This edition brings to our readership a selection of papers based upon presentations made at the SSRG conference in Manchester earlier this year. As in previous years, the conference edition is only able to offer a fraction of the material that comprised another successful annual event bringing together an impressive range of research, practice and policy innovation in UK social care. In this edition we start with the paper by Rhidian Hughes and Alan Rosenbach from the Care Quality Commission who address the fast moving changes and complexities that now confront those who use, deliver and regulate health and social care. The paper outlines an increasingly pressured service context in which achieving desired outcomes will place ever more emphasis upon effective joint commissioning. Their paper clearly demonstrates the need for good evaluative studies of service activity and quality in order to plan strategically and this links nicely to the paper by Rachel Taylor, Liz Cairncross and Sara Livadeas who describe their research into home care admissions in Oxfordshire. This careful and encouraging study into care pathways and prevention demonstrates the need for rigorous local planning.

The Oxfordshire study takes the reader naturally to Hannah Roscoe's careful discussion of evaluation methodologies that can measure the impact of joined up adult mental health and children's services. This paper draws upon guidance from SCIE around what constitutes good enough evidence to inform policy. The paper offers a refreshing critique of the orthodoxies surrounding what counts as 'gold standard' evidence and we are urged to consider the more nuanced approach of a 'realist evaluation' that can map and learn from complex interventions rather than simply pronounce narrowly on success or failure.

At the core of good social care lies assessment. This deceptively easy and familiar claim is forensically examined by Emma Miller from the Glasgow School of Social Work whose review of new developments in assessment practice brings the reader up to date with current challenges. The multiple (and not always complementary) functions of assessment are considered in relation to a shift from service-led to a person-centred outcomes focused assessment.

Our final paper takes the reader in a different direction and towards the momentous landmark that will be the birth of the College of Social Work. The paper by Dorit Braun (SCIE) and Bridget Robb (BASW) charts the recent debates and current thinking that will help inform the establishment of the College in 2011. Their insights make for fascinating and timely reading into the proposed functions and purposes of this wholly unique development in the history of UK social work. While the College will initially be England facing, ongoing discussions in the other countries of the UK will likely broaden its membership and remit. In that sense the paper, as the authors advise, is not yet the final word on this unfolding and momentous event for the profession.

As in all issues there are reviews of new books and we are indebted to Josie Collier (social worker, Peterborough), Catherine Rees (social worker, Addenbrookes Hospital) and Gillian MacIntyre (lecturer, Strathclyde University) for their detailed and constructive treatments of three new texts, respectively - *Learning from Child Deaths and Serious Abuse* (Vincent, S.); *The Primal Wound: Understanding the Adopted Child* (Newton Verrier, N.); *Social Work Skills with Adults* (Mantell, A.).

Finally, it is with sincere thanks and much appreciation that we say farewell to some of the editorial team who have been at the centre of the journal's activities and development in recent years. Greg Mantle, from Anglia Ruskin University, who has edited RPP with Andy Pithouse since 2006, has decided to step down as joint editor and we shall miss his considerable energy and breadth of academic interest and expertise. Sue Harrington, also from Anglia Ruskin, will also withdraw as production editor. Sue has played a central role in co-ordinating and administering the journal - laying out the papers in the journal's house style, proof reading – liaising with reviewers, authors, editors and printers, making sure that the journal is published on schedule. The Editorial Board would like to thank both of them for their time, enthusiasm and commitment. Peter Scourfield (also from Anglia Ruskin) who has overseen a very successful revival of the book review section of the journal will remain as Book Review Editor but will step down when a successor can be found.

We have been fortunate indeed to find a new editorial home for the journal that should prove every bit as successful as the Anglia Ruskin arrangement. The new host for RPP is University of Derby and the new editorial board comprises Guy Daly, (currently at Coventry University but from January 2011 at the University of Derby), prior to Coventry he was Head of the School of Health and Social Sciences at the University of Gloucestershire. Guy is joined by John Woolham, of Coventry University. Prior to becoming a Research Fellow at Coventry University last year, John worked for Northamptonshire County Council for almost two decades as a Senior Research Officer. Andy Pithouse, Director of Research at the School of Social Sciences Cardiff University continues as joint editor. We enter a new and turbulent period in UK social care and it is ever more important we have a vibrant and independent voice that can speak for the many constituencies that together seek to care for some of our most vulnerable citizens. We need your support to do that – send your papers, discussion pieces and comments to the editorial board – we can't promise to publish everything we receive but we will do our best to publish that which speaks persuasively to a progressive citizen-focused inclusive social care.

Andy Pithouse

Making a difference to people's lives: policy principles and the role of health and social care regulation

Alan Rosenbach and Rhidian Hughes

Care Quality Commission

Abstract

Society is experiencing significant demographic changes and this, coupled with the consequences of the 2008-2010 economic recession, has put enormous pressures on health and social care services. The first two parts of the paper are background and contextual and provide an overview of these changes and pressures, and the priorities of the new coalition government. The regulatory framework for health and social care is also discussed. The substantive part of the paper examines the following key policy issues and challenges: putting people at the centre of their care; joining-up care; promoting independent living; providing safe and effective care; safeguarding people in vulnerable circumstances; reducing inequalities; and securing fair access to care. The paper reviews evidence, largely drawn from regulatory work, which demonstrates that more needs to be done to improve outcomes for people using services. In conclusion, services need to be commissioned and provided in ways that maximise their value for money and put people first.

Keywords: Social care, health care, regulation, policy

Introduction

Health and social care is all about people. Health and social care can enrich people's lives and excellent care is about providing what matters most to people, as much as it is about providing a service. All needs are individual, distinctive and personal. There is not a 'one size fits all'.

Health and social care services touch everyone's lives at some point – a health check by a nurse, a visit to a hospital, a family member who needs domiciliary care or someone moving into a care home. The quality of services has a profound impact on people using services, as well as those around them.

There are a number of pressing social, demographic and economic challenges facing the health and social care systems in England. How government and policy makers respond to these challenges shapes people's experiences and their outcomes.

Regulation has a key role to play in ensuring better care and services that put people first. The focus of this paper reflects these issues.

First – by way of background and context, the paper begins by outlining some of the key issues facing health and social care, including growing demands and expectations for services; managing the consequences of the economic downturn; and responding to the priorities of the new coalition government.

Second – the paper goes on to describe the regulatory backdrop of health and social care in England. This section of the paper briefly outlines the remit, role and vision of the Care Quality Commission (CQC) in England.

Third – from putting people at the centre of decisions about their own care to the effective management of resources – the substantive section of the paper provides an overview of key issues and challenges

shaping high quality care. It draws on recent evidence, including reviews and studies by CQC, to highlight some of the challenges facing health and social care services. These case examples are by no means an attempt at systematic representation, nor are they mutually exclusive, but they do afford the opportunity for policy analysis across the broad spectrum of health and social care provision.

The paper strives to maintain a people oriented focus. It seeks to identify where people's experiences of services and outcomes can be improved. To these ends, and drawing on work from CQC, we highlight people's views and experiences of services where appropriate. These views and experiences have been obtained via CQC's ongoing programme of user, public and stakeholder involvement (CQC, 2009a). CQC's methods of involvement are not set up as research interviews or subject to the rigours of research and detailed analyses as might be found in academic work. Notwithstanding, the views captured from these involvement activities help to illustrate the issues discussed from the perspective of people who use services, providers and commissioners.

For the purposes of this paper we use the term 'people who use services' in its broadest sense. This therefore includes carers, families, friends and the public as well as patients in health services and people who use social care services.

Background and context

There are two key issues that have been shaping health and social care in recent years. First, managing growing demand for services, especially in the light of rising expectations for services to be personalised. Second, and more recently, managing the effects of the economic downturn and reducing the deficit. By way of policy context, it is also important to recognise the emerging ideology and priorities of the conservative-liberal coalition which came to power in May 2010.

Demographic pressures: growing demands and rising expectations

Society is experiencing significant demographic changes, largely arising from an ageing population, increasing life expectancy of many disabled people and a growing number of people with long-term conditions. Over 15 million people in England currently live with conditions such as diabetes, chronic lung disease, heart disease, cancer and dementia. A significant proportion of these are older people (Department of Health, 2009a).

Demands on services are growing. By 2026, we expect to see 1.7 million more adults who need social care and support. In the next 20 years, the number of people over 65 will increase by just under half, those over 85 in England will double, and the number over 100 will quadruple. These positive trends in people living longer also mean that they have greater needs and will reflect a growing number of people with chronic and complex needs. Alongside this people will, rightly, expect more choice and control over services (HM Government, 2010a).

These trends will lever greater pressures on the use and uptake of services and will ultimately put pressures on the public purse. Recent estimates put the cost of dementia, for example, at £27,647 per year per person living with the condition. These figures are set to increase as the numbers with dementia rise and are expected to double in the next 30 years (Alzheimer's Research Trust, 2010). Overall, the King's Fund (2009) estimates that the demographic pressures facing the UK require additional NHS spending of between £1 billion and £1.4 billion each year.

Consequences of the economic downturn

The NHS has experienced considerable growth in recent times. Growth in funding has averaged nearly 7% in England up to 2010/11 (King's Fund, 2009). Following the recession, however, significant budget reductions are set. During the previous administration the Chief Executive of the NHS for England, David Nicholson, gave early warning and advised the sector to plan efficiency savings of between £15 billion and £20 billion over 3 years (Office of the NHS Chief Executive for England, 2009). It soon became apparent that a much more significant amount of savings across services would be required. The then Government's operating framework confirmed the need for savings, adding that the health budget would contribute some £2.3 billion to Government's announced £5 billion efficiency savings required for 2010/11 (Department of Health, 2009b).

During 2009, the leadership across health and social care published a number of reports outlining the key pressures across the sector (Department of Health 2009c; NHS Confederation, 2009; Royal College of Psychiatrists *et al*., 2009). The recession was described by one group as "the greatest ever leadership challenge for the NHS" (NHS Confederation, 2009).

Money aside, it is important not to forget the social consequences of the economic downturn and the effect stringent economic times can have on people:

- Work for the Cabinet Office highlights how certain social groups, including people with lower levels of education, those on lower incomes, young people and people living in deprived areas, tend to be the worst affected (Barnes *et al*., 2009). People's feelings of insecurity are greater in recession, older people and those close to retirement are more likely to lose their jobs and the effects of job loss on longer-term depression were found to be statistically significant.

- Carers UK (2009) highlighted the struggle that many of the UK's 3 million carers face, combining paid employment with their caring responsibilities. Eighty six per cent of carers report to Carers UK that their financial position is worse than 12 months ago.

- The downturn in the housing market has made it difficult to buy or sell property. For people who fund their own social care and are not eligible for public funding, the downturn in the housing market is making it difficult to sell property which would normally be used to meet care costs. Councils are required to offer deferred payment schemes, essentially interest-free loans, which are recoverable on the sale of the property. However, concerns have been raised that councils are restricting access to these schemes owing to increasing demands (Samuel, 2009).

Priorities for the coalition

Following the 2010 general election and the formation of the Conservative-Liberal coalition, a new programme for government was announced (HM Government, 2010b). Government's aim is to seek to distribute power to "build the free, fair and responsible society we want to see" (HM Government, 2010b). Building on these values a new programme of work is underway to reform health and social care, all brought together in the White Paper, *Equity and Excellence* (Department of Health, 2010b). The reforms set out huge changes for health, as well as its partner agencies including social care.

In health:

- Considerable power will be devolved to general practitioners (GPs) to enable them to commission care on

behalf of their local community. Particular emphasis is placed on meeting the needs of disadvantaged groups.

- People can be registered with a GP of their choice, without restriction of where they live.
- Similarly, people will be able to choose any healthcare provider that meets NHS standards, within NHS prices, including independent and voluntary run nursing providers.
- Community care is a cheaper and more cost effective means of managing the care needs of older people. People will be encouraged to live at home for longer and the use of solutions such as home adaptations and domiciliary care will be encouraged.

Across social care and welfare:

- Reform of the social care system is urgently required. The current system is unsustainable in the face of changing demographics and growing demand. It is over a decade since the Royal Commission on Long Term Care (1999) reviewed this issue and reported to government.
- An independent Commission on Long Term Care will be established "tasked with delivering a sustainable settlement, which is a fair partnership between the state and the individual".
- Personal budgets provide an allocation of funding sufficient to meet people's assessed social care needs. Individuals can choose to take their personal budget as a direct payment or, whilst directing their own support, leave councils to commission services. Alternatively, people may choose a combination of approaches. Government's commitment is to "extend the greater roll-out of personal budgets to give people and their carers more control and purchasing power"

- Dignity and respect will be embedded into the provision of services, including support for older people, people with long-term conditions and people with social care needs (HM Government, 2010b).

These reforms and commitments are surrounded heavily by caveats that deficit reductions take absolute precedence. This was made clear in the revisions to the operating framework for the NHS which called for a "relentless focus on achieving the £15 billion efficiency savings" (Department of Health, 2010a). The 2010 'emergency' budget announced further reductions in public spending – an additional £17 billion to what had previously been projected by 2014-15.

Health spending is, however, ring fenced. Government has committed to increase spending on health in real terms each year (Department of Health, 2010b). However, such measures require cuts in other areas of welfare and tax rises (King's Fund, 2009), measures we saw implemented in the June budget and comprehensive spending review.

Modern regulation

CQC was established to bring together the regulation of health (including mental health) and social care. Following the Health and Social Care Act 2008, CQC came into operation on 1 April 2009, combining the functions of the Healthcare Commission, Commission for Social Care Inspection (CSCI) and the Mental Health Act Commission. The remit of CQC is to inspect all health and adult social care services. This includes services provided by the NHS, local councils, private companies and voluntary organisations. The interests of people whose rights are restricted (via detention) under the Mental Health Act are also monitored.

CQC has a number of powers and duties, including:

- Registering providers of health care and social care to ensure they meet the essential standards.
- Monitoring how providers comply with standards.
- Using enforcement powers, such as fines and public warnings if services drop below the essential standards. Where necessary, taking more stringent enforcement actions.
- Acting to protect the rights of people who are restricted under the Mental Health Act.
- Promoting improvement in services by conducting regular reviews of how well those who arrange and provide services are performing.
- Carrying out special reviews and studies of particular types of services and pathways of care, and undertaking investigations on areas where we have concerns about quality.
- Supporting public accountability by assessing performance of how well people are being served by their local public services.
- Seeking the views of people who use services and involving them in our work.
- Telling people about the quality of their local care service.

The government programme recently strengthened CQC's role as a quality inspectorate (HM Government, 2010b). The White Paper also confirmed CQC's continued role as the quality regulator for health and adult social care. Under the proposals, the current risk-based regulatory regime will remain largely unchanged. However, the White Paper does set out a number of important changes for CQC:

- HealthWatch England will be established as a new independent consumer champion within CQC;
- Providers will have a joint license overseen by both Monitor and CQC;

- The NHS Board will take over assessment of commissioning (Department of Health, 2010b).

CQC does not regulate most social care services for children as these are regulated by the Office for Standards in Education, Children's Services and Skills (www.ofsted.gov.uk). CQC's remit is for England only. The following are regulators for health and social care in Wales, Scotland and Northern Ireland:

- The Healthcare Inspectorate Wales (www.hiw.org.uk*) and* Commission for Social Services Inspection in Wales (www.csiw.wales.gov.uk)*;*
- NHS Quality Improvement Scotland (www.nhshealthquality.org) and Care Commission (www.carecommission.com); and
- In Northern Ireland, the Regulation and Quality Improvement Authority (www.rqia.org.uk).

Regulation remains under the jurisdiction of separate health and social care agencies in Wales and Scotland. In Northern Ireland an integrated approach is adopted, which mirrors the integrated approach to health and social care provision (Heenan & Birrell, 2006).

Regulatory principles and vision

Regulation and inspection costs, both in time and money for the organisations involved and to the public purse. Over 3 million inspections occur each year in the UK across public, private and voluntary organisations. The challenge is for the regulator to prove their worth and deliver better outcomes for people. In 2004, a review of regulation was initiated and the subsequent Hampton (2005) report set out an ambitious programme to reduce the burdens created by regulatory systems and a number of key principles for regulators to follow:

- Regulators, and the regulatory system as a whole, should use comprehensive risk assessment to concentrate resources on the areas that need them most;
- Regulators should be accountable for the efficiency and effectiveness of their activities, while remaining independent in the decisions they take;
- All regulations should be written so that they are easily understood, easily implemented, and easily enforced, and all interested parties should be consulted when they are being drafted;
- No inspection should take place without a reason;
- Businesses should not have to give unnecessary information, nor give the same piece of information twice;
- The few businesses that persistently break regulations should be identified quickly, and face proportionate and meaningful sanctions;
- Regulators should provide authoritative, accessible advice easily and cheaply;
- When new policies are being developed, explicit consideration should be given to how they can be enforced using existing systems and data to minimise the administrative burden imposed;
- Regulators should be of the right size and scope, and no new regulator should be created where an existing one can do the work;
- Regulators should recognise that a key element of their activity will be to allow, or even encourage, economic progress and only to intervene when there is a clear case for protection (Hampton, 2005).

CQC's principles and vision are grounded in these Hampton (2005) principles of better regulation and recommendations set out in associated reports (National Audit Office, 2008). CQC's (2010a) 5 year corporate priorities aim to drive improvement in the quality of care experienced by people by:

- Making sure care is centred on people's needs and protects their rights;
- Championing joined-up care;
- Helping to eliminate poor quality care;
- Promoting high quality care; and
- Regulating effectively and in partnership.

More information on how these priorities are being delivered is set out in CQC's annual reports and accounts (CQC, 2010b).

Politics, policy and practice: key issues and challenges

I had to ask too many different people for advice. It was too disjointed. (carer for husband with long term condition, CQC consultation event)

Recovering from his coma in hospital, 'Paul' asked for physiotherapy, which he felt he needed after 60 days in bed, but was told: "This is a neurological ward. We don't do physiotherapy on this ward". (person using services, CQC consultation)

How do you exercise your rights when you are being faced by a group of professionals who are talking over your head and about you at the same time? (person using services, CQC consultation)

People who use services, and their carers, raise a number of common concerns about the provision of health and social care services. These issues and concerns have influenced and shaped this section of the paper. They include:

- Putting people at the centre of their care;
- Joining-up care;
- Promoting independent living;

- Providing safe and effective care;
- Safeguarding people in vulnerable circumstances;
- Reducing inequalities; and
- Securing fair access to care.

It is important to recognise that these topics are not mutually exclusive, nor the sole preserve of people who use services, but are also issues shared by providers and commissioners of care:

Trust is an issue, for example, not accepting assessments from each other's organisations. This is not helped by charging; [generally] social care charge for services and health don't. (commissioner of social care services, CQC consultation event)

If we, inside the system, don't understand how the system works, what chance do the public have of navigating through? (provider of health care services, CQC consultation event)

Putting people at the centre of their care

Personalisation means putting people at the centre of the design and delivery of services, acting to respect their rights and choices, and providing care, treatment and support that respects their wishes. In policy terms, the concept of personalisation is coupled with a shift towards early intervention and prevention. Successive governments have sought to embed the principles and practices of consumer voice and power into their health and social care policies, and in public policy more broadly. However, it requires a significant transformation of services to put people first (Social Care Institute for Excellence, 2010). This vision was reflected in a multi-agency concordat (HM Government, 2007), which was recently revised by the coalition into a sector-wide agreement to move personalisation and community-based support forward (HM Government, 2010d). Government's vision for social care is expected to be published

following the report from the Commission on Long Term Care.

The end of life care strategy seeks to involve people in identifying their preferences and emphasises that people should have a choice of where they die; whether that be in hospital, care home, palliative care setting or home (Department of Health, 2008a). Most people express a preference to die at home but, at present, about 60% of people die in hospitals. There are differences according to people's illness, and slightly more deaths due to cancer occur in the home. Deaths at home, having been subject to decline, are now starting to rise. These trends are recognised as a welcome move in the right direction (Department of Health, 2009d).

CQC's (2009b) annual performance assessment of councils found evidence that partnerships were being used to develop and deliver effective end of life strategies. A co-ordinated multi-agency approach with health and social care services has been beneficial in offering a range of support and palliative care to people in their own homes, with increased opportunities for individuals to die at home. Better access to services and support has helped people to make more informed and positive choices about end of life care, as well as helping to retain personal dignity:

People who receive end of life care are supported to live as independently as they choose, and have well timed, well co-ordinated treatment and support through increased services to support them in their own homes, such as the 24/7 Macmillan and district nursing services. (CQC annual performance assessment report, 2009b,)

Dedicated specialist teams and services and trained staff were identified as key strengths in councils performing well in the provision of end of life care. However, there is clearly scope for improvement, with a fifth of

councils still requiring further development and implementation of end of life strategies. The White Paper signalled government's commitment to introduce national choice to support people's preferences about how to have a good death (Department of Health, 2010b).

Joining-up care

People who use health and social care services rarely require just health or social care services. Rather, to meet people's cross-cutting and often complex or long-term needs requires dedicated multi-agency and 'whole system' responses. This can be particularly important for people with learning disabilities, mental health needs and older people with complex conditions such as dementia.

The importance of providing joined up care is reinforced by the need to provide a person-centred approach that maximises outcomes for people. Joined-up care is about those working in health and social care and the relationships that are forged both within individual services as well as between services and across sectors. By working together, improvements can be made to the ways in which people access and experience services as well as overall levels of service satisfaction and quality. Sharing investment and planning between services can also improve their efficiency and effectiveness and, in the longer term, may reduce the demands placed on health and social care services, thereby maximising opportunities to deliver services that offer good value for money (Ham, 2009, 2010).

Inter-agency working and coordination between adults' and children's services are highlighted as key to ensuring that services adopt a 'think family' approach (HM Government, 2010b). A study by one of CQC's predecessor bodies, the CSCI (2009) examined how far council policies, services and practices were providing appropriate support to disabled parents and their

families and children. A survey of 50 councils and in-depth study workshops with disabled parents and their families, providers and commissioners found:

- Disabled parents and their families continue to face difficulties in accessing services which support family life. This includes universal services such as education and health, as well as social care services.
- 66% of councils reported their policies focused separately on adults and children.
- 34% of councils systematically collected data to show, for example, how many disabled parents live in their area, the services used and their needs, so few are planning and commissioning on a basis of knowledge.
- 30% of councils had joint working protocols on supporting disabled parents which means that roles and responsibilities between agencies are not clearly set out.
- Health and social care services and their partners should make extra efforts to ensure that there is not a disjointed approach to family life.

Promoting independent living

When people are supported to live as independently as possible, it not only improves the quality of their daily lives but also minimises permanent admissions to care homes and the need for emergency hospital care. Both represent very high costs to the NHS and social care. Trends from CQC's (2010c) state of care report illustrate positive signs that people are being better supported to live independently:

- Numbers of people receiving council funded non-residential intermediate care to prevent hospital admissions have nearly doubled in the last 5 years;

- Rates of council-funded permanent admissions to residential and nursing care are falling.

However, across England there are considerable variations, up to three-fold, in the use of council-funded nursing and residential care. There is higher use of long-term care in England compared with many other countries in the Organization for Economic Co-operation and Development (2005), and, whilst 8% of areas have reduced repeated emergency admissions, 15% of areas have seen a rise.

If local areas reduced their rates of emergency admissions and the associated occupied bed days, this could have a significant impact overall. Analysis for CQC (2010c) suggests that, if every local area could reduce emergency stays in hospital for people over the age of 75 years to the levels seen in the best performing parts of England, this would result in 8 million fewer days in hospital for people, and a saving of about £2 billion a year for NHS hospitals.

Providing safe and effective care

Discussions of safe and effective care have, traditionally, been the preserve of health care policy and guidance. It was highlighted as one of the 6 dimensions in the *NHS Next Stage Review* of the last administration (Department of Health 2008b). The topic was also given renewed impetus when the House of Commons Health Committee (2009) published its report *Patient Safety*. The provision of safe and effective care has been one of the central elements of the coalition's healthcare reforms. The vision for the NHS includes a refusal to tolerate unsafe and substandard care (Department of Health, 2010b). Safe and effective care reads across, of course, to social care. For example, the management of medicines, recognising and acting upon the signs of deterioration, minimising falls, ensuring good nutrition and hydration and managing

the spread of healthcare-associated infections across organisations.

Healthcare-associated infection can be a major problem for people living in care homes. Because individuals tend to have regular contact with health care services, it can lead to a 'revolving door': people bring infections they have picked up in hospital into the care home and are then readmitted to hospital because the care home feels unable to manage the infection. A study examined the arrangements for infection prevention and control between hospital and care homes (CQC, 2009c). The work mapped how care homes interact with healthcare and other social care providers and surveyed over 1000 care homes in England. The study found that care homes and hospitals were not providing information on infections to each other in a co-ordinated way. In the survey, 17% of care homes had received no information about individuals' infections when discharged from hospital:

> *The local hospital does not always inform us of the presence of infection and we have, in the past, found out by the medication the person is on. This stage of communication could be improved but sometimes data protection and confidentiality are quoted as the reason.* (care home manager)

The lack of information sharing on infections – which effectively brings together the issue of joined-up care with safe and effective care – can mean that people may not receive the best service possible. People's recoveries may be hindered, or even curtailed, and there is risk of infection to others living in the home.

Safeguarding people in vulnerable circumstances

Protecting children and adults from abuse is everyone's responsibility. However, there are a number of high-profile instances

where the performance of care services in safeguarding people in vulnerable circumstances is not consistently high. Compared with the general population, people living in vulnerable circumstances – including older people, individuals living with a dementia, people with learning disabilities, physical disabilities or long-term conditions – tend to experience worse outcomes (CSCI, 2008a).

Safeguarding arrangements have improved across health and social care, but more needs to be done to ensure a stronger, more consistent focus on keeping people safe. A small but significant number of services are particularly weak (CQC, 2010c).

One of the starkest safeguarding cases is the circumstances leading up to the death of Peter Connelly ('Baby P'). A review found that communication was very poor, both between the health professionals and between the NHS, social services and the police. This badly affected the assessment of Peter's needs and the professionals' ability to protect him (CQC, 2009d). Since then, CQC has closely monitored progress which shows improvements, but further work is still required (CQC, 2010d).

CQC also conducted a national review of arrangements for safeguarding children (CQC 2009e). The review found that most trusts have the right arrangements in place. Ninety-five per cent of trusts said that they had protocols for sharing information on children and their families, both within their own organisation and with other key agencies. However, there are still some concerns:

- 36% of acute trusts did not have a policy for joint working between maternity services and social services; and
- 81% of mental health trusts had joint protocols in place between their services and children's services.

Reducing inequalities

There are still wide inequalities in England. A recent report from government found:

- 5.3 million people in the UK suffer from multiple disadvantage;
- Families with children with some or all of the following characteristics; lone parents, those living in social housing or rented accommodation, those living in large families, those who have a young mother, those who have a black mother, and those who live in urban and the most deprived areas, are most at risk of persistent multiple disadvantage;
- Income inequality in the UK is now at its highest level since comparable statistics began in 1961;
- People living in the poorest neighbourhoods in England will, on average, die 7 years earlier than people living in the richest neighbourhoods;
- Health inequalities, as proxied by life expectancy at birth, are higher now than they were in the 1970s;
- Disabled people are more likely to live in poverty, to be workless and to have lower skills than non-disabled people – among disabled people, 32% report difficulties in accessing goods and services, and 22% do not have frequent choice and control over their lives (HM Government, 2010c).

A CQC (2009f) study contributed to existing efforts to reduce inequalities in people's health. It focused on the prescription of statins (drugs that lower cholesterol) and stop smoking services as part of wider prevention programmes to reduce inequalities in cardiovascular disease, the largest contributor to health inequalities. The study found that the financial incentives offered by the quality and outcomes framework have greatly improved health outcomes for people using services and reduced inequalities in

secondary prevention of cardiovascular disease. However, the study also surfaced a number of concerns, including an inverse care process in place - whereby people who are most in need of services are least likely to obtain access and receive them. Notably, people living in deprived areas were less likely to be prescribed nicotine replacement therapy by their GPs, be referred to NHS stop smoking services or to quit smoking with NHS services.

Tackling inequalities is not the sole responsibility of healthcare organisations, but rather a joint challenge for health and social care:

> *The focus of the local area agreement is on tackling the underlying deprivation and inequalities in the borough, including the need to improve health inequalities, and there is good progress on some targets. Partnership working with health has led to significant investment in preventive health services in targeted areas.* (CQC annual performance assessment report, 2009b)

Of those councils that were delivering improved health and emotional well-being for people using social care in 2009, 91% were performing well or excellently. The 29% of councils that were assessed as excellent were reducing local health inequalities and providing a wider range of advice services. These councils use a variety of approaches to promote healthier lifestyles: information prescriptions, DVDs for people with learning disabilities, community magazines and health checks (CQC, 2009b).

Securing fair access to care

Across the country, people receive different levels of care because of the ways in which services are organised locally (a 'postcode lottery'). In social care, the Fair Access to Care Services (FACS) framework was introduced in 2003 to address inconsistencies across England about who receives publicly-funded social care. The aim was to provide a fairer and more transparent system for the allocation of services. FACS sets out 4 levels of need: low, moderate, substantial and critical. Councils decide at which level they will fund care. People whose needs fall below these levels receive no publicly-funded care and have to arrange and pay for their own care and support (Department of Health, 2002).

The policy set out in FACS is based on sound principles that have validity. For example, the emphasis on a needs rather than service-led approach, people with similar needs achieving similar outcomes, taking a rights based approach and ensuring carers' needs are taken into account. However, a review by CSCI (2008b) found the majority of evidence critical of FACS, some in principle and considerably more in respect of its implementation. Briefly, these concerns relate to:

- A lack of clarity and transparency in practice, particularly related to the complexity of the framework;
- A lack of fairness in the way criteria are applied;
- The continuing influence of service-led, rather than needs-led approaches;
- Limitations of a risk/needs-based model that has led to inadequate and unduly standardised assessments and neglect of some groups of people using services;
- Insularity and fragmentation, where FACS does not include considerations of other important areas such as health, housing and leisure;
- Marginalisation of the prevention and inclusion agendas;
- Inadequate diversion and signposting; and
- Tensions between FACS and personalisation (CSCI, 2008b).

Excellent performance for access to social care is characterised by good support and information for people who fall outside the eligibility criteria, with good signposting to other services. This is particularly important for councils that only fund care for people with substantial and critical needs. However, concerns remain when, in 72% of councils, people's needs have to be substantial or critical before they can get support from social services.

Since CSCI's (2008b) review, the Department of Health (2010c) has consulted on and issued new guidance. It is important to note that the Department's new guidance is framed within the context of improving the current system while longer-term options for the reform of the care and support system as a whole are explored. Government has established an independent Commission on Long Term Care (HM Government 2010b). The Law Commission (2009) is also reviewing the law in this area with a view to proposing a single statute for adult social care.

Conclusion

The health and social care system has a finite amount of public funding. Resources therefore need to be rationed – however individuals and the general public may feel about this. At one time, the message from the centre was for public services to make better use of available resources. In more recent years, there has been recognition of insufficient resource within the system to support growing health and social care needs. As CSCI (2008b) set out with regards to eligibility criteria for social care, "the size of the 'cake' is limited, whilst the number of people who want a 'slice' is increasing … [i]n the long term, there is no alternative to radical reform … the key issue is not simply the criteria used to assess people's eligibility for publicly funded care and support, but the amount of resources currently allocated – the size of the cake itself".

These concerns prompted the previous administration to examine and set out future proposals for funding social care shortly before the 2010 general election (HM Government, 2010a). The new coalition recognises the need for urgent reform and has established an independent commission. However, in the midst of the aftermath of the longest and deepest recession on record nationally since the Second World War, the economic climate confounds the pressing social and demographic forces further. How these forces will be reconciled represents one of the biggest challenges for the new administration.

There will be challenges. For example, the Audit Commission (2010) recommends that the most effective means for councils to release monies for investment in the future is to reduce the proportion of spend on adult residential care. However, despite some positive trends, councils are still failing to make a shift to spending away from residential care.

Notwithstanding, there are solutions and success stories. The Partnership for Older People Projects (POPP) aimed to develop services to promote health, well-being and independence and to reduce the need for higher intensity or institutional care (Personal Social Services Research Unit, 2010). The evaluation of these projects found that early preventative work could improve both the quality of life for older people as well as yielding improved working relationships between services and financial savings. Most notably a reduction in hospital emergency bed days resulted in considerable savings, to the extent that for every extra £1 spent on the POPP services, there has been approximately a £1.20 additional benefit in savings on emergency bed days. Government has signalled its intention to accelerate efforts to promote joined-up care (HM Government, 2010b; Department of Health, 2010b). For example, hospitals will be responsible for people who have been admitted for 30 days after

discharge – should an individual be readmitted within that time the hospital will not receive any further payment for the additional treatment (Department of Health, 2010a).

Earlier this paper noted that policy issues and challenges are far from mutually exclusive. This was borne out in the evidence presented from the regulator. Taken together the findings suggest that more should be done to improve people's outcomes, whether they are using health, social care or a combination of services. It is more important than ever for services to be commissioned and provided in ways that maximise their value for money and put people's needs first.

Acknowledgements

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Oxfordshire County Council's research into preventing care home admissions and subsequent service redesign

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Abstract

Oxfordshire County Council worked in partnership with the Institute of Public Care on a study of the pathways of older people who had entered a care home in 2008-2009. The aim of the research was to identify the critical characteristics, circumstances and events which led to a care home admission in order to provide appropriate services to prevent or delay such an admission. The project combined a literature review with a quantitative and qualitative approach. An analysis of 115 admissions of people admitted in 2008-9 was carried out to identify common characteristics. This was followed up with interviews of people who had entered a care home, their carers and care managers, to explore more fully the circumstances and experiences prior to entering a home. The study found that certain conditions and experiences were particularly prevalent - these included incontinence, dementia, falls and depression. Most people had been receiving social care support prior to entering the care home as well as informal care. However, despite common features, individual situations were both varied and complex. In response to the research, Oxfordshire County Council is working with the PCT to develop a co-ordinated continence service. In addition, 'Turnaround' is being piloted in Oxfordshire County Council, a holistic, targeted, outcomes-based service which aims to support people to become more independent and reverse a potentially inevitable course towards more costly and intensive care.

Keywords: care home admissions, elderly people, care home avoidance, prevention, promoting independence

Introduction

This paper presents Oxfordshire County Council's (OCC) research into issues surrounding care home admission and subsequent service redesign. The main part of this paper reports on methods and results of the research. A future paper will be written on the service pilots being developed as a result of the research.

Background and literature review

As part of its Promoting Independence and Prevention Programme, Oxfordshire's Social and Community Services (SCS) undertook research which aimed to identify the critical characteristics, circumstances and events which lead to a care home admission. The overall aim was to be better informed about what is needed to prevent or delay such admissions and which services are most beneficial. The research was undertaken by SCS and the Institute of Public Care (IPC) and overseen by a Steering Group which included service user representation, the PCT, operational and strategic staff. The research design and resulting commissioning decisions evolved in a participatory manner through regular Steering Group meetings.

Similar research had been undertaken by Northamptonshire County Council (Woolham *et al.*, 2009) and is currently being completed by Kent County Council. Meetings with both these councils were held during the design phase of the study. Each

council's project involved an analysis of case file data but Oxfordshire's research had the additional aspect of interviews with older people, carers and care managers.

IPC undertook a review of the broad prevention literature as well as honing in on particular key areas as they arose during the course of the research. These specific areas of foci included continence, falls, stroke, and carers of people with dementia. Two of these areas, falls and continence, are discussed briefly here by way of background literature. A fuller review of the literature will be available at www.oxfordshire.gov.uk. This includes research on targeting interventions because early on in the project it became clear that the most useful study outcome would be a more finely grained understanding of how to target those people on a potential route into residential care, with a view to preventing or delaying that admission. Key messages from our review are outlined below.

Current social care policy in England (Department of Health, 2009) emphasises the role of prevention and early intervention and the need for joint working across local government and with health services. Such an approach is also consistent with recent health and housing policy statements (Department of Health, 2008). However, the term "prevention" is not clearly defined and there is no agreement as to what is included in "preventive services". Therefore, for the purposes of this paper preventive services are defined by us as those that:

> *prevent or delay the need for more costly intensive services, or, proactively promote the independence of older people and engagement with the community.*

Even using the above definition, it is not always easy to determine where and how to focus preventative interventions. This is underpinned by recognition that,

particularly in the current economic climate, there are scarce resources that need to be allocated in the most appropriate way.

Research indicates that key explanatory variables for care home admission include, for example, age, sex, ethnicity, deprivation, morbidity, health service use, drugs prescribed, as well as patterns of social care needs and usage (Barton *et al.*, 2006). Lewis (2007) indicates that most studies on factors statistically predictive of institutionalisation have considered age, dementia/cognitive impairment, activities of daily living (ADL) restriction, number of family members, and use of day services. People living alone are at greater risk of institutionalisation and of worsening mental health. However, older people who have never married are much more likely to be in residential care than those who are still living with their partners (Wenger, 2000) and, in particular, older men without partners are more likely to live in residential care, despite lower levels of disability than lone older women (Arber & Ginn, 1995; Tinker, 1997). The importance of these factors was highlighted in our audit of a sample of over 100 files of those admitted in Oxfordshire in 2008-2009.

All of these factors are potentially open to 'upstream', preventive intervention. However, it is still unclear, how, when or where best to invest. Research has been undertaken, particularly in health, to predict health risks with a view to intervening and reducing risk and therefore cost. One approach is predictive modelling which seeks to establish relationships between sets of variables in order to predict future outcomes, for example, Patients at Risk of Readmission (PARR). This model usually incorporates formulae to allow interpretation of historical data and make predictions about the future, map associations and statistical relationships to a specific target. Evidence indicates that predictive models are superior to both threshold models and clinician knowledge in identifying patients at risk of future

admission. It appears that diagnoses and prior utilisation are key predictive variables when combined with demographic data (Curry *et al.*, 2005).

Curry *et al.* (2005) suggest interviewing the first 50 patients (and their providers) flagged by the PARR system to determine the needs of these patients and the factors that contributed to any preventable/ avoidable admission. This information could then be incorporated into efforts to design interventions, whether the services are ultimately "made" or "bought" by the PCT/SHA. A similar approach, taking a sample of recent admissions to residential care, or delayed discharges and looking at the factors that contributed to preventable or avoidable admission could be adapted and developed as part of the Oxfordshire prevention project.

A review of the literature on falls found that a third of people aged over 65 and nearly half of people over 80 fall each year without effective intervention. Falls are the main cause of disability and the leading cause of mortality due to injury in people aged 65 and over in the UK. A hip fracture is the most common serious fall-related injury, resulting in a cost to the NHS of £1.7 billion each year. Mortality after hip fracture is high; over 10% within 30 days of the fracture (National Centre for Health Outcomes Development Clinical and Health Outcomes Knowledge Base, 2010) and around 30% at one year (Scottish Intercollegiate Guidelines Network, 2002)

Our review of literature surrounding incontinence revealed that it affects 25% of the older population, 24% experience urinary incontinence whilst faecal incontinence affects 1-4%. In care homes these figures are considerably higher being 30-60% and 25% for urinary and faecal incontinence respectively. The difference in these figures may be due to underreporting in the community (Edwards & Jones, 2001; Tan, 2003). Furthermore, incontinence may

contribute to premature referral for care home admission, as the older person or their carers reach the point whereby they can no longer manage the situation. Thom (1997, p.367) demonstrated that urinary incontinence was a significant factor in increasing the likelihood of care home admissions in the United States. His work concluded that urinary incontinence 'increases the risk of hospitalisation and substantially increases the risk of admission to a nursing home independent of age, gender and the presence of other disease conditions'.

Evidence shows that many causes of incontinence are amenable to treatment and that continence in older people can be restored in most cases (Shaw *et al*., 2007) Though conservative treatment is frequently possible (Teunissen *et al.*, 2004), management of the problem seems to be the dominant approach to helping people cope with incontinence. Containment (e.g. limiting activities, wearing pads) rather than cure is expensive from a health, financial and personal perspective.

Methods

Our project combined a quantitative and qualitative approach. Ethical approval was obtained through Oxfordshire County Council's Research Governance Group. Social and Community Services research staff carried out an audit of a random sample of 115 care home admissions (2008-9) across the county, approximately a quarter of all admissions over the last year The data for each case was held on two separate electronic files both of which were examined. It should be noted that the information held on file will typically reflect what staff thought relevant to record, for example the severity of an older person's situation may be strongly emphasised in order to ensure that they are considered eligible for admission to a care home. Health data was not obtained due to data protection and consent issues. Therefore, as

is often the case in this type of research, only part of the whole picture was obtained.

This bias was redressed to some extent by the second phase of the study which focused on interviewing an opportunity sample of the older people, their informal carers where available, and care managers. In order to exclude contacting people who lacked the capacity to consent to the research, a preliminary discussion was held with care managers and care home managers. Recruitment of participants was through letters to the care home manager and to the individuals and was time consuming. We sent letters to care home managers asking them to pass on letters to residents and carers. A total of 20 audio-taped interviews were carried out, including 5 interviews with older people on their own, 2 with an older person and their carer, 6 with carers on their own (3 were carers of people with dementia) and 7 interviews with care managers and care staff. The interviews covered the cases of 10 older people. The completed interviews were transcribed and an analysis of the transcripts carried out using qualitative data analysis software (NVIVO). The results of this analysis and those from the file audit were contrasted in order to test and inform our developing understanding of the reasons for admission within the authority.

Older people and their carers were asked about circumstances and experiences prior to entering a care home, including: the previous living arrangements of the older person; their health and need for care in the 4 to 5 years leading up to admission; the circumstances around the decision to go into care and whether there were any services or support that they felt could have enabled them to continue living in their own home for longer. This phase of the project also included mapping timelines for the older people who were interviewed to visually demonstrate their pathway into care (please contact authors for an example).

Results

The results are separated into the following sections: demographics, predisposing conditions, continence, dementia, falls, depression, health and social care services, informal carers.

Demographics

The median age at placement was 85.0 years with a range from 65 to 103.

The majority of people going into care were White British (97.5%) and nearly three-quarters (71%) were female. This is similar to the profile of older people in Oxfordshire, particularly those aged 85 and above and identical in terms of gender to an earlier national study based on 1995-1996 data (Bebbington *et al.*, 2001).

Prior to admission, more than 3 out of 5 older people aged 75 and over (63%) had been living alone, whilst 19% lived with a spouse or partner and 19% with another family member. In comparison, less than 50% of people aged 75 and over are estimated to live alone in Oxfordshire, reflecting in part a younger age profile. It is not known whether the higher proportion of older people living alone who are admitted to a care home reflects their higher age profile or indicates a greater likelihood to be admitted to a care home. However, a national study (Bebbington *et al.*, 2001) of care home admissions in 2001 found 70% of people admitted to a care home and 52% of people admitted to a nursing home lived alone.

More than two-thirds (70%) had been living in their own home, with 22% coming from sheltered housing, and 8% from their son or daughter's home. There may be scope to reduce the relatively high proportion of people moving to care homes from sheltered housing with greater provision of extra care housing as an alternative to sheltered housing. Bebbington *et al.* (2001) reported

6% of admissions were people coming from sheltered housing.

Predisposing conditions

The case file audit identified a number of conditions among those being admitted:

|	
Urinary incontinence	45%
Dementia	40%
Bowel incontinence	34%
Depression	25%
Visual impairment	21%
Stroke	19%
Diabetes	17%
COPD	6%
Learning disability	2%

Bebbington *et al.* (2001) found similar rates of dementia (38%) and stroke (21%), but lower levels of incontinence (29%), depression (13%) and visual impairment (10%) in their study of admissions to care homes. Broadly similar distributions of the conditions found by Oxfordshire were reported by Northamptonshire County Council (Woolham *et al.*, 2009).

More than half of those in our audit had multiple health problems at the time of admission: 56% with 3 or more conditions. Common combinations included: dementia and incontinence (19%); dementia and depression (17%); dementia and stroke (10%); and dementia and diabetes (9%). It is possible that there has been under-recording of the full range of health problems experienced by those in the audit. Interview data also revealed that all of the older people in the sample had experienced multiple health problems in the years leading up to their admission. These included: stroke and associated disability, incontinence and urinary tract infections (UTI), dementia, cancer, visual impairment and depression. In several cases, people were living with the consequences of a health condition from many years ago, e.g. a stroke in 1987:

He had the stroke in '95. But that limited his movement on his right side and you know I suppose getting older as well, he struggled getting around a bit more, then he got diagnosed with prostate cancer. ... And he had to have a catheter fitted and he gets quite prone to infection and he had falls and things. Carer 1

When she was admitted to the [care home] she had a chest infection, a UTI, her diabetes was ridiculously unstable. So add that to the dementia, it all blew up. Care Manager 3

Figure 1   Number of placements by age (n=115)
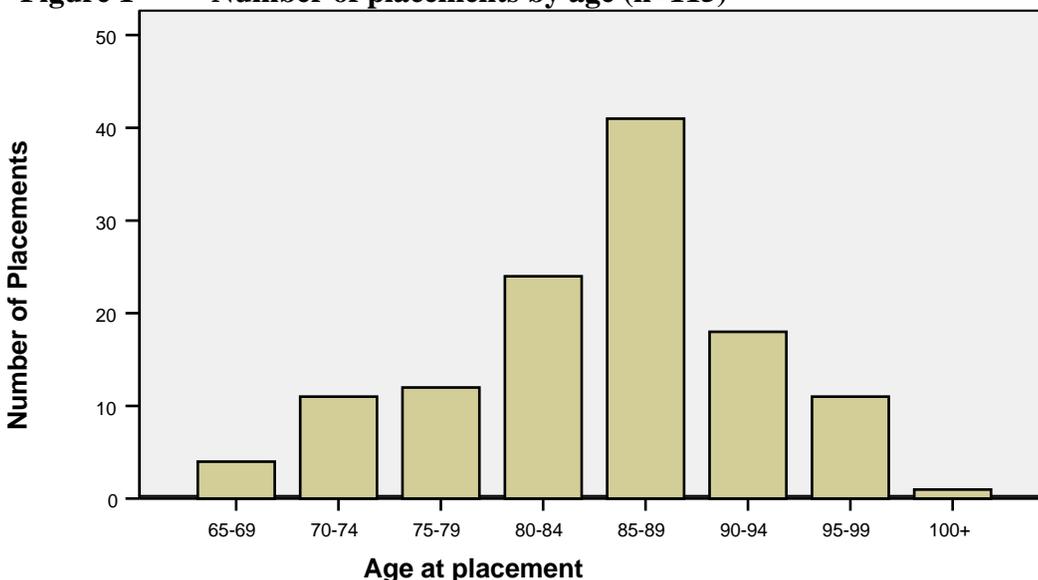
The file audit revealed levels of ill-health that were well above national prevalence rates for incontinence, dementia and stroke. However, prevalence data from directly comparable age groups is rarely available. Twenty per cent of men and 25% of women aged 85 and above in the general population are estimated to have dementia (Alzehimer's Society, 2007) and between 10% and 20% of those aged 65 and over is estimated to be incontinent (prevalence data for higher age groups are not available) (DH, 2000).

Continence

Incontinence was a common characteristic of those admitted to a care home: 51% of the sample in the file audit experienced some kind of incontinence. Seven of the 13 interviews with the older person, carer, or both highlighted continence issues prior to admission. These findings suggest continence is an influential driver towards care. This may be in terms of the condition itself leading to people concluding that they cannot remain in their own homes but also through secondary factors such as the stress that managing incontinence puts on carers, its apparent link to UTI and falls, or people restricting their mobility because of anxiety about their continence. Care managers commented on the significance of incontinence:

There is one particular couple we get that the wife is the primary carer and she consistently says, "oh I can't cope my husband has got to go in permanent care". And the trigger for her is the fact that he has problems with his catheter now that is just one thing that just tips her over. Care Manager 4

It was terrible, it was terrible ... I suppose towards the end I'd got to the stage where I sort of resented it really, because the British Legion gave us an electronic bed for her, so that was nice, but it was just sponge, it was ruined and

that was every morning. Mum was buying her own incontinence pads, because the doctor, we didn't even realise we could get them on prescription right up until probably 6 or 7 months before she came in here, before she went to hospital. Carer 2

UTI was mentioned as a factor linked to falls:

But the paramedics kept coming because she kept having urinary tract infections. One after the other. She used to drink a lot and that's what they thought was causing a lot of this [falls]. Carer 3

UTI's is a biggie. We get lots of people coming in with urine infections .... But of course with a UTI quite often comes confusion, disorientation and falls. Care Manager 1

The relationship between continence and night care services was mentioned by several care managers:

If you think for the sake of going to the toilet once, you go into a home, leave your own home, possibly your husband just for that reason. Until we realise that complex care does not stop at 9 p.m., I can't see how we can ever stop people going into homes unnecessarily. Care Manager 3

Dementia

Dementia was the other condition common to a high proportion of those admitted to a care home. It was also an important factor mentioned in the interviews although, for ethical and practical reasons, people with dementia were not themselves interviewed. Carers mentioned concerns about the behaviour of those they had cared for with dementia in terms of wandering (particularly at night) and aggression. These concerns were echoed by care managers:

Yeah, he did get support but it is very difficult with dementia because the times that you need support are the times that are unpredictable. So someone went in everyday and the carers were great, they would pop in in the morning and if she didn't want to know in the morning they would come back at lunch time and get her up and dressed and all those things. Care Manager 4

This lady's dementia made her unsafe to be at home because, you know, we can't keep sending somebody home who is pulling out their catheter and a high risk to themselves really and I know that from reading back my notes her son and her daughter were very distressed and really struggling to hold the whole thing together. Care Manager 1

Falls

The data indicated that more than one quarter (26%) of people had fallen requiring a hospital admission in the last 12 months; whilst 18% had a recorded fall although this had not resulted in a hospital admission in the last 12 months. Falls were mentioned by several interviewees and there appeared to be a possible link with incontinence. The unpredictability of falls and concerns about frail elderly relatives falling while on their own were a common concern for carers:

I think everything was being done, I think it was just purely dad with his falls and his safety issue and I don't think anything else could have been done. He had the alarm, he had the carers coming in, but I mean ... I turned up one day and he was just laid on the floor. He hadn't been able to press his alarm because he was in such an awkward position. Carer 1

So what would you say was the main reason that you came into a care home? Researcher
*M*ainly because my daughter didn't want to come home from work and find me on

the floor. That's what she's frightened of. Older Person 1

Another carer stated:

She can't stand, she can't walk and I didn't want that. I used to work in London, before mum came in here and I'd very often get a phone call, "I've fallen" or "I've this or that", so really it's just for her own safety. I couldn't keep thinking about her constantly when I was at work all day. Carer 2

Depression

A quarter of those admitted to a care home (in the file audit) had suffered from depression. Mental health problems were mentioned in some of the interviews as factors contributing to the older person's admission to a care home. Bereavement and isolation had in a couple of cases resulted in depression:

He had depression but I think it got, well it did get worse when my step-mum became quite poorly so that put strain on dad because he was caring for her. Carer 2

Isolation and lack of social contact were mentioned in a number of instances as factors which contributed to an older person's deteriorating health and well-being:

... the other big one that I find that people tend to go into long-term care that aren't hospital admissions, a lot of it is isolation, is loneliness, is feeling vulnerable and at risk and especially during the winter months. Care Manager 7

I think she felt quite isolated at night in the flat. I think if there had been a warden there she would have been ... but even now I think they are finding that she doesn't sleep very well, and they make

her a cup of tea in the night and that sort of thing. And I think if somebody could have been on hand at night she may have been different. Carer 3

Social isolation was sometimes due to or compounded by a disability; for example, as a result of visual impairment, one older man stopped going out despite living in a sheltered housing complex where community rooms were available:

He wouldn't go out. He was frightened and so he got very isolated and although they had a community room at [sheltered housing scheme], because of the dark nights and that, he wasn't going to go; you know he didn't go so most days the only person he saw would be the warden, the lady who came to put him to bed, the one who came in the morning. So that was the only people he ever spoke to. Carer 4

Most people depended on their family and formal carers for social contact and only one older person had received a befriending service. One care manager commented on the waiting list for befriending services and a lack of any service in one part of the county.

Mainstream services

Prior to admission to a care home, at least 84% of older people had received social care to help them live at home, including 50% who had received intensive home care, i.e. more than 10 hours of home care or 6 or more visits a week. However, this also means that 50% of those admitted had not been receiving an intensive care package prior to admission. Of the smaller sample who were interviewed all had been receiving a care package prior to admission.

More than three fifths (61%) of people in the file audit were admitted from hospital. Where information was recorded nearly two fifths (39%) had been in hospital for 8 weeks or more prior to admission. The national study by Bebbington *et al.* (2001) found only 10% of those admitted to a care home had been in hospital for 8 weeks or more prior to admission. The higher figure for the file sample in Oxfordshire may be due to higher need thresholds for admission to a care home now in operation, but there may be local factors at play, such as policies and procedures around hospital discharge. Nearly one fifth (18%) of people admitted to a care home were known to have been in hospital in the last 12 months (excluding the time immediately before admission to the care home).

Most of those participating in the interviews were admitted to a care home directly from hospital, often after a protracted stay. In some cases, it appears that admission to hospital was the first time that the older person's health problems (such as dementia) were properly assessed and diagnosed: in other words, hospital provided an opportunity to assess the whole person. Some carers commented on the pressure on beds leading to prematurely early discharges:

The most stressful time that my sister and I had was when she [mother] used to go into the (hospital) and they kept her in. All they wanted to do was get rid of her really quickly. Which I can understand because this is … they couldn't wait to get rid of her and sometimes they sent her home and she was back in the next day. Carer 3

There was praise from some interviewees for the hospital social workers and the support they provided; "they were wonderful". There were positive and negative comments about the support provided by social care staff. Some were praised for their helpfulness but there was frustration at the length of time home care staff could stay for, delays in getting help (carer of person with dementia "it was just like hitting my head against a brick wall to

get any help") and lack of information. A carer commented that because her mother had not wanted personal care, the care staff were cut back even though the mother was suffering from social isolation.

Continuity was also mentioned as an issue by service users and care managers. One older person had 6 different care managers or social workers, partly as a result of admission to 2 different hospitals and alterations in her care package, over a period of 6 months:

> *I had lots of lovely people coming and going but you'd ring them the next time and I'd say "oh can I speak to so and so". "Oh she's not dealing with the case now. It's been handed on to so and so" and so you'd ring so and so.* Carer 5

Informal care

More than three quarters of the audit sample (82%) had received informal care in the shape of help with daily tasks and a smaller percentage (30%) of the total had received informal personal care from family or friends. Of those receiving informal care, the main informal carers prior to admission were sons or daughters (59%), followed by partners (14%) and other family members (14%). More than one third (37%) had family members living in Oxfordshire, although the closeness of informal carers and the frequency of the care provided varied. Of those who received informal care, in 12% of cases the carer had fallen ill or died in the last 12 months. From the small numbers where the breakdown in care was recorded (such as death of a carer), it is not possible to assess the extent to which the loss of a carer was a major factor in admission to a home. However, the low percentage is surprising given the perceived importance of informal carers in supporting people at home and other evidence from the audit (e.g. people living with someone less likely to be admitted to hospital) indicates there may be other factors at play.

Many carers had provided large amounts of informal care while working and bringing up their own families. The interviews highlighted the impact of caring on carers' health, income and family relationships. Carers spoke of the strain and practical difficulties which caring created:

> *On a Sunday morning I got a phone call and I'd only just finished a 10 hour shift at work and I had to spend all day at Banbury hospital with him, so it was causing a bit of strain all round. I think Dad realised that it was not just him, it was affecting me as well.* Carer 1

There were a variety of views about the amount of support provided to carers. Some felt that they had been provided with a lot of help. Others thought that the support offered had not been appropriate to their needs or sufficiently practical:

> *I was offered support as a carer but only through a group which I did not want. I didn't want to sit and listen to everybody else's troubles as I felt my brother and I were only just about coping and we had enough on our plates.* Carer 6

> *I needed good information and a 'kind word' from time to time. I didn't know what the implications were of my mother having dementia and it would have been really helpful to have someone to give advice, talk through options, and prepare me for what might happen in the future in terms of the progression of the disease.* Carer 6

Respite care was something that one carer mentioned as a form of support that would have been useful. However, the difficulties of obtaining respite care were evident:

> *As a service user that would have been something that would have been really helpful to me, to have easy access to respite care.* Carer 7

Research impact on service design

The purpose of this research was to find out how Oxfordshire can better support people in the community and avoid unnecessary admissions to residential care. There was a commitment from the Steering Group that the research should result in piloting at least one new or redesigned service and some funding was made available for this. There was a great deal of discussion on how best to target limited resources and this work is ongoing. However, decisions have been made on the areas to be piloted and below is a short outline of progress on current areas.

Continence

A key finding was the critical aspect of continence and its potential contribution to care home admission. Research shows that it is often under reported, under recognised, that there is a tendency to manage rather than cure and that cures might be very low cost (see Teunissen *et al.*, 2004). Funding was obtained from the Department of Health to scope the redesign of the continence service in Oxfordshire. Further work has been undertaken looking at how to raise awareness of continence issues and break down barriers of stigma and embarrassment. Both these pieces of work are ongoing and will be reported on in another paper.

The 'Turnaround' approach

Extensive discussions and research have been taking place in the design of a predictive model for identifying those most likely to be on a pathway to intensive care and most likely to benefit from services. It is likely that an outcomes-based holistic re-ablement service (called 'Turnaround') will be delivered through the case management model, targeting people in need of some extra support before they reach crisis point. However, there is concern that ostensibly spreading the social care net wider could encourage further dependency so how the service approaches this issue will be crucial.

It is important that we do not miss psychological issues; we have undertaken consultations on the concept and targeting of Turnaround which revealed that social isolation and bereavement can be debilitating. One older person described their loneliness thus: "I scream at the walls sometimes" (see Roberts, 2010). What is clear is that while older people are frequently dealing with huge issues of social isolation, loneliness and bereavement, social services has very little response to this, something Turnaround will attempt to redress.

Carers Training and Support (CTAS)

The research revealed important insights regarding carers. Given that most of the older people contained within the file audit and in the interviews did have a significant informal carer of some kind, it was notable that having a carer *per se* did not prevent an admission. In addition, in only 12% of cases in the file audit had there been a carer death or breakdown in the previous year, again suggesting that carers are not necessarily the sole factor in staying out of a care home. However, it can of course be hypothesised that admissions would have happened earlier and with more frequency but for carer support. In contrast to this aspect of the file analysis, the interviews revealed the physical and psychological toll on carers, particularly those caring for someone with dementia which makes up a large proportion of care home admissions. The interviews also revealed that support and information is patchy and often inadequate. As a response to this finding, Oxfordshire County Council has designed a package of training and support for people caring for people with dementia involving, among other things, condition-specific training and cognitive behavioural therapy. The service will run for 2 years and aims to support 400 carers. It will be important to examine if this programme of training and support adds decisively to the skills and preventive capacity of the carers.

Conclusion

The study highlighted that, although certain conditions and experiences were particularly prevalent, individual situations were both varied and complex. Therefore, delivering services that can help a range of people is challenging. The research revealed that most people going into care homes do have high levels of need and the data from all those interviewed and from the majority of audited files indicated that at the point of entry there seemed little other choice. However, the often lengthy period of deterioration coupled with a service interface with social care and health suggests that there are likely to be opportunities earlier along the pathway to support people to remain independent longer. Finding out what works and when is an ongoing challenge with which the Steering Group continues to grapple.

There were some obvious limitations to this study. As mentioned earlier, the file recording reflects the particular occupational perspectives of health professionals and is inevitably partial in that regard and cannot be expected to reveal the 'whole' story. A second limitation was that the older people who were interviewed were being asked about a time that was stressful and where their health was at a low point (i.e. the run up to entering a care home). We found the interviewees often had trouble remembering what had happened thereby making it less easy for us to identify retrospective opportunities for interventions. A third limitation was that we did not have access to health data which holds vital clues to the individual pathway and what support was available and given.

Further research would be valuable into what is happening in the hospital setting as there is anecdotal evidence that people develop health problems while in hospital for long periods as a result of enforced immobility. Similarly, it is thought that some health professionals may direct people unnecessarily towards residential care due to a lack of knowledge about other forms of support that may be available and more appropriate.

Another area that was not explored is the importance of the 'messages' older people get from carers, professionals and significant others about their potential to remain independent, active and valued. These messages could be vital for their sense of self-esteem and for their ability to remain living at home. Oxfordshire County Council plans to undertake a study into the 'characteristics of independence' which will aim to find out what personal qualities may be significant for remaining independent for longer.

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Challenges in evaluating a 'Think child, think parent, think family' approach to adult mental health and children's services

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Abstract

The rise of evidence-informed policy-making has led to an increased demand for evidence of the effectiveness of interventions in health and social care. Experimental evaluation methodologies, such as randomised controlled trials (RCTs), are often considered to be the 'gold standard' in evaluating impact. However, there is growing recognition that the use of 'pure' experimental designs may not be possible or even desirable (Pawson & Tilley, 1997) for the evaluation of certain types of initiative.

This article discusses the implementation and evaluation of the Social Care Institute for Excellence (SCIE) guide on parental mental health and child welfare in ten sites in the UK, which is currently in its early stages. It suggests that the concept of a 'complex intervention' (MRC, 2008) is helpful in thinking about implementation of the guide in terms of allowing local flexibility, targeting multiple parts of the health and social care system and the range of possible outcomes of the work. In line with the principles of realist evaluation (Pawson & Tilley, 1997), a key role of the evaluation is to help further understand and map the intervention rather than simply to provide a summation of success or failure.

Keywords: Evaluation, realist evaluation, complex intervention, parental mental health, child

Introduction

The Social Care Institute for Excellence (SCIE) is an independent charity funded by the Department of Health and the devolved administrations in Wales and Northern Ireland. SCIE identifies and disseminates the knowledge base for good practice in all aspects of social care throughout the United Kingdom. SCIE also has an interest in promoting high standards in evidence production and use, and contributing to the debate on evidence-informed policy and practice.

In 2009, SCIE published *Think Child, Think Parent, Think Family: A Guide to Mental Health and Child Welfare*. The guide is based on reviews of the relevant evidence (Beresford *et al.*, 2008; Parker *et al.*, 2008; Stanley & Cox, 2009) and a practice enquiry carried out at five sites in England. The guide makes recommendations about how

services can better support families in which there is a parent with a mental health problem.

The guide defines 'parents with mental health problems' as those parents with a primary diagnosis or need, identified as a mental health problem. In the guide, the term 'children' is used to refer to all children 18 years or younger, some of whom will be young carers. SCIE's guide forms one of a suite of guidance and protocols in relation to families with complex needs which were promoted by the then Department for Children, Schools and Families (DCSF) and the Department of Health (DH). The guide is also supported by the Department of Health, Social Services and Personal Safety in Northern Ireland (DHSSPSNI).

SCIE is currently working with five sites in England and the five Health and Social Care

Trusts in Northern Ireland to implement the guide. An evaluation of the work is planned and is currently in the design phase.

A note on terminology

The terms 'Think child, think parent, think family' and the shorthand 'think family' and 'think family approach' are used interchangeably in SCIE's work and in this article. These terms denote a whole-family approach to service delivery, in this case in relation to mental health services. It is important to note that this work is related to, but distinct from, the former cross-governmental 'Think Family' initiative in local authorities.

Evaluation and complex interventions

The question of 'What works?' lies at the heart of evidence-informed practice and policy-making in health and social care, yet is notoriously difficult to answer. Numerous evaluations seek to evidence the impact of particular programmes and interventions and inform whether these should continue or be replicated elsewhere. In many hierarchies of evidence the use of experimental evaluation designs such as randomised control trials is seen as the 'gold standard' for ascertaining impact. However, several authors have argued that, for many interventions, use of experimental evaluation designs may be inappropriate, and may not yield the information required by policy-makers (Pawson & Tilley, 1997; Fisher, 2002; Kazi, 2003).

For example, Pawson and Tilley (1997) argue that many social policy interventions are highly complex and vary depending on the context in which they are implemented. They argue that the local context, which would be regarded as a confounding factor in an experimental design, is, in fact, intrinsic to the manner in which a programme works and in determining its success or failure. They argue that greater attention must be paid in evaluation to describing the contexts in, and mechanisms by, which a particular intervention operates. They term this 'realistic' and, later, 'realist' evaluation.

Taking this approach to evaluation changes the role of the evaluator in comparison to a traditional impact-focused approach. Traditionally, an evaluator may have judged, usually at the end of an intervention, whether or not the intervention has 'worked'. Using the realist evaluation approach, her or his role is to describe 'what works for whom in what circumstances and in what respects, and how?' (Pawson & Tilley, 1997). The evaluator may therefore have a key role in helping to clarify or refine the original policy (Mackenzie *et al.*, 2007).

A related school of thought deals with the implementation and evaluation of complex interventions. Guidance provided by the Medical Research Council (MRC, 2000, 2008) conceptualises complex health interventions and their associated evaluation challenges. It has been used as a framework for evaluating public health interventions by a number of research groups including Mhairi Mackenzie and colleagues at the University of Glasgow (Mackenzie *et al.*, 2007; Mackenzie *et al.*, 2010). In the most recent guidance, complex interventions are defined by the MRC primarily as "interventions with several interacting components" (MRC, 2008, p.6). The guidance also suggests that a complex intervention may be 'complex' according to a number of dimensions, namely:

- *Number of and interactions between components within the experimental and control interventions;*
- *Number and difficulty of behaviours required by those delivering or receiving the intervention;*
- *Number of groups or organisational levels targeted by the intervention;*
- *Number and variability of outcomes;*

- *Degree of flexibility or tailoring of the intervention permitted.* (MRC, 2008, p.7)

In common with proponents of realist evaluation, the MRC guidance therefore emphasises the need to investigate "... how the intervention works, in other words, what are the active ingredients within the intervention and how are they exerting their effect" (p.7).

Earlier guidance on complex interventions (MRC, 2000) emphasised that evaluation activities should be sequential – building up from theoretical and modelling/exploratory work to the development of RCTs and then long-term implementation. Although the emphasis on progressing towards the use of RCT study designs is lessened in the new guidance, the notion of different stages in understanding and evaluating an intervention is a helpful one.

'Think family' approaches to parental mental health and child welfare

SCIE's approach to parental mental health and child welfare has its basis in the Family Model (Falkov, 1998). This model (see Figure 1) suggests that the mental health and wellbeing of the children and adults in a family where a parent has a mental health problem are intimately linked in at least three ways, namely:

- Parental mental health problems can adversely affect the development and, in some cases, the safety of children;
- Growing up with a mentally ill parent can have a negative impact on a person's adjustment in adulthood, including their transition to parenthood;
- Children, particularly those with emotional, behavioural or chronic physical difficulties, can precipitate or exacerbate mental ill health in their parents/carers. (Falkov, 1998, cited in SCIE, 2009)

The adverse impact of parental mental health on child welfare has been of particular concern to policy-makers. By no means all children whose parents have mental health problems will suffer adverse impacts. However, in some cases, parental mental ill health can lead to: adverse impact on children's emotional and cognitive development (Department for Education and Skills & Department of Health, 2004); increased likelihood of the child experiencing mental health problems themselves (Meltzer *et al.*, 2000); and, in a small number of extreme cases, fatal abuse or neglect (Royal College of Psychiatrists, 2002).

Figure 1 The Family Model (Falkov, 1998)
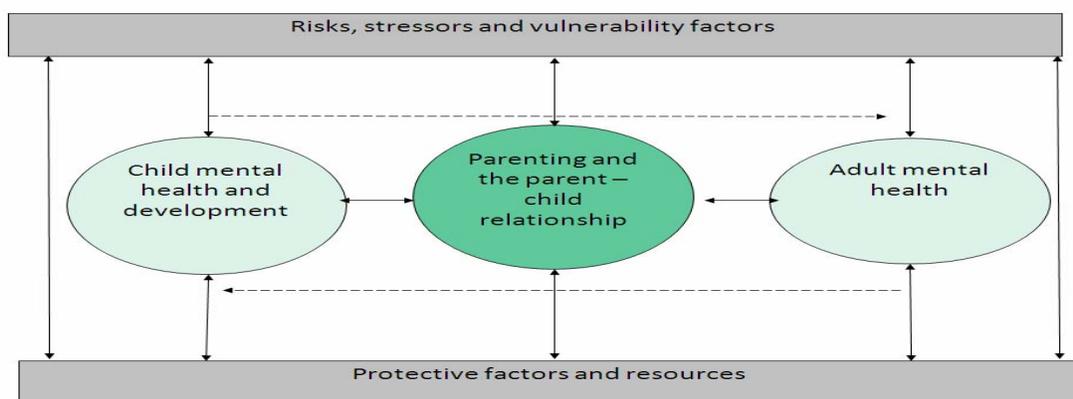
Adapted from Falkov (1998)

The effects of parental mental ill health on children can arise in a number of ways. Smith (2004) posits two main 'routes' by which parental mental ill health can have an impact on children. She distinguishes between 'direct' impacts, which result from exposure to the parent's symptoms, such as children becoming involved in or the targets of a parent's delusional behaviour, and 'indirect' impacts arising from the disruption of parenting caused by mental ill health. Indirect impacts may involve the child being separated from a parent whilst they are in hospital; disruption to the parent's ability to carry out parenting tasks; or the impact of other factors which are linked to the parent's mental health problem such as separation and divorce, or poverty.

Despite the importance of the interaction between the mental health of the parent and the safety and welfare of the child, services tend to be structured around either the adult with the mental health problem or around the needs of children (Stanley & Cox, 2009). Adults' and children's services are frequently separated by the organisation within which they are located (e.g. NHS trust versus local authority), professional background of staff, policy and legislative imperatives, information and recording systems and organisational cultures. Practitioners may also be reluctant to work outside what they see as their professional boundaries (SCIE, 2009). The separation of adult mental health and children's services along multiple dimensions can make it difficult for professionals to take a holistic view of family needs. This can mean that some of the family's existing needs may be overlooked, even though they are already in contact with services. Opportunities for preventing problems from arising in the future may also be missed.

The 'Think child, think parent, think family' guide

Prompted by our findings about the difficulties in supporting families where a parent has a mental health problem, SCIE's guide (SCIE, 2009) makes a number of recommendations about how services can take a 'whole family' perspective. This can involve changing both within- and inter-agency ways of working.

The guide makes specific recommendations in relation to what organisations, managers and practitioners need to do at each stage of a care pathway (screening, assessment, care planning, provision of care and review of care) in order to achieve a more holistic approach. For example, two 'priority recommendations' from the guide are as follows:

> ***Screening -*** *Ensure screening and referral systems and practice routinely and reliably identify and record information about which adults with mental health problems are parents, and which children have parents with mental health problems. This means developing systems and tools in collaboration with parents and young people, to ensure the right questions are asked and the data is recorded for future use.*
>
> ***Assessment -*** *All organisations need to adapt existing assessment and recording processes to take account of the whole family and train staff in their use. This means developing and implementing 'family' threshold criteria for access to services to take into account the individual **and** combined needs of parents, carers and children. Strategies for the management of joint cases should be recorded where the situation is complex or there is a high risk of poor outcomes for children and parents.*
> (SCIE, 2009, p.3)

Implementation and evaluation

Whilst the need for effective inter-agency working between adult mental health and children's services is widely accepted, achieving this in practice remains

challenging. As one of the reviews underpinning the guide states '... in the past much policy and guidance has relied on exhortations to collaborate rather than offering constructive mechanisms for doing so' (Stanley & Cox, 2009, p.5).

SCIE was, therefore, keen to undertake further work, following publication of the guide, looking in greater detail at *how* the recommendations of the guide might be implemented. In September 2009, a project team at SCIE began working with five sites in England and the five Health and Social Care Trusts in Northern Ireland to implement the guide and gather further learning about good practice and solutions to some of the barriers identified. The five English sites are those which participated in the practice enquiry.

In England, the implementation is being led in each site by a multi-agency steering group, typically comprising managers from adult mental health services, children's services and the voluntary sector. The steering groups are supported by a SCIE Practice Development Manager. In Northern Ireland, two full-time project managers are funded by the DHSSPS to lead the project at a regional level, supported by a project board and the SCIE Practice Development Manager for Northern Ireland. Work in each Health and Social Care Trust is led by a Project Locality Team, the chairs of which meet on a regular basis. Each English site has received £10,000 from the Department of Health to assist with some of the costs associated with the project. However, in general, this work will need to be accomplished using existing resources.

At the time of writing, each site is in the process of developing and signing off a 'local implementation plan', outlining how they will implement the recommendations of the guide. Each site will undertake a number of 'workstreams' to address different aspects of the guide. Specific actions vary across sites, but commonly selected activities include:

- Development of a strategy to guide the work;
- Implementation of protocols for joint work between adult mental health and children's services staff;
- Training for staff, including joint training;
- Amendments to screening and assessment processes.

The implementation project will last initially for two years in England and three years in Northern Ireland.

An evaluation of the work is being conducted in parallel with the implementation. The aims of the evaluation are to:

- Capture and disseminate learning about **how** to implement the *Think child, think parent, think family* guide (process evaluation);
- Capture and disseminate learning about **early indications of impact** of implementing the guidance in a local area (impact evaluation).

The findings from the implementation and evaluation work will be used to produce more detailed advice for other sites about how to implement the guide, culminating in a revised version of the guide in early 2012.

'Think child, think parent, think family' as a complex intervention

Designing an evaluation of the 'Think child, think parent, think family' implementation sites has proved challenging, particularly in terms of how to define and measure the impact of implementation. The MRC's concept of a complex intervention (MRC, 2008) has been useful in articulating some of these challenges and in positioning the role of the evaluation. In this section the implementation of the guide is discussed in

terms of three of the MRC 'criteria' for a complex intervention: local flexibility and tailoring, the number of groups targeted, and number and variability of outcomes.

Local flexibility and tailoring

One of the criteria for a complex intervention suggested by the MRC is the 'degree of flexibility or tailoring of the intervention permitted', with a greater degree of flexibility/tailoring leading to greater complexity.

Early indications from SCIE's work with the implementation sites suggested that there would be significant tailoring of the guide to suit local circumstances, for example implementing only parts of the guide or adopting slightly different mechanisms for implementation. Strictly speaking, SCIE has no power to 'permit' (to use the MRC's phraseology) or not permit this tailoring: SCIE has no regulatory powers and all the sites are participating voluntarily in the project, with the aim of improving outcomes for their service users. All local implementation plans are being 'signed off' by SCIE to ensure that they adhere to the overall principles of the guide but a certain amount of variation will still occur. However, the SCIE project team thought that there were a number of benefits in recognising that sites would tailor and interpret the guide, and so did not try to persuade sites to adopt a more uniform approach.

Firstly, the sites differ in terms of the extent to which local ways of working already reflect 'think family' principles. Locally tailored plans can, therefore, take account of the existing context in a particular area. Secondly, allowing local tailoring has enabled the sites to link the implementation to local priorities, for example existing Family Mental Health strategies or action plans arising from Serious Case Reviews. The early experience of the sites suggests that making links with existing local

priorities can be a useful mechanism of ensuring that the work takes place in the absence of a statutory requirement to do so. Thirdly, a key function of the project is to gather knowledge about how to implement the guide, and to harness local skills and expertise in doing so. If SCIE had been too directive in guiding the implementation, this element of the work would have been jeopardised.

What are the implications of this for evaluation?

In some ways, local tailoring of the guide posed a problem in terms of defining the subject of the evaluation. It cannot be said that we are evaluating the impact of the guide because the guide is being 'filtered through' and interpreted by the local areas to a significant extent. In fact, we are evaluating the sites' implementation of the guide which, whilst operating within the overall principles of the guide, may bear a greater or lesser resemblance to the 'letter' of the recommendations.

However, by recognising that tailoring and interpretation is taking place, this variation can be built in to the design of the evaluation. In line with the principles of realist evaluation, explicit recognition of local contextual factors and interpretation allows these to become objects of investigation for the evaluation, rather than inconvenient confounding factors, as they could be in an experimental design (Pawson & Tilley, 1997). An important part of this evaluation will, therefore, be to map and understand local variations in implementation.

Targeting multiple parts of 'the system'

Another of the criteria for a complex intervention set out by the MRC is 'the number of groups or organisational levels targeted by an intervention'. The 'Think child, think parent, think family' guide meets this in two ways. First, the guide

explicitly makes recommendations focusing on different levels of an organisation – organisational (strategic), managerial and practitioner/clinician. Second, and as has posed a greater challenge for implementation and evaluation, the guide is applicable to a number of different services within the health and social care system. This, in turn, means that the guide is applicable to a number of different groups, both of staff and service users. This second aspect of complexity is discussed in more detail below.

The guide makes recommendations for "staff in mental health and children's services from all sectors" (SCIE, 2009, p.1). Particular teams or staff groups are intentionally not specified within the guide: it was SCIE's intention that this guide be widely applicable across the sector and the specific inclusion of some teams or staff groups could be taken to imply exclusion of other groups. However, neither mental health nor children's services are monolithic, but comprise a set of services designed to meet differing levels and types of need. The implementation of the guide can, therefore, potentially entail targeting a number of different agencies and groups within the health and social care system.

For example, the *Every Child Matters* Green Paper (HM Government, 2003) set out three main levels within children's services:

- Universal services for children and families (e.g. health visitors, schools);
- Targeted services for families with complex problems (e.g. children's social care); children and families with identified needs (e.g. disabled children) or those in targeted areas (e.g. Sure Start);
- Specialist services for children at high risk (e.g. child protection services).

Service levels within mental health services are less clearly defined in government policy. However, the following five-level framework has been suggested to support mental health commissioners (Haselgrove & Tibbles, 2005):

- **Level 0** – self care and support from family and friends;
- **Level 1** – primary mental health care;
- **Level 2** – community residential, day and home-based services providing a range of short term interventions for common mental health problems and recovery-orientated services for people with longer term needs;
- **Level 3** – emergency and acute care, including acute inpatient care and crisis resolution and home treatment;
- **Level 4** – highly specialised 'low volume, high cost' services such as for people who offend, those who need medium to long-term secure settings and people with complex and severe eating disorders.

The issue of 'think family' in relation to parental mental health problems is relevant to services at all levels of both adult mental health and children's services, although it may be of greater relevance in some areas than others. Full implementation of a 'think family' approach to parental mental health and child welfare in a local area is likely to require some consideration of all these service areas, although localities may choose to prioritise particular services first. It is also important to note that, depending on the needs of the family as a whole, different levels of the two systems may be interacting with each other. The specifics of what constitutes effective inter-agency working - or the implementation of a 'Think child, think parent, think family' approach - will differ in each of these cases. Different groups of staff and service users will be involved depending on which part of this system is targeted.

A range of outcomes

The 'think family' approach can be applied to a number of different services within children's and adult mental health services. A corollary of this is that what constitutes a good outcome will vary in different settings. We distinguish here between short-/medium-term outcomes (relating mainly to the way in which services are delivered) and long-term outcomes (relating to outcomes for service users). Three examples are given below of different service interfaces, as illustrated in Figure 2, and what may constitute a 'think family' response at each of these interfaces. Some possible short- to medium-term outcome measures are discussed.

Potential long-term outcomes for service users in terms of mental health, family functioning educational attainment (for children) and so on are not discussed here. Much as a 'think family' approach must be differentiated for different types of services, it must again be differentiated for service users with different types of needs, although this is beyond the scope of this article.

Example 1: Links between children's social care and psychiatric inpatient provision

The admission of a parent to psychiatric hospital can have a number of impacts on children and young people, including a different person caring for them or having to move house (Hawes & Cottrell, 1999). In some cases, admission of a parent can lead to children and young people entering the care of the local authority (Scott *et al.*, 2007). In the instance of a parent being admitted to psychiatric hospital, where a child is already known to social care, elements of a 'think family' approach could include:

- Where possible, early liaison between adult mental health and children's social care services to highlight that a parent may need to be admitted and to explore options for the child's accommodation, in consultation with the parent;

Figure 2 Adult mental health and children's services interface
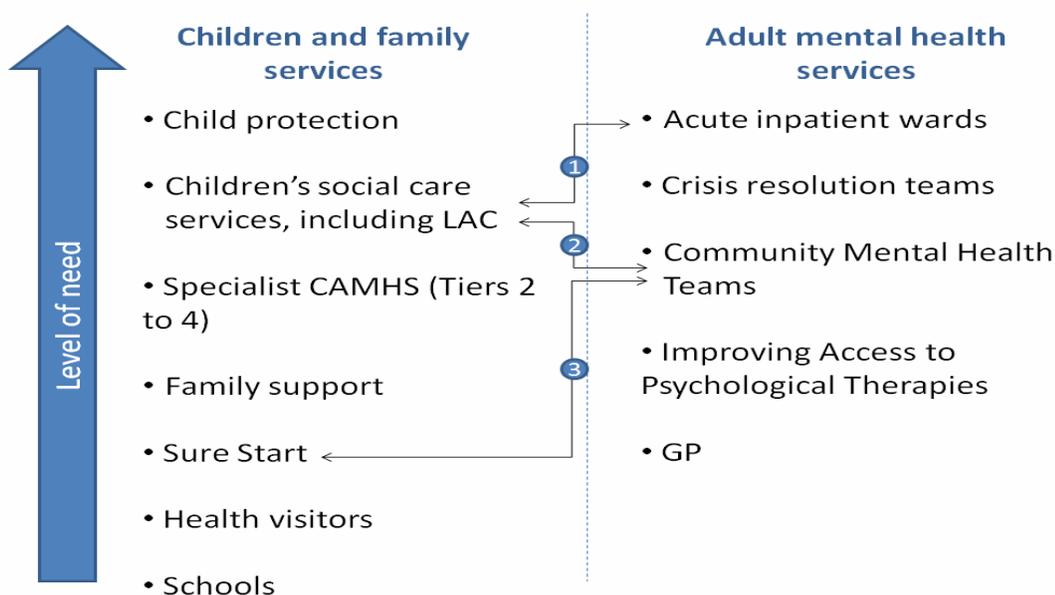
- Assessment of whether ongoing contact with the parent is in the best interests of the child or young person in consultation with both the parent and young person (National Institute for Mental Health in England, 2004), and in line with the local protocol relating to child visits to psychiatric hospitals;
- Hospitals providing appropriate spaces for this contact to take place, such as designated 'Family Rooms' (Barnardo's, 2009);
- Continued use of the Care Programme Approach and care co-ordination whilst in hospital to ensure that arrangements for discharge, including the person's needs as a parent, are considered from the beginning (Department of Health, 2008);
- Use of the pre-discharge planning meeting to ensure that the needs of both the adult and child are met (Royal College of Psychiatrists, 2002).

In this case, possible short- to medium-term outcome measures that a 'think family' approach is being taken might include:

- Increased numbers of mental health facilities with family rooms;
- Increased appropriate and supported contact between parents in psychiatric hospital and their children;
- Reducing numbers of emergency admissions to local authority care of children of mentally ill parents.

Example 2: Interface between a community mental health team and children's social care

Children's social care services will not need to be involved within all families in which there is a parent with a mental health problem (Stanley & Cox, 2009). However, where parental mental ill health, which is being managed in a community setting, is having an adverse impact on family functioning, children's social care services

may need to become involved. The following example suggests how a 'think family' approach could work in this case:

- If an adult is referred to community-based mental health services, the adult mental health worker ascertains at an early stage whether the person has parenting responsibilities.
- The worker is then vigilant for any negative impact of the parent's mental health problem on their child or children, including direct and indirect impacts (Smith, 2004), and for signs that the person may need support in their role as a parent. Achieving this may involve visiting the parent at times when the children will be around and talking openly with the parent about the impact of being a parent on their mental health, and any support needs they have.
- If there are concerns about, for example, the child's wellbeing and development, the adult mental health worker discusses this with the parent and makes a referral to children's social care, and may undertake joint assessment with a children's social worker if appropriate.
- If the adult mental health worker's concerns are confirmed, but there are no concerns of significant harm, ongoing co-ordination with children's social care services would be required to ensure a joined-up service. As there are no concerns of significant harm, parental consent would need to be obtained for information sharing between the two services (HM Government, 2008).
- The adult mental health worker may wish to inform children's social care of any deterioration in the parent's mental health, changes to medication and so on which could affect the child. It may also be helpful for the child's social worker to provide information about the children which could have a negative impact on the parent's mental

health, such as displaying violence or behavioural problems (Falkov, 1998).

In this case, possible short- to medium-term outcome measures that a 'think family' approach is being taken might include:

- Increased number of appropriate referrals from adult social care to children's social care and vice versa;
- Increased number of joint assessments undertaken in complex situations;
- Improved communication between adult mental health and children's services staff – for example, through attendance of the adult mental health practitioner at Team Around the Child meetings or children's social care staff at Care Programme Approach reviews and young carers' reviews.

Example 3: Interface between a community mental health team and preventative services such as Sure Start Children's Centres

Sure Start children's centres (based on the original Sure Start Local Programmes, or SSLPs) are described by government as 'service hubs' providing integrated services to children under five and their families. Whilst many Sure Start programmes provide services to support mental health, such as counselling and anger management services (Barlow *et al.*, 2007) and screening for postnatal depression (Kurtz *et al.*, 2005), evidence suggests that supporting parents with existing or more severe mental health problems has been a challenge for the programmes (Garbers *et al.*, 2006).

Building on the existing 'think family' approach to mental health in children's centres may, therefore, involve improving relationships and communication with local primary and secondary mental health services, and there is evidence that this has already started to occur within the programmes (Pinney *et al.*, 2007). A good example of this is the secondment of staff

from adult mental health teams to work within Children's Centres (as is currently being undertaken in two of the SCIE implementation sites).

In this case, possible short- to medium-term outcome measures that a 'think family' approach is being taken might include:

- Increased number of parents with existing diagnosed mental health problems being supported by Sure Start centres;
- Increased number of appropriate referrals from Sure Start to relevant primary or secondary mental health services.

What are the implications of this for evaluation?

The preceding two sections have highlighted that the 'think family' approach to parental mental health and child welfare can be applied to different parts of both the adult mental health and children's service systems, and that one would expect different short- to medium-term outcomes in each case. The implication of this is that there is no single outcome nor set of outcomes that the evaluation can measure to determine the 'success' or 'failure' of implementation.

Rather, the evaluation will aim to describe and investigate further the different ways in which the 'think family' approach is applied using a case study approach. The evaluation will focus on one or two 'workstreams' in each site, and investigate these in detail through qualitative research with various stakeholders, including the 'workstream lead', managers, practitioners and service users, and examination of relevant performance measures, as agreed in consultation with the workstream lead.

It is hoped that the case studies will allow a greater understanding of when different outcomes are applicable and why. In realist evaluation terminology, these are known as

'outcome patterns'. In line with the MRC's recommendation of an incremental approach to evaluation (MRC, 2000), these case studies should allow more specific hypotheses to be generated in terms of the impact of the approach on processes and practice, and on outcomes for service users.

Conclusion

There is increasing recognition from a variety of quarters that 'pure' experimental approaches to impact evaluation are not always possible, or desirable (Pawson & Tilley, 1997; Fisher, 2002; Kazi, 2003). Approaches such as realist evaluation and the MRC's guidance provide a useful way to conceptualise and evaluate impact of complex interventions in health and social care. By using these frameworks to guide the evaluation of the 'Think child, think parent, think family' implementation project we hope to gain further information about *how* this approach may work and achieve outcomes, rather than provide a summation of success or failure.

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Can the shift from needs-led to outcomes-focused assessment in health and social care deliver on policy priorities?

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Introductory summary

Assessment, planning and review are at the heart of the provision of services and support in health and social care in the community, providing key means through which professionals interact with people using their services. These interactions provide opportunities for relationship building, with evidence that involving the person in identifying their priorities and required support can itself improve outcomes. At the same time, professionals use assessment to assess eligibility for support, and assessment has also increasingly become a mechanism for data gathering, to inform a range of requirements at local and national level including planning, commissioning, inspection and performance management. Despite attempts to move assessment from being service-led to person-centred, meeting such a broad range of objectives and requirements can create tensions at the front line, influencing both how interactions are conducted, and the resulting decisions. More recently, there has been an increasing emphasis on outcomes for individuals using health and social care services, including a shift from needs-led to outcomes-focused assessment. This paper will consider both a recent review of literature about shared health and social care assessment, and emerging evidence from implementation of outcomes-focused assessment in the UK, before considering whether and how the recent shift towards outcomes might resolve longstanding tensions around assessment.

Keywords: needs-led assessment, outcomes-focused assessment, eligibility, person-centred practice, partnership working

Introduction and policy context

The role of assessment in health and social care in the community has been an area of concern over the past twenty years. Before the current system of community care was established by the NHS and Community Care Act (DH, 1990), assessment procedures were service-led, involving slotting people into a limited range of inflexible and traditional services, with limited attempts made to respond to the individual needs of people requiring support. Crude criteria such as age or impairment could be used as the basis for allocating services to individuals (Petch, 2008). Wide-ranging community care reforms were signalled by The White Paper *Caring for People* (DH, 1989) which emphasised that the primary objective was "to make proper assessment of need and good case management the cornerstone of high quality care" (DH, 1989, p.5). Following the White Paper, the 1990 Act introduced the requirement for a community care assessment focused on identifying the needs of the individual and determining the appropriate response. Needs-led assessment was heralded as the means by which users of services would receive personalised, tailored care co-ordinated by a care manager acting as a broker on their behalf:

There was ... the need for a cultural shift amongst those conducting assessments, a switch from the tradition of 'this person

requires a day centre' to *'this person has a need for support and activity during the day'*. (Petch, 2008, p.47)

The extent of the implementation challenge was summarised by the Audit Commission's (1992) report *Community Care: Managing the Cascade of Change.* This cascade of change included the purchaser-provider split, development of needs-led assessment tools and eligibility criteria and decisions about who would be care managers. As well as the shift from service-led to needs-led approaches, there was also emphasis in policy on partnership working. Reflecting the challenges associated with the divide between health and social care in the UK, the vision of a one door approach to community service delivery underpinned the changes. However, the 1990 Act was also part of a wider programme for introducing 'government by the market' (Hudson & Henwood, 2002), presenting further challenges for partnership working. Further, social services were given the lead role in conducting assessments of the needs of individuals, in collaboration with other professionals. However, the different funding arrangements for health and social care services meant that service users and carers could still be subject to both assessment and care management and the nursing process (McNally *et al.*, 2003).

With regard to the quality assessments required to deliver on the user-centred aspects, evidence from research soon suggested that the way in which assessment and care management systems were implemented may have restricted the use and development of the interpersonal skills required (Means *et al.,* 2008). From the outset, local authorities tended towards an administrative approach, with care managers spending increasing amounts of time on administrative tasks at the expense of spending time with service users and the balance shifting away from therapeutic intervention (Lewis & Glennerster, 1996). A further concern was the balancing of the

identified need of an individual with organisational requirements for rationing (Parry-Jones & Soulsby, 2001).

Shared assessment

With the arrival of a New Labour government in 1997, there was a renewed emphasis on partnership working, not least between health and social care. From around 2000, with continuing recognition that community care assessment was not delivering on policy objectives, there was increased emphasis on shared inter-agency assessment. The key policy drivers in the UK varied by country. In Scotland the broad aims of collaboration were set out in the report *A Joint Future* (Scottish Executive, 2000) including procedures for single shared assessments. In England, the *NHS Plan* (DH, 2000) and the *National Service Framework (NSF) for Older People* (DH, 2001) were key policy documents, with the latter also identified as a significant driver in Wales and Northern Ireland. Northern Ireland has developed shared assessment more recently, with the development of the Northern Ireland Shared Assessment Tool (McCormack *et al.,* 2008). There was renewed emphasis in all relevant policy documents on the importance of involving the assessed service user in decision-making as well as continued concern about individuals being subject to multiple assessments, with corresponding inefficiencies. There was a further concern to introduce a broader range of assessors than social workers.

With regard to decision-making about allocation of services and support to individuals, the Fair Access to Care Services (FACS) Guidelines (DH, 2003) were developed in England and introduced there alongside the Single Assessment Process (SAP). The FACS criteria are based on individuals' needs and associated risks to independence, and include four eligibility bands - critical, substantial, moderate and low. When placing individuals in these

bands, councils were not only to identify immediate needs but also needs that would worsen without timely help. The FACS guidelines were separate in England but were integrated within the Unified Assessment (UA) guidance in Wales (Welsh Assembly, 2002). Scotland recently introduced new mandatory eligibility criteria for local authorities in relation to services for older people, prompted by the Sutherland Review (Scottish Government, 2008a). Northern Ireland also operated eligibility criteria, but these were determined at the local level.

Shared assessment: key findings from literature review

Before going on to discuss outcomes-focused approaches to assessment, brief consideration will be given to a recent literature review of shared assessment in the UK, undertaken by the author and a colleague with the aim of informing continued development of assessment in Scotland. Although not a systematic literature review, key databases were included in the effort to identify relevant literature and an account of the methods is available (Miller & Cameron, forthcoming). The review confirmed that introduction of shared assessment brought with it a further cascade of change for health and social care in the community, including requirements to develop new tools and information sharing protocols and processes, to find ways of sharing information between different IT systems and training of a range of professional staff in assessment and care management. Thematic analysis of the literature identified some evidence of benefits emerging from shared assessment, particularly around user and carer involvement as well as examples of efficiencies. However, a range of challenges also emerged from the review. Two of the three predominant themes will be discussed briefly here because of their resonance with previous concerns about health and social care assessment.

The first dominant theme identified was the challenge of resolving the tension between standardisation and flexibility in developing assessment tools. Reflecting the policy requirement that assessment should be person-centred, there was a widespread view that tools should open up communication between service users, carers and professionals. Although it was a secondary concern that, as far as possible, consistency should be promoted for its potential to yield data for other requirements, such as service planning, the literature overall reflected a tendency for efforts to be focused on processes and tools. Organisational requirements to focus on standardisation and data had resulted in staff viewing shared assessment as an overly cumbersome process.

The second key and continuing challenge for staff which emerged from the review is the balancing of the identified need of an individual with organisational requirements for rationing. The requirement made of practitioners to balance user-defined need against fixed agency eligibility criteria in framing decisions about support and services was highlighted as representing an issue of real conflict for practitioners (Abendstern *et al.,* 2008). The requirement for staff to focus on needs in assessment as a means of establishing eligibility encourages staff to focus on what the person or carer is unable to do, to focus on their problems and deficits and commensurate risks, in order to establish a sufficiently high band to be able to access services. The lack of attention to outcomes, goal-setting and involvement of the person in assessment is inconsistent with person-centred, personalised and preventive services. Indeed, evidence has shown that while FACS criteria may support greater standardisation, they are likely to lead to people not receiving the support they need with subsequent cost implications for the individuals, family carers and services (CSCI, 2009).

Richards (1994) asserts, with reference to community care guidance, that effective implementation of a needs-led approach depends on creating a clear separation between the tasks of needs assessment and care management. Therefore, practitioners must distinguish between the assessment of need and consideration of the service response to avoid predetermination of the outcome of an assessment. She comments that:

> *... to identify need appropriately, practitioners must have an unimpeded view, free from the distorting effect of service considerations.* (Richards, 1994, p.5)

One way to facilitate this process is the separation of needs assessment and subsequent decision-making about eligibility. This depends on the concept of need operationalised independently of the agencies' policies and guidelines (Richards, 1994). If the distinction between service-driven and needs-led is not clarified by such a separation, the consequence will be a definition of need in terms of eligibility criteria for specific service interventions. An alternative approach is the adoption of outcomes-based working, which can revitalise person-centred aspects of assessment, as well as the potential for greater overall efficiency.

Outcomes in policy and research

Outcomes have become a policy theme in health and social care in the latter half of the last decade. In England, the DH (2006) outlined seven national outcomes for service delivery in *Our Health, Our Care, Our Say:* improved health and well-being, making a positive contribution, economic well-being, freedom from discrimination, improved quality of life, choice and control and personal dignity. The Joint Future Agenda has been the overall policy driver for joint working between health, social care and housing in Scotland, acknowledging the need to move from process and structures to increased emphasis on outcomes. Four national outcomes for service users and carers were to serve as the objective for partnership activity, as set out in *Better Outcomes for Older People* (Scottish Executive, 2004). The four high level outcomes were as follows: supporting more people at home, assisting people to lead independent lives, ensuring people receive an improved quality of care and better involvement of and support for carers. More recently, there has been the development of an outcomes-focused performance framework (Gooday & Stewart, 2009), with increasing emphasis on outcomes in standards for assessment (Scottish Government, 2008b). In Wales, there is an emphasis on outcomes in the guidance for unified assessment (Welsh Assembly, 2002).

In parallel with the policy emphasis on outcomes, service user and carer outcomes have been a feature in research and practice both south and (more recently) north of the border. Longstanding work on personal outcomes by the Social Policy Research Unit (SPRU) at York University has been particularly influential in social care practice in the UK over the past ten years (see Qureshi, 2001; Glendinning *et al.,* 2006). With this approach, outcomes are understood as follows:

> *The impacts or end results of services on a person's life. Outcomes-focussed services therefore aim to achieve the aspirations, goals and priorities identified by service users.* (Glendinning *et al.,* 2006, p.2)

In this model, there are three broad sets of outcomes (Nicholas *et al.*, 2003): maintenance – with a focus on quality of life and *maintaining* health and well-being; change – with a focus on short term removal of barriers to quality of life or *improving* health and well-being; process – with a focus on the *way that services are delivered,*

or how the person feels they have been treated. Consistent with the policy intentions behind health and social care assessment over the past twenty years, early evidence from SPRU suggested that an outcome-focused model supports a person-centred approach, effective partnership working and best value, including the requirement for greater efficiency (Nicholas *et al.*, 2003).

More recently, in Scotland, the Talking Points: Personal Outcomes Approach, has developed from Department of Health funded research at the University of Glasgow, for which the researchers used an adapted version of the SPRU outcomes to evaluate services provided in partnership by health and social care (Petch *et al.,* 2007). The Talking Points approach has subsequently been developed by the researchers working with the Joint Improvement Team (JIT) of the Scottish Government and representatives from community care organisations across Scotland since 2006. Talking Points is currently being implemented in over 40 partnerships and provider organisations. Similar to the approach adapted by SPRU, Talking Points seeks to maximise outcomes for users of community care services and their unpaid carers as follows:

- By focusing on outcomes in interactions with people using services and their unpaid carers, including finding out from individuals what is most important to them in life and identifying how everyone can work together to achieve the best outcomes possible for that person. The information gathered can be recorded in outcomes-focused support plans. The circumstances of the person can be revisited at review, including checking out whether outcomes are being achieved.
- By using information on service user and carer outcomes captured during these interactions to complement other routine locality-based data sources, to

support service improvement and the planning and commissioning of services and performance management.

A range of resources has been developed by the JIT and partner organisations to support implementation. More information and issues of direct relevance to practice and culture change are covered in the Key Messages Document and the Implementation Guidance. These resources are freely available from the JIT website: http://www.jitscotland.org.uk/action-areas/user-and-carer-involvement/.

Outcomes in assessment: key findings from implementation

In this section, consideration will be given to early evidence from England and emerging evidence from Scotland and Wales on the potential benefits of outcomes-based approaches to assessment. To take the early work from England first, one of the key challenges is the investment required to support the change in culture. Although some staff may easily adopt an outcomes perspective, for many others opportunities for training, discussion and practice are important facilitators in achieving the culture change required (Qureshi & Nicholas, 2001). With regard to benefits, early research by SPRU undertaken with older people suggested that, once professionals have a clear understanding of the concept of outcomes, then the identification of agreed intended outcomes during assessment helps to focus intervention on the desired aims of services and the aims and preferences of users. It also provides a clear basis for planning and briefing providers (Qureshi, 2001). Slightly later work by SPRU confirmed that practitioners participating in projects reported a number of specific benefits from this approach which contributed to person-centred practice:

- assessment process more focused;

- gave attention to aspirations and not just problems;
- highlighted the user's and carer's sense of priorities;
- greater recognition for carers;
- made care plans more creative;
- clearer guidance for providers about the purpose of help and individual preferences;
- clarified differences in perspectives which could assist negotiation;
- feedback about the impact of services helped in fine-tuning care packages.
  (Ball *et al.*, 2004, p.15)

In Wales, although outcomes-focused elements have been incorporated into the Unified Assessment, a range of professional, technical and operational issues are as yet unresolved and requirements for further investment in staff development programmes have been identified (Seddon *et al.*, 2010). Innovative work is underway in some areas, including a range of outcomes-focused and relationship-centred pilots in Swansea, with positive early feedback from staff, providers and service users (Andrews *et al.*, 2009). This work has incorporated the 'Senses Framework', emphasising the inter-dependence between service users, carers and staff and the creation of 'enriched environments' of support (Nolan *et al.*, 2006), within which service users, carers and frontline staff can all achieve a sense of:

- Security – to feel safe within relationships;
- Belonging – to feel 'part of things';
- Continuity – to experience links and consistency;
- Purpose – to have a personally valuable goal or goals;
- Achievement – to make progress towards a desired goal or goals;
- Significance – to feel that 'you' matter.

In Scotland, the focus on personal outcomes has been promoted by the Joint Improvement Team, with its focus on supporting partnership working. Therefore, Talking Points has been promoted to both health and social care staff, and more recently to other providers. In some localities, the approach has been taken up by different agencies at different stages. Mirroring early work involving SPRU and North Lincolnshire social services, researchers in Scotland worked closely with staff in early implementer sites from 2007 to develop shared understanding of outcomes in practice. As was the case with SPRU and North Lincolnshire, the local authority staff in one area, North Lanarkshire, had already decided to focus on outcomes prior to involvement with the researchers.

In order to assess progress and barriers to implementing an outcomes approach in North Lanarkshire, the author jointly conducted focus groups with staff, frontline managers and senior managers in 2008. This exercise confirmed that a shift in the culture of social work in North Lanarkshire was evident. The focus on outcomes was viewed positively by staff at all levels for both restoring the values and principles of professional practice, which were described as having been diminished through care management and bureaucracy. The focus on outcomes was also viewed as providing a sense of clarity and purpose to practice and also as improving partnership working with service users. There was an additional concern in the managers' group to ensure that a methodology should be developed locally to measure and evidence outcomes, and to counterbalance existing performance indicators with user and carer outcomes. Otherwise, there was a risk that the outcomes approach would not endure (Miller & Johnston, 2008).

More broadly, early implementers of the Talking Points approach have recently reported on their outcomes-based activities. Themes which emerge repeatedly include the role of outcomes in supporting person-centred and enabling approaches to

assessment and planning with individuals. Another theme, consistent with policy objectives for community care assessment, is the potential for outcomes to support partnership working through providing a common language and concepts. Table 1 below is based on learning from practice in Scotland and was produced to support understanding of the potential of the personal outcomes approach to progress some of the policy priorities which have not been fully realised through previous service-led approaches to assessment in health and social care.

Table 1 Service-led and outcomes-focused approaches compared

Service-led	Outcomes-focused
Tools encourage information gathering through standardised question and answer approaches to assessment, support planning and review	Semi-structured conversations with individuals in assessment, support planning and review
'Tick box' approach to assessment	Analytical skills involved in assessment
The person's views may be included in decision-making	The person's views/preferences are central to decision-making
The person is viewed as a client, service user or patient	The person is a citizen with rights and responsibilities
Where needs link to strict eligibility criteria, the assessor is required to maximise individual difficulties to access services	Involves consideration of difficulties, limitations and aspirations or goals. The priority is to identify what to work towards
If the person is deemed eligible, identified needs are matched to a limited range of block-provided services, resulting in service-driven approaches	Identifying outcomes involves considering a range of solutions/strategies including the role of the person, family supports and community-based resources
Where needs are tied to eligibility criteria, preventive work with people with low level needs may be excluded	Outcomes allow preventive work to take place while services and resources are prioritised for those most in need
Focusing exclusively on deficits and difficulties, and how needs are to be met, results in a focus on tasks and in services which do things *to* people	By focusing on strengths, capacities and goals, while mindful of limitations, the role of the person is maximised. Services do things *with* people
Matching needs/deficits to services tends to result in static service delivery	Outcomes may change in the person's life journey and so should be revisited
Where outcomes are identified, these tend to be professional or organisational outcomes e.g. improved nutrition, or avoid delayed discharge	Outcomes are what matter to the person, though often consistent with professional and organisational outcomes e.g. being able to get out and about
Starting from what services are currently available restricts communication and limits options	Starting from the person's priorities supports enabling relationships, creates clarity and identifies goals at an early stage. Being listened to, involved and respected supports better outcomes

Source: Miller, E. *et al*. (2009) *Philosophy and Principles Underpinning a Personal Outcomes Approach.*

This table highlights some of the lessons from outcomes-focused practice in Scotland, and the potential for outcomes to deliver on long sought after policy objectives in community care assessment, although not without caveats. Some of the emerging benefits from the outcomes approach were also amongst the expectations from needs-led assessment, following the 1990 Act, and subsequently from shared assessment. The review of shared assessment highlighted how competing priorities impeded realisation of the benefits of shared assessment. Similar risks to delivering on policy intentions to improve person-centredness and fulfil the enabling potential of assessment in health and social care have also emerged in relation to outcomes-based assessment north and south of the border.

First, there is the challenge of merging an outcomes focus with existing needs-led approaches. Glendinning *et al.,* (2006) particularly highlight the Single Assessment Process (Single Shared Assessment in Scotland, Unified Assessment in Wales) as continuing to be service-led and prescriptive. They found that assessments often emphasized dependency or overlooked psychological and emotional needs and did not challenge low expectations of services or the limited range of help older people think it is legitimate to request. Although evidence from Scotland has shown that staff want to move from a perceived bureaucratic model to spend more time with people, it can still be a challenge to shift from a deficit or dependency approach to one which is not service-led (Jarvis, 2010) and deficit-based models of assessment still predominate over outcomes-based elements within assessment processes.

Second, as identified in the literature review, rigid imposition of FACS eligibility criteria presents a significant risk to outcomes-focused assessment and may result in further inefficiencies. The Institute of Public Care (2009) recently concluded

that developing outcomes-based eligibility criteria need not necessarily call for a major overhaul of the eligibility system but rather its refinement and improved application. They identified three hurdles that require to be overcome:

- By tightly linking needs with resources the eligibility process discourages other forms of help being brought into the package;
- Eligibility tests discourage a preventative approach because if people do not cross the threshold at the time of assessment they are not eligible for resources even though the acquisition of help now may prevent poor outcomes later;
- By making the eligibility threshold increasingly hard to cross it encourages people to hold onto resources once obtained and hence provides no incentives for improvement either by the service user or the provider.
  (IPC, 2009, p.23)

In practice, some early implementers of the outcomes approach in Scotland have identified the eligibility criteria as the key challenge to progress, and work is underway in two areas to try to identify ways of implementing the criteria so that they are consistent with the outcomes focus, and the associated emphasis on a more enabling approach to practice.

Third, it has been noted how tension emerges around outcomes-based interactions for evaluations, where these are very firmly focused on evidencing the value of the service, or where the performance management agenda overrides value-based practice in the organisation. As already identified, evaluation was the focus for the research on outcomes of partnership working which informed the development of Talking Points (Petch *et al.*, 2007) and it is feasible to use Talking Points this way. In practice, however, evidence from Scotland

has shown that tensions can emerge in some evaluation exercises. One of the advantages of a personal outcomes approach is that it is not service-led, which means that the role of the person and other supports in their lives and communities are part of the picture, which supports more enabling relationships. Analysis of qualitative information gathered through use of Talking Points can develop understanding of how individuals, either supported by the organisation or independently, have worked towards achieving their outcomes. Where the evaluation exercise is very service-led, this may mean that practitioners are required to focus on the impact of the service only, with no attention paid to the role the person or informal supports have played in achieving their outcomes (Cook & Miller, 2010). Similarly, performance management should support rather than undermine outcomes for individuals. There are examples from implementation of Talking Points whereby outcomes-based information has been collated and discussed with staff at feedback sessions, in line with Seddon's (2010) assertion that the most important learning occurs at the front line where staff and service users interact, rather than a reliance on targets and bureaucratic performance management systems built on relationships of mistrust.

A further challenge which is not so much about the assessment process itself, but is very relevant to the outcomes of assessment, emerges from a contracting culture emphasis on task and time, with the plethora of providers which have entered the market in community care following the 1990 Act. Considerable effort has been invested in developing outcomes-focused contracting, which was a feature of early work by SPRU in England (Qureshi, 2001) and more recent development work is underway in Wales (Andrews *et al,.* 2009) and in Scotland.

Discussion

Reviewing the history of health and social care assessment over the past twenty years confirms that key challenges endure, despite policy objectives to improve partnership working and the quality of assessment as well as user and carer involvement. These objectives were emphasised in the NHS and Community Care Act 1990, which heralded the new focus on needs in assessment. Some years later, given the continuing difficulties in achieving these objectives, shared assessment was promoted and implemented at various points across the UK. The recent review of literature on shared assessment identified that some benefits were evident. However, despite the enormity of efforts involved in developing and implementing shared assessment across three of the four countries of the UK[1], assessment in practice has not as yet significantly realised these objectives. The review also found continuing concerns amongst staff around the amount of time spent on form-filling and requirements to balance needs assessment with gate-keeping.

Recent evidence from implementing outcomes-focused approaches to assessment in Scotland, England and Wales has demonstrated shared concerns amongst practitioners to progress from previous bureaucratic processes and their impact on person-centred practice. There is also evidence to suggest that the personalisation agenda in England, with its emphasis on putting people first through a focus on the process of providing Individual Budgets, is adding to, rather than reducing, the amount of time spent on form filling and bureaucracy (Samuel, 2010). Meanwhile, outcomes-focused assessment has been identified as restoring relationship-based approaches to practice, ensuring that the priorities of service users and carers are considered as part of the planning process, rather than being determined solely by agency priorities (Nicholas & Qureshi, 2004; Andrews *et al.,* 2009; Miller *et al.,*

2009). The enabling potential of focusing on outcomes has also been highlighted, as the focus moves from being about matching needs to services to identifying what matters to the person and working out what role each person will have in achieving that outcome (Miller *et al.,* 2009). Recent studies highlight the emphasis that service users place on the nature and quality of the relationship and the importance of positive human qualities in workers (Beresford *et al.,* 2005, 2006; Nolan *et al.,* 2006; Andrews *et al.,* 2009). The importance of relationships is not an add-on to efficient practice. Rather, good relationships skills and successful alliances are related to better outcomes (Horvath & Symonds, 1991; Howe, 1998).

However, achieving outcomes-focused assessment in practice has been found to be more challenging than anticipated (Qureshi & Nicholas, 2001; Andrews *et al.,* 2009; Miller *et al.,* 2009). This is partly due to the challenge for practitioners who have had to work within service-led cultures but also because wider systems need to adapt. Shifting to outcomes-focused assessment does therefore require a further 'cascade of change', although the change is more about re-orientation than restructuring. Relationship-centred approaches would also suggest that the well-being of frontline staff and carers need to be taken into account in the achievement of good outcomes for service users (Nolan *et al.,* 2006).

A further continuing challenge is the competing requirements made of assessment, including person-centred aspects which require flexibility and qualitative elements, as compared to information requirements for service improvements and more managerialist concerns such as centrally directed performance management systems, which tend towards standardised and quantitative approaches. One study in the review of shared assessment concluded that it is questionable whether any instrument can be developed to meet all the ideal requirements

(Richardson *et al.,* 2005). It is a question therefore, of balancing and prioritising these demands.

There are very promising signs that outcomes-focused assessment can progress policy objectives for assessment in health and social care, where previous efforts have faltered. It is becoming increasingly clear at the time of writing that funding levels for health and social care are facing serious constraint, while demographic trends suggest that demand is unlikely to diminish. Ensuring that service users and carers are involved in decision-making and that the right support is made available to those who need it, as opposed to the often prescriptive and service-led solutions currently on offer, can deliver on person-centred objectives whilst also resulting in more efficient and effective use of resources. However, some of the longstanding barriers to achieving these objectives also need to be reviewed, which would include re-prioritisation of the many drivers influencing assessment practice, so that they support rather than impede delivery of outcomes for people.

Footnote

[1] The new Northern Ireland Shared Assessment Tool is still being implemented at the time of writing.

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Developing The College of Social Work

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Summary

This document, written jointly by The College of Social Work Development Team and BASW, provides a detailed overview of the proposed key functions and purposes of The College of Social Work.

The College Development Group is currently running a series of major consultation events across the UK. Working with Social Work sector professionals, service users and carers, the consultation events will explore and clarify the key values and strategic aims of The College, prior to its establishment as a legal entity in April 2011.

Introduction

Being a social worker is a very demanding but rewarding job. Social workers deal with very complex personal cases in often complex community and organisational contexts, which involve making difficult decisions about people and their lives. In England, the profession has a high profile but generally low esteem with the public, press and policy-makers. There remains a lack of clarity with employers, other professions, the media and the general public about what it is that qualified social workers can do that other professions cannot. The England Social Work Task Force identified that the initial and continuing education and training system for social workers can be confusing and incoherent with no clear career pathway or structure. Supervision and support for front line social workers can be very patchy and all too often focused on targets and performance management, sometimes at the expense of case work.

All of these factors make it an even harder job. Unsurprisingly, there are problems with recruitment and retention, leading to considerable frustration on the front line. The image of social work with the public

can make it even harder for social workers to build trusting and productive relationships with people who use social work services and their carers.

Social workers can find it difficult to influence other agencies and professionals and often feel 'damned if they do and damned if they don't' when making tough decisions about intervening, or not. When things go wrong, social workers are too often pilloried in the press. There are almost no stories about the difference that good social work can make to the lives of millions of people. In response to these chronic difficulties, BASW has campaigned for a College of Social Work and its arguments were fully accepted by the England Social Work Task Force.

The Task Force made the following recommendation:

> *We are recommending the establishment of an independent national college of social work. This will articulate and promote the interests of good social work. It will give the profession itself strong, independent leadership; a clear voice in public debate, policy development and policy delivery and*

strong ownership of the standards to be upheld. (Building a Safe, Confident Future: The Final Report of the Social Work Task Force: November 2009)

This recommendation has already been accepted by the government in England. Discussions are taking place with the devolved administrations in Northern Ireland, Scotland and Wales and with the profession across the UK as to how this development should appropriately work with the different national arrangements for social work. As a UK organisation, BASW has a clear mandate from its member referendum to work for a single UK College, within which the appropriate national structures can be established.

The content of this article is based on the discussions that have taken place in England, but will be developed further as the four country engagement gathers momentum.

Thus far, it has been identified that the College of Social Work will:

- stand up for the profession in discussions with government, the public, regulators and the media;
- clarify the role of the profession;
- advise on training and professional development.

Many professions already have the support of a national college to support them. For example: The British Association and College of Occupational Therapists and The Royal Development Group is looking at these examples to make sure that The College of Social Work will be the equivalent for social workers, developing a College for the 21st century. We have an exciting and once in a generation opportunity to build a College for the social work profession that takes account of the unique College of Nursing. The College will highlight the relationship between social workers and the people who use social work

services, making the most of technological opportunities, and providing readily accessible resources to social workers.

Aspirations for The College

In its first meeting, the Development Group considered what a college should do and the difference it should make. A facilitated discussion group considered the difference a college could have made at the time of the Baby Peter crisis. The group recognised that not all child deaths are preventable and that The College must cover all areas of social work practice, not just child protection. Focusing on the difference that a College could have made when things go wrong led the group to conclude that a strong college is needed to gain more clarity about what actions should be taken in times of crisis. Following this discussion, The Development Group published a paper outlining the proposed values and purpose of The College (Purpose and Functions of The College of Social Work: Consultation Paper). This paper was the subject of a series of wide consultations, which took place between May and September 2010.

The paper outlines the following proposed aspirations:

- **Leadership:** The College will provide leadership to the profession;
- **Excellence:** The College will enable and guard excellence in the profession;
- **Pride:** The College will have pride in, and bring pride to, the social work profession;
- **Partnership:** The College will actively seek partnerships with people who use services and their carers;
- **Independence:** The College will be independent and willing to challenge when necessary;
- **Led by the profession:** The College will mobilise the considerable expertise of the profession and its

members to inform all College activity;

- **Starting from strengths:** The College will build on existing good practice in the UK and overseas;
- **Collaborative:** The College will work collaboratively with allied professions, and with organisations affecting the profession;
- **Coherence:** The College will bring coherence and clarity to the profession.

These aspirations are the subject of consultation. Early responses indicate that the objectives do meet the aspirations of social workers and of people who use social work services.

Proposed strategic aims for the first three years

The Development Group proposes the following strategic aims to guide the first three years of The College's development. These aims will be used as the organising principle for the development of the services of The College in its first years of operation:

- to be a powerful voice for the social work profession;
- to provide strong leadership for the profession;
- to develop The College;
- to work with people who use social work services and their carers;
- to be an international centre of excellence for the social work profession.

These aims are similar to those of other colleges.

These strategic aims mean that The College will invest energy and effort into working with the media and will call on its members to become actively involved in all aspects of its work, so that it has a strong and clear mandate from the profession to speak on its behalf. The College will need to be influential with government, employers, the media and the general public. Early debates about how influential a non statutory body can be have been very interesting. A quick look at the work of the voluntary sector and the work of trade unions, suggests that non statutory organisations can be highly influential, provided that they have a strong mandate and work very effectively with the media. The College's mandate will come from a vibrant, active, involved and large membership base.

The College has no plans at present to ask for legislation to support its work. This is because, once The College is enshrined in legislation, it would lose independence and its functions could all too easily be subject to government policy changes. The College will flourish because social workers want to belong to it, rather than because anyone says they must belong to it. The wide consultation should tease out the priorities of social workers, so that The College can offer the benefits that are most needed at the right price.

Proposed objectives

The Development Group proposes that to make a real difference to social work The College will need to:

- generate cultural change and raise the status and standard of social work;
- act as the source and guardian of high professional standards within and outside the social work profession;
- bring clarity and coherence by defining and guarding the reserved functions of the profession;
- improve public understanding and support for social work, through sustained public education and by representing the profession in the media and public debates;
- facilitate peer review and support to improve and develop the profession;

- facilitate employee union representation (via partnerships with trade unions);
- act as an essential source of advice to bodies who regulate, inspect and support social work and social care, and to organisations who deliver social work and social care; ensure that its work is grounded in how to best support people who use social work services, and their carers.

The Development Group has recognised that these objectives are long term and that generating cultural change could take at least 10 years to achieve. The Development Group wants to build a College that will be the key feature of the professional landscape of social work in the same way as colleges work for other professions.

The College needs to make a real and lasting difference to the profession so that social workers can make a real difference to the people they work with. To do that, The College will need to work within the regulatory framework for social work and to become very influential with the different bodies and agencies with statutory responsibilities for social work. The Development Group members will reflect the key stakeholders, enabling that process to begin right at the start.

Proposed functions

In order to fulfil its objectives, it is proposed that The College will:

> *Provide a strong voice for, and leadership to the profession.*

A feature of recent bad press surrounding social work indicates that no-one is speaking up for the profession. Similarly, serious case reviews seem to suggest that the opinions of social workers are not always valued by other professions, and that social workers can struggle to influence, let alone lead, other professionals.

The College will represent and lead the social work profession. It will:
- influence the development of national policies that impact on social work and social workers, acting as an advocate for the profession;
- build relationships and develop policies with other professional bodies on issues of common interest (e.g. occupational therapists, nurses, probation officers, teachers etc.), acting as an advocate for the social work profession;
- build relationships and develop policies with the academic community including researchers, lecturers and teachers;
- represent the social work profession in discussions with policy-makers in government, employers, the public, the media and other professions;
- establish links with, and become a member of international organisations, in order to learn from and share good practice in supporting social work, contributing to the development of European and International social work policies and practice.

Defining the values and purpose of the social work profession

The current and future role of social work in light of impending public expenditure cuts means that it is critical to clarify exactly what it is that only social work practitioners can do. The College will:

- set out and promote the values and purpose of social work – including a commitment to placing people who use social work services and their carers at the heart of the process;
- define and promote the reserved functions of social work (i.e. the activities which only qualified social workers can undertake).

Developing, promoting and supporting standards

Social workers should be working to the highest professional standards. The General Social Care Council regulates social workers and holds them to account in line with a Code of Practice. The College can help to raise the standards even further by building on the current work of the Social Work Reform Board and will work closely with social workers, their employers and the regulators in order to:

- agree, establish and promote professional standards for good practice, based on internationally agreed ethical principles. This should include clarifying the personal responsibilities of individual social workers, and what these standards mean in a range of different work settings.
- agree, establish and promote standards that employers of social workers should meet. This should include standards for employing, supervising, supporting and developing social workers at all levels of seniority. It should also clarify what social workers or other professionals should do if these standards are not in place or are not met. The College will work with the organisations that regulate employers of social workers (i.e. the Care Quality Commission and Ofsted) to 'accredit' employers who meet these standards.

Providing guidance and support to the profession and allied professions

Keeping up-to-date with the latest policy and practice in social work, and what it means for individual cases, can be difficult. The College will support social workers, other professionals who work with them and people who use social work services. Currently, people who use social work services and other professionals are unclear

about the role of social workers, their responsibilities and their duties. The College will:

- provide national practical guidance to clarify what good practice means in difficult situations at all levels of the social work profession;
- provide up-to-date information and guidance on issues affecting the profession;
- collect and disseminate knowledge, evidence and exemplars of what works.

Shaping training and development

Social workers need to use a range of complex skills, including excellent judgement, listening, negotiation and analytical skills, as well as hold appropriate qualifications. As with all professions, social workers are required to continue their professional development throughout their career. We have already received feedback about the variable quality of practice placements in initial training, the lack of clarity about where to find high quality and relevant ongoing and in-service training and the need to obtain specialist knowledge and skills for particular social work roles, for example in mental health, working with vulnerable adults, child protection, or sensory impairment. The College will improve the selection, training and ongoing development of social workers by working with those who select, train, employ and regulate them. The College will:

- agree, establish and promote standards for the quality of training;
- influence the development of a more coherent approach to the initial selection and training of social work students;
- promote learning when they are in practice and promote the ongoing training and development of the profession; be the source of expert advice to government on workforce

planning, working in partnership with the sector skills councils, employers and training providers;

- approve and promote the provision of Continued Professional Development (CPD).

Initial priorities for The College

The Development Group proposes the following priorities for the first three years of operation:

Establish The College as a legal entity

- Move from transitional arrangements to an established legal entity;
- Further develop dialogue with the devolved administrations and social work bodies in each of the countries of the UK, enabling The College to become a UK-wide body in due course;
- Define and agree governance and legal structure;
- Appoint Chair and Board members and agree board policies;
- Appoint Director and staff as required
- Develop the business model to achieve viability and sustainability.

It is hoped that The College will exist as an independent legal entity by April 2011.

Define the values and purpose of the profession

- Gather evidence from existing work from the UK and internationally;
- Build consensus by fully involving the profession and those who use services and carers, as well as employers and regulators;
- Set out the values and purpose of social work;
- Set out the reserved functions of social work;
- Consult with social workers, members of the College, and other stakeholders

including service users, carers and regulatory bodies, on the proposed values and reserved functions;

- Agree, promote and uphold the values and reserved functions of social work.

This work is essential, especially in a climate of cuts to public expenditure. The majority of registered social workers are employed in the public sector (about 70%)[1] and, without sufficient clarity about what it is that only social workers can do, there is a risk that cuts to the profession will result in a loss of these aspects of critical importance.

Support improvements in the reputation of social work

- Engage with social workers, people who use services, carers and allied professionals to demonstrate what social work can and does achieve;
- Develop and promote a narrative about social work, focusing on what social work is about and the context in which it operates, to employers, social workers, policy-makers, and the media.

It is important to recognise that, to improve the reputation of social work, The College will need to invest in high level public education activity as well as provide the leadership that the profession so urgently requires to help transform the public image of social work.

Develop standards

- Gather evidence from existing work and standards from the UK and internationally;
- Build consensus by fully involving the profession, those who use services and their carers;
- Agree, promote and uphold standards once consensus is achieved.

The College will aspire to develop and promote 'gold standards' for the profession, promoting and leading good social work.

Establish different types of membership

Licensing arrangements will not be in place immediately but The College is consulting on and will then define future membership categories such as:

- Students (including those in employment who are not yet fully registered);
- Those registered/licensed to practice;
- Those qualified but not in practice;
- Associate membership for those with an interest in the profession (possibly non-voting).

The College is consulting on membership categories, membership benefits and the subscription price that people would be willing to pay. Decisions will be made by the Interim Board once the outcome of the consultation is known.

Specific benefits to members of The College

Once the purpose, functions and aspirations for The College are agreed following the consultation period, The College will be in a position to start to offer benefits to members and prospective members. Looking at the benefits that other colleges offer suggests that some or all of the following are likely to be of importance:

- A regular news magazine;
- A peer reviewed journal;
- Professional indemnity insurance;
- Representation and employment advice (including partnership with trade unions);
- Practical guidance and advice, via a helpdesk and through publications;
- Practical tools and resources to use in social work practice;

- An annual conference;
- Online library with access to up-to-date information and research;
- Awards for study;
- Special interest groups (e.g. for newly qualified social workers, those working in mental health or child protection, or for practice teachers).

The consultation included specific questions about these potential benefits in order to gauge demand and interest.

Developing The College

The College will be established as an independent organisation, led and run by social workers. Funding for the set up and logistical work covers England but the Development Group has agreed that The College will seek to become a UK body should this be desired in the devolved countries. A major consultation exercise involving the social work profession, people who use services and their carers, took place between May and October 2010.

The College will build strong links with trade unions and will work collaboratively with the various bodies that have statutory responsibilities for social work, working within the regulatory framework for social work.

A temporary Development Group was established in January 2010 to guide the initial development until the appointment of an Interim Chair and Interim Board. The Development Group comprised key stakeholders and handed over responsibility for leading the next stage of development to the Interim Board in Autumn 2010. The Interim Board were recruited via an open recruitment process. Membership of the Development Group and Interim Board can be found on The College website, **ww.collegeofsocialwork.org**.

The Interim Board will guide The College into existence, ensuring that it is sustainable

and has sufficient members to be viable. The composition of the Interim Board covers different specialisms within social work and also includes a service user.

The precise role and activities of The College will be decided through an in depth analysis of feedback from the consultation process. The full reports of the consultation exercise have been submitted to The College's Co-Chairs and Interim Board and they will discuss these reports at their next board meeting in November. A college in this sense of the word means a membership organisation that supports a professional group, rather than a college which provides training.

Development process

The development of The College is being facilitated by SCIE, an independent, not-for-profit organisation. SCIE has considerable experience of enabling the establishment of independent organisations, including the National Skills Academy for Social Care and C4EO.

SCIE has employed a small interim development team to support the Development Group and is providing communications expertise and staff alongside logistical support. Once the Interim Chair and Interim Board are in place they may decide to employ more interim staff.

A development process was devised and approved by the Development Group to ensure that the establishment of The College will be carried out in a manner that ensures that it responds to the needs and aspirations of the profession, and will be financially viable and sustainable.

SCIE has been provided with funding specifically for the set up and logistical support for The College; The College will be self financing through membership subscriptions once established.

Consultation

The Development Group arranged a very wide consultation about the purpose and functions of The College. A range of stakeholders, including social workers, those who use social work services, those who employ social workers and specialist agencies were involved. The consultation took place between mid May and October 2010 and will inform the further development of The College. Details of the consultation process and the top-line findings from the events with social workers and the online questionnaire are now available online at **www.collegeofsocialwork.org.**

Feedback from consultation events is now being collated and will be carefully analysed and reported to the Interim Board at their next meeting in November 2010. The feedback will be used to determine the legal form that The College takes, as well as the key priorities, functions and activities.

It was vital that social workers contributed to the consultation and had the opportunity to shape their College. Discussions are now underway about how best The College should consult with social workers in Wales, Scotland and Northern Ireland.

Community Care hosted a forum to enable a series of discussions about the development of The College.

Challenges

The formation of The College will have an impact on other organisations in the field. The Development Group comprises most of the key stakeholders, including BASW. These stakeholders will continue to be involved following the appointment of The Interim Board.

It is crucial that we all keep sight of the end game. We must improve the quality of social work practice and we must improve

public perceptions of social workers (including the media, policy-makers and people who use social work services). As long as we can keep a clear focus, it should be possible to determine how roles and activities of different agencies in the field can change and adapt.

Change can sometimes be difficult and uncomfortable. Those helping to create The College need to make use of the very best social work skills, insights and approaches to the profession. They will need to make decisions at a time of uncertainty and economic difficulty that will serve the profession well for the future, so that those people who need social work services can benefit from them in the long term.

Footnote:

[1] The State of the Adult Social Care Workforce in England, 2008. The third Report of Skills for Care's Skills Research and Intelligence Unit. Researched and compiled by Christine Eborall and David Griffiths, February 2008.

Notes on Contributors

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Book Reviews

Social Work Skills with Adults
Mantell, A.
Exeter: Learning Matters, 2009, pp.182, ISBN: 9781844452187, £19.99(pbk.)

As part of the Learning Matters "Transforming Social Work Practice" series, *Social Work Skills with Adults* is written primarily for students undertaking the social work degree qualification. Each chapter begins with a helpful overview of the *National Occupational Standards* and the *Social Work Benchmarks* that the chapter will help students to achieve. The chapters then draw on a range of case studies, research and activities designed to encourage readers to interact and engage with the text.

The book is split into three discrete sections. Chapters One to Three outline the range of skills needed to engage effectively with adult service users. Chapter One discusses the importance of building good working relationships between social workers and service users, carers and other professionals in the context of a changing environment. It takes the reader through 'introductions' to 'maintaining' and then 'ending' relationships. It highlights the importance of actively listening as well as clarifying, negotiating and planning.

Chapter Two looks in detail at the range of communication skills required by social workers working with adults. It takes the reader through the skills needed and draws on research with service users and carers that highlights the particular skills that they value in social workers. The chapter begins to tease out some of the challenges that social workers face in relation to keeping emotionally and physically safe. Chapter Three introduces the reader to the concept of empowerment. It discusses various models of empowerment, highlighting the contested nature of the concept. In addition, this chapter draws on research identifying good practice in relation to the involvement of service users and carers before going on to focus on advocacy and its function in relation to the promotion of service user and carers' rights.

Chapters Four to Seven focus on intervention with adult service users. Chapter Four looks at assessment - arguably the most important intervention with adult service users. It introduces the reader to various models of assessment and the skills required to carry out assessments effectively and ethically. The chapter also highlights the tensions and ethical dilemmas faced by social workers in carrying out the assessment task, particularly when the demand for resources exceeds supply. Chapter Five discusses the various stages of the decision-making process and introduces the reader to the challenges of balancing a range of views. Of particular importance is the concept of risk and the chapter highlights the need to balance positive risk-taking with the protection of potentially vulnerable service users. The chapter provides helpful exercises to enable the reader to deconstruct taken for granted skills.

Chapter Six focuses on the concept of collaborative working and highlights the opportunities and challenges involved. It is argued that developing relationships between professionals can result in greater success, in terms of collaborative working, than more formal arrangements. The main challenges relate to sharing of resources and information. Strategies for overcoming these challenges are suggested. The potential for collaborative working to transform social care, particularly by involving service users and carers, is also highlighted. Chapter Seven focuses on negotiation skills and introduces the reader to different models of negotiation. The

importance of identifying one's own style of negotiation is emphasized. This chapter explores the particular challenges of negotiating on behalf of a service user while at the same time representing an agency that is restricting access to resources.

The final four chapters cover professional accountability and competence and focus on the professional skills required by competent, reflective practitioners. Chapter Eight looks at the writing skills required by social workers including report writing and case recording. It highlights the ways in which academic writing skills are transferable to practice. Chapter Nine explores self-presentation and discusses the ways in which our own thoughts and beliefs impact on our actions. The chapter offers a number of useful exercises that can be used to explore the self in more depth. Chapter Ten emphasizes the importance of critical reflection in social work practice. It begins by introducing the concept and its usefulness as a learning tool before offering techniques and questions to aid reflection.

Finally, Chapter Eleven looks at skills for self-management. The focus of this chapter is on managing one's day-to-day role as a social work practitioner. It recognizes the stresses that this role brings and offers strategies to assist in the management of stress focusing particularly on the importance of supervision. It looks at ways to support daily practice and also looks to the future and introduces personal development planning to assist as a tool for future career development.

Overall this book has a number of strengths. Edited by a social work academic, it draws on a range of perspectives in the various chapters including those of current social work practitioners, practice assessors, service users and carers and this is particularly helpful. Across the various chapters, a number of themes relating to social work with adults become apparent. These relate to promoting the rights and protecting the welfare of service users, partnership working and the involvement of service users and carers in the process. A number of ethical dilemmas are also highlighted. In particular, these relate to promoting choice on the one hand but protecting service users from harm on the other. Likewise, advocating or negotiating on behalf of a service user can be difficult when representing an agency structured around budgetary constraints. This can lead to role confusion and a perceived threat to personal autonomy on the part of the individual social worker as highlighted in the final chapter of the book.

This book is written at a time of change in the world of adult social care. In particular, the personalisation agenda raises a number of questions in respect of the future direction of social work and the role of the social worker within this new world. The book touches upon these dilemmas at a number of points. Some greater discussion of these developments, drawing upon the relevant policy documents, legislation and the theoretical framework behind the developments would have strengthened the book further.

This book is a welcome addition to the literature on adult social care. Although aimed primarily at students wishing to work with adults, many of the skills it discusses are transferable to work with service users in a range of contexts including children and families and criminal justice. Likewise, it provides a useful refresher to more experienced practitioners and academics teaching in this field. A worthwhile read and useful starting point for those wanting an overview of the main issues in working with adults.

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The Primal Wound: Understanding the Adopted Child
Newton Verrier, N
London, BAAF, 2009, pp.208,
ISBN: 978-1-905664-76-4, £11.95 (pbk.)

Originally published in the USA in 1993, it took a further 16 years to see *The Primal Wound* published in the UK. Challenging assumptions and unrealistic expectations of adoption, Newton Verrier takes a somewhat controversial, straight-talking look at the impact of adoption on individuals and families. Her premise is that a child cannot fail to suffer when separated from his or her birth mother, regardless of the circumstances. She argues that a loving set of adoptive parents is not enough when a child is subjected to that initial trauma. Much of Newton Verrier's writing comes from her own experiences of being both an adoptive and birth mother, a therapist and a researcher interviewing many adoptees.

In part one, Newton Verrier defines what she has termed 'the primal wound': the experience of separation, abandonment and loss felt by a child separated from its biological mother. She recognises the deep significance of the nine-months *in utero* experience and explores the impact of the separation of mother and baby. Through conversations with adoptees, Newton Verrier picks out themes of feelings of not fitting into the adoptive family; a need for fantasy and, with reference to Stern (1985), the loss of a sense of self experienced by adoptees and to a greater or lesser extent recognised by them. The author touches on physical symptoms, as well as feelings of loss, rejection and abandonment and the enduring nature of these experiences.

In the second part, Newton Verrier moves on to explain how this initial experience of abandonment and loss is played out in an adoptee's life. She highlights issues including rejection, trust, shame and identity and explains how they can manifest themselves in different ways through various relationships throughout the life of an adoptee. There are often conflicting and opposing feelings experienced by the same person and outworked in a number of different ways at different periods in the adoptee's life.

Thirdly, Newton Verrier moves on to more practical aspects of how to deal with this, what she sees as inevitable, primal wound. She looks at this from the perspectives of the adoptee, adoptive mother and birth mother, recognising the strong feelings experienced by each throughout the adoptive child's life. Whilst primarily considering children relinquished as babies, the author takes a chapter to look at how to deal with the issues of adoption with a child placed when slightly older. Newton Verrier tackles controversial and emotional issues that may occur during reunions - such as sexual attraction or further rejection.

In conclusion, Newton Verrier reiterates her reasons for writing the book. These are to encourage pregnant mothers to take time to consider the impact of relinquishing their baby, to support adoptees to understand their own feelings and behaviour and to enable prospective and current adoptive parents to explore both their own issues of abandonment and loss as well as those experienced by an adoptee. Newton Verrier hints at her concern over policies that aim to meet the desire for childless couples to have a baby rather than addressing the need to prioritise and promote a child remaining with his or her birth mother. Originating from the USA, I hope this trend that Newton Verrier perceives cannot be said to apply to the UK today. Newton Verrier focuses on relinquished babies and their mothers whereas, in the UK, the significant number of adoptions are of children removed from their mother's care. While not diminishing the relevance of the theory of a wound caused by separation of mother and baby, there are perhaps different feelings, or articulations of feeling, when the story of the 'adoption triad' is that of a mother who

did not choose adoption but had the decision taken away from her by the Court. These issues could have been discussed further.

Whilst at times labouring, perhaps deliberately, her fundamental idea of the primal wound, Newton Verrier offers a blunt and honest look at the situation as experienced by many adoptive families. There has been a traumatic experience, sometimes not one within a child's memory, but one that needs acknowledging as significant and not something to be brushed over or even assumed that an adoptive family can heal.

This is not a book to be read lightly, particularly by potential or current adoptive parents, as there are no guaranteed solutions. Likely to cause offence to some who struggle to hear Newton Verrier's strong views (not just on adoption as she also touches on childcare, anonymous sperm donation and abortion), Newton Verrier is willing to say what perhaps many involved both personally and professionally think. That is, that adoption is not a straightforward solution for looked-after children. Each child comes with deep hurt and trauma, and there is no quick or easy answer. What is required is 'parenting plus' and, quite often, adopters have many issues of their own that they must also be willing to address.

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Reference
Stern, D. (1985) *The Interpersonal World of the Infant,* New York: Basic Books.

Learning from Child Deaths and Serious Abuse
Vincent, S.
Edinburgh: Dunedin Academic Press (2010), pp.133, ISBN: 978-1-903765-96-8, £14.99 (pbk.)

Dr Vincent's book seeks to describe what can be learned from looking at cases of significant child abuse, including some that resulted in the death of a child in Scotland between 1975 and 2009. The first two chapters amount to a highly informative critique of the extent of child death due to maltreatment and of the processes behind child death enquiries and reviews across the United Kingdom. These chapters include description and analysis based on key research and identification of the shortcomings in the collection of data about child death. There is a clear argument throughout for the support of the new Child Death Overview Panel (CDOP) processes but also for ensuring that the public health approach is wide enough to identify better how to lower the number of preventable child deaths.

What was of surprise, for the English reader, was the way in which inquiry practices into child death due to maltreatment in England (and Wales) have diverged from those in Scotland. In England, the Area Child Protection Committee (ACPC) had had responsibility to conduct Serious Case Reviews since 1988, and Local Safeguarding Children Boards (LSCB) have had a statutory responsibility since the Children Act (2004). However, in Scotland the responsibility (not statutory) upon Scottish Child Protection Committees (CPCs) and resultant single countrywide process has only been in place since 2007. Currently, there are no plans to introduce wider child death reviewing systems such as CDOP in Scotland.

The first two chapters of the book are an excellent introduction to understanding the legislation and guidance which ensures that

child deaths are reviewed. They are, therefore, of relevance to all practitioners working with vulnerable children in the UK.

The rest of the book is dedicated to understanding better the themes that emerge from enquiries into the death or serious injury of children due to maltreatment in Scotland. The restriction on the author due to the paucity of information is clear. There were 13 reviews in all during the period 1975-2009 (with none between 1975 and 1990). These include 7 enquiries regarding death or abuse in the home; 4 regarding abuse in residential care involving significant numbers of children and individual perpetrators and 2 of child death in the community (including the Dunblane Inquiry).

It would be of interest to the reader to know why there were no reviews conducted and why there was so little drive to know why children had died. However, the answers to these questions may not be so easily found. Across the cases, there was no one clear process of notification of who commissioned or conducted the inquiry and how. Dr Vincent uses all information available and conducts a comparative study, pulling themes from the systematic overviews of Serious Case Reviews in England and in Wales and examining the learning that can be gleaned from the Scottish cases. Attention is paid to child, family, environmental and agency factors that need to be addressed.

The latter chapters are of use again to all practitioners across the UK in that they methodically approach each theme and learning point arising from child death reviews. But the book serves a more essential purpose in making all of this learning much more relevant and interesting to practitioners in Scotland. When the demands of social work place pressure upon those working in child protection, a possible tendency is for individuals and organisations to become more introverted

and less outward looking both in their work and learning styles. Dr Vincent's book makes it clear that child death and serious injury through maltreatment does happen in Scotland and that there is learning for all involved in child protection from looking at such reviews.

Hopefully, it will help to stimulate debate about how best to conduct such reviews or enquiries and to ensure that the learning is embedded in to practice. It also raises, for the reader, the vital point that practice developments across the UK may be too reactive and dependent upon the headline-grabbing cases and not upon a systematic reviewing of all child deaths. Practitioners across all disciplines stand to learn much more about preventing child death if the learning from all child death enquiry processes are emphasised as important and relevant to practice in safeguarding children.

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