

Organisation



Children and Young People's Services

# Strengthening Managers Programme

## Strengthening **Organisation**

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**Digital Workbook Edition**

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# Introduction

## Part three: Strengthening the organisation

You should already have attended the first two workshops, and received the workbooks on Strengthening Self and Strengthening Staff as part of the Strengthening Managers Programme. This will have been followed by support to help you transfer your learning into practice.

You are now embarking on the third and final part of the programme, which is about strengthening your organisation. This workbook will take you through Part Three. We will start with a review of the aims and values of the programme.

### Strengthening managers programme

This course supports front-line managers in social care to improve the experience and outcomes of children, adults and families. First-line managers are in a position not only to strengthen their own work, but also to strengthen the practice of their staff and to strengthen the organisational culture. Therefore the programme is in three parts:

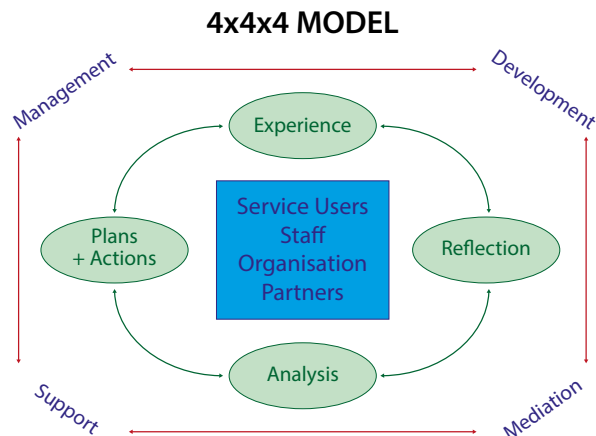
- Strengthening self;
- Strengthening staff;
- Strengthening the organisation.

### Programme objectives

The learning goals of the programme are to:

- Strengthen managers' practice;
  - Develop professional judgement through increased self-awareness and reflective work;
  - Deliver management tasks with confidence under pressure;
  - Identify and meet their own learning needs;
  - Ask for support appropriately and use support constructively;

- Take ownership of their role within the organisation.
- Support managers to strengthen the practice of their staff
  - Act as role models for critically reflective practice;
  - Challenge appropriately to improve performance;
  - Promote individual and team learning to improve practice;
  - Provide appropriate support to manage uncertainty, risk and emotional impact;
  - Balance individual, team and organisational demands.
- Enable managers to contribute to the development of social care in their organisation;



- Contribute to a professional culture;
- Support service improvement;
- Contribute to a learning culture;
- Contribute to a positive working culture;
- Act as ambassadors for the organisation.



# Strengthening the Organisation



## Agenda

### **9.30 – 9.50 Introduction**

- Feedback from coaching
- Reminder of the programme

### **9.50 – 10.30 Session three: Purpose**

- The vision and goals of social care in this area
- The meaning of this for children and adults and families
- What this course will offer in terms of learning and training transfer

### **10.30 – 11.10 Session two: Reflection**

- Impact of uncertainty on social care practice
- Cynefin model for responding to different situations
- Building a reflective culture

### **11.10 – 11.30 Break**

### **11.30 – 12.00 Group exercise: the Activity Map**

### **12.00 – 12.30 Session three: Management**

- Expectations of social care
- Meaningful quality assurance

### **12.30 – 13.00 Lunch**

### **13.00 – 13.30 Group exercise: How do we know we are doing a good job?**

### **13.30 – 14.00 Session four: Development**

- Working under scrutiny
- Double loop learning

### **14.00 – 14.30 Session five: Support**

- The impact of blame
- Safety culture

### **14.30 – 14.45 Break**

### **14.45 – 15.10 Group exercise: Valuing staff**

### **15.10 – 15.45 Session six: Mediation**

- Conflicting roles in social care
- Influencing change

### **15.45 – 16.15 Session seven: Action planning**

### **16.15 – 16.30 Close**

# Exercises

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## Exercise 1: Learning needs analysis - organisation

Look at the learning areas below and reflect on how capable and confident your practice is in each area. Give yourself a score from 1 (very low) to 5 (very high) – make notes in the comments section to summarise why you have given yourself that score.

Learning area	1 Very low	2	3	4	5 Very high	Comments on learning needs
I understand the impact of uncertainty on organisational practice						
I advocate for good practice and emerging practice rather than simplistic solutions						
I contribute to building a reflective, organisational culture						
I contribute to clear expectations of social care						
I contribute to meaningful quality assurance						



Learning area	1 Very low	2	3	4	5 Very high	Comments on learning needs
I help my organisation to avoid kneejerk responses						
I support my organisation to question why it does what it does						
I contribute to a culture that does not blame or scapegoat but seeks to understand						
I help my organisation to learn from mistakes, near misses and successes						
I support my organisation to manage the conflicting roles, aims and values in social care						
I help my organisation to explain what social care can offer						

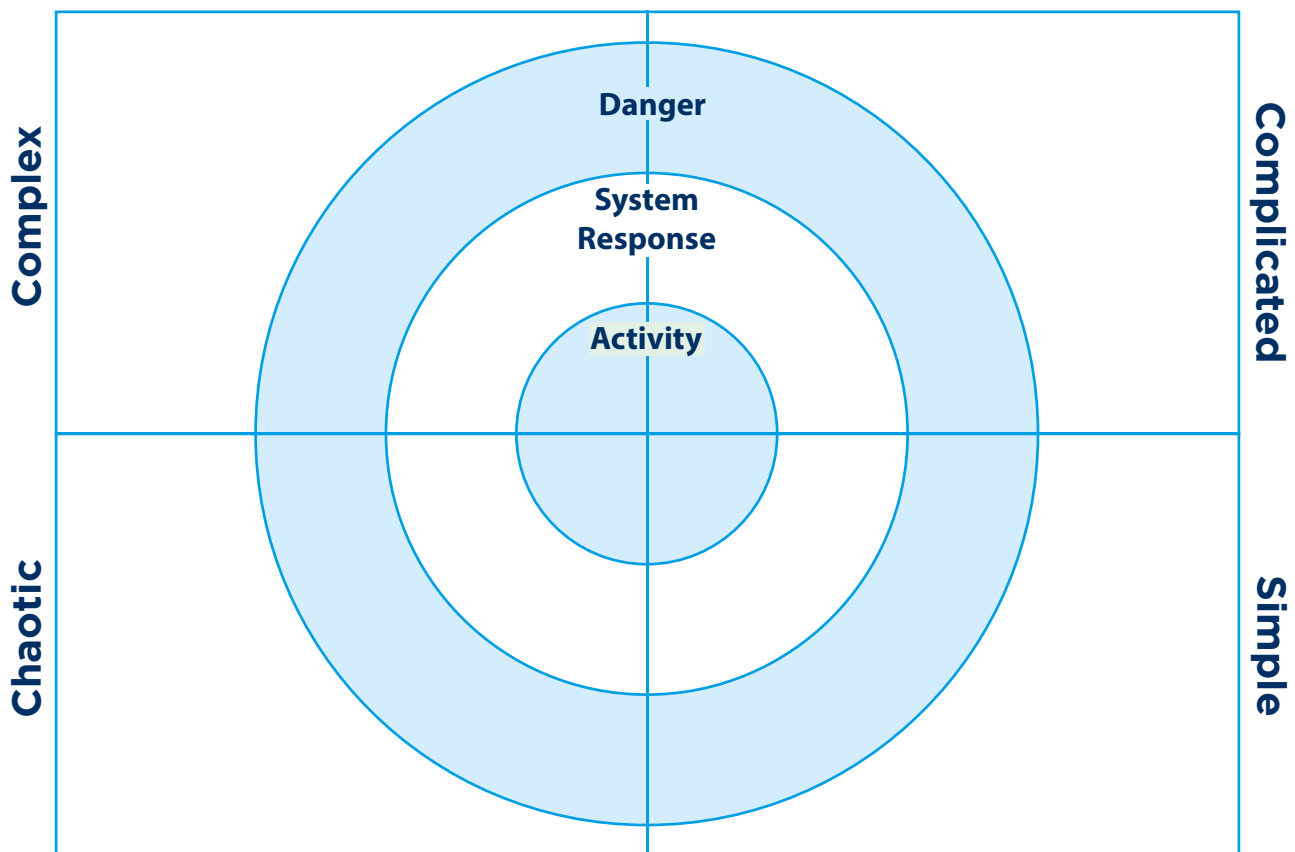
## Exercise 2: The activity map

Within your organisation there will be a number of different functions and tasks that will fall into one of the following four categories. NOT everything you are required to do will be complex, or simple.

**Step 1:** Using the Leader's Framework for decision making chart on page 22 to support you, list which of your day day activities fall into each of the four categories.

**Step 2:** Using the same framework generate actions and methods for dealing with the activities listed. One activity could have a number of responses ranging from simple to complex.

**Step 3:** What could go wrong? Think about how these systems could fail and what you might need to do to correct them.



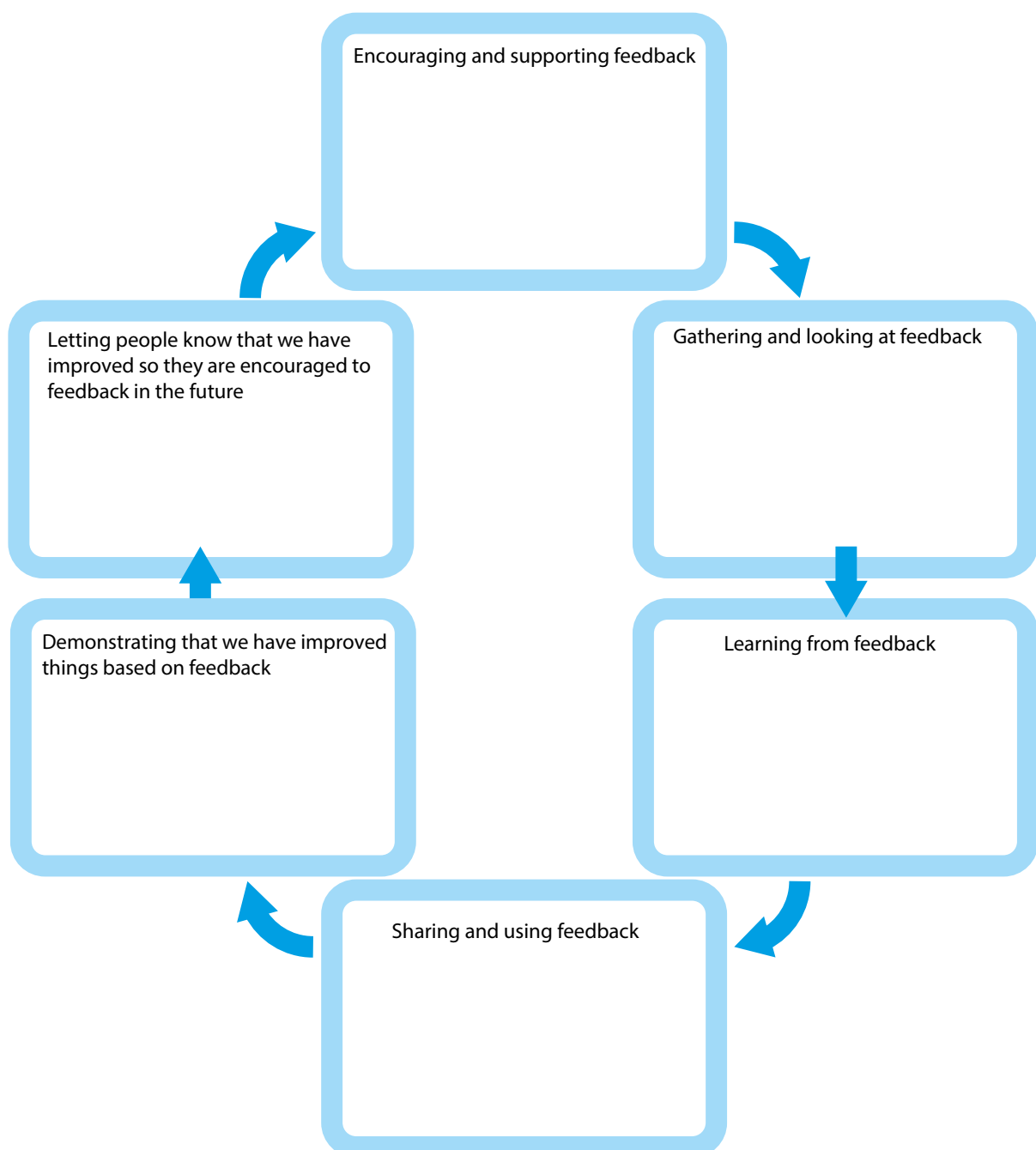


## Exercise 3: How do we know we are doing a good job?

This exercise helps you to discuss in your team what you are currently doing and what else you could do to help your organisation know:

- How well you are supporting children, adults and families;
- What difference you are making to children, adults and families.

Use the cycle below and for each box think about what is already happening and what else you could do.







## Exercise 5: Practice Improvement Plan

Revisit your learning needs analysis – what were your learning needs?

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Look at your learning logs - what have you learned or remembered that you want to use in your practice?

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Discuss the learning from this workshop with people around you

Identify a practice area that you want to improve in and why

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In the table on the next page, identify:

The actions you will take to achieve your goal

The possible barriers that will prevent you from achieving your goal

The support you will, therefore, need to achieve your goal

When you will have done this

The target that you want to reach, which will show you that you have achieved your goal – this target should be SMARTER:

- **Specific**
- **Measurable**
- **Achievable**
- **Realistic**
- **Time-bound**
- **Ethical**
- **Reviewed**

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My practice goal is:

Action	Barriers	Support	When will I have done this?	(SMARTER target)

Action	Barriers	Support	When will I have done this?	(SMARTER target)

You will receive support to help you to carry out these actions:

- A coaching session to discuss your actions and the difference they have made to your practice, and to develop ongoing implementation plans.
- An individual conversation to discuss barriers and enablers to training transfer.

# Strengthening the organisation

“A culture is the sum total of behaviours in a group. You are part of that group. Your vision, behaviour and action contributes towards the organisational culture.”  
– (Jo Fox)



“IMPLEMENTING THESE CHANGES WON'T BE EASY. WE'RE PRETTY SET IN DOING THINGS THE WRONG WAY.”

priorities that the people who voted for them care about. The executive, the people who arrange and deliver the services, report to councillors regularly about how well they are meeting the agreed aims. They also report on how they are using resources to do this and on the quality of their delivery.

Organisations' aims therefore are based on:

- Acting lawfully;
- Achieving national outcomes;
- Meeting local needs and priorities;
- Using resources effectively;
- Ensuring quality services.

Organisations need to understand:

- How much they are doing;
- How well they are doing;
- What difference they are making.<sup>2</sup>

Organisations undertake Strategic Needs Assessments to identify the make-up of their local population and the needs that they have. They monitor and measure how much they do and for whom. They gather feedback from people who use services. They also undertake consultations and evaluations to understand how well they are doing and what difference they are making.

Managers largely work at the operational level; that is, they are concerned with helping the organisation to do things. They can and should also contribute to the strategic level; that is, helping the organisation to plan and improve.

## Purpose

The overall goal of this part of the programme is to enable managers to contribute to the development of social care in their organisation.

**Goal: Ensure participants are ready to learn in order to improve their practice**

## The aims of social care organisations

Social care organisations deliver goals that come from national law and policy, and local priorities. Organisations that are under the direction of local authorities report to elected councillors, who are accountable to the citizens who vote for them. Councillors are accountable for how services will be delivered in their area. They have to meet statutory duties and are expected to achieve a range of other national outcomes. Councillors will also have a range of local considerations and

<sup>2</sup> Outcome-based Accountability



Managers again can do this in three ways:

- **Doer** – trying things out and feeding the learning back;
- **Model** – suggesting ways that the organisation can improve based on their expertise;
- **Leader** – advocating for better ways of working within and outside the organisation.

You need to be familiar with your organisation's strategic plans. You should be offered the opportunity to feed into these. If not you should make an opportunity.

Again, you should be able to see the link between your role, what your team is doing, what the organisation aims to achieve, and then the difference this will make for children, families and adults.



#### Reflective question

How do I make sure I understand?

Many organisations operate in a top-down way where senior people decide what the aims are and cascade these down.

It is possible to work in a bottom-up way. For example:

- Carry out appraisals in the team and identify what individuals think would help the experience and outcomes of your clients;
- Hold a team away day where you agree what you think the team priorities should be and how the organisation can improve to make this possible;
- Work with other managers to complete a joint proposal for front-line priorities and areas for organisational improvement for your senior management team;
- Your senior management team considers this and uses it to underpin the organisation's strategic plan.

The advantage of this is that front-line staff have the most contact with children, adults and families and so their input helps to ensure the relevance and impact of the plan for the people it aims to help.

However organisational aims are set they must involve children, adults and families.



#### Reflective question

How can the people in my team, including me, input to our organisation's strategic plan on

You will use the four functions of your role to support your organisation. Each of these areas helps the organisation to meet its aims and helps to identify how the organisation can improve:

- Management (including reflective practice);
- Development;
- Support;
- Mediation.

## The meaning for children, adults and families

The ultimate aim of strengthening the organisation's practice is to improve the lives of children, adults and families.

There should be a direct line from the organisation's way of working; to the impact on the experience and outcomes of children, families and adults.

Organisational culture has a significant impact on how able people are to support children, families and adults.<sup>3</sup> A positive organisational culture supports proactive work, reflective professional judgement, ongoing learning, emotional awareness and support, and good relationships. These ways of working within the organisation are then reflected in how the organisation interacts with its customers.

<sup>3</sup> Brown E, Moore S and Turney D (2014) Analytical Thinking in Assessment, Research in Practice



# Reflection

“The society of today and tomorrow – with a knowledge based economy and the global market – needs organisations that are productive, innovative, flexible and good places to work and live for members of the organisation.” – (Steen Hoyrup, Danish University of Education, 2004)



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“We look for people who can quickly adapt to changes in the workplace.”

**Goal: Contribute to a professional culture**

## The impact of uncertainty on social care practice

Uncertainty and risk are features of working in social care. The quote below taken from the Munro report into child protection highlights the difficulties that professionals can encounter in these organisations.

*“Uncertainty pervades the work of child protection. Many of the imbalances in the current system arise from efforts to deal with that uncertainty by assessing and managing risk. Risk management cannot eradicate risk; it can only try to reduce the probability of harm. The big problem for society (and consequently for professionals) is working out a realistic expectation of professionals’ ability*

*to predict the future and manage risk of harm to children and young people.”<sup>4</sup>*

Ayre and Preston Shoot speak of a need for understanding issues on three levels:

Level one analysis takes the problem and reformulates it as an instruction: ‘this child was injured because we did not do X’ is associated with a recommendation stating that ‘we must do X in the future’.

Level two analysis is takes a more procedural approach – the problem is addressed by suggesting change to, or enhanced promotion of, approved processes for managing the issue in question. For example we should write more procedures, provide more training, create more records, audit more. This approach assumes failure has arisen because of a lack of knowledge or guidance to support the worker to do the essential task. However it does not explain the numerous cases where the processes and training were in place and the key participants failed to take practice action that they would have understood in principle were the right things to do.

Level three analysis is a systemic approach such as the one undertaken by Munro. It seeks out the answer to the question ‘why, then, despite adequate training and guidance, did they still fail to take the action required?’

*“Rational managers, senior or junior, will seek to ensure that the services which they offer are judged effective by those above them in the chain of responsibility. They will, in short, seek to give us what we ask for.”*

<sup>4</sup> Munro, 2011, pg 38 The Munro Review of Child Protection: Final Report – A child-centred system

The Level three approach looks beyond personal failure, seeking out and describing the fundamental organisational and relational weaknesses which underpin and encourage failures in performance.<sup>5</sup>

Expectations from the organisation, from stakeholders both inside and outside the system and the professionals involved can seem contradictory and impossible to achieve. The system itself often seems at edge of chaos, neither predictable or controllable.

The people working within these cultures strive to find ways to manage in this 'hostile' environment. It can become attractive to make a lot of rules, regulations and procedures in a mistaken belief that the unpredictable can be made tame and manageable. However this approach has a number of limitations. It is very difficult to deal with complex, evolving situations with linear approaches such as counting occurrences, auditing files against specific criteria, and examining cause and effect with simple or complicated equations.

*"Of primary concern is the temptation to fall back into traditional command-and-control management styles—to demand fail-safe business plans with defined outcomes. Leaders who don't recognize that a complex domain requires a more experimental mode of management may become impatient when they don't seem to be achieving the results they were aiming for. They may also find it difficult to tolerate failure, which is an essential aspect of experimental understanding. If they try to overcontrol the organization, they will preempt the opportunity for informative patterns to emerge. Leaders who try to impose order in a complex context will fail, but those who set the stage, step back a bit, allow patterns to emerge, and determine which ones are desirable will succeed."*<sup>6</sup>

<sup>5</sup> pg 4-5, Ayre and Preston Shoot, Children's Services at the Crossroads, 2010, RHP

<sup>6</sup> David J. Snowden and Mary E. Boone, A Leader's Framework for Decision Making, harvard business review November 2007

## Working in complexity

Complexity requires an evolutionary approach where both intended and unintended consequences are tracked. A complex system has the following characteristics:

- It involves large numbers of interacting elements;
- The interactions are nonlinear, and minor changes can produce disproportionately major consequences;
- The system is dynamic, the whole is greater than the sum of its parts, and solutions can't be imposed; rather, they arise from the circumstances. This is frequently referred to as emergence;
- The system has a history, and the past is integrated with the present; the elements evolve with one another and with the environment; and evolution is irreversible;
- Though a complex system may, in retrospect, appear to be ordered and predictable, hindsight does not lead to foresight because the external conditions and systems constantly change;
- Unlike in ordered systems (where the system constrains the agents), or chaotic systems (where there are no constraints), in a complex system the agents and the system constrain one another, especially over time. This means that we cannot forecast or predict what will happen.

Complex systems often appear, in retrospect, just like one that is knowable. This is a problem for the decision makers and designers as they tend to use patterns from the complicated and simple parts of the cycle to craft their solutions. In Social Services, we tend to use either simple or complicated solutions to deal with complex situations. An example would be Quality Assurance methodology based on sets of Indicators, which once full of complexity in the research environment that identified them, have been incrementally flattened and distorted as they become 'targets' for staff to achieve and things to measure performance on.



The intention and the implementation become separate and the outcome 'hits the target but misses the point'.

*"So it's a lot about performance indicators rather than quality of work sometimes, which is a struggle for me at times because I'd like to try and do comprehensive piece of work and the system doesn't always allow that. So I think some social workers probably just sort of get the process done so that they can move onto the next stage rather than thinking about being able to spend more time on doing a fuller piece of work. So I think it feels as though you sort of completed sometimes just to get the next process done really if that makes sense."*<sup>7</sup>

Consider this statement from Lord Laming, *"It has been put to me that it is inevitable that some adults, for whatever reason, will deliberately harm children. That may well be so. Nevertheless, it cannot be beyond our wit to put in place the means of securing their safety and proper development."*<sup>8</sup>

Laming's statement could be interpreted as a desire for a complicated solution with simple rules to manage the increasingly complex world of child protection.

The government, the College of Social Work and the vast array of 'experts' and commentators acknowledge that *"the Frontline staff in each of the key services have a demanding task. Their work requires not only knowledge and skill but also determination, courage and an ability to cope with sometimes intense conflict."*<sup>9</sup>

The attempt to address the complex issues with workforce reform recommendations such as creating a higher level of qualifications for social work, encouraging more on the job mentoring and protected case loads, against the demand for an earlier response to children, families and adults, creates a tension in terms of numbers of social workers available and able to handle the case loads.

This can lead to dishonest conversations within organisations where mantra such as 'do more with less' and 'there is no such thing as failure' and 'it is all important' is accepted as rational.

Effective leaders learn to shift their decision-making styles to match changing business environments. Simple, complicated, complex, and chaotic contexts each call for different managerial responses. By correctly identifying the governing context, staying aware of danger signals, and avoiding inappropriate reactions, managers can lead effectively in a variety of situations.

<sup>7</sup> Social Worker 2, Barnet, Feb, 2009

<sup>8</sup> Lord Laming, March 2009, pg 10, The Protection of Children in England – a progress report.

<sup>9</sup> Lord Laming, March 2009, pg 11, The Protection of Children in England – a progress report.

**Decisions in multiple contexts: A leader's guide**

	<b>THE CONTEXT'S CHARACTERISTICS</b>	<b>THE LEADER'S JOB</b>	<b>DANGER SIGNALS</b>	<b>RESPONSE TO DANGER SIGNALS</b>
<b>SIMPLE</b>	<p>Repeating patterns and consistent events.</p> <p>Clear cause-and-effect relationships evident to everyone; right answer exists.</p> <p>Known knows.</p> <p>Fact-based management.</p>	<p>Sense, categorise, respond.</p> <p>Ensure that proper processes are in place.</p> <p>Delegate.</p> <p>Use best practices.</p> <p>Communicate in clear, direct ways.</p> <p>Understand that extensive interactive communication may not be necessary.</p>	<p>Complacency and comfort.</p> <p>Desire to make complex problems simple.</p> <p>Entrained thinking.</p> <p>No challenge of received wisdom.</p> <p>Overreliance on best practice if context shifts.</p>	<p>Create communication channels to challenge orthodoxy.</p> <p>Stay connected without micromanaging.</p> <p>Don't assume things are simple.</p> <p>Recognize both the value and the limitations of best practice.</p>
<b>COMPLICATED</b>	<p>Expert diagnosis required.</p> <p>Cause-and-effect relationships discoverable but not immediately apparent to everyone; more than one right answer possible.</p> <p>Known unknowns.</p> <p>Fact-based management.</p>	<p>Sense, analyse, respond.</p> <p>Create panels of experts.</p> <p>Listen to conflicting advice.</p>	<p>Experts overconfident in their own solutions or in the efficacy of past solutions.</p> <p>Analysis paralysis.</p> <p>Expert panels.</p> <p>Viewpoints of nonexperts excluded.</p>	<p>Encourage external and internal stakeholders to challenge expert opinions to combat entrained thinking.</p> <p>Use experiments and games to force people to think outside the familiar.</p>
<b>COMPLEX</b>	<p>Flux and unpredictability.</p> <p>No right answers; emergent instructive patterns.</p> <p>Unknown unknowns.</p> <p>Many competing ideas.</p> <p>A need for creative and innovative approaches.</p> <p>Pattern-based leadership.</p>	<p>Probe, sense, respond.</p> <p>Create environments and experiments that allow patterns to emerge.</p> <p>Increase levels of interaction and communication.</p> <p>Use methods that can help generate ideas: Open up discussion (as through large group methods); set barriers; stimulate attractors; encourage dissent and diversity; and manage starting conditions and monitor for emergence.</p>	<p>Temptation to fall back into habitual, command-and-control mode.</p> <p>Temptation to look for facts rather than allowing patterns to emerge.</p> <p>Desire for accelerated resolution of problems or exploitation of opportunities.</p>	<p>Be patient and allow time for reflection.</p> <p>Use approaches that encourage interaction so patterns can emerge.</p>

'A Leader's Framework for Decision Making' by David J. Snowden and Mary E. Boone, Harvard Business Review, 2007

	THE CONTEXT'S CHARACTERISTICS	THE LEADER'S JOB	DANGER SIGNALS	RESPONSE TO DANGER SIGNALS
CHAOTIC	<p>High turbulence.</p> <p>No clear cause-and-effect relationships, so no point in looking for right answers.</p> <p>Unknowables.</p> <p>Many decisions to make and no time to think.</p> <p>High tension.</p> <p>Pattern-based leadership.</p>	<p>Act, sense, respond.</p> <p>Look for what works instead of seeking right answers.</p> <p>Take immediate action to reestablish order (command and control).</p> <p>Provide clear, direct communication.</p>	<p>Applying a command-and-control approach longer than needed.</p> <p>"Cult of the leader".</p> <p>Missed opportunity for innovation.</p> <p>Chaos unabated.</p>	<p>Set up mechanisms (such as parallel teams) to take advantage of opportunities afforded by a chaotic environment.</p> <p>Encourage advisers to challenge your point of view once the crisis has abated.</p> <p>Work to shift the context from chaotic to complex.</p>

### Building a reflective culture

At all levels of the organisation it is essential to be curious and to keep asking 'why are we doing this and why are we doing it in this way'. There should be a culture of reflection that actively encourages people to ask questions.

This requires a functional organisational environment that is able to tolerate uncertainty and absence of complete control. It will require structures that enable and expect constructive communication and challenge from the bottom up.

### What is organisational resilience

*"Organisational resilience is both planning to manage the unexpected, as well as adapting and reacting to changing circumstances"*

What is it that makes some organisations able to not only survive, but also to thrive in the face of adversity?<sup>10</sup>

A resilient organisation has the following characteristics:

- Leadership and culture: strong, aware, and empathetic leadership combined with staff that are empowered, trust each other, and are well looked after;
- Networks: Effective external partnerships, well-managed internal resources, and the ability to leverage knowledge across the organisation;
- Change-readiness: a unity of purpose and a proactive posture combined with the regular testing of plans to counter vulnerabilities.

*A good working example of this comes from a talk given by a Local Authority whose Children's Services was recently inspected under the new Ofsted inspection regime in 2014. After the inspection the Director was relaying to an audience what went well. He talked of calling his multi-agency partners in on the weekend and feeding them take out and coffees to get all the files audits done. The whole safeguarding team around the child knew their strengths and weaknesses and were able to present a balanced picture of miles travelled and direction to go in. He spoke of 'knowing yourself' as an authority*

<sup>10</sup> This section of work is taken from the Resilient Organisations. This involves a team of researchers from around New Zealand, particularly the University of Canterbury and University of Auckland.

*and having a clear vision. Some of us were left wondering 'how on earth did you get other agencies to come in on 24 hours notice & work all weekend?' The answer leadership, networking and change readiness.*

### Indicators of resilience

Researchers from Resilient Organisations have identified 13 indicators that we look for to assess the resilience of an organisation:

1. **Leadership:** Strong crisis leadership to provide good management and decision making during times of crisis, as well as continuous evaluation of strategies and work programs against organisational goals.
2. **Staff Engagement:** The engagement and involvement of staff who understand the link between their own work, the organisation's resilience, and its long term success. Staff are empowered and use their skills to solve problems.
3. **Situation Awareness:** Staff are encouraged to be vigilant about the organisation, its performance and potential problems. Staff are rewarded for sharing good and bad news about the organisation including early warning signals and these are quickly reported to organisational leaders.
4. **Decision Making:** Staff have the appropriate authority to make decisions related to their work and authority is clearly delegated to enable a crisis response. Highly skilled staff are involved, or are able to make, decisions where their specific knowledge adds significant value, or where their involvement will aid implementation.
5. **Innovation and Creativity:** Staff are encouraged and rewarded for using their knowledge in novel ways to solve new and existing problems, and for utilising innovative and creative approaches to developing solutions.
6. **Effective Partnerships:** An understanding of the relationships and resources the organisation might need to access from other organisations during a crisis, and planning and management to ensure this access.
7. **Leveraging Knowledge:** Critical information is stored in a number of formats and locations and staff have access to expert opinions when needed. Roles are shared and staff are trained so that someone will always be able to fill key roles.
8. **Breaking Silos:** Minimisation of divisive social, cultural and behavioural barriers, which are most often manifested as communication barriers creating disjointed, disconnected and detrimental ways of working.
9. **Internal Resources:** The management and mobilisation of the organisation's resources to ensure its ability to operate during business as usual, as well as being able to provide the extra capacity required during a crisis.
10. **Unity of Purpose:** An organisation wide awareness of what the organisation's priorities would be following a crisis, clearly defined at the organisation level, as well as an understanding of the organisation's minimum operating requirements.
11. **Proactive Posture:** A strategic and behavioural readiness to respond to early warning signals of change in the organisation's internal and external environment before they escalate into crisis.
12. **Planning Strategies:** The development and evaluation of plans and strategies to manage vulnerabilities in relation to the business environment and its stakeholders.
13. **Stress Testing Plans:** The participation of staff in simulations or scenarios designed to practice response arrangements and validate plans.





### Reflective question

Which of these 13 indicators are working well in your organisation? How do you contribute to these working well? What are you worried about? How are you trying to address these?

### Resilient to what?

Each organisation has their own 'perfect storm' – a combination of events or circumstances that has the potential to bring that organisation to its knees.

Social Care has experienced increased public scrutiny due to a number of drivers such as high profile Serious Case Reviews, the sexual exploitation of children and young people, the Care Home investigations to name a few. In combination with this is the increased demand on both Children and Adult services, as our population ages and we become more aware of issues that impact on children such as sexual exploitation and neglect.

The fragile economy and the current economic policies mean that more people are experiencing poverty and are in need of help and support. Local Authorities are being forced to make radical cuts to mainstream budgets including social care. This exerts a pressure on the workforce that is seen in lowered morale and high staff pre-occupation with job security. So called "transformation" agenda's can feel more like cost cutting exercises to over-worked and pre-occupied staff.

Healthy organisations are able to keep their eye on the bottom line during these times of turbulence. The bottom line in social care is about being helpful to children, families and adults who are experiencing difficulties managing parts of their day to day life and need active support to prevent further deterioration. This requires a work force that is relational, active, supportive, empathetic and authoritative enough to make a difference.

Munro writes "to be able to practise well, social workers have to be employed in an organisation that supports them and their professional development.

Ferguson's research on direct work with children and families concludes:

*'The extent to which social workers are able to delve into the depths to protect children and explore the deeper reaches and inner lives of service users – the degree to which they feel able to get up and walk across the room to directly engage with, touch, and be active with the child or follow through on seeing kitchens and bedrooms – is directly related to how secure and contained they feel in separating from the office/car. They can only really take risks if they feel they will be emotionally held and supported on returning to the office that their feelings and struggles will be listened to. Workers' state of mind and the quality of attention they can give to children is directly related to the quality of support, care and attention they themselves receive from supervision, managers and peers'*<sup>11</sup>

### Resilience is a strategic capability.

It isn't just about getting through crises; a truly resilient organisation has two other important capabilities –the foresight and situation awareness to prevent potential crises emerging; and an ability to turn crises into a source of strategic opportunity.

Social care as an entity is required to be ever changing. It is part of society's response to the more vulnerable in their communities. The needs, the identity and the numbers of people who require social care will shift as communities both local and global develop and change.

### Healthy organisations develop a capacity and belief in continuous improvement by encouraging employees to:

- Seek better ways of delivering existing services;
- Be critical of the purpose of existing services;
- Seek to change services where necessary;
- Be willing to develop entirely new services.

<sup>11</sup> Pg 106 The Munro Review of Child Protection: Final Report – A child-centred system

“The resilience of an organisation is directly related to the resilience of the other organisations on which it depends (customers, suppliers, regulators, and even competitors)”.



### Organisations sit within a larger system

The resilience of organisations (businesses, government agencies, institutions etc), sits within an ecological like system and resilience is required at all levels of this system.

The resilience of an organisation is directly related to the resilience of the other organisations on which it depends (customers, suppliers, regulators, and even competitors). An organisation is also dependent on and contributes to the individual resilience of its staff and the resilience of the communities that they live in. Similarly, an organisation's resilience is directly related to the resilience of its sector, and the sector's resilience is intertwined with the resilience of the nation.

The partnerships organisations are able to make with each other can be compromised during difficult times. This tendency to look inwards risks any one organisation missing the big picture and opportunities for both growth and identifying danger.

### Using positive organisation behaviours to promote resilience

Positive Organisational Behaviours (POB) is defined by Luthans (2002) as “the study and application of positively-oriented human resource strengths and psychological capacities that can be measured, developed, and effectively managed for performance improvement in today's workplace.” The belief that these are skills which can be taught to most people supports organisations to develop a learning culture.

### The four positive organisational behaviours

Self-efficacy, Hope, Optimism, and Resiliency are the four key capacities that best meet the inclusion criteria for POB, which enhances managing effectiveness and organisational performance.<sup>12</sup>

<sup>12</sup> Luthans and Youssef (2007), (p.52).

1. **Self-efficacy**, defined by Bandura as the belief that one has the capabilities to “execute the courses of actions required to manage prospective situations,” represents the best fit with all the criteria of POB among all the four capacities. Self-efficacy belief appears to determine how much effort people will spend on a task and how long they will persist with it.
2. **Hope** - With the hope to achieve certain goals, employees have the sense of urgency or internalised control that creates the determination and motivation (willpower) to accomplish their goals. They would also be able to create and use alternative pathways and contingency plans to achieve their goals and overcome obstacles (waypower).
3. **Optimism** is defined by positive psychologists as a cognitive characteristic in terms of an expectancy of positive outcome and/or a positive causal attribution. However, Christopher Peterson, the Science Director of the VIA Institute on Character, has once noted that managers should keep in mind that “Optimism is not simply cold cognition, and if we forget the emotional flavour that pervades optimism, we can make little sense of the fact that optimism is both motivated and motivating.”
4. **Resiliency** is defined by Luthans (2002) as “the capacity to rebound or bounce back from adversity, conflict, failure, or even positive events, progress, and increased responsibility.” Unlike traditional conceptualisations of resiliency as an extraordinary capacity that can only be observed and admired in highly unique individuals, the positive psychology perspective in management on resilience is that it is a learnable capacity that can be developed in most people.

### Why are positive organisational behaviours useful?

First, instead of focusing on people's weaknesses, POB encourages managers and leaders to build on peoples' strengths, rather than just focusing on fixing weaknesses.

Second, the four key POB capacities are state-like, not trait-like, which means they can be learned and developed. This implies that performance can be improved by focusing on self-efficacy, hope, optimism, and resiliency — more effective than trying to change fundamental personality traits.

Third, POB not only improves performance and management effectiveness, it results in positive behaviours such as altruism, conscientiousness, civic virtue, sportsmanship, and courtesy. POB encourages principled actions and appropriate whistle-blowing.

POBs in workplace can:

- Empower employees and encouraging them to express their opinions on the firm's issues;
- Develop and maintain optimism in workplace, especially during adverse times;
- Develop a more comprehensive recruitment or appraisal system, analyzing strengths rather than weaknesses.



[Exercise 2: The activity map](#)



[Tool 1: What is good work?](#)

# Management

Middle managers need to see it as their main business not to be the brutal enforcers of targets but to be the benign designers of the workplace... In an organisational context, this means the design of systems made up of people, processes and technology in order to achieve the best possible performance. Finding the best way of organising the workplace, in more prosaic terms. If this is not the primary business of management, then what on earth is?

– (Wastell and White, 2010 Managers Man)



**Goal: Support service improvement**

## Expectations of social care

Service improvement involves knowing what people want and need from you and knowing how far you are achieving this. This is the basis for an organisation then being able to learn, develop and make progress.

Organisations need to know what people want and need from them. This allows them to co-produce and agree their purpose with people who use their services, and to co-produce and agree what they will do to achieve this.

Meeting customer expectations is what leads to good customer service.

**Customer Expectations + Service Performance = Customer Satisfaction**

A good service is what the customer says that it is, rather than what an organisation believes to be the case.

Organisations need to be open about their purpose and how they will achieve it. They need to understand their customers' expectations and strive to meet them.

This is complicated in social care because:

1. It is not really a business and people aren't really customers.

Many people do not choose to use social care and do not want it. Consequently the way that the organisation (by which we mean the people in the organisation) relates to them should be about their rights, needs and citizenship, rather than about them being consumers or customers.<sup>13</sup> For example, talking to a parent about their rights and the responsibilities that go alongside them, or talking to an older person about their entitlement to an assessment.

2. There are different stakeholders.

Your organisation has a national legal mandate – to promote the welfare of children and the wellbeing of adults, and a range of activities that it should undertake to do this. It

<sup>13</sup> Mark Smith, Michael Gallagher, Helen Wosu, Jane Stewart, Vivien E. Cree, Scott Hunter, Sam Evans, Catherine Montgomery, Sarah Holiday, and Heather Wilkinson (2012) Engaging with Involuntary Service Users in Social Work: Findings from a Knowledge Exchange Project, British Journal of Social Work 42, 1460–1477

is accountable to the government and to the regulatory bodies for this. Your organisation also has a local mandate from elected councillors and is democratically accountable to them to fulfil locally agreed objectives. Your organisation also is made up of people who have professional standards to meet. The way to reconcile these is to base national and local and professional requirements on what will give children, adults and families a good experience and good outcomes in terms of welfare and wellbeing. However, there are conflicting views about how to do this and conflicting needs within this. Your role includes supporting your organisation to reconcile some of these conflicts.

### 3. There are barriers to people getting a good service.

People face barriers to accessing and using social care. These include: lack of awareness, cultural barriers, stigma, discrimination, social and economic barriers, service criteria and past experience. You can support your organisation to consider who is accessing your services and what is preventing others from doing this, and how to overcome these barriers.

These factors add to the need for you to act, model and lead sensitive engagement with children, adults and families about what they want and need from you and what you are able to provide. You can help your organisation to understand:

- What people understand about what you do;
- What they want you to do for them;
- How you can best manage these expectations and explain your purpose and activities transparently.



#### Reflective question

How do you help your organisation to understand and agree expectations?

## What people want from social care

People who have received social care have identified some of the main elements that are important to them.

For adults, Think Local Act Personal has identified what good social care looks like:

1. Information and Advice: Having the information I need, when I need it;

*"I have the information and support I need in order to remain as independent as possible."*

*"I have access to easy-to-understand information about care and support which is consistent, accurate, accessible and up to date."*

*"I can speak to people who know something about care and support and can make things happen."*

*"I have help to make informed choices if I need and want it."*

*"I know where to get information about what is going on in my community."*

2. Active and supportive communities: Keeping friends, family and place;

*"I have access to a range of support that helps me to live the life I want and remain a contributing member of my community."*

*"I have a network of people who support me – carers, family, friends, community and if needed paid support staff."*

*"I have opportunities to train, study, work or engage in activities that match my interests, skills, abilities."*

*"I feel welcomed and included in my local community."*

*"I feel valued for the contribution that I can make to my community."*

### 3. Flexible integrated care and support: my support, my own way

*"I am in control of planning my care and support."*

*"I have care and support that is directed by me and responsive to my needs."*

*"My support is coordinated, co-operative and works well together and*

*I know who to contact to get things changed."*

*"I have a clear line of communication, action and follow up."*

### 4. Workforce: my support staff

*"I have good information and advice on the range of options for choosing my support staff."*

*"I have considerate support delivered by competent people."*

*"I have access to a pool of people, advice on how to employ them and the opportunity to get advice from my peers."*

*"I am supported by people who help me to make links in my local community."*

### 5. Risk enablement: feeling in control and safe

*"I can plan ahead and keep control in a crisis."*

*"I feel safe, I can live the life I want and I am supported to manage any risks."*

*"I feel that my community is a safe place to live and local people look out for me and each other."*

*"I have systems in place so that I can get help at an early stage to avoid a crisis."*

### 6. Personal budgets and self-funding: my money

*"I can decide the kind of support I need and when, where and how to receive it".*

*"I know the amount of money available to me for care and support needs, and I can determine how this is used (whether it's my own money, direct payment, or a council managed personal budget)."*

*"I can get access to the money quickly without having to go through over-complicated procedures."*

*"I am able to get skilled advice to plan my care and support, and also be given help to understand costs and make best use of the money involved where I want and need this."*

Customers have also identified what they want from joint or integrated working between adult social care and health (and other partners).<sup>14</sup>

*"I can plan my care with people who work together to understand me and my carer(s), allowing me control, and bringing together services to achieve the outcomes important to me."*

#### My goals/outcomes

- All my needs as a person are assessed;
- My carer/family have their needs recognised and are given support to care for me;
- I am supported to understand my choices and to set and achieve my goals;
- Taken together, my care and support help me live the life I want to the best of my ability.

#### Care planning

- I work with my team to agree a care and support plan;
- I know what is in my care and support plan. I know what to do if things change or go wrong;
- I have as much control of planning my care and support as I want;
- I can decide the kind of support I need and how to receive it;
- My care plan is clearly entered on my record;
- I have regular reviews of my care and treatment, and of my care and I have regular, comprehensive reviews of my medicines;
- When something is planned, it happens;

<sup>14</sup> National collaboration for integrated care and support (2013) Integrated care and support: our shared commitment, Department of Health

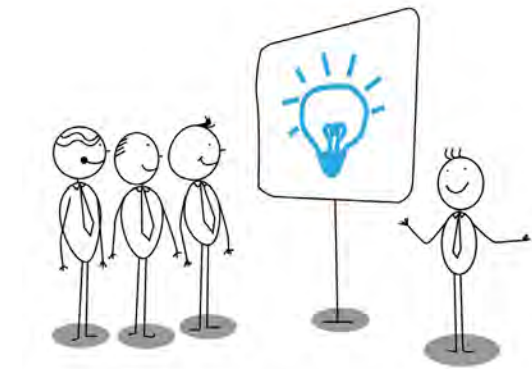
- I can plan ahead and stay in control in emergencies;
- I have systems in place to get help at an early stage to avoid a crisis.

### Communication

- I tell my story once;
- I am listened to about what works for me, in my life;
- I am always kept informed about what the next steps will be;
- The professionals involved with my care talk to each other. We all work as a team;
- I always know who is coordinating my care;
- I have one first point of contact. They understand both me and my condition(s). I can go to them with questions at any time.

### Information

- I have the information, and support to use it, that I need to make decisions and choices about my care and support;
- I have information, and support to use it, that helps me manage my condition(s);
- I can see my health and care records at any time. I can decide who to share them with. I can correct any mistakes in the information;
- Information is given to me at the right times. It is appropriate to my condition and circumstances. It is provided in a way that I can understand;
- I am told about the other services that are available to someone in my circumstances, including support organisations;
- I am not left alone to make sense of information. I can meet/phone/email a professional when I need to ask more questions or discuss the options.



### Decision making including budgets

- I am as involved in discussions and decisions about my care, support and treatment as I want to be;
- My family or carer is also involved in these decisions as much as I want them to be;
- I have help to make informed choices if I need and want it;
- I know the amount of money available to me for care and support needs, and I can determine how this is used (whether it's my own money, direct payment, or a 'personal budget' from the council or NHS);
- I am able to get skilled advice to understand costs and make the best use of my budget;
- I can get access to the money quickly without over-complicated procedures.

### Transitions

- When I use a new service, my care plan is known in advance and respected;
- When I move between services or settings, there is a plan in place for what happens next;
- I know in advance where I am going, what I will be provided with, and who will be my main point of professional contact;
- I am given information about any medicines I take with me – their purpose, how to take them, potential side effects;
- If I still need contact with previous services/ professionals, this is made possible;
- If I move across geographical boundaries I do not lose my entitlements to care and support.

## For children, young people and their families

Many of the behaviours listed above also chime with the wishes and rights of children, young people and their families. There are also some specific challenges in working well with children and young people and their families that are covered under legislation.

The participation of children and young people in decisions that affect their lives is not new and is central to Government policy. Both the Children Acts of 1989 and 2004 require a local authority to ascertain the 'wishes and feelings' of children when determining what services to provide, or what action to take, including when it is looking after children. This legislation provides the legal framework for children's rights.

The UK Government's ratification of the United Nations Convention on the Rights of the Child in 1991 recognised children's rights to expression and to receiving information. This was reinforced by Article 10 of the Human Rights Act 1998. It is vital that these legislative priorities translate to practice at the front line.

The Munro report in 2010 highlighted what a good Children Social Service looked like from the point of view of the children, young people and their families.

*"Children's experiences of bureaucracy are that their social workers are liable to change, that appointments are cancelled and that workers are under stress. Responsibility for improving practice with children and young people lies with managers who should prioritise creating a space for it to happen."*<sup>15</sup>

A study carried out by the Children's Rights Commission gave children and young people a voice to offer the following messages to practitioners and managers in social care:

*"I don't like people looking down on me and I don't like people looking up at me like I'm an adult. I like people talking to me for my age."*

<sup>15</sup> pg 113 The Munro Review of Child Protection: Final Report – A child-centred system

*"Kids aren't as naïve as you think. I think the reason that people don't listen to kids is that they're kids."*

*"You've got to trust [the social worker] and she's got to trust you. Otherwise there's no point."*

*"The reason for speaking to children and young people is that they are a key source of information to understand the problems they and their families have, and the impact this is having on them in the specific culture and values of their family. It is therefore puzzling that the evidence shows that children are not being adequately included in child protection work."*<sup>16</sup>

There are five main messages with regard to the voice of the child. In too many cases:

- The child was not seen frequently enough by the professionals involved, or was not asked about their views and feelings;
- Agencies did not listen to adults who tried to speak on behalf of the child and who had important information to contribute;
- Parents and carers prevented professionals from seeing and listening to the child;
- Practitioners focused too much on the needs of the parents, especially on vulnerable parents, and overlooked the implications for the child;
- Agencies did not interpret their findings well enough to protect the child.<sup>17</sup>

A rare study in which children were asked about their views of the child protection system revealed that:

- Children were not always well informed by professionals but they tried to piece together information to make sense of what was happening, mainly by getting the information from family members;

<sup>16</sup> Munro (2011) Munro review of child protection Interim report the child's Journey DfE

<sup>17</sup> Ofsted, The voice of the child: learning lessons from serious case reviews A thematic report of Ofsted's evaluation of serious case reviews from 1 April to 30 September 2010



- Children wanted to maintain a sense of control throughout the child protection process and did not want to hand over their worries to a professional to sort out. However, they wanted to share them and work with a trusted adult on finding the best solution for making them safe;
- A key part of the child protection process is the child protection conference where various professionals and parents/carers offer their assessment of the situation and are meant to work together to suggest a plan to reduce the risk to the child. It is also recommended that, when appropriate, children attend the child protection conference;
- However, children who attended a child protection conference were not well prepared for it and found the conference difficult to understand. Children felt they were asked awkward questions and felt that others did not listen to what they had to say.<sup>18</sup>

The key characteristics that children and young people look for in a social worker are:

- Willingness to listen and show empathy.
- Reliability;
- Taking action;
- Respecting confidences;
- Viewing the child or young person as a whole person;
- Not overly identifying a child with a particular problem;
- Ability to communicate with children of varying abilities;
- Ability to address the emotional needs of children at key points in their lives.<sup>19</sup>

<sup>18</sup> Ivana La Valle, Lisa Payne and Helena Jelcic, Research summary 7 Research June 2012 Centre The voice of the child in the child protection system NCB Research Centre

<sup>19</sup> Munro (2011) Munro review of child protection Interim report the child's Journey DfE

## Anti-oppressive 'customer service'

In social care, it is not enough to aim for good individual customer service. It is also essential to be proactive in overcoming the structural barriers that people face which contribute to them:

- Becoming 'clients';
- Being labelled as a particular kind of 'customer';
- Being unable to get, or facing difficulty in getting, support that they need;
- Lacking power in the transaction with the organisation;
- Having previous experiences of disempowerment, discrimination or oppression compounded by their new social care experience;
- Having their experiences of social care appropriated for organisation improvement without acknowledgement or the opportunity to lead on how this is done.

As you can see from this, anti-oppressive practice is difficult to do by its nature, and also because it is easy for anti-oppressive practice itself to become oppressive if it does not acknowledge who the real experts are – people who experience oppression.

First-line managers are often the bridge between practitioners – who have knowledge of what people need and wish for from social care, and what they get – and senior managers who determine what the organisation will do and how. You can remind your organisation of the importance of:

- Addressing barriers at a community level, not just at a local level;
- Engaging with the whole community about what they need;
- Ensuring that services are aware of the impact of oppression and the need to combat this as well as not causing it;
- Seeking input by experts by experience to help service improvement.



**Reflective question**

How does your organisation learn from children, adults and families? What more could you do?

**Meaningful quality assurance**

The purpose of doing quality assurance is for an organisation to know how far it is meeting agreed standards and what else is required to do so. As discussed, agreeing expectations is a first step. The organisation then needs to know how it is doing in meeting these.

A good model for understanding how an organisation is doing is the Outcomes-based Accountability Framework.<sup>20</sup> This framework asks three important questions:

- How much did we do?
- How well did we do?
- What difference did we make?

	Quantity	Quality
Effort	<p>How much did we do? (the quantity of the effort)</p>	<p>How well did we do it? (the quality of the effort)</p>
Effect	<p>How many customers are better off? (the quantity of the effect)</p>	<p>Percentage of customers better off? (the quality of the effect)</p>

**How much did we do?**

The first question is often asked by organisations and usually answered fairly well – how many people received a service, how long for, how much did it cost etc. This is usually done through management information systems that require

staff to input particular data at particular times. Managers have an important role in ensuring that the data is captured in a timely manner. This depends on people understanding the purpose of the data. For example, asking people about their sexual orientation is an important part of anti-oppressive practice as it enables an organisation to see when its services are not being accessed by particular group.

The manager's role includes:

- Helping staff to understand why it is being asked for;
- Questioning if that is not clear or doesn't seem useful;
- Modelling timely input;
- Monitoring and supporting staff to input;
- Questioning how the organisation is using the information;
- Using the information in your own team and making suggestions for the implications for the organisation.

**How well did we do?**

The second question is asked and answered less well – this is a question about experience and usually involves gathering qualitative data from children, adults and families. Gathering this data raises more ethical issues. Essentially asking people about their experience should be:

- **For a clear purpose;**
- **Voluntary;**
- **Confidential;**
- **Safe** – in that they shouldn't face any adverse consequences based on what they say from your organisation or anyone else;
- **Safe** – in that it shouldn't cause them distress and distress should be alleviated – there are particular considerations about asking children about their experience;

<sup>20</sup> Friedman M (2005) Trying hard is not good enough, Trafford Publishing

- **Responsive** – both in terms of responding to concerns about their experience and in terms of letting people know what you have done as a result of learning from them.

The manager's role includes:

- Helping to identify what you need to ask about;
- Helping to identify who to ask;
- Support people to engage and respond – this includes your team asking people about their experience as part of their assessments and reviews;
- Helping to ensure that ethical standards are met;
- Following up on any concerns raised or distress from people that your team supports;
- Feeding back information on experience that your staff and you find out about to your organisation – for example from compliments, complaints, reviews etc.;
- Questioning how the organisation is using the information and telling people about this;
- Using the information in your own team and making suggestions for the implications for the organisation.



### What difference did we make?

The third question is the most difficult one to answer. It involves looking at the outcome or end result of what was done. This is difficult because social care outcomes (welfare and wellbeing) are difficult to measure and also because of the many factors that affect outcomes for example an older person might be well supported but, due to illness, their quality of life may still reduce.

Organisations need to ask about what happened as a result of their interventions. How did people's lives change and what was the effect of this on their welfare/ wellbeing.

At an individual level, this is about practitioners identifying:

- What the needs are and the impact of needs on someone's welfare/ wellbeing;
- What it would look like if those needs were met in terms of their welfare/ wellbeing (outcomes);
- How we will get there (actions);
- How we will know when we have got there (measurable indicators).

For example in an assessment process this would look like:

- What the needs are and the impact of needs on someone's welfare/ wellbeing – needs and risks in an assessment;
- What it would look like if those needs were met in terms of their welfare/ wellbeing – outcomes in a child protection or support plan;
- How we will get there – actions in a child protection or support plan;
- How we will know when we have got there – what we will look for during the review.

It may be difficult to see that the outcomes have been achieved and so we may be looking for:

- **Self-reporting** – what the child, young person or adult says has improved;
- **Proxy indicators** – things that indicate that something else has happened for example regular attendance at school or not being admitted to hospital as indicators of welfare or wellbeing.

The manager's role includes:

- Supporting staff to identify the impact of a situation on welfare/ wellbeing;
- Making sure that staff agree outcomes with children, adults and families;
- Checking that the actions are likely to achieve the outcomes;
- Ensuring that staff monitor and review outcomes based on agreed indicators.

### The organisational role


At an organisational level, the organisation needs to understand what difference it is making. Some of this understanding will come from teams letting the organisation know what difference they are making and managers have an important role in this.

Some of the understanding will come from audit of work, for example looking at cases, observations of staff and gathering examples. Managers are likely to have a role in audit and they need to help to ensure that:<sup>21</sup>

- Audit is proportionate – not everything needs to be looked at and not always to the same depth;
- Audit focuses on outcomes not outputs;
- Audit doesn't distort practice by making people focus on things that aren't important to children, adults and families;
- Audit information is used;


- Audit doesn't adversely affect morale – it is motivating in recognising good practice and improving practice, rather than punitive.

Some of the understanding will also come from asking people about outcomes. The same ethical considerations apply as for asking them about experience and managers' role is similar.



**Reflective question**

How do you and your team know what difference you make? How do you let your organisation know?

 [Exercise 3: How do we know we are doing a good job?](#)

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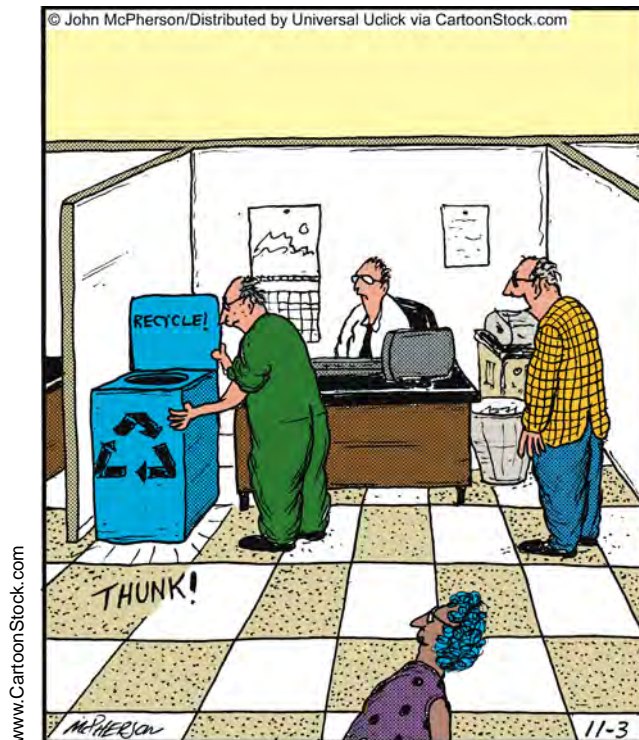
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<sup>21</sup> Munro E (2008) The impact of audit on social work practice, British Journal of Social Work, 34, 1075-95

# Development

“Stimulating or challenging work is a prerequisite for implementing a learning organisation. Work should be organised in such a way that it promotes human development.” – (Steen Hoyrup 2004)



"Our space utilization study revealed that you have two square feet more than is allotted, so we're going to keep the office recycling bin in here."

**Goal: Contribute to a learning culture**

## Learning culture

The organisational culture affects practice and how practice develops. This culture is visible through:

- The organisation's vision, purpose and aims;
- The organisation's values;
- The behaviour of leaders in the organisation;
- The way language is used.

Culture can be thought of as 'the sum of the individual behaviour of people who work in the organisation'. This culture is normally both formal (aspects to do with the organisational aims) and informal (aspects to do with how people think and behave).



A learning culture in an organisation is one that takes account of the following laws of systems:

- Today's problems come from yesterday's solutions – we need to understand what we have done to know why things are happening as they are now;
- The harder you push, the harder the system pushes back – if what you are doing has side effects then, the more you do it to overcome the side effects, the more side effects you get;
- Behaviour grows better before it gets worse – if you do something to fix the symptom of a problem it is likely to improve but then the problem will come back in some new way;
- The easy way out usually leads back in – quick fixes rarely actually fix things;
- The cure can be worse than the disease – sometimes the easy solution actually creates dependency and increased problems;

- Faster is slower – it is best to aim for the optimal rate of growth rather than try to force change;
- Cause and effect are not closely related in time and space – we need to look far and wide for the causes;
- Small changes can produce big results but the areas of highest leverage are often the least obvious – changes that will have a big impact can be very hard to see;
- You can have your cake and eat it too, but not at once – you need to consider how you will achieve the aims you have over a sensible time frame;
- Dividing an elephant in half does not produce two small elephants – if you split things up then you will also split up potential solutions from problems;
- There is no blame – ‘they’ are part of the same system and you influence each other.<sup>22</sup>

If you think of yourself as part of a whole system where everyone can help each other to solve problems and improve, so long as you learn and share your learning, then the culture will be very different from an organisation where each part is looking for another part to blame.

Learning behaviours in an organisation include:

- Asking about what has been done before and why, and what happened;
- Finding out about the consequences of what you are doing for other people;
- Thinking through and monitoring the impact of any change you make;
- Thinking in the medium and long term, not just the short term;
- Taking responsibility rather than asking other people in to fix things for you;
- Being realistic about the investment of time, resource and effort to improve;
- Sharing information about how things are

going and what is happening so that you can build up a picture of how things interact;

- Having relationships and communicating between different parts of the organisation;
- Not talking about ‘them’ and ‘us’ but talking about ‘we’.

This is made difficult in social care because of:

- Staff turnover;
- Workload;
- Silos;
- Time pressure;
- Externally set targets;
- Lack of resources.

However, managers can model and lead questioning, learning and sharing.



### Reflective question

How do you find out what your colleagues need and know, and share with them what you need and know?

### Double-loop learning

Single-loop learning is a cycle of:

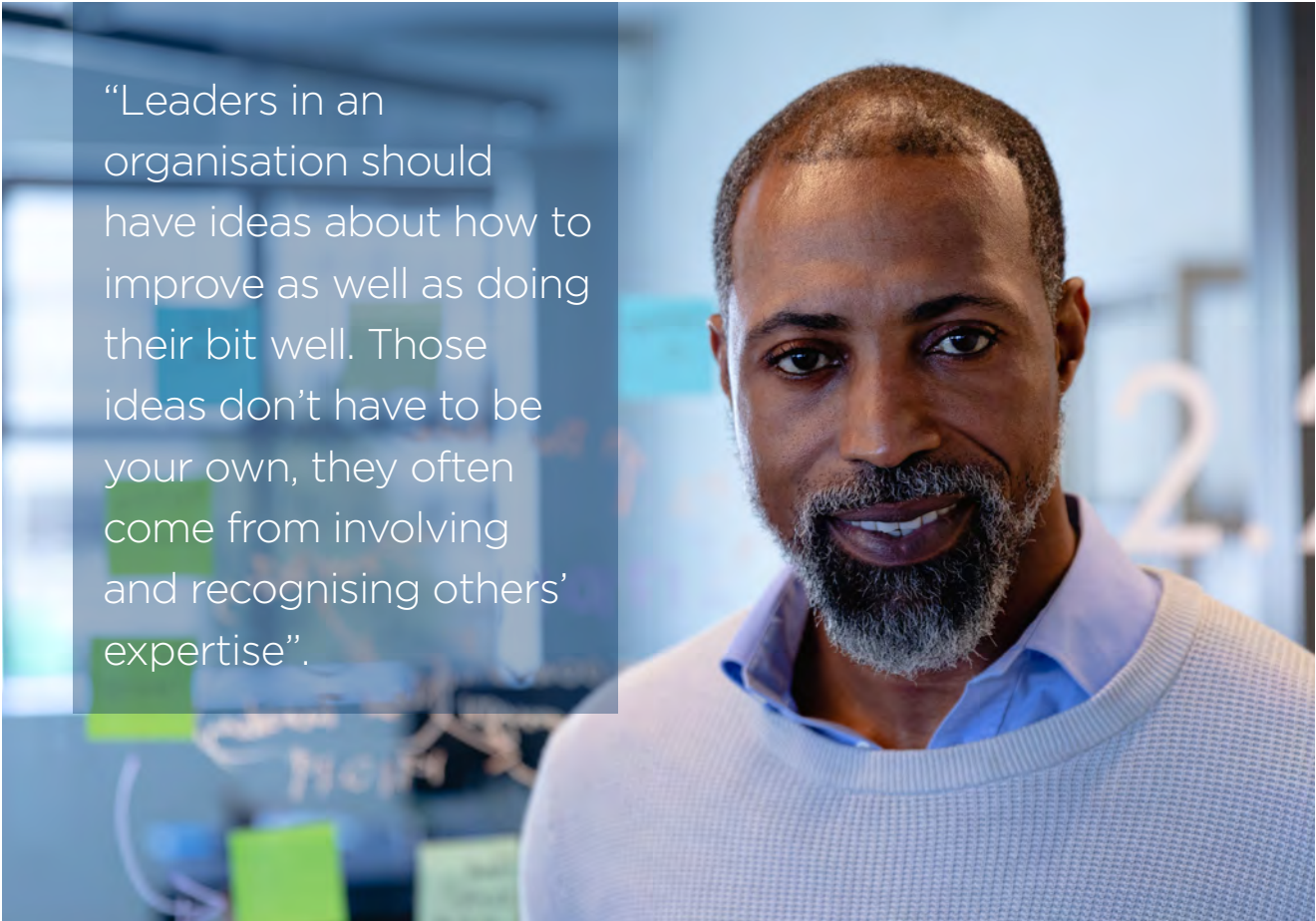
- Do;
- Learn;
- Review;
- Do better.

Double-loop learning adds an additional element to this:

- Do;
- Learn;
- Review how we are doing and whether we are doing the right thing;
- Do better or do something different.

Double-loop learning involves all levels of an organisation asking: how are we doing and are we doing the right things?

<sup>22</sup> Senge P (2006) *The Fifth Discipline: the art and practice of the learning organisation*, Random House



In an organisation, often the information about what to do differently is held by someone who isn't asked. Managers can help to counteract this.


Leaders in an organisation should have ideas about how to improve as well as doing their bit well. Those ideas don't have to be your own, they often come from involving and recognising others' expertise. That's why it is important to know what people are up to:

- Be visible;
- Talk to everyone in your team at least once a week;
- Meet everyone in your team for a review at least once a month.

Always give credit for an idea to the person that it comes from.

Collaborative leadership involves creating shared vision, purpose, outcomes and values across

organisations by building trust, sharing influence and finding solutions when starting from different viewpoints or priorities.



**Reflective question**  
Who knows what we should be doing differently?

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# Support

“Managers have to satisfy the needs of both today and tomorrow. They provide day-to-day stable and consistent management of child protection services. But they also exercise leadership to challenge and bring about change and improvement focused on securing a better future” – (Eileen Munro, 2011)



**Goal: Contribute to a positive working culture**

## The impact of blame

*“For some organisations, the change will need a move away from a blaming, defensive culture to one that recognises the uncertainty inherent in the work and that professional judgment, however expert, cannot guarantee positive outcomes for children and families.”*

*“In child protection, a key responsibility of leaders is to manage the anxiety that the work generates. Some degree of anxiety is inevitable. Whilst practitioners have a key role in protecting children, their safety and welfare cannot be guaranteed. Additional anxiety is fuelled by the level of public criticism that may*

*be directed at child protection professionals if they are involved in a case with a tragic outcome.”*

*“In the review’s analysis of why previous reforms have not had their intended success, unmanaged anxiety about being blamed was identified as a significant factor in encouraging a process-driven compliance culture.*

As William Tate wrote to the review:

*‘Managers should use their leadership role to monitor and improve (i) the way the system continually learns and adapts; (ii) what the system requires of front-line workers; and (iii) how healthy and free of toxicity is the work environment. They will need a high level of awareness of how organisations perform as systems.’<sup>23</sup>*

## Safety culture

Safety culture is the outcome that organisations reach through a strong commitment to acquiring necessary data and taking proactive steps to reduce the probability of errors and the severity of those that occur. (Merritt & Helmreich, 1997)<sup>24</sup>

Safety cultures were first developed in aviation – another sector with high risk activities and potential for tragedy. In a safety culture, the emphasis is on understanding the factors that contribute to poor outcomes and that reduce them, rather than on looking for the person to blame. It is assumed that the pilot didn’t intend to cause a crash since s/he

<sup>23</sup> pg 107, The Munro Review of Child Protection: Final Report – A child-centred system

<sup>24</sup> Merritt, A. C., & Helmreich, R. L. (1997). CRM: I hate it, what is it? (Error, stress, culture)



perished along with everyone else, so there must have been something else going on.

In social care, we tend to look for the human error, maybe because it is a human service. We are good at blaming, and at creating more and more guidance and governance to limit people's scope. However, people don't operate outside of a context. We tend to learn when there is a tragedy and, therefore, we tend to learn the same lessons – about the proximate causes. However, we don't learn about enough the web of factors that lead up to these causes, and we don't spend enough time examining the factors that prevent and reduce them. We don't look at the whole system.

The opportunities and rationale for using a systems approach to build a safety culture in social care have already been identified. For example the Social Care Institute for Excellence advocates for a systems approach to safeguarding.<sup>25</sup>

The aim is to identify what the factors are that support good practice or that create an environment in which poor practice is more likely. This requires the following:

- **Firstly**, recognise that poor practice will happen and needs to be identified as early as possible so that it can be corrected or reduced;
- **Secondly**, encourage everyone to speak up about problems at an early stage (this will only happen if there isn't a blame culture);
- **Thirdly**, collate information about good and poor practice, and to analyse the factors that contributed;
- **Fourthly**, use the analysis to prevent or reduce problems arising in the future by creating environments where poor practice is less likely and good practice is more likely.

This approach doesn't mean that individuals aren't accountable for what they do, but it does mean that why they do what they do is understood so that good practice can spread and poor practice become rarer.

Managers are in a position to help with this:

- They have the opportunity to understand what happens in a service, why it happens that way, and what the factors are that contribute to moments of good and poor practice;
- They can encourage everyone in their team to report poor practice at an early stage by ensuring that it is used constructively to improve services, and by acting as role models for a learning culture rather than a blame culture;
- They can act as a repository for information about the factors that lead to good and poor practice, and can disseminate learning to staff through supervision.

## Hierarchies

Historically a command and control, a directive 'presidential' style of management has been adopted and delivered results for sector organisations, however as recent research on sector professionalism confirms, there is a drive now to acknowledge a maturity and encourage and enable greater self-management across all levels of the workforce and leadership. This reflects the move away from the old notions of status and hierarchy that are today, challenged by British society as a whole.<sup>26</sup> The command and control model is still very much in use in Local Authorities today. Its main features should be instantly recognisable.

Hierarchies are the most common form of organisational structure and the one used in Local Authorities to support delivery of services. This organisation structure groups people into areas of specialisation. A functional manager who has expertise in the same field, which helps him/her to utilise the skills of employees effectively, supervises these people. This ultimately helps the

<sup>25</sup> SCIE (2009) Guide Learning together to safeguard children: developing a multi-agency systems approach for case reviews.

<sup>26</sup> <http://www.excellencegateway.org.uk/node/27315>

manager in achieving the organisation's business objectives.

In this kind of organisation structure, people are classified according to the function they perform in the organisation. The organisation chart for a functional organisation structure shows you the Corporate Director, Directors of departments such as Health, Education, Social Care and their senior managers, through to team managers and professionals that deliver the services directly to the client. The decision making power will be delegated within that structure and each individual will have ceiling for the types of decisions they are able to make.

Image courtesy of sheelamohan at FreeDigitalPhotos.net



### Advantages of hierarchies

When the organisation is functioning in a healthy manner there are a number of advantages to hierarchies including:

Employees are grouped as per their knowledge and skills, which helps achieve the highest degree of performance;

Employees are very skilled and efficient because they are experienced in the same work and hence they perform very well;

- Their role and responsibility is fixed, which facilitates easy accountability for the work;
- The hierarchy is very clear, and employees don't have to report to multiple bosses. Each employee reports to his functional manager, which reduces the communication channels;

- There is no duplication of work because each department and each employee has a fixed job responsibility;
- Employees feel secure, and therefore they perform well without any fear;
- Since there is a sense of job security, employees tend to be loyal to the organisation;
- Employees have a clear career growth path;
- Within the department, cooperation and communication is excellent.

### Disadvantages of hierarchies

- Even when an organisation is functioning well there are still disadvantages:
- Employees may feel bored due to the monotonous, repeated type of work;
- If the performance appraisal system is not managed properly, conflicts may arise.
- For example, an employee may feel demoralised when a lower performing employee is promoted;
- The cost of high skilled employee is higher;
- The departments have a self-centered mentality. The functional manager pays more attention to only his department; he usually doesn't care about other departments;
- Communication is not good among the departments, which causes poor interdepartment coordination. This decreases flexibility and innovation. Moreover, there is a lack of teamwork among different departments;
- Employees may have little concerns and knowledge about anything happening outside their department. This causes obstacles in communication and cooperation;
- The functional structure is rigid, and therefore is slow to adapt to changes;
- Due to bureaucratic hierarchy, delays happen in decision making;
- Generally the functional manager makes decisions autocratically without consulting the

team members, hence it may not always work in favour of the organisation;

- When the organisation becomes larger, functional areas can become difficult to manage due to their size. Each department will start behaving like a small company with its own facilities, culture and management style;
- Functional departments may be distracted by their own goals, and focus on them rather than the organisation's goal.<sup>27</sup>

*“Organised Human activity takes place within a system or a process. When there is a problem 85% of the time the problem is in the system or the process. 15 % of the time the problem is with the worker” Myron Tribus, A template for Creating a Community Quality Council.*



#### Reflective question

What are the advantages and the disadvantages of your organisational structure to the people you are serving?

How can this type of structure encourage reflection in practice?

How does this type of structure promote resilience within your organisation?

#### Listening culture

“An intrinsic part of developing a learning and adaptive system is the creation of channels through which frontline practitioners can notify those in authority of how the current operational arrangements and other features of the practice system are affecting their work with children and families.”<sup>28</sup>

There have been a number of studies and methods for creating listening cultures in the workplace.

The important emphasis is upon acting information and ideas generated by the key stakeholders (employees and customers).

There is a real need for organisations to support those who work within them to create the solutions for sustainability – to genuinely collaborate in acknowledging employee expertise and knowledge and supporting this to inform future plans and actions. The NHS in Wales has released a white paper called 1000 Lives Plus, 2013 The Listening Organisation. The paper identifies a Framework for Assuring Service User Experience identifies three domains of patient experience:

1. First and lasting impressions, including dignity and respect.
2. Receiving care in a safe, supportive, healing environment.
3. Understanding of and involvement in care.

The paper goes on to identify three levels at which it is vital to keep listening to our patients:

- At the frontline among clinical teams directly working with patients;
- At department or “middle management” level to listen to what is happening on the frontline in a range of services;
- At Board level to get a whole system picture, to gain assurance and ensure departments are working together to provide one, fluid, excellent patient experience.<sup>29</sup>

Social Care has similar challenges in terms of understanding and acting upon the messages from service users and staff about their day to day experience in receiving and delivering services. In 2009, the McLeod report introduced the concept of the ‘Employee Voice’.<sup>30</sup> The report highlighted the benefits to organisations of listening.

<sup>27</sup> Fahad Usmani , PM Study Circle at <http://pmstudycircle.com>

<sup>28</sup> Pg 112 The Munro Review of Child Protection: Final Report – A child-centred system

<sup>29</sup> Williams,A.(2013)TheListeningOrganisation.Cardiff: 1000 Lives Plus

<sup>30</sup> Engaging for Success: enhancing performance through employee engagement, D. MacLeod & N. Clarke, Department for Business Innovation and Skills,2009)

“The employee voice can have a transformational impact on an organisation and improve performance and help deliver sustainable business success by:

- Acting as a key enabler of employee engagement;
- Enhancing decision making;
- Driving innovation”.

There are clear benefits for all the stakeholders involved in any organisation that seeks to develop Employee Voice effectively. The benefits for three key groups of stakeholders can be summarised as follows:

For the Organisation as an entity:

- Improved access to innovative ideas and solutions;
- Improved reputation and reduced organisational conflict;
- Improved communications from front line to senior management, greater collaboration and co-operation;
- Inclusive view of staff supporting development of talent mindset;
- Talent mindset developed with improved talent management;
  
- Greater staff engagement, less absence, improved retention.
- Customers (service users and other agencies):
- Greater focus on the organisation’s customers;
- Authentic leadership across the organisation, reflecting and living the organisational values;
- Service user success is at the heart of the organisation;
- Better service user experiences;
- Better relationship management with employers;
- Coherent and consistent approach from all staff.

- Individual benefits for employees:
- Increased motivation and wellbeing, confidence, feeling valued;
- Improved levels of commitment – to go that ‘extra mile’;
- Increased personal focus and ‘what is in it for you’;
- Reduced levels of stress and increased levels of resilience;
- Improved levels of inclusion and opportunities for development;
- Improved dignity at work, reduced grievances and disciplinaries.



[Exercise 4: Valuing staff](#)

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# Mediation

"The better able team members are to engage, speak, listen, hear, interpret, and respond constructively, the more likely their teams are to leverage conflict rather than be levelled by it." – (Runde and Flanagan, 2007)



www.CartoonStock.com

"We're looking for managers that demonstrate high levels of emotional intelligence. Here, please try on this mood ring."

*politicians, chief executives and senior officers, so that the demands placed on child and family social work services are directly related, so far as is possible, to improving and supporting frontline practice."*<sup>31</sup>

Mediating between these tensions and operational intentions is the manager. Leading your staff well requires an ability to articulate a clarity of purpose and a willingness to advocate for that purpose in the face of organisational opposition and change. Managers can play a role in countering balancing organisational structures and achieving difference for clients. A study by Glisson and Green in 2006 found that when managers promote constructive organisational cultures – which focus on achievement, client responsiveness and competency (as opposed to a passive defensive culture that focus on conformity, rule following and blaming) the probability of clients receiving needed services is almost five times greater.<sup>32</sup>

Social workers have an obligation to challenge social conditions that contribute to social exclusion, stigmatisation or subjugation, and to work towards an inclusive society (International Federation of Social Workers, Code of Ethics)

Social care is work at the margins of society. It is work with people who would otherwise lack the resources to manage, maintain or restore their lives. This role is sanctioned, agreed and voted for by the public so what social care does and how it does it is greatly affected by the public context.

**Goal: Act as ambassadors for the organisation.**

## Working in context

The Social Work Task Force, a focus on improving practice and the appointment to Government of the Chief Social Work role can be seen as positive developments. However, the context of social work and social care also includes limited resources, bureaucracy and blame.

Munro wrote of in her report that:

*"... most bureaucracy which limits practitioners' capacity and ability to practise effectively, is generated and maintained at a local level. This includes financial and personnel arrangements, procedural requirements, poorly functioning or under resourced ICT arrangements. To undo these arrangements requires commitment, resource and focus. To generate and complete change of this scale also requires different behaviours and expectations from local*

<sup>31</sup> Pg 106 The Munro Review of Child Protection: Final Report – A child-centred system

<sup>32</sup> Frey.L. LeBeau. M, Kindler. D, Behan. C, Morales. I, and Freundlich.M,(2012) The pivotal role of child welfare supervisors in implementing an agency's practice model, Children and Youth Services Review

The social and economic context influences the decisions that society make about what social care is for and how much to spend on it. We need to consider how the amount of money that people have and their aims affect the way in which they relate to people who need social care.

Changing perceptions of what society can afford and what it should put up with make people more or less willing to help others.

Managers and practitioners don't get to decide what social care is there to do. That is a political question decided based on the values of citizens, who elect central and local representatives to enact law, policy and plans. However, we can engage in the debate about what social care should do in three main ways.

- We can help people better understand the problems that social care is there to address.
- We can help people better understand what is likely to work.
- And we can help people to better understand the likely consequences of particular laws, policies and plans.

Each of these requires us to use evidence. Otherwise, we are just giving an opinion, and may add to misguided and oppressive action or experiment with people's lives.

This starts with an awareness of why we are in social care and how much we are prepared to invest in the people we work with. Then we need to seriously consider the evidence we have to back up our views. After this, we will be able to engage in useful debate with others, learn from them and find allies to help us to affect the context.

If we do not engage with this debate, then social care can become used as a force that manipulates people's lives to fit with the consensus. We are in a position to engage with the people that these policies and actions affect, and with other agents who are asked to carry them out. Our power can be used to create a partnership between the people who are affected and those who can stand alongside them. This partnership is increasingly important when there is a growing gap between some people's experience and the experience of

society as a whole. Failure to thrive in society can become seen as an individual problem or even a choice. As inequalities increase and experiences become more diverse, the partnership role that allows us to create a louder voice for people at the margins becomes more crucial.

Managers can act to use evidence, and model and lead this for others, in order to challenge and shape what social work is and what it does. We need to be prepared to use our power to do this well.

### Diversity and exclusion

Human preferences work on the basis of sympathy which is strengthened by relationships. We are more likely to help people that we know or who are similar to us. Social care immediately struggles, therefore, because we tend to work with people who are less well known or have uncommon characteristics and situations. Part of our public role is reminding society of people that are easy to forget or people prefer to ignore. Rawls' theory of justice starts from the premise that a just society would be developed based on how we would like to be treated if we didn't know where we would end up in society. How we treat people who are considered least important is the mark of how just our society is, and is a matter of personal interest to all of us: we will (hopefully) get old, we may become ill or injured, we may struggle to be good parents.

Social care is regularly divided up into different sorts of situations for example child protection, older people with mental health problems, younger adults with a learning disability. In reality, adults, children, people with different needs, from different backgrounds, at different ages all interact. These services need to interact with each other to make sense of the experience of people they work with and to combat exclusion together. This also helps to avoid situations falling into more or less deserving, for example where children are seen as in need but their parent's drinking is seen as a problem. Managers can lead services to support each other's work and stand up for people together.

Through joining together, we can also strive to avoid people falling through the gaps. This can happen particularly to the invisible or unrecognised, for example refugees, who become ignored and pushed right out of any relationship with social structure. People are cut off by barriers that don't take account of diversity, such as transport that doesn't enable disabled people to access it and information that doesn't take account of different communication needs.

### Working under scrutiny

Social care takes place in public view. There is legitimate public interest in what we do because we are working for society.

Scrutiny is affected by some significant biases: lack of knowledge, hindsight and sensationalism. All of these impact on public opinion and how able we are to do our job. We need to engage with public opinion for the sake of clients as well as our own integrity. It is right that social care should be judged but it needs to be judged as objectively as possible.

We have a role in helping the public to understand what we do. This is partly a matter of accountability – social services make up a large proportion of local government spending. It is also a matter of social justice. If we think that people who need social care should be able to get it, we need to make the case for it being useful.

It is often the extreme cases, and more often than not the disasters that are noticed. People are more interested in sensational information and in unusual events than in the mundane. The media responds to and feeds this appetite. When disasters do happen, then it is news, and it leads to blame so that people can be reassured that they won't have such a shock in the future. The murder of Baby P, where social workers were at fault but as part of a system, is a case in point. Simplistic and sensational reports mean that the public have a distorted picture and can lead to social workers reacting in unhelpful ways such as taking many more children into care.

We can try to redress the balance. Firstly, we can share positive examples of our work. It will not help people who need support to believe

that the service they get is likely to be useless or damaging. We can share stories of helpfulness personally and through our organisations. We can find allies – clients, other agencies, pressure groups – who have evidence of our value and help them to emphasise this. We do, however, need to be honest about failings in order for there to be trust in what we say.

Secondly, we can avoid falling into the hindsight trap ourselves. It is often possible to see after the event what should have been done differently. However, we need to use analysis properly to be clear about how good the decisions and action at the time was. We can then talk sensibly about what could have been done differently in that case, and what we can learn to improve in the future.

Thirdly, we need to be aware that there is an impact on practitioners from this scrutiny. Munro found defensiveness, feelings of being scapegoated, anger and frustration, and low morale. We need to provide practical and emotional support to staff in this environment so that staff can do the same for their misunderstood clients.

When things go wrong we should always start by listening and accepting the reality of what we are told for the person who experienced it. We should then say we are sorry that they were hurt. Then we can start to talk about what can be done to improve things.



#### Reflective question

How do I build trust for social care?

### Acting as a change champion

Change in social care organisations is now 'status quo'. It is both rapid and accelerating in pace. Factors that drive organisational change are many but they fall into two broad categories:

1. Changes to the environment in which organisations operate; and
2. Changes to do with the members of the organisation.

Under the heading of the environment falls drivers as large as the philosophy and value base of the current government (in this case Small bureaucracy and services delivered by the private sector), the world wide recession and the impact that has had on available government resources and local council budgets. Membership of the organisation can come down to the leadership style and mandate of the Director in your own organisation.

- Change in goals of the organisation;
- Change in technology;
- Change in membership of the organisation;
- Change in demand for the organisational outputs.

Change can occur along a continuum with EVOLUTION at one end and REVOLUTION at the other. Evolution is slow, gradual, imperceptible and comfortable. Revolution is sudden, traumatic and painful, it may have no constructive goals with the result that things are no better or even worse than before.

Evolution	Planned Change	Revolution
←—————→		
<b>Benefits</b>		
• Slow	Agreed	Swift
• Comfortable	Accepted	Sweeping
• Unnoticed	Supported	Recognised
• Organic	Clear	Provoked
• Responsive	Defined	Radical
<b>Challenges</b>		
• Unclear	Rigid	Chaotic
• Inertia	Strategic rather than human led	Idealistic
• Maintains status Quo	Locked in power struggles	Destructive
• Follows trends	Follows process	Traumatic
• Resistant to innovation	Resistant to innovation	Ephemeral

### Conditions for successful organisational change

- Those affected by the change are involved in the planning;
- Accurate and complete information is provided;
- People are given a chance to air their objections and feel heard;
- Group norms and habits are taken into account;
- Only essential changes are made;
- Adequate motivation (eg: rewards, opportunities to develop) is provided;
- People know the goal of and reasons for change.

To be effective in supporting positive change within an organisation, the manager must be able to think systemically and:

- Take in and communicate information reliably and validly;
- Demonstrate flexibility and creativity;
- Integrate and commit to organisational goals;
- Create a climate of support that is free from threat (threat stimulates self protection rather than concern for the total system).

### Making change stick

- Freezing;
- Unfreezing;
- Refreezing (Lewin's three step change theory).<sup>33</sup>

### Resistance to change

Munro in her report on child protection in 2011, speaks of a system that is curiously resistant to change despite many intelligent and well thought through reviews. She notes that the cumulative effect is one of very regulated and prescribed working environments.

<sup>33</sup> "How Social Change can Happen." <http://newcity.ca/Pages/moorechange.html>. Lippitt, R., Watson, J. and Westley, B. The Dynamics of Planned Change. New York:Harcourt, Brace and World, 1958.



She goes on to note that *“this has been particularly apparent in social work, where the over- bureaucratisation is reducing the time workers spend with children and families, building strong relationships, so that they can better understand and help them. Reforms have been implemented through top-down direction and regulation, which has contributed to problems and led to an over-standardised response to the varied needs of children. Managerial attention has been excessively focused on the process rather than the practice of work. In social work, targets and performance indicators have become drivers of practice to a degree that was never intended by those who introduced them. In turn, this has created an image of the inspection process that perplexes those Ofsted inspectors who seek to take a wider and more qualitative assessment of practice. This top-down approach has also limited the system’s ability to hear feedback from children, families or frontline workers about problems in practice.*

*The system’s poor ability to learn from feedback is also evidenced in the findings of Serious Case Reviews (SCRs) which have, over the past two decades, repeated the same messages. Even in those SCRs which concluded that deficiencies in knowledge and skills were at the heart of practice errors, recommendations have tended to focus on increasing compliance with a growing number of procedures.”*<sup>34</sup>

As managers mediating effectively between the organisation and the individual it is useful to think about reasons for resistance to change. Too often staff experience change as unpleasant and undermining. Part of the role of the manager is to lead their staff through the change. Taking a curious stance about what could be causing resistance to change can be helpful in re-framing difficult feelings aroused by change.

Work by Lippitt et al suggests that there are several reasons for resistance to change including:

- The purpose of the change not being made clear;
- Person affected by the change not being involved;
- The appeal for change is based on personal reasons;
- The habit patterns of the work group are ignored;
- Poor communication regarding the change;
- Fear of failure;
- The people involved are under excessive work pressure maintaining the status quo;
- The cost is too high or the reward is inadequate;
- Anxiety over job security;
- People may see vested interests behind the change;
- Lack of respect or trust in the initiator;
- Satisfaction with the status quo.

Other organisational pitfalls identified by Beckhard in the Beckhard/Harris model of organisational change include:

- A continued discrepancy between top management statements of value and styles and their actual management behaviour;
- A big program of activities without any solid base goals;
- Too short a time framework;
- Over-dependance on outside help and/or internal staff specialists;
- Trying to fit a major change into an old structure;
- Searching for ‘cookbook’ solutions.

<sup>34</sup> Pg 128 The Munro Review of Child Protection: Final Report – A child-centred system

## Using influence well

One of the most useful strategies a middle manager can adapt is that of influencing. Influence can be defined as a process in which you use your energy with other people to get them to change in some way, to start or stop doing something, to behave or think differently, or to perform according to certain standards.

Effective and successful influencing requires a balance and blend of PUSH and PULL styles. By staying away from extremes such as pushing all the time (power struggles with people 'buckling under' giving in or leaving) or pulling all the time (lose of energy from drawing other s out, disclosing and sharing but not much decision making or action) you will find a way to be part of constructive organisational progress that is meaningful.

When a manager is utilising the skills of influencing they are seeking a number of possible outcomes including:

- **Internalisation or commitment** = The other person becomes committed and 'owns' the course of action or decision;
- **Compliance** = the other person 'goes along' with the conclusion;
- **Identification** = The other person takes action or agrees on account of their respect or sympathy for you;
- **Exchange or Negotiation** = The other person agrees or acts on account of a 'deal' they have struck with you;
- **Engagement or Collaboration** = To jointly discover the 'best' solution.

Any one of these outcomes could be right depending on the situation. The person seeking to influence needs to decide two things:

1. What outcomes am I trying to achieve?
2. What Influencing Style will support me gaining this outcome?

There are five different styles of influencing behaviour. Each style can be effective if it is used in the right situation. The more conscious the manager is of the skill of influencing, the more effective they will become at selecting the right approach for the right situation.

The first two are Persuading and Asserting. These style are PUSH styles. Some managers believe that Pushing other is undesirable or bad. However there are a number of circumstances where a PUSH style is justified and will gain positive results (the anti smoking campaign is a good example of a successful push campaign which is changing behaviour).

**Persuading:** Individuals who use this style skilfully make suggestions and proposals which get the attention of others. They support their own ideas, and use their energy logically to persuade other people to accept their proposal, or suggestion, based on the facts of the situation. When using this style a person usually participates actively in discussions and arguments about ideas, plans and proposals.

Persuading consist of two key behaviours, proposing and reasoning:

Proposing is putting forward ideas, suggestions and recommendations and asking questions that present a position.

3. Reasoning is giving facts in support of ones own position and disagreeing with another's idea or casting doubt on the position of others.

**Asserting:** Individuals who use asserting styles effectively are good communicators. Such persons are seen as consistent, predictable and fair by their staff and co-workers.

Asserting consists of using energy to get others to accept your personal needs or wishes in a given situation by:

- Stating exactly what you want, require, or expect from another person;
- Providing positive and/or negative feedback about how the other person has behaved until now;

“Individuals who use asserting styles effectively are good communicators. Such persons are seen as consistent, predictable and fair by their staff and co-workers”.



- Offering incentives and/or applying pressures to get the other person to change their behaviour.

To use this style effectively, a person must be able to offer rewards (incentives) or invoke sanctions (pressure).

Asserting consists of three key behaviours:

1. **Stating expectations** = Communicating demands, expectations, needs, requirements or standards.
2. **Evaluating** = Judging others negatively or positively based on standards or evidence.
3. **Applying incentives and pressure** = offering incentives to motivate or get agreement or applying pressure to gain agreement or to change.

Bridging and attracting are the next two influencing styles and they are PULL styles. Some people react negatively to the PULL styles, categorising them as weak with limited to no power. Effective managers are able to use bridging to involve other

people and gain commitment and most leaders are able to use attracting to create a sense of vision.

**Bridging:** Individuals who use this style get other people involved in discussion and activities and listen to understand other points of view and gain trust. This style requires the person to be patient and other minded, able to see the situation from another's point of view.

Bridging is rarely used by itself but to support other influencing styles, especially persuading and asserting. When you have used bridging well you know whether asserting or persuading will work best in a given situation, because you will have seen the situation from the other person's point of view. Moreover, you will know which arguments to use or what incentives or pressure to apply.

Bridging can also influence others to change. When people feel they don't have to defend or justify their feelings, or position, they will often stop and look at their point of view more objectively.



# Practice improvement planning

People who perceive that training is useful, learn and transfer more.

– (Research in Practice, Training Transfer)

**Goal: Identify goal to transfer learning into practice**

## Reminder of training transfer principles

As with the Strengthening Self and Strengthening Staff workshops, the aim is for there to be a direct line from your learning; to changes in your practice; to improved experiences and outcomes for children, adults and families.

This is more likely to happen if you:

- Reflect on how the learning from this workshop relates to your learning needs;
- Identify the main learning that you want to use in your practice;
- Identify what your practice will look like when you are using this learning (your goal);
- Identify the actions you will take in order to change your practice;
- Identify when and how you will know that these actions have happened.

The actions that you identify should be SMARTER:

- Specific;
- Measurable;
- Achievable;
- Realistic;
- Time-bound;
- Ethical;
- Reviewed.

It is helpful to identify the likely barriers and the enablers for you doing your action now. This will support you to avoid the main pitfalls and to get the help of others in carrying out your action.

Try and enlist the support your manager and your peers through sharing your goal and the actions you will be taking.

Your goal should be something that will help you in your role and that you are motivated to do. Look for intrinsic and extrinsic motivation:

- Intrinsic – makes you feel good;
- Extrinsic – others recognise your efforts.

Try not to add to your workload. Think about:

- Things you can stop doing;
- Things you can start doing;
- Things you can do differently.



### Reflective question

How do you want your day-to-day work to be different?



### [Exercise 5: Practice Improvement Plan](#)

# Tools

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## Tool 1: What is good work?

Diagnosing 'good working practice' in your organisation. Tick either 'YES' 'NO' or 'NOT SURE' after each statement according to which most applies to you and your service.

Characteristics of a 'good' working environment	YES	NO	Not Sure
Job security.			
Are your team clear of what is expected of them at work? For example, have you set them clear targets and objectives through job specifications and performance appraisals?			
Do your team know how the work that they do fits into the overall aims of the organisation.			
Do your team all have up to date employment contracts?			
Challenge and task variety.			
Do your team have enough opportunities to develop their skills?			
Do your team have enough opportunities to learn new skills?			
Do you encourage your team to solve their own problems rather than give them solutions?			
Is work that our team does varied?			
Autonomy, control and task discretion.			
Can your team decide when to take a break?			
Do you trust your team to get on with their own work in the way they chose?			
Do you involve the team in decision making?			
Do you always consult your team about change at work?			
Do you make sure you give every team member the right level of responsibility?			
Balance between reward and effort.			
Do you feel that employees are paid adequately for the work that they do?			
Do you thank your team for a good job done?			

Characteristics of a 'good' working environment	YES	NO	Not Sure
Do you give more positive than negative feedback?			
Do you let your superiors know of the good work that your team members are doing?			
Skills available to cope with pressure.			
Do your team have the appropriate technical skills for the job they do?			
Do you encourage skill development and learning?			
Does your company provide stress management or relaxation training?			
Do you highlight to your team where resources for personal skill development are (such as occupational health, employee assistance program).			
Fair treatment.			
Is the working time of your team members flexible?			
Is work delegated equally in your team?			
Do you treat all team members of the team with equal importance?			
Are there sufficient policies in place to deal with bullying, harassment, violence and discrimination?			
Do you feel that all processes and policies in the organisation are equally fair to all employees?			
Strong workplace relationships.			
Can your team members rely on their colleagues to help them out if they have a problem?			
Do your team members come to you if they are upset or annoyed?			
Are relationships strong and positive in your team?			
Do you have regular one to one discussions in your team?			
Do you encourage informal communication within the team?			
Do you know what motivates each of your team members?			
Are you available to talk when needed?			

Adapted from Key Skills for Social work managers by Heywood and Masters, 2002



## Tool 2: Mapping the environment

To understand how to work well within the organisation it can help to picture your services as the centre of the universe surrounded by all the key people, groups, other systems, regulations, and frameworks. All of these will impact on how well you are able to deliver services to your clients.

These stakeholders will fall into one of the four categories below:

1. Low interest, low influence – those you need to keep informed.
2. High interest, low influence – those you need to involve and consult with.
3. Low interest, high influence – powerful stakeholders you need to engage.
4. High interest, high influence – partners you need to collaborate with.

**Step One:** Map out your service's stakeholders using the map below.

**Step Two:** To understand the impact other stakeholders in the organisation have on your role, it can be helpful to map out what demands each stakeholder makes on your team and what the typical response is. If the demands and response cycle is unhelpful then you can use the future scenario to think about what might need to change.



Stakeholder	CURRENT		FUTURE	
	Demands made	Typical response	Demands made	Typical response

## Tool 3: Influencing styles questionnaire

Please read each of the following statements carefully and decide the extent to which they describe your behaviour in situations where you need to influence others. Base your answers on typical day-to-day activities which occur in your job.

Please be as frank as possible. The questionnaire will be of little value unless you provide an accurate and objective description of your behaviour. Against each statement, enter in the appropriate box the score which corresponds to your choice from the five possible responses below.

Enter the score:

- 4** If you definitely agree, that is, if the statement accurately describes your actions.
- 3** If you are inclined to agree, that is, if the statement describes your actions with reasonable accuracy.
- 2** If you are undecided, that is, you are genuinely unsure whether or not the statement describes your actions accurately.
- 1** If you are inclined to disagree, that is, if you think the statement probably does not describe your actions accurately.
- 0** If you definitely disagree, that is, if the statement definitely does not describe your actions.

Please answer the questionnaire as quickly as possible and don't hesitate to use the extreme score where appropriate.

Influencing Style Questionnaire		A	B
1.	I often delegate important tasks to others even when there is a risk that I will be personally criticised if they are not done well.		
2.	I put forward lots of ideas and plans.		
3.	I am willing to be persuaded by others.		
4.	I usually put together good logical arguments.		
5.	I encourage people to come up with their own solutions to problems.		
6.	When opposed, I am usually quick to come forward with a counter argument.		
7.	I am usually receptive to the ideas and suggestions of others.		
8.	I often provide detailed plans to show how a task should be done.		
9.	I am quick to admit my own mistakes.		
10.	I often suggest alternatives to the proposals which others have made.		
11.	I show sympathy towards others when they have difficulties.		
12.	I push my ideas vigorously.		
13.	I listen carefully to the ideas of others and try to put them to use.		
<b>TOTAL THIS PAGE:</b>			

<b>Influencing Style Questionnaire</b>		<b>A</b>	<b>B</b>
14.	It is not unusual for me to stick my neck out with ideas and suggestions.		
15.	If others become angry or upset, I try to listen with understanding.		
16.	I express my own ideas very clearly.		
17.	I readily admit my lack of knowledge or expertise in some situations.		
18.	I defend my own ideas energetically.		
19.	I often put as much effort into developing the ideas of others as I do my own.		
20.	I often anticipate objections to my point of view so as to be ready with an answer.		
21.	I often help others to get a hearing.		
22.	I frequently disregard the ideas of others in favour of my own proposals.		
23.	I often listen sympathetically to people who do not share my own views.		
24.	When other people disagree with my ideas I do not give up: instead I try to find another argument to persuade them.		
25.	I am quite open about my hopes, fears and aspirations and my personal difficulties in achieving them.		
26.	I am imaginative in producing evidence to support my own proposals.		
27.	I usually show tolerance and acceptance of other people's feelings.		
28.	I usually talk about my own ideas more than I listen to those of others.		
29.	I usually accept criticism without becoming defensive.		
30.	I present my ideas in a very organised way.		
31.	I often help others to express their views.		
32.	I frequently draw attention to inconsistencies in the ideas of others.		
33.	I go out of my way to show understanding of the needs and wants of others.		
34.	It is not unusual for me to interrupt others while they are talking.		
35.	I don't pretend to be confident when in fact I feel uncertain.		
36.	I often put a lot of energy into arguing about what I do.		
	<b>TOTAL THIS PAGE:</b>		
	<b>TOTAL ALL PAGES:</b>		
	Now calculate your overall scores in boxes A and B by adding together the scores on each page. Turn the page for the interpretation of your scores.		

## Interpretation of scores

The questionnaire gives an indication of the extent to which you use two different styles of influence in your job.

**Box A** gives your overall score for the PULL influence style.

**Box B** gives your overall score for the PUSH influence style.

Your overall score for each style can be interpreted as follows:

- 54 - 72** Definite use of the style.
- 42 - 53** Tendency to use the style.
- 30 - 41** Neither use nor avoidance of the style.
- 18 - 29** Tendency to avoid use of the style.
- 0 - 17** Definite avoidance of the style.

## Influencing styles - push-pull

Research over several years into the behaviour of effective influencers has revealed two basic types of influencing called PUSH and PULL.

### Push style

The Push style is characterised by extensive use of three types of behaviour. The influencer spends 70% or more of their time in these activities:

- Proposing;
- Giving Information;
- Blocking/Shutting Out.

The rationale of the Push Style is that people are influenced by convincing proposals which are well supported. The keys to successful use of the push style are: the quality of the proposals; the information given; the ability to get those proposals heard by shutting others out.

The Push style tends to be most effective under one or more of these conditions:

1. The recipient has little experience or understanding of the issue and recognises the need for help or guidance.
2. There is no vested interest in the status quo and the recipient does not feel threatened by accepting the proposal.
3. The recipient recognises the legitimacy of the influencer's power base (e.g. expert, position, physical).

4. The recipient trusts the influencer's motives.

### Pull style

The Pull style is characterised by concentration upon three different behaviours. The influencer spends 35% or more of their time in these activities:

- Testing Understanding;
- Seeking Information;
- Building.

The rationale of the Pull Style is that people are influenced more readily by uncovering their needs, motives, aspirations and concerns. The keys to effective use of the Pull Style are: the quality of questions used to test understanding and to seek information, and the ability to build upon ideas and proposals.

The Pull style tends to be effective in most situations, but is particularly useful under these conditions:

1. The recipient of the influence attempt has strong opinions and views.
2. The recipient has a vested interest in the status quo and could have difficulty in accepting the influencer's proposals.
3. It is unknown what the recipient will find acceptable.
4. The influencer has no recognised power base, or wishes not to use an established power base.
5. It is important that the influence attempt has a long-lasting effect i.e. the influencer wishes to obtain more than compliance from the recipient.
6. The relationship between the two parties is new or there is a history of mistrust.
7. Previous attempts using a Push Style have failed.

Research evidence suggests that when Push and Pull styles are mixed during an influence attempt the result is a decrease in effectiveness. The two styles appear to cancel each other out. It is therefore important to consciously choose a particular style before attempting to influence another and to stick to that style throughout the meeting.

It is, of course, possible for an influencer to use a different style with the same recipient on another occasion or after an adjournment. Sometimes the two styles can be used together if a pair of influencers, acting as a team, each employ one of the styles.

## Tool 4: The value of social care

Recently the Social Work Task Force defined social work as follows:

- Social work helps adults and children to be safe so they can cope and take control of their lives again;
- Social workers make life better for people in crisis who are struggling to cope, feel alone and cannot sort out their problems unaided.<sup>35</sup>

How will you explain what your organisation does to others?

My organisation...

<sup>35</sup> Social Work Task Force (2009) Building a safe, confident future - The final report of the Social Work Task Force

## Tool 5: How do you rate yourself as an instrument of change?

Here are some of the strengths and difficulties which you might have as an insider working in the organisation on change. Which of them broadly applies to you?

STRENGTHS	Broadly true of you? (Y/N)
You understand the organisation (who has power, how the networks operate, where the barriers are, etc).	
You speak about the organisational purpose and values both now and in the future.	
You understand the local culture and can act in accordance with its rules.	
Your mental and/or material well-being depends on the organisation prospering.	
You are a familiar and non-threatening figure to colleagues.	
You speak the organisation's language (its jargon and in jokes and stories).	
DIFFICULTIES	Broadly true of you? (Y/N)
You are too involved with one part of the organisation to see it as a whole or without bias.	
You do not have special expertise or comfort in the business of organisation innovation.	
Your other duties leave you insufficient time and energies to devote to your change role.	
Your power base is secure enough to protect you from challenge from superiors and others.	
Your past successes and failures may prejudice other people against you.	
Other people's expectations of you in other roles conflict with your efforts to work with them on change.	

*What implications does this analysis have for you in your role in the project? Do you need to build in support from others to help you overcome your less strong areas? Have you been able to identify any particular development needs in you and your colleagues?*

*What are you going to do to help minimise the effects of difficulties, maximise the impact of strengths and enhance the strengths?*

Adapted from *Managing Radical Change* by Steve Kahlmann and Michael Jones, M.H.N.A Publications 1991.

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