences of community care service provision for different client groups is needed in order to explore issues of equity, especially in relation to age and the state of health and social care budgets.

Team working and manager support

The support of colleagues and managers appears to be important for creating the right environment in which to conduct innovative care management practice. Both managers and peers can provide knowledge and guidance during assessment and care management to assist in identifying and finding ways of meeting service user needs. In Study 1, the social work care managers reported working with health colleagues was facilitative of

their practice, indicating that multidisciplinary practice was both supportive and feasible. Several survey respondents (Study 2) specified multidisciplinary working as helping support their innovative practice. Thus, for these practitioners the poor history of collaborative working between health and social services noted by commentators (*e.g.* Higgins *et al.* 1995; Nolan & Caldock 1996) did not appear to impede their practice. However, a small number of survey respondents reported lack of joint working policies and ingrained cultural differences between agencies hampering their innovative practice. Co-working in general was regarded as facilitative, in common with King & West's (1987) qualitative study of individual innovation in managers and professionals.

From the comments of practitioners in both studies, managers appeared to hold a key position in the facilitation of innovative care management practice. Not only did they hold the budget, but they were a source of constructive supervision. Discussion, encouragement and praise from managers and being given opportunities to learn knew skills and take part in forums were valued by practitioners. Unsupportive management, in terms of not picking up suggestions and not providing feedback, was considered a hindrance to innovative practice. The influence of the quality of supervisor-subordinate relationships on the innovative behaviour of subordinates has been reported in the innovation literature (Oldham & Cummings 1996; Scott & Bruce 1994). Others, too, have found relationships with supervisors to be important in individual innovation (King & West 1987; West 1989). The finding that praise and encouragement from managers facilitates innovative practice fits with evidence that verbal rewards enhance self-reported interest in tasks (Deci, Koestner & Ryan 1999; Eisenberger & Cameron 1996).

Knowledge and skills

Past experience, knowledge and skills, and the acquisition of new knowledge and skills, were considered helpful in the pursuit of innovative practice by practitioners in both studies and the managers in Study 1. Developing and up-dating a knowledge base around particular client groups, local provision

and the state of budgets, and maintaining or enhancing practitioner skills were considered important.

Although not explicitly mentioned by study participants, the experience of prior success in implementing innovative ideas is also likely to encourage further innovative behaviour. Amabile (1983, 1988a), in her work on the social psychology of creativity, found evidence for the importance of task motivation in stimulating creativity. Several survey respondents in Study 2 noted having *the right attitude* was facilitative of their innovative behaviour. Perhaps self-motivation and other aspects of personality, were not directly reported by respondents because they are less readily accessible to conscious recollection. Certainly, the vast majority of cited facilitators and hindrances of innovative practice were extrinsic factors, which were presumably more easily recollected. It was never the intention of the present research to investigate personality factors, however, the huge creative personality evidence base (see Chapter 3) should not be neglected. There are almost certainly variations between participant practitioners in innovative practice on the grounds of individual differences.

Autonomy

Although autonomy was only reported by a small proportion of survey respondents (15%) as helpful of innovative practice, quantitative analysis found job discretion to be one of the main predictors of innovation frequency (alongside undertaking service development work). High levels of job discretion were associated with more frequent innovative behaviour, supporting earlier individual innovation and creativity research findings (*e.g.* Amabile 1984; Glassman 1986; King & West 1987; Unsworth & West 1998).

Types of innovative care management practice

Survey respondents in Study 2 were asked to give one example of their innovative practice whilst planning, implementing or evaluating care packages. Sixty-five percent of respondents provided an example. The fact

that so many were able to give an example adds weight to the argument that innovative care management practice is feasible, if infrequent. A great diversity in the types of care management innovations was evident, with fourteen different categories emerging from analysis of the examples (for a summary of the categories see Chapter 11).

The database of innovative practice examples given in Appendix 10 could provide a useful reference point for community care managers and trainers wishing to promote an innovative approach to care management. However, the task of deciding which examples are the most innovative (those that would perhaps be the most useful to use in training and supervision sessions) is clearly a difficult one, given the low level of inter-rater agreement by the 'experts'. Comments from some of the 'experts' suggest that there was insufficient information contained in the examples to make a reasonable decision regarding degree of innovativeness (imaginativeness). Reasons why the practice given in the examples had occurred might have been helpful, as could information regarding the relative benefits to service users and carers. Experts also indicated that having some information about what might be considered standard practice and what innovative practice would have helped. Thus, it may have been useful to prompt respondents to provide such details about their innovative practice example. Perhaps the degree of innovativeness of a practitioner's practice should also have been judged by the practitioner his- or herself, since he or she will be aware of his or her own standard and non-standard care management practice.

There is no doubt that further research is needed to identify how best to rate individual innovativeness. In one of the few other studies to include innovativeness ratings, West (1989) asked health visitors (n = 92) through a questionnaire to describe any innovations (*i.e.* changes to work methods, objectives, how they dealt with people, or any new skills learnt) that they had implemented over the past year. They were also asked to rate the degree of impact each area of change had had on clients, colleagues, and their jobs using a 3-point scale (from 1 = 'minor impact' to 3 = 'major impact'). These impact ratings were then summed to produce an overall 'innovation' score for

each health visitor. To validate the innovation measure, the first-line managers (n = 3) were asked to rate the innovativeness of every health visitor over the previous year. So long as managers have regular contact and supervision sessions with their supervisees, then they should in theory be in an ideal position to judge both standard and innovative practice for each of their supervisees. However, an insignificant correlation was found when manager and health visitor ratings were compared (r = 0.08). This result may have occurred because the managers did not have enough insight into the working practices of their supervisees, or because the impact rating scale was not appropriate for measuring innovativeness. Interestingly, a positive, significant correlation (r = 0.27; p 0.01) was found between the managers' ratings of innovativeness over the past year and the practitioners' ratings of their own general innovativeness as a person, suggesting the latter explanation is most likely. Such a finding also suggests that degree of innovativeness rating is a viable proposition.

In future research into practitioner innovation, it may be useful to ask practitioners to provide non-innovative (*i.e.* standard) as well as innovative practice examples. The practitioners could then be asked to describe in what ways their non-innovative and innovative examples differed. Exploring qualitative differences might help practitioners to subsequently quantify the degree of innovativeness of their innovative practice examples. Having a range of non-innovative to innovative practice examples might also assist 'experts', whether first-line managers or more independent raters, to make more informed decisions regarding degree of innovativeness. Additionally, the practice examples combined with their innovativeness ratings should provide more concrete exemplars of innovative practice, which in turn could be used in supervision or training.

Stress and innovation in care management

The third, and final, overarching aim of the research was *to investigate the relationship between innovative practice and occupational stress*. This was addressed in Study 2.

Stress

The increasing levels of stress reported by the majority of survey respondents is a similar trend to that found in other studies of stress in community care practitioners (*e.g.* Balloch *et al.* 1998; Carson *et al.* 1995; MacLellan 1990; Parry-Jones *et al.* 1998b – see Chapter 4). In the present research, increased stress was found to be correlated with reduced job satisfaction and high levels of job demand ($r = -0.31$ and $r = 0.38$, respectively; $p = 0.01$). A significant, though small correlation was also found between increased stress and low levels of job discretion ($r = -0.19$, $p = 0.01$). Typically, respondents reported high levels of job demands and middling levels of job discretion, although almost a third reported high demands combined with low discretion. Analysis of variance results provided support for the prediction from Karasek's (1979) model of strain that low job discretion and high job demands would be associated with perceived increased stress.

Despite finding support for Karasek's model, job demands and job discretion were not found to be main predictors of increased stress in regression analyses. Reduced morale of colleagues, increased workload and decreased ability to manage one's workload were, explaining 42% of the variance in the stress variable. Job satisfaction, communication with managers, and resource change variables were additional, though less important predictors, able to explain a further 4% of the variance. Thus, these six variables were predictive of a considerable proportion of the variance in the stress variable (46%). In the earlier survey of care management practitioners in Wales (Parry-Jones *et al.* 1998b), workload and workload-associated variables

were also found to be predictive of increased stress. Such findings, combined with those from other studies (Bradley & Sutherland 1995; Carson *et al.* 1995; Collings & Murray 1996; Gibson *et al.* 1989; McGrath *et al.* 1989), provide support for the idea that heavy workloads are major sources of stress for community care practitioners. However, since almost all studies of stress and community care practitioners have been cross-sectional in nature, direction of causality cannot be assumed. It may be that stressed practitioners find juggling the demands of their workload difficult, resulting in poor planning and time management and a subsequent perception of high workload demand.

Innovation and stress

One of Study 2's hypotheses was that increased stress would be associated with less frequent innovative practice. Only a very weak correlation was found ($r = -0.16$, $p = 0.05$), suggesting that there is little, if any, genuine relationship between the two variables (possible explanations for this are given in Chapter 11). This is contrary to the evidence of other studies, where greater innovation or creativity has been linked with enhanced mental well-being (Carter & West 1998; Norowol *et al.* 1993; Talbot *et al.* 1992 - see Chapter 4). However, such studies have methodological problems (as outlined in Chapter 4), making it difficult to place much weight on their findings. None of the studies, including the present one, were designed to enable direction of causality, if any, to be determined. However, the present study did attempt to examine associations with possibly common underlying factors.

Karasek's (1979) model was used to ascertain whether perceptions of high job demand and low job discretion were associated with both reports of increased stress and less frequent innovative care management practice. As noted above, the association was found in the predicted direction for the stress variable. Only job discretion, and not job demands, was found to correlate significantly with innovation frequency ($r = 0.29$, $p = 0.01$). Thus,

more frequent innovative practice was reported by those respondents who also reported high levels of job discretion.

Similar to the treatment of the stress variable, analysis of variance testing was conducted to explore any possible relationships between innovation frequency and the quadrants of Karasek's model. A trend was found in favour of the prediction that high demands combined with low discretion would be associated with lower levels of innovation frequency. However, it was not statistically significant, reducing the impact of the finding. It appears, though, that the (weak) association between stress level change and innovation frequency may exist partly because of the influence of moderating variables, such as job demands and job discretion. Future research should consider not only these and other potential moderators of the stress-innovation relationship, but also the processes involved. Qualitative and longitudinal research designs are most likely to facilitate this work.

Implications for policy and practice

Highlighting the innovative care management process

Although innovative care management practice appears to be infrequent it, nevertheless, does occur. Thus, it seems that practitioners have been able to "give full rein to their creativity in devising new ways of meeting needs" (Social Services Inspectorate 1991a, paragraph 4.12). However, the degree to which practitioners have been able to *give full rein* is debatable. Whilst innovative practice examples were given by survey respondents, it is uncertain what levels of innovativeness practitioners are able to obtain. Comments from some of the expert raters, and the bulk of degree of innovativeness ratings, indicate that many of the innovative practice examples cited could be considered standard practice. Overall, though, it would appear that care management practice is considered innovative by practitioners when an atypical element is included in a care package, such as the provision of hot meals for service users by publicans, rather than by

home care workers or a statutory 'meals on wheels' service. Whilst an innovative outcome or 'product' may be achieved in the pursuit of meeting needs, it is the conclusion of this research that innovative care management practice is distinguished from non-innovative practice by the nature of the 'process' involved. Therefore, one of the main implications from the research is that:

- Policy and/or policy guidance should highlight how innovative practice in care management can be achieved. Making use of the innovative care management process model could assist in this.

Regardless of whether policy makers and guidance writers pay heed to such advice, care management practitioners, their managers, and community care trainers could utilise the model. Indeed, a further implication is that:

- Training and supervision in the innovative care management process should be made available for community care practitioners.

Supporting innovative care management practice

Numerous factors that influence innovative care management practice have been identified through the course of the research. Whilst there appear to be many barriers to innovative practice, there also appear to be many facilitating factors. Therefore,

- Policy makers and health and social services managers should work towards improving conditions that support the innovativeness and creativity of practitioners.

There are a number of specific areas in which this can be done.

- To enhance autonomy and provide concrete purchasing limits for care packages, budgets should be devolved to practitioners or their first-line managers.

- To reduce the workload (including the caseloads) of care management practitioners, additional finances need to be made available to fund new posts in care management (older adults and physical disabilities services, in particular).

- To provide opportunities for sharing knowledge and innovative practice examples, team working, especially multi-disciplinary team working, should be encouraged and new structures provided to allow this to occur. Use of the new joint working flexibilities, such as pooled budgets, lead commissioning and integrated provision (Department of Health 1998; National Assembly for Wales 2000; Welsh Office 1998, 1999b), provide the means for assisting this.

- To help motivate practitioners to think innovatively and implement their innovative ideas, supervision should include praise and encouragement, as well as concrete advice, for innovative practice.

- To further skills and knowledge in innovative care management practice, training should be provided for supervisors and practitioners in not only the innovative process model but also the factors that help and hinder innovative practice.

- To assist in the development of appropriate community resources, service development systems should be established and monitored. Clear guidance on unmet need identification and recording should be provided for practitioners.

- Additional finances should be made available for service development.

Easing practitioner stress

There is substantial evidence, from this research and elsewhere, that community care practitioners are experiencing high and increasing levels of stress. The adverse impact of job stress on workers has been thoroughly documented (see Chapter 4). There are also major implications of employee stress on employing organisations, such as in terms of turnover, absenteeism and productivity (see Kompier & Cooper 1999). If care management practitioners do not perform at their best, or are absent from work, then service users and carers are likely to suffer as a consequence. Thus, an important implication of the research is that:

- Stress intervention strategies should be introduced into health and social services organisations, to help alleviate employee stress.

Three types of interventions have been identified in the literature: primary, secondary, and tertiary (Cooper & Cartwright 1997). *Primary* intervention strategies aim to prevent stress occurring in the first place, by tackling the sources of stress, and include job or task redesign, enhancing social support and feedback systems, participative management, promoting flexible working arrangements, and giving consideration to employee career and development needs. *Secondary* intervention focuses on early identification and amelioration of experienced stress by employees. Stress management training is typically used to help raise awareness and teach relaxation and time management skills. *Tertiary* interventions are targeted at individuals already suffering ill health as a result of workplace stress. Such interventions aim to treat or rehabilitate workers and include information provision, counselling, and referral to health and support services.

Since many of the factors influencing innovative care management practice are also associated with the experience (or amelioration) of stress, by addressing such factors (as suggested above) policy makers and managers should help develop a less stressful work environment (*primary* intervention). However, separate stress reduction and innovation promotion strategies should be considered, because of differences in stress and innovation processes, influencing factors and outcomes. Since high and increasing levels of stress are already being experienced, implementing secondary and tertiary stress intervention programs is an urgent imperative.

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APPENDIX 1

Study 1:

Care manager "Involvement Schedule"

Phase 2: Assessment and Care Management Practice
SW Involvement Schedule

Name of SW:

Name of case no.1:

Name of case no.2:

Involvement detail	Date	Completed (✓)
Background interview		
Assessment visit no.1		
Assessment visit no.2		
Post assess. discussion: no.1		
Post assess. discussion: no.2		
Post review discussion: no.1		
Post review discussion: no.2		
Further contact		

APPENDIX 2

Study 1:
Case questionnaire

Assessment and care planning research

Client: .....

Social Worker: .....

Date: .....

Please return to: Beth Parry-Jones,
Centre for Social Policy Research and Development,
University of Wales, Bangor,
Gwynedd LL57 2DG.

Factor		Needs-Assessment			Care Planning			Further Details
		Present	+ve	-ve	Present	+ve	-ve	
Communication	Client							
	Carer-informal							
	Carer/care organiser-formal							
	Health personnel							
	Voluntary sector							
	Own c.m. team (SWs)							
	Own admin. staff							
	Own manager(s)							
	Other SW team(s) - state *e.g.*Hosp./Comm. SWs:							
	Other-state:							
Referral aspects	Length of notice for asst.							
	Hospital discharge procedure							
	Other-state:							
Time for undertaking each process-if negative factor, state reason for lack of time:								
Documents	Assessment-social care							
	Assessment-financial							
	Care plan							
	Benefit forms							
	Contract forms/letters							
	Other forms/letters-state:							

		Present	+ve	-ve	Present	+ve	-ve	
Financial	Undertaking financial assessment/implementing charging policy							
	Ceiling on care costs per client/week							
	Client/family partly or wholly financing care							
Local resources	Home care service							
	Agency domicillary care service(s)							
	Day care: in-house							
	Day care: agency							
	Respite care: in-house							
	Respite care: agency							
	Respite care: hospital							
	Specialist assessment service: hospital/unit							
	Primary care - state professionals:							
	Voluntary sector - state organisation(s):							
	Church/chapel							
	Neighbour(s)							
	Family							
	Other-state:							

Factor		Needs-Assessment			Care Planning			Further Details
		Present	+ve	-ve	Present	+ve	-ve	
Family Dynamics								
Disability/health problem(s)/behaviour of client *e.g.* confusion, memory impairment, aggression - state main factor(s):								
Specialist knowledge/skills in regards to specific client groups	Self							
	Health professionals - state which:							
	Social services colleagues							
	Client							
	Family/informal carer(s)							
	Formal carer(s)							
	Other people - state:							
Other factors not mentioned - state:								

APPENDIX 3

Study 1:
Interview schedule

Phase 2: Assessment and Care Management Practice
Social Worker Interview Schedule

Community Care

- Overall view of c.c. within locality
- Main aims and objectives of c.c. - Are they being achieved?

Also ask :-
1. How long in post?
2. How long in c.m.?
3. Year qualified?
4. How many in team?
5. Size of case (load).
6. No. of assts. per month.

Assessment and Care Management

- Feelings about assessment and c.m. work
- Goals of assessessment and c.m. - Are they achieved?

Process

- Are assessment and care planning considered separate processes?
- Describe how need identified
- Describe what involved in care planning process
- What factors appear to facilitate or hinder assessment and care planning?

Inter-agency and inter-professional working

- What is current situation?

Team

- Supportive team?
- Do colleagues discuss aspects of their c.m. work with other colleagues?
- Supportive manager? - Sufficient supervision / feedback?
- Morale within team / stress levels
- Expectations about LGR

Innovative Practice

- Do you consider yourself to be innovative at times during care planning?
- Examples of innovative practice or innovative care packages
- Advantages and disadvantages of innovative approach
- What factors appear to facilitate or hinder innovative practice?
- Does innovative practice help achieve aims of c.c.?

APPENDIX 4

Study 1:
Manager questionnaire

Assessment and care management study: manager questionnaire

This questionnaire focuses on **your opinions and experiences** of assessment and care management practise within your team from **your perspective as a manager**. It has been designed with open-ended questions to enable you to express your opinions and experiences without constraint. A few words in response to each question are all that is required, but please feel free to elaborate if you wish.

There are no right and wrong answers as it is your opinions and experiences that count. The questionnaire should take approximately 15-20 minutes to complete.

Thank you for your participation.

Name: _____ Date: _____

1. What do you feel are the **main factors** which appear to facilitate or impinge upon assessment and care management practice?

2. What do you consider the **main aims and objectives** of assessment and care management to be?

3. Do you consider **innovative thinking and practice** is necessary or desirable* (please delete as appropriate) to achieve the aims and objectives of assessment and care management?

YES / NO

If "YES", how do you encourage innovative thinking and practise within your team?

4. What factors in particular appear to facilitate or impinge upon innovative practise within your team?

5. How is the issue of **unmet need** dealt with by yourself as Team Manager?

Please return to: Beth Parry-Jones, CSPRD, Bryn Afon, University of Wales, Bangor, Gwynedd LL57 2DG.

APPENDIX 5

Study 1:
Summary report

Assessment and Care Planning Case Study Research: Feedback Summary Report

This summary report is of initial impressions gained from the research data and is designed to provide feedback to those who were involved in the study. More detailed analysis, writing and dissemination will follow after the researcher returns from maternity leave.

The aim of the research was to investigate at first hand the processes and skills employed by social workers in assessment and care planning and the factors which facilitate and impinge upon the construction of individually tailored packages of care. Evidence of innovative practice was also sought as it is considered this could provide a valuable means for understanding the design potential of care packages. Eight cases, taken from the caseloads of five social work care managers, were tracked prospectively from referral information, through initial assessment to first review of home-based care packages. Several methods of data collection were used including observation of initial assessments and/or first reviews, discussion of cases with care managers, reading of case notes, short interviews with care managers about care management practice in general, and a questionnaire completed by line managers on care management. In addition, a tick-box questionnaire, designed after gaining data from approximately two-thirds of cases, was completed by care managers on factors influencing the assessment and care planning of cases. Data collection was undertaken between January and May 1996.

The main factors found to be influential in the assessment and care planning work of the care managers involved in the study were administration, financial matters, communication, resource availability, and time. Administrative work, for instance, appears to both facilitate and hinder assessment and care planning. In regards to the individual cases, the actual social care assessment and care plan documents were seen as a help to assessment and care planning processes. They focused the practitioner's mind on key areas, provided a place for structured comment, and formalised agreement between care managers, service users and their families, and carers/care organisers. However, they were not viewed as appropriate in their entirety for all service users. For instance, the structure of the assessment form did not provide sufficient space to record all aspects of EMI cases, nor was it sufficiently flexible to adapt to new information gathered over a period of time. Completing financial assessment documents and discussion of charging policy appeared to be a barrier to the construction of care plans with users and their families. Although some users and families understood the financial constraints placed upon social services and were willing to supplement care charges, others appeared to feel they had little choice. One client, a stroke case, became very distressed during discussions which, presumably, was not conducive to h health. The amount of administrative work in general was considered a constraint, especially in relation to innovative practice. Time spent in bureaucratic endeavour meant reduced time for tapping into unconventional or underdeveloped community support for clients.

Communication, rather expectedly perhaps, appears to be a particularly important factor in assessment and care planning work. Ease of communication with clients and their families varied across cases and seemed dependant upon the type of disability or health problem and family dynamics. For instance, clients with confusion and/or memory disfunction, which included those who could be classified as elderly mentally infirm, some stroke cases and an alcohol abuse case, appeared to be the least able to communicate effectively about their needs and often seemed oblivious to their conditions and the risks they put themselves under.

Without these insights attempts to involve them in assessment and care planning appeared to leave care managers in a dilemma: on the one hand practitioners wished to enable clients to make their own care choices, empowerment being congruous with social work practice and the needs-led approach, and on the other hand they were obliged to take the leading role in decision-making to minimize risk and keep care costs within budgetry ceilings.

Liaison with health personnel occurred as part of assessment and care planning processes for the majority of cases and was regarded as mainly facilitative. Community psychiatric nurses, district nurses, occupational therapists, ward nurses and one general practitioner provided specialist knowledge and assessment skills to enable a more holistic picture of the circumstances of clients to be gleaned. However, two cases involved hasty hospital discharge, leaving the care managers involved little notice to assess and set up care arrangements, and in these instances communication with ward staff was considered more negative than positive. In another case, an alcohol abuse case, the care manager had had difficulties in establishing the involvement of a CPN and felt that perhaps the nature of such cases, often typified by aggressive behaviour and an unwillingness to progress therapeutically, made them less of a priority than conventional EMI cases.

In several cases care managers sought support from their line managers, which was always regarded as facilitating assessment and care planning processes. Administrative staff were acknowledged as helping with the voluminous paperwork, particularly in regard to financial assessment, and with accessing computers. One care manager mentioned in a general discussion about care management practice that she would tap into her colleagues' knowledge of local community support to aid creative care packaging when her own knowledge was limited. However, in regard to the particular cases studied no care managers recorded communications with other care managers as being influential in their assessment and care planning work.

Discussions with agency care organisers, their responsiveness to crises and their flexibility in meeting needs were regarded highly by care managers. The specialist knowledge of agency care staff dealing with a particular EMI case was praised as invaluable during the initial assessment and implementation of h care package. Their identification and rapid communication of problems shortly after the client was discharged home from hospital dramatically reduced the risk the client had placed herself into.

Social services domicillary and respite care facilities were utilised in a number of cases. Generally, the communication and responsiveness to need of these services was regarded favourably by care managers. However, there were instances where their involvement hindered assessment and care planning work. Some in-house care staff failed to either observe or communicate specifics of client behaviour which might have facilitated the fine tuning of care arragements at an early stage. Perhaps they were not aware of the monitoring potential of their role, or perhaps their knowledge was insufficient to spot possible difficulties before they arose. There also appeared to be a lack of flexibility in meeting needs at particular times of day by the home care service in certain areas. However, care managers overcame this lack of flexibility by combining social services with agency domicillary care.

There was only one instance of voluntary sector involvement, the befriending service of Age Concern, in care planning. Voluntary sector support was investigated for an alcohol abuse case, but the local organisation which offers alcohol counselling only works with the under

65's. Other forms of community support, such as via the church, were not evidenced in the care planning of any of the cases, although in one instance a neighbour did provide information at the assessment stage. Care managers seemed to employ two strategies regarding the potential of community resources: firstly they would only investigate not-for-profit community resources (excluding families, or friends and neighbours who were already providing a degree of support) if the for-profit care sector could not meet all assessed needs; secondly they would only spend a limited amount of time inquiring into not-for-profit community resources. As time is a precious commodity to care managers with heavy caseloads such strategies are understandable.

In regard to innovative practice generally, the majority of care managers felt they employed it to varying degrees when tailoring care packages to individuals. Supportive management was mentioned as being particularly helpful and indeed the managers themselves expressed the importance of innovative practice to meeting the objectives of care management. Care managers acknowledged that having budgetry ceilings of a certain level (it was £300 per client/week in the area) helped focus the mind on priority needs and economical and creative means of meeting them. However, the wider issue of insufficient finances to develop community services was regarded as impeeding innovative practice as was a lack of time.

Beth Parry-Jones, June 1996.

Centre for Social Policy Research and Development, University of Wales, Bangor.

APPENDIX 6

Study 1:

Manager comments on summary report

Ms B Parry-Jones
Centre for Social Policy Research & Development
University of Wales,
Bangor
Gwynedd

2nd July 1996

Dear Beth

Re: Assistance and Care Planning Case Study Research: Feedback Summary Report

My comments re the above:

1. We are concerned at the limited scope of your sample, 8 cases just doesn't seem enough to justify conclusions.

2. I didn't understand the link between 'innovative practice' and 'design potential of care packages'. What I think is worth looking at is the conditions under which innovative care packages can flourish.

3. In your 3rd paragraph you talk of 'assistance' and 'care plan' documents as administrative work. All the guidance indicates that assessments and care plans are written documents. This is not administrative work but a cornerstone of community care. If this is seen as purely administrative then it becomes less essential than it is.

4. Top of Page 2. Care Managers should not be in a dilemma over this. Ultimately, it is SSD's role to assess and provide a care plan - with or without the assistance of users.

5. Middle of Page 2. The views you picked up about agency care staff and in-house staff are reflected in a survey we have undertaken into users perceptions about domiciliary care.

6. Top of Page 3. Two points: (1) If SSD has assessed a need then they are responsible for meeting that need: Clwyd SSD defined need in terms of significant risks to health and safety. Basically I think that it is quite right that Care Managers are seeking secure arrangements for meeting those needs which means paid workers. I would be very unhappy about a service which met assessed needs by voluntary/community resources. (2) In parenthesis you exclude family, friends, neighbours, etc. Does that mean that Social Workers were building on existing informal support?

7. I think an analysis of why care packages are to varying degrees innovative would be very useful. (The field here is 'immense': databases of community resources, flexible contractual arrangements, locality working, etc.).

APPENDIX 7

Study 1:

Author reply to manager comments

25th March 1997

Canolfan Ymchwil a Datblygiad Polisi Cymdeithasol

Centre for Social Policy Research and Development
Cyfarwyddwyr/Directors
Gordon Grant, G. Clare Wenger

Dear

Assessment and Care Planning Case Study Research and Care Manager Survey

Thank you for your letter of 2/7/96 regarding feedback from the case study research. I apologise for my delay for responding. I was on maternity leave from mid-June 1996 until January 1997 and since my return I have been, amongst other things, focusing on the development of the enclosed care manager survey questionnaire.

Your comments on my initial analysis of the case study research have been useful during the more in-depth analysis that I am currently undertaking. They have helped to validate my analysis and add additional insight. I acknowledge your concern, and that of your colleagues', that 8 cases appear an insufficient number from which to draw conclusions. However, case study research is characterised by low case numbers. Depth rather than breadth, quality rather than quantity, of data is sought. Findings are not intended to be generalised. Conclusions, however, can be drawn on the insights gleaned from such in-depth data gathering providing they are placed in context.

The case study research that I undertook was the second phase of a two-phase piece of qualitative research into assessment and care management practice. The first involved 64 interviews of a variety of health and social service practitioners and managers across Clwyd and Gwynedd. I omitted to state the context of the case study research in the feedback report because, firstly, I was only providing feedback on the case study phase and, secondly, I was feeding back to people who were involved in that phase and to whom I had previously explained the context. In future, however, I will make sure I always refer to context and am grateful that you caused me to consider this aspect.

The enclosed care manager questionnaire is a modified version of one we at CSPRD used to conduct a Welsh Office funded all-Wales survey in 1995. The initial survey tapped into practitioners' views and experiences of care management practice after the implementation of the community care reforms in April 1993. The follow-up survey, which we intend to run in April-May of this year, has been designed to investigate care management practice since local government reorganisation in April 1996.

In addition to piloting the follow-up questionnaire with practitioners, we are seeking comments from relevant others including several SSD managers, independent academic advisors and Social Services Inspectorate personnel. I am therefore writing to you to seek your opinion on the content of the follow-up questionnaire. I would particularly welcome your comments on the innovative practice section (pages 7 & 8) in view of your interest in this area.

Thank you, in anticipation, for your comments on the questionnaire.

Yours sincerely,

Beth Parry-Jones.

Beth Parry-Jones, Research Officer.

APPENDIX 8

Study 2:

Care management practitioner questionnaire

CSPRD

Questionnaire

CONFIDENTIAL

CARE MANAGEMENT 1997

A SURVEY OF FRONT LINE WORKER EXPERIENCES IN WALES

YOU ARE INVITED TO SHARE YOUR VIEWS AND EXPERIENCES ABOUT:

- YOUR ROLES AND RESPONSIBILITIES
- DEVELOPING NEEDS-LED SERVICES
- ACHIEVING CHANGE

Prifysgol Cymru · University of Wales
BANGOR

CENTRE FOR SOCIAL POLICY RESEARCH AND DEVELOPMENT
UNIVERSITY OF WALES, BANGOR

CARE MANAGEMENT

A SURVEY OF FRONT LINE WORKER EXPERIENCES IN WALES

In 1995 we undertook a survey of practitioners' experiences of care management after the implementation of the NHS and Community Care Act (1990) in April 1993. This follow-up questionnaire invites you to focus on your experiences since **local government reorganisation in April 1996.**

This questionnaire is intended for completion by practitioners with responsibility for any of the following:

i. comprehensive/full assessments under the NHS and Community Care Act

ii. coordinating specialist assessments

iii. arranging care packages

iv. monitoring care packages

Please note:

We acknowledge variation in the meaning of the terms *care management* and *care manager* across Wales. These terms are used in this questionnaire to refer to people involved in *care management*, *case management* or *key working*.

It is important to gain the views of as many practitioners as possible so that the findings are reasonably representative of existing practice models. We therefore hope that, despite work pressures, you will be willing to participate in the research.

SOME ORGANISATIONAL FEATURES ABOUT YOUR WORK

1. With which client group/s do you spend most time?
(please **tick** the appropriate box/es)

☐ elderly people	☐ elderly mentally ill people	☐ physically disabled people under 65 yrs
☐ hearing impaired people	☐ people with terminal illness	☐ visually impaired people
☐ people in hospital	☐ people with mental health problems	☐ adults and/or children with learning disability
☐ people affected by HIV/AIDS	☐ chronically sick people	☐ people affected by substance misuse

Other (please specify)

2(i) What is/are your team(s) called?

2(ii) How would you characterise your team(s)?
(please **tick** the appropriate box/es)

Generic social work	☐	Specialist social work	☐
Care management	☐	Single-agency multidisciplinary	☐
Multi-agency multidisciplinary	☐	Other (please specify)	☐

3(i) Do you work: (please **ring**)

full time/part-time

If part-time
how many hours a week do you work?

(ii) For approximately how many cases are you currently responsible?

(iii) Roughly how many cases are you involved with as a care manager?

(iv) Approximately what percentage of your time do you spend working as a care manager? (please **ring** as appropriate)

None	less than 25%	25-49%	50-74%	75% or more

NOTE: All the following questions refer to your total caseload unless otherwise stated.

ASSESSMENT AND CARE MANAGEMENT

4(i) Assessment For approximately what proportion of cases do you undertake the following tasks?
(please **ring** the appropriate response)

	None	less than 25%	25-49%	50-74%	75% or more
Screen to determine level of assessment	0	1	2	3	4
Explore with the user their needs	0	1	2	3	4
Explore with (informal) carer(s) their needs	0	1	2	3	4

continued

	None	less than 25%	25-49%	50-74%	75% or more
Arrange specialist assessments	0	1	2	3	4
Collate other professionals' assessments	0	1	2	3	4
Consult with other professionals	0	1	2	3	4
Financially assess for services	0	1	2	3	4
Check welfare benefit entitlement	0	1	2	3	4
Decide eligibility for services	0	1	2	3	4

4(ii) Direct work For approximately what **proportion of cases** do you undertake the following tasks? (please **ring** the appropriate response)

	None	less than 25%	25-49%	50-74%	75% or more
Counsel users/families	0	1	2	3	4
Provide therapy/treatment	0	1	2	3	4
Provide emotional support	0	1	2	3	4
Act as an advocate for user/family	0	1	2	3	4
Carry out crisis intervention	0	1	2	3	4
Carry out primary preventive work	0	1	2	3	4

4(iii) Arranging services

For approximately what **proportion** of cases do you undertake the following tasks?
(please **ring** the appropriate response)

	None	less than 25%	25-49%	50 - 74%	75% or more
Design individual care packages	0	1	2	3	4
Cost service packages	0	1	2	3	4
Broker in-house services	0	1	2	3	4
Broker services with private care agencies	0	1	2	3	4
Broker voluntary/not-for-profit services	0	1	2	3	4
Arrange direct payments	0	1	2	3	4
Record/report unmet need	0	1	2	3	4
Monitor/evaluate care packages	0	1	2	3	4
Collaborate with other professionals	0	1	2	3	4

continued

4(iv) What helps or hinders your ability **to perform effectively in your care management role?**

helps.....

hinders.....

5. **If you record or report details of unmet need** what use is made of these data? (please **ring** the appropriate response)

	Yes	No	Don't Know
Collated on an area basis	Y	N	DK
Collated on a county wide basis	Y	N	DK
Used for service development	Y	N	DK
Used to revise and set team priorities	Y	N	DK
Recorded but not used	Y	N	DK

INNOVATIVE PRACTICE

Within this section being innovative refers to introducing something as new or making changes within your work role.

6. In your opinion is being innovative a necessary function of your care manager role?

Yes/No/Not sure

7. Approximately how frequently are you able to be innovative whilst planning, implementing or evaluating individual care packages? (please **ring** appropriate response)

Never	Occasionally (at least 1 in 50 cases)	Sometimes (at least 1 in 20 cases)	Often at least 1 in 5 cases)	Always

8. Please give one example below of your innovative practice whilst planning, implementing or evaluating an individual care package?

9(i) Do you undertake service development work? Yes/No

(ii) If yes, please give one example

10. What helps or hinders your innovative practice?

helps.....

hinders....

INFRASTRUCTURE

11. In your opinion how adequate have the following been in enabling you to perform effectively as an assessor/care manager?
(please **ring** the appropriate response)

	adequate	neutral	inadequate
Local practice guidance	1	2	3
Administrative support	1	2	3
Assessment forms	1	2	3
Resources to purchase services	1	2	3
Arrangements for negotiating services	1	2	3
Choice of providers of community care	1	2	3

12. Do you have adequate access to up-to-date information that you can use about: (please **ring** the appropriate response)

	Yes	No
Services provided by independent sector agencies	Y	N
Unit costs of all/most services	Y	N
Means testing for service charges	Y	N
Service eligibility criteria	Y	N
Statutory responsibilities under the NHS and CC Act	Y	N
Agency policy on risk taking	Y	N
Current status of the local community care budget	Y	N
Responsibilities under Carers' Act	Y	N
Direct payments legislation	Y	N

TRAINING (please **ring** the appropriate response)

13(i) The following questions relate to training about care management:

	(a) have you experienced training about?		(b) If "Yes" to what extent has this helped?			
	yes	no	not at all	to some extent	quite a lot	very much indeed
budgeting	Y	N	1	2	3	4
NHS and CC Act	Y	N	1	2	3	4
Carers Act	Y	N	1	2	3	4
CC (Direct Payments) Act	Y	N	1	2	3	4
needs assessment	Y	N	1	2	3	4
purchaser/provider split	Y	N	1	2	3	4

(ii) In relation to what aspects(s) of your work do you most need training?

INTER-PROFESSIONAL/INTER-AGENCY WORK IN CARE MANAGEMENT

14. Some aspects of inter-professional/inter-agency working may facilitate care management.

	(a) have you experienced?		(b) If "Yes" to what extent has this helped?			
	yes	no	not at all	to some extent	quite a lot	very much indeed
Multidisciplinary training	Y	N	1	2	3	4
Multi-agency client database	Y	N	1	2	3	4
Multi-agency assessment instruments	Y	N	1	2	3	4
Access to case records of other agencies	Y	N	1	2	3	4
Multidisciplinary/multi-agency case meetings	Y	N	1	2	3	4
Shared work base with other agencies' staff	Y	N	1	2	3	4
Shared values with other agencies	Y	N	1	2	3	4
Formal liaison mechanisms with other agencies	Y	N	1	2	3	4
Informal liaison	Y	N	1	2	3	4
Other (please specify)	Y	N	1	2	3	4

BUDGET ARRANGEMENTS

(Please **ring** appropriate responses unless otherwise stated)

15. Do you have control over a budget through which services are purchased? | Yes/No |

If **NO**

(a) Is there an intention to devolve budgetary control to your level? | Yes/No/Don't Know |

(b) Has there been any change in the control you have over financial resources since April 1996/LGR? | More/Same/ Less control |

16. What is the maximum amount you can spend on any one service user per week without authorisation? | £ |

17. Can you purchase services outside of your agency without authorisation? | Yes/No |

18. Is there any separation between the purchasing and providing arms of the SSD in your area? | Yes/No/Don't Know |

19. Over the last 12 months the available resources have:
(please **ring** the appropriate response)

Decreased	Stayed the same	Increased

20. Over the last 12 months the demands for services have:
(please **ring** the appropriate response)

Decreased	Stayed the same	Increased

HOSPITAL DISCHARGE

(Please **ring** the appropriate responses unless otherwise stated)

21. Do you work with people who are being discharged from hospital? | Yes/No |

If **NO** move to question 23

If **YES**

(a) Have you had access to a copy of your local hospital discharge policy? | Yes/No |

(b) Did you receive training or advice about the existing procedures? | Yes/No |

22(i) How well do the arrangements for hospital discharge work?

Very well	Quite well	Neutral	Not well	Not very well

(ii) Please specify the main reasons for your response

WORK ACTIVITIES

23. Please indicate how well each of the descriptions below characterise your daily work activities (please **ring** as appropriate)

	not at all	to some extent	quite a lot	very much indeed
Have to work very hard	1	2	3	4
Allows opportunity to learn new things	1	2	3	4
Lack of time to finish tasks	1	2	3	4
Allows you to make your own decisions	1	2	3	4
Creative	1	2	3	4
Lots of work	1	2	3	4
Allows freedom	1	2	3	4
Allows you to participate in decision making	1	2	3	4
Work gives rise to conflicting demands	1	2	3	4
Have to work fast	1	2	3	4
Work requires a high level of skill	1	2	3	4
Not enough time to do the work	1	2	3	4
Allows you to have a say in what you do	1	2	3	4
Excessive amount of work	1	2	3	4

)UTCOMES

4. The present care management arrangements facilitate: **(please ring the appropriate response)**

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
'lexibility of care plans	1	2	3	4	5
;peed of arranging care plans	1	2	3	4	5
ıdividual tailoring of care plans	1	2	3	4	5
'alue for money	1	2	3	4	5
:hoice for user/carer	1	2	3	4	5
Jser/carer empowerment	1	2	3	4	5
\ccountability to user/carer	1	2	3	4	5
\ seamless service	1	2	3	4	5

PRACTICE CHANGE

25. Over the last 12 months to what extent have the following occurred?

	Decreased a lot	Decreased a little	Stayed the same	Increased a little	Increased a lot
The level of responsibility I have has	1	2	3	4	5
My job satisfaction has	1	2	3	4	5
My workload has	1	2	3	4	5
The ability to manage my workload has	1	2	3	4	5
The morale of my colleagues has	1	2	3	4	5

continued

	Decreased a lot	Decreased a little	Stayed the same	Increased a little	Increased a lot
The levels of stress I feel have	1	2	3	4	5
My feeling of being a valued employee has	1	2	3	4	5
The quality of service I am able to give has	1	2	3	4	5
My satisfaction with my overall working conditions has	1	2	3	4	5
The amount of administrative work I have to do has	1	2	3	4	5
The amount of time I have for direct client contact has	1	2	3	4	5
The sense of personal achievement I get from work has	1	2	3	4	5
My confidence in the future of community care has	1	2	3	4	5
The quality of communication with my managers has	1	2	3	4	5

26. What are the main ways in which LGR has affected your work as a care manager?

FINALLY ABOUT YOU

27. What is your profession?

28. What is your job title?

29. Grade/level

30. Gender M/F

31. Please list here any professional qualifications you hold

32. How many years is it since you received your basic professional qualification?

33. Please list here the languages you use in your professional work

34. Where is your work base? (please **tick** appropriate box/es)

- Hospital
- SSD locality office
- Primary care setting
- Res/day care setting
- Other community base

35. For what type of organisation do you work?

☐	Local authority	☐	NHS Trust	☐	Voluntary agency

Other (please specify)

36. Is your post jointly funded? Yes/No

If **YES**
please specify the funding agencies

37. In which unitary authority/county do you work?

38. In which county did you work before local government reorganisation?

continued

Any additional comments you would like to make would be very welcome.

Thank you for taking the time to fill in this questionnaire. Completed questionnaires should be returned anonymously within the freepost envelope provided to CSPRD.

Findings and Implications

We would like to thank all practitioners who have completed this questionnaire and/or the previous one in 1995. Findings and implications from the original survey are available in the form of brief research summaries, the CSPRD ***Research Update*** series, and academic papers. Copies of ***Research Updates*** and working papers are available upon request.

Research Update 1	What practitioners most enjoy about care management	Free of charge
Research Update 2	What practitioners least enjoy about care management	Free of charge
Research Update 3	Care management and client groups Part 1: Elderly and physically disabled service users	Free of charge
Research Update 4	Care management and client groups Part 2: EMI, other mental health and learning disability services	Free of charge
Research Update 5	Mixing the economy of community care in Wales: Purchasing, power and protectionism	Free of charge

Published papers/working papers: topics covered include roles and tasks of care managers, assessment practice, hospital discharge, mixing the economy of care and practitioner stress.

CSPRD

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APPENDIX 9

Study 2:

Questionnaire covering letter

Prifysgol Cymru • University of Wales
BANGOR

Canolfan Ymchwil a Datblygiad Polisi Cymdeithasol

Centre for Social Policy Research & Development

Cyfarwyddwr/Director: G. Clare Wenger

June 1997

Dear practitioner,

Assessment and care management 1997: a survey of front-line worker experience in Wales

We hope that you will feel able to spare about half an hour to take part in this survey funded by the Wales Office of Research and Development for Health and Social Care.

It provides an opportunity for you as a practitioner in Wales to record your views and experiences about present care management practice. Two years ago we undertook a similar survey and a comparison of findings from both surveys will provide important evidence about how things have changed from a practitioner perspective. Findings from the 1995 are available now (see inside back cover of questionnaire). Findings from the 1997 survey will be available from October 1997.

The survey has been designed to preserve the anonymity of participants.

Should you have any queries, please feel free to contact any one of us by phone or fax (numbers below). May we thank you in advance for your help.

Yours sincerely,

Gordon Grant
Beth Parry-Jones
Paul Ramcharan
Catherine Robinson

CSPRD, Canolfan Ymchwil Meddygaeth a Gofal, Prifysgol Cymru, Bangor, Gwynedd LL57 2DG
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Ffôn/Tel: (01248) 382225/382230 • Ffacs/Fax: (01248) 362029 • Llyth-el/E-mail: csprd@bangor.ac.uk

APPENDIX 10

Study 2:
Examples of innovative care management practice

APPENDIX 10 INNOVATIVE PRACTICE EXAMPLES

Case	Example[a]	Prof. group[b]	Code[c]	Sum of scale scores[d]
1002	Introducing client with mental health problems to work with horses which he had requested. Persuading employer/owner of racing stable to employ client.	SW	AB	4
1003	Using community care funding to install a safety isolation gas switch for a confused elderly lady.	SW	ADR	3
1005	Organising a package of care at a university for a locally based disabled student. Used locally (college town) based user controlled care purchase scheme.	SW	AER	2
2001	Introducing voluntary work as a form of respite for both patient and family.	Nurse	ABCM	2
2003	The provision of day care at a residential home coupled with regular respite that hopefully will lead to long-term placement there.	Nurse	AG	0
2008	Use of shared care bed facilities. Client home with main carer part of a week – residential or hospital care rest of week.	SW	AG	0
2009	Giving client log book for friends, family and professionals to give chronological account of events. Lot of co-operation if unofficial. Client has acute or chronic problems and memory can be poor. Health fluctuates rapidly. Close links maintained and allows for swift action.	SW	AEH	3
2010	Using community resources such as good neighbour scheme to ensure someone attended a luncheon club as they did not want MOWs.	SW	AIO	2
2011	Exploring changing package [of] personnel to meet client's needs. Yes this is possible if the contracts are set up positively.	Nurse	AJ	0
2012	For one patient hands-on care was not appropriate to be funded by S. Services but it would improve the life of the patient if he could go into his garden in a wheelchair. So Social Services agreed to pay to have garden upgraded for this purpose.	Nurse	AKR	3
2014	Evaluation of a care package. Asking clients to look at care plans and discuss what they thought would happen? How well the package worked? If their objectives were met, if not how could they be and then drawing up	SW	AE	1

	a new care plan.			
2016	I have helped a client to set up a user led self-help group for clients suffering with depression.	Nurse	AEFH	4
2020	Case management of dual diagnosis client with HIV. Good example of inter-agency co-operation to provide a comprehensive package of care which incorporated 8-10 agencies.	SW	AN	1
2021	Ability to use a support service provided by Age Concern in a more flexible way – with full backup and encouragement of Age Concern. The client's needs were regarded as more important than a rigid adherence to the service provision.	SW	ALO	3
2022	A person wanted to go on holiday. This man had Parkinson's disease – the cost of an escorted holiday – the escort part was cheaper than his care package so funding was agreed.	SW	AKR	1
2024	Allowing time for a carer to undertake a social activity.	SW	AKM	0
2027	Use of two different agencies. In-house provision for morning calls. Private agency for evening calls as home care unable to pick this up.	SW	AN	0
2028	Arranging for client in nursing home to continue to attend day centre, although strictly speaking, this is not normally permitted.	SW	AGL	2
2029	Working out an intensive care package, from a variety of sources – health, voluntary and family, to ensure adequate support. The financial limit currently imposed by our authority would not have allowed an adequate package.	SW	ANOR	0
2036	Negotiating changes with respite houses for adults, i.e. doesn't have to include overnight stay. One client who's scared of staying away from home at night will be using respite for days instead.	SW	AGL	1
3004	Introducing a group of students to one sheltered housing complex and arranging that they call to get to know individuals to undertake tasks such as shopping, transporting elderly person to visit brother 20 miles away or just generally sitting down for a chat. Supporting group on monthly basis.	Other	AP	3
3008	Persuading the LA that a stroke/brain damaged victim could spend the nights in	SW	AGN	4

	residence and go home at times during the day working towards rehabilitation home and have H/C (ie Home Care) to help at home at the same time.			
3009	Able to allocate 8 hours (i.e. 1 day/week) to relieve carer who only worked 1 full day off/week.	Nurse	AM	2
4001	Use of private care agency in combination with statutory services and health professionals to ensure total care at home for a terminally ill patient.	SW	AN	1
4002	Designing action plan for and with a client who has made several suicide attempts. This clearly identifies early warning signs of predictable deterioration in mental health and who to contact at relevant times and places.	SW	AEH	2
4004	Brought together an extended family to discuss a care package for a pregnant woman with learning disabilities – share care with family members and council staff.	SW	AN	1
4005	Arrange a care package for the children so the mother can attend physiotherapy at the hospital.	SW	AH	1
4008	OT work. Client with MS falls regularly. Finds it easiest to get up by crawling to stairs. Paid builder to make two steps – carpet covered. Kept in bedroom for just such occasions.	Other	ADR	2
4015	Introduction of two young clients to each other to facilitate mutual confidence-building activities.	SW	AEF	2
4016	Buying respite locally rather than arranging 'asylum'.	Nurse	AG	0
4017	To encourage/introduce community integration/activities which is user led. These are monitored monthly during club meetings. Users encouraged to participate on committees etc in order to improve services – increase choice according to need.	Therapist	AE	3
4020	Having some flexibility concerning some budgets to purchase staff to work individually with clients in an innovative way to meet individual need and provide new life experiences.	Nurse	ALPR	2
4021	Introducing 24 hour private specialist home care for client who is totally paralysed on a respite basis thus doing away with the need to use res. care.	SW	AG	0
4022	Using support workers to help with detoxification of alcohol programmes.	Nurse	AHP	1

4024	'Skills matching' among clients. Arrange meeting in neutral venue to discuss and negotiate what skills exchange could be achieved. E.g. one client repairs clothes in exchange for hedge being trimmed.	Therapist	AEF	4
4025	Helping a client identify individual foster parents for her one and a half year old to enable her to use the short stay unit at short notice and coordinate it with child care.	Therapist	AEGJ	3
4027	Arrange Day Care in private respite homes.	SW	AG	0
5003	Using a voluntary agency (which supports carers) to provide a volunteer for a stroke damaged client to practice her speech and writing because speech therapy from health sector has been withdrawn and the client is very motivated towards regaining these skills.	SW	AHO	4
5004	Persuaded consultant psychiatrist to amend his recommendation from EMI nursing to nursing. Relatives had disagreed with his first opinion associating it with madness (misconceptions /labeling/socially not acceptable). The placement met client need, calmed relatives and released one acute hospital bed.	SW	AGJM	0
5005	Initiating setting up a dietary group at the local day centre with a community dietician.	SW	AH	3
5006	Client with alcohol dependency, receiving training as a nursing assistant while in receipt of receiving ongoing counselling and maintenance work to sustain level of abstinence.	SW	AQ	3
6002	Introduced new groups: "Making changes" group for long term clients. Series of one day skill based workshops for clients.	Therapist	AHQ	3
6006	Enlisting one client as tutor to a group of clients in an arts/crafts workshop, to develop his social contact and self-esteem.	SW	ABEF HQ	4
6007	Confused, agitated man in residential care, searching for his wife constantly. Use of smell (lavender oil) for relaxation and reassurance (she used to grow lavender) rather than tranquilizers.	Nurse	AH	3
6008	Getting isolated users of service to work with/support others.	Nurse	AEF	3
6009	Involving a Mencap representative in the initial assessment meeting provided a link to the local resource centre and a face to remember from the beginning.	SW	AO	2
6010	Recommending use of tandem for adult with autistic tendencies with lots of energy.	Nurse	AHK	3

6011	An individual spends most of the year in college but has a link family to come home to for holidays.	Nurse	AJ	1
6012	Using multi disciplinary approach to get management to meet a person's needs [,] with specialist reports and assessments.	Nurse	AJN	0
6013	Using a voluntary sector mental health drop-in to help with a holiday for a client	Nurse	AKO	2
6016	Networking with local community support project to provide emotional and carer support to someone with terminal cancer and arranging specific request for a home carer through a local agency set up.	SW	AMO	0
6017	Using e.g. education authority to arrange divisional [diversional?] activity (pottery class)	Nurse	AK	0
6018	Using a private home to provide day care.	SW	AG	0
6019	Introduction of communication training for clients and their families in the home.	SW	AQ	3
6023	Housing – negotiating joint funding for caravan and services to adult with learning disability to enable person to lead lifestyle suitable to his needs.	SW	AGR	2
6029	Removing shower screen to make use of bath aids, replacing screen with shower curtain. Equipment now being used efficiently.	SW	AD	1
6030	Introduced eye movement desensitization into treatment.	Other	AH	1
6031	Accessing [arranging?] a tailor made holiday for a client to suit her needs perfectly.	SW	AK	0
7001	Arranging for independent living fund package for service user.	SW	AR	0
7002	Use of voluntary sector provision on an ordinary integrated basis and use of personal/religious networks.	SW	AO	1
7004	Identifying and delivering a counselling package on an individual basis with a female service user.	SW	AH	0
7005	Extending care to more detailed training with patients and carers, e.g. individual packages for assertiveness/communication/ relationships or anger management.	Nurse	AQ	0
7006	Meals provided in public house for elderly confused. Meals paid for on weekly basis.	Other	AIR	1
7007	Sexuality work.	SW	AH	0
7008	Most recent example is negotiating a rehabilitation plan and package with local day centre and Housing Association for a man in his early 40s. He has been disabled from birth, is a wheelchair user and had lived with	SW	AGHN PQR	2

	his elderly parents until their deaths last year. He was re-housed to an independent living scheme with housing support workers, which was jointly funded with Social Services and Tai Cymru. He had never completed any life skills or social skills training prior to parents' death so I negotiated with day care for programme to be jointly drawn up with myself, OT, day services manager and housing support staff to maximize his potential for independent living.			
7010	Working with an individual home owner to help maintain a residential placement for a very difficult client. Therefore [there was] the provision of intensive support for the home-owner – regular meetings with her etc.	SW	AG	2
7011	Being able to offer variety of services to enable person to live independently.	Nurse	AN	1
7015	Important to be creative in meeting client need. Clients wishing to live independently, mental health and physical problems immense. Used volunteer to live in rent free in lieu of rent.	SW	AOP	2
7019	Arranged evening social activities with other people with learning disabilities using community facilities.	SW	AKO	0
7020	Whilst planning a care package earlier this year, working together with a Housing Officer from a local Housing Association, we were frustrated as the service user was unable to move into her new flat as there was no Home Care available. We were successful with an application for a special needs management allowance from the Welsh Office which allowed us to employ a worker which meant that the client could move in.	SW	AOPR	3
7021	Arranged for a local pub to deliver a cooked lunch on a daily basis to an adult with learning disability who wanted to remain in his own home after the death of a carer. This was an interim measure while he underwent a process of independent living skills training.	SW	AIQ	1
7023	Arranging voluntary work.	SW	ABC	0
7025	Meals provided from local pub to disabled lady – housebound – whilst waiting for community services.	SW	AI	1
7027	Links [established?] for day care with local nursing home.	SW	AG	0
7031	Asking a local shop to call in to a housebound couple while they were without a	SW	AO	3

	phone or neighbours were away.			
7032	A client was turned down for a community care grant for furniture so we were able to look to various charities to provide a number of grants which enabled the client to buy furniture to equip his flat.	SW	AR	1
7033	Set up self-help between clients of like disabilities.	SW	AEF	1
7035	Arranging SSD/Voluntary day care for hospital in-patient in order to promote psychological welfare.	SW	AGHN	2
7037	Raising over £1,000 from various sources to purchase a second-hand stair lift for a chronically sick person.	SW	ADR	4
7038	Use of local pub to provide meals to pensioners when meals on wheels service was not available.	SW	AI	1
7039	Arranging trial at home without services.	SW	AJ	1
7045	Acting as an advocate to assist client in buying into a service not provided by Social Services/ Health Service. Payment for this service met from Social Service Day Care funds.	Nurse	AER	1
7046	Approaching local cafes, pubs for meal (lunch time) delivery for service users.	SW	AI	1
7049	Having meals delivered to clients by local 'pubs' i.e. 'pub grub'.	SW	AI	1
7050	Accessing funding from voluntary agencies – holidays.	SW	AKO	1
7052	Identified the need for health screening e.g. a lady with a SMI who does not respond to a request for smear test.	Nurse	AH	1
7053	Arranging to take blood for serum lithium levels at the home of a patient when compliance was a major issue.	Nurse	AH	0
7056	Recently arranged package in a hostel for homeless people using voluntary and private agencies.	SW	AGNO	0
7057	Negotiating with private sector for reduced cost temporary residential care in home of client's choice to permit client to pay from benefit income, following imposition of increased financial constraints by Department in current financial year.	SW	AGR	3

[a] Valid practice examples only shown (N = 89)
[b] Professional group – SW = social worker
[c] Category code (from content analysis of innovative practice examples):
'A' = 'Valid example'
B = Employment
C = Employment/Voluntary work
D = Equipment

E = User empowerment
F = User empowerment/self-help arrangement
G = Day, residential, respite care
H = Aid to health
I = Eating arrangements
J = Other
K = Leisure
L = Increased service flexibility
M = Carer benefit
N = Mixed or multi-agency care
0 = Community or voluntary agency involvement
P = Support worker
Q = Education or training
R = Finances mentioned

[d] Sum of degree of innovativeness scale scores reported (using first binary scale scores of the four researcher experts–the practitioner expert scores were excluded because they were so different to the other experts' scores):

0 = Not rated as 'innovative' by the 4 experts
1 = Rated as 'innovative' by one of the 4 experts
2 = Rated as 'innovative' by 2 of the 4 experts
3 = Rated as 'innovative' by 3 of the 4 experts
4 = Rated as 'innovative' by all 4 experts

(First binary scale: original rating scale scores of 0,1 & 2 were reclassified as '0' = 'Not innovative'; original rating scale scores of 3 & 4 were reclassified as '1' = 'Innovative').

APPENDIX 11

Study 2:
Expert raters' instructions

Prifysgol Cymru · University of Wales
BANGOR

Canolfan Ymchwil a Datblygiad Polisi Cymdeithasol

Centre for Social Policy Research & Development

Cyfarwyddwr/Director: G. Clare Wenger

28 August 1998

Dear

Innovative practice of care management practitioners

Thank you for agreeing to be an expert rater for the above. I enclose the examples of innovative practice given by care management practitioners in response to the following questionnaire item:

> *Please give one example below of your innovative practice whilst planning, implementing or evaluating an individual care package.*

Please rate the 89 responses for innovativeness/imaginativeness using the scale at the top of each page of examples. This should take no longer than an hour.

Respondents were given the following definition:

> *Being innovative refers to introducing something as new or making changes within your work role.*

Reading the examples you will not be able to tell how novel each one is to the respondent (i.e. how innovative in relation to the work practice of the practitioner concerned). However, from your experience you should be able, with most responses, to indicate how imaginative or creative each example is.

As I am imminently about to give birth (4 September 1998) I am not in a desperate hurry for return of your ratings. However, I would appreciate having them by the end of October this year.

Thanks for your time and effort.

Yours sincerely,

Beth Parry-Jones
Research Officer

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INNOVATIVE PRACTICE: EXAMPLES

To what extent do you think each example is innovative (imaginative)? Using the rating scale below please place appropriate number in the box on the right-hand side of each example.

Rating Scale				
Can't decide	*Not at all*	*To some extent*	*Quite a lot*	*Very much indeed*
0	1	2	3	4

1002
Introducing client with mental health problems to work with horses which he had requested. Persuading employer/owner of racing stable to employ client. [4]

1003
Using community care funding to install a safety isolation gas switch for a confused elderly lady. [3]

1005
Organising a package of care at a university for a locally based disabled student. Used locally (college town) based user controlled care purchase scheme. [0]

2001
Introducing voluntary work as a form of respite for both patient and family. [2]

2003
The provision of day care at a residential home coupled with regular respite that hopefully will lead to long term placement there. [1]

2008
Use of shared care bed facilities. Client home with main carer part of a week - residential or hospital care rest of week. [2]

2009
Giving client log book for friends, family and professionals to give chronological account of events. Lot of co-operation if unofficial. Client has acute or chronic problems and memory can be poor. Health fluctuates rapidly. Close links maintained and allows for swift action. [3]

2010
Using community resources such as good neighbour scheme to ensure someone attended a luncheon club as they did not want MOWs. [3]

2011
Exploring changing package [of] personnel to meet client's needs. Yes this is possible if the contracts are set up positively. [0]

Rating Scale				
Can't decide	*Not at all*	*To some extent*	*Quite a lot*	*Very much indeed*
0	1	2	3	4

2012
For one patient hands-on care was not appropriate to be funded by S. Services but it would improve the life of the patient if he could go into his garden in a wheelchair. So Social Services agreed to pay to have garden upgraded for this purpose. [4]

2014
Evaluation of a care package. Asking clients to look at care plans and discuss what they thought would happen? How well the package worked? If their objectives were met, if not how could they be and then drawing up a new care plan. [2]

2016
I have helped a client to set up a user led self-help group for clients suffering with depression. [4]

2020
Case management of dual diagnosis client with HIV. Good example of inter-agency cooperation to provide a comprehensive package of care which incorporated 8-10 agencies. [0]

2021
Ability to use a support service provided by Age Concern in a more flexible way - with full backup and encouragement of Age Concern. The client's needs were regarded as more important than a rigid adherence to the service provision [3]

2022
A person wanted to go on holiday. This man had Parkinson's disease - the cost of an escorted holiday - the escort part was cheaper than his care package so funding was agreed. [4]

2024
Allowing time for a carer to undertake a social activity. [2]

2027
Use of two different agencies. In-house provision for morning calls. Private agency for evening calls as home care unable to pick this up. [1]

2028
Arranging for client in nursing home to continue to attend day centre, although strictly speaking, this is not normally permitted. [3]

2029
Working out an intensive care package, from a variety of sources - health, voluntary and family, to ensure adequate support. The financial limit currently imposed by our authority would not have allowed an adequate package. [2]

2036
Negotiating changes with respite houses for adults, i.e. doesn't have to include overnight stay. One client who's scared of staying away from home at night will be using respite for days instead. [3]

Rating Scale				
Can't decide	*Not at all*	*To some extent*	*Quite a lot*	*Very much indeed*
0	1	2	3	4

3004
Introducing a group of students to one sheltered housing complex and arranging that they call to get to know individuals to undertake tasks such as shopping, transporting elderly person to visit brother 20 miles away or just generally sitting down for a chat. Supporting group on monthly basis. [4]

3008
Persuading the LA that a stroke/brain damaged victim could spend the nights in residence and go home at times during the day working towards rehabilitation home and have H/C [i.e. Home Care] to help at home at the same time. [3]

3009
Able to allocate 8 hours (i.e. 1 day/week) to relieve carer who only worked 1 full day off/week. [3]

4001
Use of a private care agency in combination with statutory services and health professionals to ensure total care at home for a terminally ill patient. [2]

4002
Designing action plan for and with a client who has made several suicide attempts. This clearly identifies early warning signs of predictable deterioration in mental health and who to contact at relevant times and places. [3]

4004
Brought together an extended family to discuss a care package for a pregnant woman with learning disabilities - share care with family members and council staff. [2]

4005
Arrange a care package for the children so the mother can attend physiotherapy at the hospital. [2]

4008
OT work. Client with MS falls regularly. Finds it easiest to get up by crawling to stairs. Paid builder to make two steps - carpet covered. Kept in bedroom for just such occasions. [4]

4015
Introduction of two young clients to each other to facilitate mutual confidence-building activities. [3]

4016
Buying respite locally rather than arranging 'asylum'. [0]

4017
To encourage/introduce community integration/activities which is user led. These are monitored monthly during club meetings. Users encouraged to participate on committees etc in order to improve services - increase choice according to need. [3]

Rating Scale				
Can't decide	*Not at all*	*To some extent*	*Quite a lot*	*Very much indeed*
0	1	2	3	4

4020
Having some flexibility concerning some budgets to purchase staff to work individually with clients in an innovative way to meet individual need and provide new life experiences. [3]

4021
Introducing 24 hour private specialist home care for client who is totally paralysed on a respite basis thus doing away with the need to use res. care. [0]

4022
Using support workers to help with detoxification of alcohol programmes. [1]

4024
'Skills matching' among clients. Arrange meeting in neutral venue to discuss and negotiate what skills exchange could be achieved. e.g. one client repairs clothes in exchange for hedge being trimmed. [4]

4025
Helping a client identify individual foster parents for her one and a half year old to enable her to use the short stay unit at short notice and coordinate it with child care. [4]

4027
Arrange Day Care in private respite homes. [2]

5003
Using a voluntary agency (which supports carers) to provide a volunteer for a stroke damaged client to practice her speech and writing because speech therapy from health sector has been withdrawn and the client is very motivated towards regaining these skills. [4]

5004
Persuaded consultant psychiatrist to amend his recommendation from EMI nursing to nursing. Relatives had disagreed with his first opinion associating it with madness (misconceptions/labelling/socially not acceptable. The placement met client need, ' calmed relatives and released one acute hospital bed. [2]

5005
Initiating setting up a dietary group at the local day centre with a community dietician. [4]

5006
Client with alcohol dependency, receiving training as a nursing assistant while in receipt of receiving ongoing counselling and maintenance work to sustain level of abstinence. [4]

6002
Introduced new groups: "Making changes" group for long term clients. Series of one day skill based workshops for clients. [4]

Rating Scale				
Can't decide	*Not at all*	*To some extent*	*Quite a lot*	*Very much indeed*
0	1	2	3	4

6006
Enlisting one client as tutor to a group of clients in an arts/crafts workshop, to develop his social contact and self-esteem. 4

6007
Confused, agitated man in residential care, searching for his wife constantly. Use of smell (lavender oil) for relaxation and reassurance (she used to grow lavender) rather than tranquillisers. 4

6008
Getting isolated users of service to work with/support others. 3

6009
Involving a Mencap representative in the initial assessment meeting provided a link to the local resource centre and a face to remember from the beginning. 4

6010
Recommending use of tandem for adult with autistic tendencies with lots of energy. 4

6011
An individual spends most of the year in college but has a link family to come home to for holidays. 4

6012
Using multi disciplinary approach to get management to meet a person's needs [,] with specialist reports and assessments. 2

6013
Using a voluntary sector mental health drop in to help with a holiday for a client. 3

6016
Networking with local community support project to provide emotional and carer support to someone with terminal cancer and arranging specific request for a homecarer through a local agency set up. 2

6017
Using e.g. education authority to arrange divisional [diversional?] activity (pottery class). 2

6018
Using a private home to provide day care. 2

6019
Introduction of communication training for clients and their families in the home. 3

6023
Housing - negotiating joint funding for caravan and services to adult with learning disability to enable person to lead lifestyle suitable to his needs. 4

Rating Scale				
Can't decide	*Not at all*	*To some extent*	*Quite a lot*	*Very much indeed*
0	1	2	3	4

6029
Removing shower screen to make use of bath aids, replacing screen with shower curtain. Equipment now being used efficiently. [3]

6030
Introduced eye movement desensitisation into treatment. [2]

6031
Accessing [arranging?] a tailor made holiday for a client to suit her needs perfectly. [2]

7001
Arranging for independent living fund package for service user. [2]

7002
Use of voluntary sector provision on an ordinary integrated basis and use of personal/ religious networks. [2]

7004
Identifying and delivering a counselling package on an individual basis with a female service user. [0]

7005
Extending care to more detailed training with patients and carers, e.g. individual packages for assertiveness/communication/ relationships or anger management. [2]

7006
Meals provided in public house for elderly confused. Meals paid for weekly basis. [3]

7007
Sexuality work. [0]

7008
Most recent example is negotiating a rehabilitation plan and package with local day centre and Housing Association for a man in his early 40s. He has been disabled from birth, is a wheelchair user and had lived with his elderly parents until their deaths last year. He was rehoused to an independent living scheme with housing support workers, which was jointly funded with Social Services and Tai Cymru. He had never completed any life skills or social skills training prior to parents death so I negotiated with day care for programme to be jointly drawn up with myself, OT, day services manager and housing support staff to maximise his potential for independent living. [3]

7010
Working with an individual home-owner to help maintain a residential placement for a very difficult client. Therefore [there was] the provision of intensive support for the home-owner - regular meetings with her etc. [4]

Rating Scale

Can't decide	*Not at all*	*To some extent*	*Quite a lot*	*Very much indeed*
0	1	2	3	4

7011
Being able to offer variety of services to enable person to live independently. [0]

7015
Important to be creative in meeting client need. Clients wishing to live independently, mental health and physical problems immense. Used volunteer to live in rent free in lieu of rent. [3]

7019
Arranged evening social activities with other people with learning disabilities using community facilities. [2]

7020
Whilst planning a care package earlier this year, working together with a Housing Officer from a local Housing Association, we were frustrated as the service user was unable to move into her new flat as there was no Home Care available. We were successful with an application for a special needs management allowance from the Welsh Office which allowed us to employ a worker which meant that the client could move in. [4]

7021
Arranged for a local pub to deliver a cooked lunch on a daily basis to an adult with learning disability who wanted to remain in his own home after the death of a carer. This was an interim measure while he underwent a process of independent living skills training. [3]

7023
Arranging voluntary work. [2]

7025
Meals provided from local pub to disabled lady - housebound - whilst waiting for community services. [3]

7027
Links [established?] for day care with local nursing home. [2]

7031
Asking a local shop to call in to a housebound couple while they were without a phone or neighbours were away. [4]

7032
A client was turned down for a community care grant for furniture so we were able to look to various charities to provide a number of grants which enabled the client to buy furniture to equip his flat. [4]

7033
Set up self help between clients of like disabilities. [3]

Rating Scale

Can't decide	*Not at all*	*To some extent*	*Quite a lot*	*Very much indeed*
0	1	2	3	4

7035
Arranging SSD/Voluntary day care for hospital in-patient in order to promote psychological welfare. 3

7037
Raising over £1,000 from various sources to purchase a second-hand stair lift for a chronically sick person. 3

7038
Use of local pub to provide meals to pensioners when meals on wheels service was not available. 3

7039
Arranging trial at home without services. 0

7045
Acting as an advocate to assist client in buying into a service not provided by Social Services/Health Service. Payment for this service met from Social Service Day Care funds. 3

7046.
Approaching local cafes, pubs for meal (lunch time) delivery for service users. 3

7049
Having meals delivered to clients by local 'pubs' i.e. 'pub grub'. 3

7050
Accessing funding from voluntary agencies - holidays. 2

7052
Identified the need for health screening e.g. a lady with a SMI who does not respond to a request for smear test. 2

7053
Arranging to take blood for serum lithium levels at the home of a patient when compliance was a major issue. 2

7056
Recently arranged package in a hostel for homeless people using voluntary and private agencies. 2

7057
Negotiating with private sector for reduced cost temporary residential care in home of client's choice to permit client to pay from benefit income, following imposition of increased financial constraints by Department in current financial year. 3