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Creating a Case Management Information System that Inspires Social Workers and Delivers for Managers: Fantasy or Realistic Possibility?

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Nik Flavell, Julie Firth, Emma Hopper, Andrew Turnell and Pippa Young

Change the Story

Creating a Case Management Information System that Inspires Social Workers and Delivers for Managers: Fantasy or Realistic Possibility?

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Abstract

IT systems are a source of considerable frustration for children's services systems around the world. This reality stands in often stark contrast to the high hopes that tend to abound when a new IT case management system is commissioned. There is a growing body of literature describing problematic IT design and implementation which identifies ineffective involvement of frontline staff as a key problem. This article describes a user centred, whole agency learning lab process undertaken with the managers and practitioners in North Tyneside to test and refine a case management system configured around the Signs of Safety practice framework. The paper describes the development of the configuration, the one-year action learning process utilised to train, test and improve the usability of the system and the outcomes, which included more than halving practitioner time on the system. Although the paper describes the development of a case management system connected to the Signs of Safety, the purpose is not to promote a particular practice approach but rather to describe a tested participatory IT development process centred on the practitioner's role and experience that could be replicated whatever practice approach is configured within the system.

Key words: Action learning, case management system, children's services, organisational change, participatory design, practice wisdom

IT recording systems have become ubiquitous in children's services over the past 20 years, replacing paper-based systems completely. The literature describing the application of digital systems within child protection services is mostly critical, describing the systems as: expensive relative to benefits, not being fit for purpose, often designed to record too much, consuming too much practitioner time, diluting professional judgement and the relational skills of social work and accelerating a technocratic, compliance driven approach to service delivery (Parton, 2006; Burton and van den Broek, 2009; Munro, 2011; Gillingham 2015; 2016; 2018; Munro and Turnell, 2020).

Designing an effective children's services IT system is a highly complex task, in part because the system is usually designed not just to support service delivery but also wider organisational and administrative tasks. The system is also meant to meet the needs of many users, managers, practitioners, administrative staff and sometimes service users and to be a key mechanism to demonstrate compliance with statutory standards to external audit bodies. As Yvette Stanley National Director of the English national audit commission Ofsted writes. 'an ICS (Integrated Children's Service) has to help social workers to do their jobs, help managers to have good oversight of what is happening so that they can identify issues quickly and, last but not least, make sure that the LA is able to do its mandatory reporting as easily as possible (Stanley, 2019).

When a system is implemented a wide range of people will often be brought together to work on the project. This team will usually involve staff from an external software developer, internal

[1] **Nik Flavell** is Senior Manager for Quality Assurance, North Tyneside Children's Services; **Julie Firth** is Assistant Director Children's Services, North Tyneside Children's Services; **Emma Hopper** is a Licensed Signs of Safety Trainer and Consultant; **Pippa Young** is Director of IT and Practice Alignment, Elia International; **Andrew Turnell** is Founding CEO, Elia International and Professor of Practice, University of Cumbria.

agency IT people, practitioners, managers and will usually be led by internal and external project managers. This participatory effort is important in developing a system that will meet agency needs and is also challenging in many ways. The term 'user centred design' is common parlance but is easier said than operationalised well. The worlds of child protection and software professionals are not easy to bring together particularly within the limited timeframe and budgets of most children's services projects. Within the agency itself while practitioners usually participate in the implementation there is often little structure around how they can best make a contribution and the voices of leaders and internal IT experts tend to dominate. Design tends to get over-organised with reporting and compliance imperatives rather than practice needs and the urge to record everything often seeps in (Gillingham, 2016; 2018).

Children's service agencies often manifest an odd mix of attitude toward the development of an IT system where strong pessimism rubs shoulders with a naïve hope that the new system will somehow magically deliver solutions (Wastell, 2011). It is also hard to develop an effective IT system when the children's services field know a lot about poor systems but is limited in its vision of what a good case management system looks like and how to create one. Information technology is never neutral and for a system to be productive within any agency careful, sustained and detailed attention needs to be given to its design, implementation and use across all levels of the agency.

This paper will describe the participatory processes that were undertaken in North Tyneside to field test and refine a case management system, describe the outcomes the project generated and offer the authors' reflections on key learnings. While the practice approach configured within this system is the Signs of Safety, the co-design and action learning processes described here could be applied to the development of IT solutions utilising other practice frameworks.

Development of the Signs of Safety case management solution

The participatory IT solution work described here arises from a twenty-five-year learning journey developing the Signs of Safety approach to child protection practice and working with organisations to implement the approach. The approach offers a straightforward assessment and planning framework alongside a range of child engagement and safety building tools and methods that are designed to place parents, children and those naturally connected to them at the centre of the assessment, decision-making, safety planning and execution. Introducing and training any practice approach on its own has limited impact since practitioners will be constrained in their use of the model when existing procedures, guidance and particularly the recording system are not in alignment with the approach. Research undertaken with ten English local authorities seeking to implement the Signs of Safety (Munro and Turnell, 2020) found that practitioners were frequently frustrated by case recording software that was poorly aligned with the approach, which:

- Led to duplication of recording because ICS did not capture their Signs of Safety practice (by far the biggest complaint)
- Hindered practice by having a workflow at variance with the approach
- Was difficult for managers to see how well the approach was being used
- The child's voice had to be filed as an appendix, rather than in the recording form itself
- Weakened the message from senior managers that the authority was now committed to using Signs of Safety.

To address these problems, the developers of the Signs of Safety approach have worked with social care software providers to create a software configuration that aligns with the approach. Having developed this original configuration, successive field testing has been undertaken to refine the solution alongside children's services agencies and practitioners. The learning lab process described here details the elements of this action learning process.

Core Principles: Think Systemically and Adopt the Practitioner as Maven

The work and productivity of many staff across all levels of a children's services agency is impacted by the design and functionality of the case management system but undoubtedly the practitioner's is the role most affected.

A case management system is created to scaffold the practice the agency expects, and the practitioner does the bulk of the data entry and likely spends the most amount of time using the system. Though they are the focal point and primary user of the system the practitioner usually has a limited role in the design of the solution and typically experiences themselves as a passive recipient of the end product. Gillingham (2015), identifies this problem as a central reason that IT systems have been problematic in practice and highlights that there is limited guidance for how to engage social workers as active and effective participants in IT system development. Gillingham describes two organisations that sought to directly involve practitioners in their IT development work and offers a series of principles to guide participatory design. However, Gillingham provides no specific guidance about how these practitioner involvement principles can be operationalised and concludes the paper by observing 'participatory design is a daunting task' (2015, p.38).

The learning lab process described in this paper offers specific participatory learning methods that are designed to locate the practitioner as maven or honoured expert about whether the solution is effective. The primary goal of the learning lab being to create a system that makes sense to practitioners that they want to use and feel ownership of. Privileging the practitioner's perspective and expertise cannot happen without leadership continually endorsing and enacting this trust in field staff. This commitment by North Tyneside senior leadership is captured in the following observation of Senior Manager Nik Flavell:

> *Amidst the multiplicity of meetings that are part of case management system replacement, there was an inflection point that changed the trajectory of the journey for North Tyneside.*
>
> *Thinking systemically, we changed the role of our practitioners from passive customers to active commissioners and in doing so they became as invested in the system's successful implementation and operation as they are in the success of the families with whom they work. In short, the system changed hands and became owned by our practitioners.*

Creating a case management system, practitioners want to use, cannot be achieved by setting the needs of the practitioner in opposition to the needs of managers and the insight that the needs of managers and practitioners are inter-dependent was vital in energising the North Tyneside participatory design process. Operationalising this insight involved sustained participation of all levels of the agency in all of the co-design and action learning tasks.

Undertaken over 12 months, the learning lab process involved four components:

- Deep dive forms and workflow analysis and redesign
- Practice/IT-aligned training
- Whole system learning cases
- Regular Review

Learning Lab Process

The North Tyneside learning lab focused on the child protection case pathway (the other case practice pathways in the English system are Early Help, Children in Need and Looked After Children). A working group was established made up of experienced and first year social work practitioners and Team Managers working in that pathway, Independent Reviewing Officers, business support officers, Service Managers, Heads of Service and the Assistant Director along with external practice approach consultants Emma Hopper and Pippa Young and Learning Lab facilitators. In the planning phase it was agreed that the Learning Lab would focus on four activities:

1. Review and re-design of the seven key child protection pathway forms
2. Time and Motion study
3. Outputs
4. Whole system learning case

With the following three-stage 12-month timeline:

1. Month one: Preparation and planning
2. Months two to five: Deep dive form analysis and redesign, testing and installation of new forms in the system by the agency's internal IT team and first round of the time and motion study with old forms
3. Months six to twelve: Practice/IT aligned training and testing of new forms for all practitioners and managers, floor walking, regular reviews, whole system learning case, output design work and second round of the time and motion study with new forms. Final specification prepared for the IT supplier.

Deep dive analysis of forms and case practice workflow

The key work of stage two involved the deep dive analysis and redesign of the seven key child protection pathway forms: Child and Family Assessment, Strategy Discussion, Section 47 enquiry, Social Work Report to Child Protection Conference, Initial Child Protection Conference Minutes and Recommendations, Core Group Review, Child Protection Conference Review, to be able to go live with them in stage three.

The focus of this streamlining work involved identifying the purpose of each form, then seeking to answer the following agreed questions:

- What aspects of the forms are harder/easier to work through?
- What are the existing barriers for practitioners when applying the practice approach within these existing forms?
- What aspects of the existing forms support the practice approach?
- What are the duplications in the existing forms?

The working group met bi-weekly, using an 'iterative gap analysis' process successively identifying critical changes, refining and redesigning the forms so that all participants felt they were as streamlined as possible, addressed their purpose, met mandated requirements and supported the practice approach.

The strong focus on form purpose helped the workgroup to resist the tendency to record everything and to carefully interrogate how the forms needed to be redesigned to align with the practice the agency wanted. Part of the work of the consultants in this stage involved presenting examples of the practice approach used well both from within the agency and elsewhere to provide a 'what good looks like' benchmark for the redesign effort.

As the form analysis work unfolded the key organising question for the workgroup became 'is this helping us do the work we want?' and the iterative process gave the group greater confidence to examine duplication between the various activities. For example, the working group identified that there were significant duplications in how they were investigating and documenting significant harm and how these inquiries were being managed in the core group stage of the workflow which led to adjusting both the practice and the forms. The group came to see that this level of analysis of the forms and practice required the active participation of practitioners, managers, reviewing officers and senior leadership to achieve the changes they were making.

The iterative process for adjusting the forms involved having participants work individually to write down their ideas and language changes of what a redesigned form could look like to better reflect the agreed purpose before sharing with the whole group. The consultants worked between sessions to adjust the existing forms based on these ideas and would make them available to all prior to the next meeting of the work group. Participants would then be asked to again work individually evaluating and writing down how they saw the existing and proposed forms supported and hindered each case work activity with particular focus on what took the most time and where the participant saw duplication.

Allowing each participant to form their own ideas, test their thinking by presenting it to their peers, listen to each of their colleague's ideas before general conversation began, helped the team avoid the traps of group think, unfocused discussion and the strongest voices dominating. This approach to making team meetings effective follows the ideas of Daniel Kahneman Nobel Prize winner for his work on decision making who suggests, *'start meetings with participants writing down their ideas about the issue at hand before anyone speaks. That way, the halo effect – whereby the concerns raised first and most assertively dominate the discussion – can be mitigated, and a range of views considered'* (Shariatmadari, 2015).

The workgroup further examined their work through a process where all participants worked together to using the redesigned forms with current agency cases. The form analysis and re-design took three months for the workgroup to be ready to pass them to the internal IT team to install in the system in preparation for testing in daily use. The practitioners in the workgroup were eager to have the forms go live in their system with one commenting, 'I can't wait to do a section 47 (investigation) with these forms'.

Practice/IT-aligned training: aiming for ownership

Training practitioners in using and navigating a case management system is only one element of enabling them to utilise a system to their benefit. Too often practitioner's use of the case management system becomes focused on data entry. For practitioners to engage with a case management system beyond the level of data entry they need to understand how the system connects directly with the practice approach and the work they are doing with the family and children. The practice and IT aligned training is designed to achieve this by walking through the key components of the practice approach and the relevant forms within the IT solution, using a live case being worked at the front of the room as practitioners record the work directly into a case record.

In this way, practitioners are given a hands-on experience of using the system in a test environment with a real case, experiencing how the elements of the practice framework are recorded and how to evidence the work they are undertaking in a clear accessible way. The training was delivered by a Signs of Safety trainer and a technical expert from the software provider, involving also the

practitioners who participated in the workgroup. This meant trainees had the opportunity to ask questions, of practice and IT experts and their colleagues who designed the forms.

The training was conducted in groups of 15 to 20 participants, each with access to a PC or laptop and with a local system support person on hand. The consultants had worked with the workgroup practitioners and local system support colleagues to prepare the training including the set-up of in system training material.

One practitioner described the practice-IT aligned training of the forms as 'transformational and gave us confidence as well as the learning [to use the forms] and then to put it into practice not just about what but also how we do it'.

The training was the launch event for the agency going live with the new forms and also for the third stage of in-depth testing and refining both the forms and the application of the practice approach aligning each with the other through using:

- Floor walking sessions
- Whole system learning cases
- Time and motion second round
- Regular reviews to distil the learning

Floor-walking and whole system learning cases

As the new forms went live two further components of the learning lab process were introduced, floor walking and learning cases.

The monthly floor walking involved the practice consultant providing in office support for users. This support was provided for all users whether in management, administration or practice, however the bulk of the support focused on how to use the IT solution to evidence current practice. Floor walking became a two-way learning process for both users and consultant as they think through solutions to issues together in real-time. The floor walking support offered by the consultant occurred in one-to-one contact, team discussions and small group work and was always conducted in conjunction with agency practice leaders to equip them to continue to offer ongoing support.

The learning case activity in particular brought greater depth for the agency in understanding the IT system's intersection with practice. The learning case process brought together the working group, the practitioners and team manager responsible for the chosen case, working group members and as many agency practitioners and colleagues as were able to join to work together with the consultant to apply the practice approach and utilise the case management system with a complex case. Since the referral screening and assessment process requires considerable initial work to meet system demands, during the first month, sessions were held twice a week. This frequency was necessary for practitioners, leaders and consultants to determine together the detail of how the practice approach assessment and safety planning methods would be applied and recorded within the English workflow as the work and decision making was happening. As the casework progressed, the sessions reduced to bi-weekly and then monthly.

Participants and the consultants observed that involving a whole group focused on one case over time looking closely at the use of each part of the seven forms as the case unfolded, slowed down thinking to a point that enabled greater depth of thinking about the purpose of the practice and how the forms supported or hindered the work with the family.

Regular review
To continue to support and strengthen the use of the case management system, regular bi-weekly working group review sessions continued. During this period, the working group undertook a second round of analysing the forms continuing to seek to answer to the questions:

- What parts of the system are harder/easier to work through?
- What are the remaining system barriers for practitioners in applying the practice approach?
- What parts of the system now give opportunities for practice?
- What forms/work remain duplicated?
- Do the forms serve the purpose?
- Do the forms reflect the process of the safety planning practice?

The regular review process throughout stage three allowed further changes to be identified. Requested changes that could be made to the system were discussed and agreed with the consultants, who were responsible to assure fidelity of the practice approach, and the IT provider. Not all requests were accepted leading to robust conversations to arrive at an agreed way forward leading to greater learning for all participants. As changes were agreed the internal IT team updated the forms within the live system.

A change log of all IT system adjustments was kept throughout. The North Tyneside learning lab was part of a wider English children's services Signs of Safety IT system user group. At the end of the 12 months project the change log specification was finalised and shared with other implementing local authorities for review, feedback and questions. This contributed a critical extra strand to the action learning process and ensured other local authorities that would be impacted by the changes North Tyneside were making, understood the rationale for the changes and had the opportunity to ask questions and provide feedback.

The work became more interesting for all participants in stage three as the new forms were being applied in practice. As we are about to discuss, the streamlining work led to significantly reduced screen time for practitioners which created further energy and motivation for all participants. The excitement generated a desire to work on more and more elements of the system which was resisted to ensure the child protection pathway work was completed as thoroughly as possible.

Outcomes

Time tracking
Probably the single biggest frustration that agencies and their staff express about case management systems is the time practitioners spend on data entry. White (2009), found that the demands of the IT system regularly absorbed 60-80% of practitioner's time, significantly reducing the time they could spend with families. Both agency leadership and front line staff most wanted the redesign work to stream line the child protection tasks by being clear about their purpose, eliminating duplication and reducing practitioner time on the computer. To determine whether and to what extent this goal was realised a before and after time tracking process was undertaken.

Two three month periods of time tracking were agreed, the first period when the old forms were still in use and then a three month period once the new forms and processes were introduced. The following table details the changes relative to each work type.

Work type	Average time before	Average time after	Average time saved	Average % saved	Cases number tracked Before/after
Strategy Discussion	4h4m	2h29m	1h35m	38.9%	19/29
C and F Assessment	7h32m	3h54	3h38m	48.2%	113/73
Sec 47 Enquiry	3h30m	24m	3h6m	88.6%	30/24
Initial CP Conf	4h17m	4h1m	16m	6.2%	16/38
Core Group	5h49m	55m	4h54m	84.2%	19/27

The savings presented here are substantial and their magnitude surprised and were a source of considerable satisfaction for everyone involved. The magnitude of the time savings led to considerable reflection about what had generated these results since they could not be accounted for purely by the reduction in the number of fields within the forms. In some cases, fields which were previously set to pre-populate from earlier in the workflow were changed so they did not pre-populate, and in these instances, practitioners had to arguably record more than they had previously. For the agency, these changes arose from connecting the forms with the workflow and practice approach resulting in a greater connection for practitioners between what they recorded and the work they were doing. Practitioners confirmed this, reporting that the learning lab had a created a bridge between the practice and the recording system, along with a much stronger understanding of what the forms were asking of them, they felt more connection to the part of the workflow they were in and were now drawing on the forms to guide them in their practice rather than simply seeing the system as something they went to after the event.

Outputs

Each form in the IT system produces an output and some of these documents are shared with the family and professionals. At the beginning of the project the workgroup and consultants identified that the outputs were often not user friendly and neither as clear, nor easy to work with as was wanted. With the view of redesigning the content and layout of the outputs, the working group collated feedback from practitioners, professionals and families to determine which of the outputs were:

- Helpful/unhelpful and in what ways
- Easily understood and which were confusing

What felt like a lot of time at the beginning of the project turned out to be too little to successfully complete the output redesign. By stage three it was clear trying to tackle all of the outputs would be beyond the scope of the project and it was decided to focus solely on the child and family assessment output. A subgroup of the working group created a revised output document that everyone was very pleased with. Unfortunately, the redesigned output was not able to be configured within the system because the agency's server could not accommodate the size of the document that had been created. Although disappointing, this is was a salutary lesson for everyone that IT redesign work needs always to stay connected to the functionality of the software and the carrying capacity of the hardware.

Reflections and Learnings

Following the completion of the learning lab, feedback was sought in a range of ways from field staff, broader leadership and the workgroup about the impact of the project. Given practitioners were located as the mavens for the project and the key arbiters of its success we want to reflect here some of the feedback from the social workers working in the child protection pathway.

Professor Harold Thimbleby from Swansea University was aware of the learning lab, at the same time he was writing a book called *Fix IT: how to solve the problems of digital healthcare* (Thimbleby, In Press). Thimbleby interviewed Angela Branston a North Tyneside practitioner about her experience of the project. What follows is taken from the book in which Angela said:

> *I've got to be honest I didn't hit the ground running with social work. I found it so, so difficult. I can vividly remember sitting in front of my computer all day at work, and not knowing what I was supposed to be writing. The forms were just endless, and they all looked the same. It was so overwhelming. It really knocked my confidence, and it actually impacted my mental health. I can remember that period of time just crying, just because I couldn't do it. I felt like such a failure, and my confidence was lower and lower and lower.*
>
> *I thought this new system is going to be great, and I could just look at it and all of the stuff will be there. We'd had all these promises of things, and then here it was, and it wasn't what we thought it was going to be.*
>
> *The thing that was really fantastic was that people listened, and then they went away and changed the system. The forms drove our practice, but in the parts where they didn't, we could talk to them and tell them actually this bit doesn't drive our practice, and if it did this instead, that it would be better. Then, we saw what they'd done with it.*
>
> *Now from being a person who sat and cried and didn't know how to write a plan, I'm advising the manager on what the right thing to do is, and this is the way it's working best. The most exciting part of it is that when we go out and do that with the families, they understand what we're doing.*

One practitioner who was also in the working group summarised the common experience of her colleagues saying that the learning lab shifted my work from: 'doing an assessment and filling in the forms, to using the forms as a platform that supports my practice of assessment'.

Another practitioner, Kirstie Turnbull the social worker responsible for the learning case observed:

> *Before the learning lab, an assessment would be a process that you would start with the family, spend a number of weeks gathering the information from the family and professionals and then write it up in one go, analysing as you wrote the evidence, and finalise with an outcome.*
>
> *After the learning lab, the practitioner experience becomes one where the form is a guide, a prompt to the practice. Assess, write up, think more curiously about what is unknown, create more questions, engage the family and continue the assessment process through to planning and review. It is a cycle of continuous work rather than a one-off assessment.*

As part of this feedback process, Senior Manager Nik Flavell wrote his reflections about the 12-month's work describing the change process and the benefits in this way:

At the same time, we were changing our case management system, we were also implementing a new practice approach, Signs of Safety. The authority was running two largescale projects concurrently but separately, with different meetings, different plans, different timelines and different trajectories. At some point, the Senior Management Team realised that the two were fundamentally co-dependent. This was our 'Eureka' moment. As soon as we began to see the case management system systemically, everything changed.

Like many large-scale ICT projects, multiple stakeholders had projected multiple claims on the new system – that it must be more accurate, cheaper to maintain, easier to train, statutorily compliant, etc. For the first time the service was able to clearly and simply articulate what it needed – a system that helped not hindered practitioners in their use of the practice approach. This, quietly but radically, reframed the whole implementation project and future operation of the system.

Most significantly, the systemic view of the case management system we have adopted makes practitioners system experts because they are practice experts. In North Tyneside, the system is now practitioner-led. Managers, systems and performance colleagues all play a part, but it is our practitioners who make the decisions. This is, we believe, foundational. We are convinced that it is only our practitioners who use the system daily who have the knowledge and experience to make informed decisions.

This also had profound implications for how we train. It meant that ICT led case management system training was, in fact, practice training. So now our training on how to find and open an electronic form is undertaken with training on how to work with children and families. This involves, ICT, Practice Leads and Practice Managers jointly delivering training together. It looks, feels and sounds different, but it means any changes we make to the system are systemically implemented.

Working group members were asked to write down and then share what they saw as the most important differences that had come out of the learning lab for themselves, the agency, for families and for Ofsted? It was striking for the practice consultants that the feedback focused mainly on practice with few comments about the changes in the case management system. Initially this seemed a little worrying but later we came to the view that perhaps this further evidenced the success of the project. When any technology is effective in whatever context, it becomes much less visible so for example, a good carpenter has a detailed knowledge of their tools and good musicians have an intimate understanding of their instruments, but this is rarely a matter for discussion. Here are some of the comments from the feedback session with the working group:

Biggest differences for yourself, the agency and families

The streamlining of the child protection case discussion meant that rather than six hours work and meeting we do it in an hour, hour and half or less.

Strategy discussions (have become) very focused across the worries, what's working and what's needed and bottom lines and transferring to partners and made that process much more concise

We've been better at capturing the voice of the child, that was strongly advocated throughout (the learning lab) and we're able to show really good examples (in the system) now

Safety planning is now well evidenced, getting clear on who's going to do what.

Being practitioner led – that gave us heaps of motivation! We now know much better what we're doing and we're wanting to do it.

We're better at creating shared understanding with the family, part of that is using the voice of the child, we don't have to keep things a secret anymore and ultimately reduces the trauma - feels better . . .

We've had this big focus on language (in the forms) on writing for the family, use of their language and that supported their ownership and (its) been a massive learning journey for us. It's been years in writing the formal way - this has been turning point.

A dad we worked with on smacking his children said: 'no one's ever put it like this before'. The children tell me 'no one's smacking us anymore'. The family came up with their safety plan rules and put it in place and the children knew who they could tell . . . that was revolutionary.

Ofsted Feedback

Ofsted is the English Government's Office for Standards in Education, Children's Services and Skills. Inspections of local authorities are conducted bi-annually without announcement. The inspection in March 2020 judged North Tyneside's children's services to be outstanding (Ofsted 2020). At section 48, the report states:

The way in which the local authority's preferred method of social work has been rolled out across early help and children's social care, and embraced by partners, has had a transformational impact. It provides a common language with which to talk about and explore issues and concerns, needs and risks, dangers and protective factors in a way that is easy to understand for parents, professionals and partners. Particularly impressive is the way in which the local authority's electronic case recording system has been adapted to ensure that it helps rather than hinders this approach. Equally impressive is the way in which senior leaders are leading by example, using the same simple methodology in reports and policy documents.

Conclusion

This paper and the learning lab it describes, is premised on the assumptions that though social work and IT are often not comfortable bedfellows, the field has to take greater responsibility for the technology it uses and though it is complex and detailed work it is possible that IT systems can be transformed into 'tools of conviviality' (Illich, 1973). There is a considerable amount spoken and written about 'participatory design' in both the IT field generally and in relation to its application to children's services. Equally, the proposal that a case management system has to help social workers to do their jobs is unquestionably the case but in reality, very hard to operationalise.

The learning lab process described here was not an unqualified success, for example the hoped-for redesign of the output documents was not achieved. Participants also learned and that this work is in no way a set and forget operation. Sustained and careful attention needs to be given to maintain the connection the agency and its practitioners have forged between practice and their use of the case management system. Perhaps the most important contribution of this project was to demonstrate the mentality and specific learning methods that can operationalise the aspiration of participatory design.

The children's services field needs to take greater responsibility for the case management systems its uses and we hope this paper provides grounded hope and a clearer picture of what is required to create an information system that satisfies inspectors, provides managers what they need and most importantly is a system that practitioners want to use.

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