

A New Conception of Social Care Outcomes and its Practical Use in Assessment with Older People

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Abstract

This paper tackles two issues: exploring stakeholder perspectives on the meaning of social care outcomes for older people; and translating the findings of this research into tools for practice. It outlines a conception of outcomes derived from extensive exploratory research with service users, carers, social care staff and managers. It then describes the process, and results, of collaborative attempts to adapt and use the research findings to develop tools to support care managers in identifying intended outcomes at the point of assessment.

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Introduction

Despite the continuing prominence of the language of outcomes in policy and practice documents, precise or detailed meanings for the concept are rarely spelled out. However the desirability of specifying, recording, evaluating and achieving outcomes is variously emphasised. Much discussion of outcomes is influenced by the prevailing model in health care, which is integrally linked to the idea of 'cure' or improvement in the person's condition or functioning, thus emphasising measurement 'before, and after, intervention'. While this can be helpful, it can also be confusing for social care staff, who perceive, quite rightly, that it does not fit the kind of outcomes achieved, or aimed for, in much of their work. Part of this paper puts forward an expanded framework for understanding social care outcomes for older people, derived from extensive consultations with older people using services, carers, staff and managers.

A second prominent theme in social care is the translation of research findings into practice. This process is sometimes conceived as simply a matter of getting messages across to practitioners and managers who ought to receive and act on them. There is a growing literature which recognises that matters are rarely so straightforward. Implementation may require considerable behavioural and organisational change, and lack of knowledge about findings may be one of the least of the barriers to overcome. Equally, findings do

not necessarily come ready made for implementation, they require adaptation for use in practice. Nor are researchers necessarily in the best position to know how findings should be used. In the research and development projects described in this paper, researchers worked in collaboration with staff and managers in social services to develop ways to use an outcome focus in practice, beginning from ideas suggested by stakeholders during the initial consultations. To illustrate the process of collaboration, and the end result in terms of a practical use for the outcomes framework, this paper will give an account of one development project which focused on outcomes and assessment with older people. This area seems particularly topical with the recent issue of a consultation paper on principles for assessment in social care stating that care plans for adults must include a record of 'the preferred outcomes of service provision' (Department of Health, 2001, para 27).

This paper draws on research and development undertaken as part of a five year programme by the Social Policy Research Unit, University of York. The work was funded by the Department of Health. The SPRU outcomes programme did not aim to construct scientific measurement tools for research purposes, but rather to investigate whether and how outcomes could be assessed as part of regular or routine practice, in ways that would be practical and useful. 'Outcome' is interpreted as the impact or effect on the lives of service users or carers, and 'Part of regular or routine practice' means a continuing or repeated method which is a useful part of the regular activity of any agency providing or purchasing social care. After a brief illustration of some of the language to be found in policy documents for social care, the outcomes framework for older people developed during this programme, and its subsequent application to assessment with older people will be described.

Background

The 1998 White Paper on Social Services saw a focus on outcomes as central to the Government's concerns:

Our third way for social care moves the focus away from who provides the care, and places it firmly on the quality of services experienced by, and the outcomes achieved for, individuals and their carers and families

(Modernising Social Services, Cm 4169, Para 1.7)

In parallel, substantial practice benefits were envisaged from a clearer focus on outcomes in care management:

12

At the individual level care planning needs to be thorough and outcome focused.

(Social Care Group, 1998, para 3.4)

However, subsequent reports have argued that practice continues to fall short of these aspirations:

'Inspections often discover that workers are not clear why they are intervening in a situation and how their intervention will tackle the problems or improve the life of those with whom they are involved'

(SSI, Chief Inspector's Report 1999, para. 1.23)

'It is rare to see the desired outcome of any service in the care plan or written in the case file' (Audit Commission/SSI, 2000, p. 5)

Review of the literature and initial exploratory studies at the beginning of the SPRU programme identified a number of barriers to the implementation of an outcome focus in social care (Qureshi, 1999). It was argued in the literature that outcomes thinking was not part of the day to day culture in social services: it simply was not an aspect of the way people thought about or discussed their work. At the same time there was some recognition of genuine conceptual and technical problems in applying health outcome models in social care; for example the lack of obvious 'end-points' to intervention, and lack of accepted measures. A further barrier was identified as staff cynicism about 'the politics of

quality'. For example, James (1994) argued that approaches to quality which seemed to flow from financial or bureaucratic concerns only, were in conflict with many managers' and professionals' own values and standards and created a feeling of acting 'inauthentically' which led to general scepticism about the pursuit of quality. Several years after James' work, we found, in discussing outcomes with care managers, an expressed commitment in principle to the need for feedback on services and to public accountability, but a continuing degree of cynicism about the ways in which information might actually be used:

Care Manager 1: Why do you think that this piece of work has been commissioned...? I mean what is the information people are looking for from it? Yes and what's the agenda and all this, is it just to say 'Look how wonderful they're doing.' Or is it....

Care Manager 2: To cut our service.

Care Manager 3: Or is it to improve our service, let's be optimistic.

Additionally, there was a range of barriers, identified to SPRU researchers, related to the reality of organisational culture and day-to-day practice in the social care context. These included factors such as: inadequate IT systems; poor use of management information; change overload; staff non-compliance with recording requirements; other external demands of greater priority. Our experience is that many of these remain equally relevant as barriers today. Certainly, change overload has not diminished. As one manager observed to us, the one constant experience for managers is the requirement to manage change. As researchers we felt that we could not directly address these latter problems, but would have to accept them as part of the context. We believed, however, that the problems of conceptual confusion and cynicism could be addressed, and that some realistic possibilities for introducing an outcome focus into routine agency activities might yet be identifiable. The SPRU outcomes programme was thus designed with two linked stages. The first stage comprised research with a range of stakeholders designed, first, to explore and clarify the meaning of outcomes in social care for adults and, second, to identify possible realistic opportunities to introduce an outcome focus into

agency activities. The second stage involved research and development with local authority partners aiming to develop and test out in practice some of the identified opportunities. As development progressed, the process was to be researched in order to identify barriers and facilitators to implementation.

Methods

In the first stage, stakeholders consulted were older people, people of working age with physical or sensory impairments, frontline staff and managers. We used a range of deliberative techniques (such as focus groups, vignettes, semi-structured interviews) to give people opportunities to discuss and think about the ideas. Most groups met more than once. We included very diverse groups of service users including people with dementia, older people with mental illness, people who were Deaf or hard of hearing, and older people of Asian and Eastern European origin. Among staff we included social workers, care managers, home care staff, occupational therapists, and middle and senior managers. The total numbers involved were: older service users 88; users of working age 39; carers 30; staff 60; and managers 32. Results reported here pertain to older service users only. Details of methodology used with older people can be found in Qureshi et al. (1998), Bamford and Bruce (2000) and Patmore (2000). The work was supported throughout by a reference group of older people. The advisory group for the programme included older people, younger disabled people and a carer.

The development process was recorded and analysed using field notes, tapes, minutes of meetings, feedback questionnaires, group discussions, and, for some projects, follow up interviews with participants. These data were used to provide an analysis of the process and the immediate products of the development work. Our approach to development was influenced by ideas from the work of Smale (1996), Rogers (1995) and Egan (1993). We sought to identify opportunities to introduce outcome ideas through changes or innovations which would: fit well with already planned changes to existing practice; not require large investment of resources; solve problems which were recognised as such by those who would have to implement the changes. We aimed to work with people to establish 'ownership' of

new ways of working. Together with our two local authority partners we selected five projects as potentially adoptable in practice. Summaries of all these projects can be found in issues of *Research Works* downloadable from the SPRU website at: <http://www.york.ac.uk/inst/spru/pubs>

Findings - stage one - the outcomes framework

One concern in relation to assessing outcomes for older people, expressed by both staff and managers, was that any model of outcome assessment had to be appropriate for reflecting the achievements of work in many situations where only deterioration in the person's health and social functioning could reasonably be expected. In broad outline, the outcomes framework which resulted from our consultations gave prominence to the idea of 'maintenance' of quality of life, although the concepts of change and the outcomes of service processes were also of importance (see Box 1)

13

Box 1

- **Maintenance** of quality of life - for example, maintaining acceptable levels of personal comfort and safety, a clean and tidy home, social contact, keeping alert and active, having control over daily life and routines.
- **Change** - for example, improving confidence, or accessibility of the environment, reducing risk, or regaining self care skills.
- **Impacts of Service Process** - for example whether people feel treated as an individual, valued or respected, or whether services fit well with other sources of assistance, or the user's preferences or priority outcomes

Maintenance

Social care intervention is often not time limited. It requires continuous input to maintain continued results, day after day. Despite the prominence given to change outcomes in health policy, improvements in health or physical or cognitive functioning are not generally the aim of social

services for older people, indeed in the majority of instances, the aim of services is to maintain quality of life in the face of illness and disability, and probable deterioration of functioning. Of course rehabilitation is important for some people, and older people should have the right to equal access to rehabilitative services. However, managers estimated that as little as 15% of work was undertaken in situations where improvements in health or functioning could be expected, but this was 'informed guesswork'. Broader evidence is thin on the ground, but Bauld *et al* (2000) in a longitudinal study, found that 58% of a sample of 281 older social service users showed an increase in the number of health problems between time 1 and time 2, while only 18% showed a decrease (page 314). (These figures underestimate the likely prevalence of those whose health had deteriorated because they exclude those who had died or been admitted to residential services by time 2).

In discussing actual or hoped for outcomes from services, older people themselves focused mainly on maintenance of quality of life, although their satisfaction with services was linked both to the achievement of an acceptable quality of life, and to service process outcomes. The specific dimensions of quality of life are drawn principally from the views of older people. Services may help to achieve the above quality of life outcomes directly, or may tackle problems which stand in the way of doing so.

Change

Change outcomes result from attempts to tackle problems or remove barriers which stand in the way of achieving desired levels of quality of life. Some of the specific changes which services might try to bring about include assisting older people to recover confidence and skills after stroke or heart attack, or modifying the environment to improve mobility. The list is potentially infinite, although it is likely that certain changes will be sought much more frequently than others. As will be obvious, changes are not always direct changes in the person or their functioning. There will be a variety of ways to achieve the desired change, and the optimum method will depend on factors in the individual situation, as well as any knowledge which might be available about potentially

effective methods. For example, improving the ability to get around, inside and outside the home might be achieved through adaptations to the building, alternative housing, equipment, physiotherapy, mobility training for people who are blind, or accessible transport. Communication may be improved through availability of interpreters, training staff to use sign language, using audio tapes or braille, reading letters for people who are blind, hearing aids, or speech therapy. Identifying the changes needed to improve, or make it possible to maintain, quality of life is a key aspect of assessment. Some barriers to quality of life may of course be beyond the scope of social services, requiring input from health or other agencies for example. However, since their services function as a 'safety net' social care workers do see it as part of their role to assist people to obtain other services such as benefits or medical intervention if the need is evident.

Service process outcomes

These outcomes reflect consequences of the way in which services are delivered, and are relevant whether the intention is change or maintenance. Much of the available evidence indicates that user satisfaction, or lack of it, is related at least as strongly to the way in which services are delivered as to any specific changes which may result (Harding and Beresford, 1996; Turner, 2000). Service process outcomes are *not* attributes of services such as reliability or continuity, but rather they are the perceived impacts on users of the process of service delivery, for example, a perception that one is, or is not, 'being treated as a person'. The overall desired impact on feelings is that the recipient of care should feel treated as a person (ie an individual), and as a fellow human being, and a valued citizen. The interpersonal aspects of the exchange between staff and users are important in achieving this outcome. However this sense of being treated as an individual is not just about interactions with staff, it is also about the degree to which services are organised in a way which supports, or does not support, choices about care-giving arrangements within the family, and cultural and religious practices or other personal preferences. Our discussions suggested therefore that the impacts of the way in which services are delivered flow from two main sources: first the staff (their competence, disposition and attitude);

and, second, the organisational logistics which permit, or do not permit, the flexibility which enables individual tailoring of the care package. We have argued elsewhere that commonly identified aspects of service quality such as reliability, punctuality, flexibility and responsiveness are identified as important for quality *because* they contribute to achieving outcomes of the kind which have been identified here (Qureshi and Henwood, 2000).

Implied models of measurement

Can these outcomes be assessed or measured? The simple answer is yes. For practical purposes a simple judgement about whether quality of life is being maintained to acceptable levels, or expectations of change achieved, or a 'good fit' with user preferences or lifestyle is being delivered, may be adequate. Professionals are making these judgements all the time, as a basis for deciding on action, and so are users and carers. Measures for research often rely on such judgements also. In making judgements, the standards of comparison, or expectations, of older people, their carers and staff who work with them, may differ of course. This makes it important for a department to be clear about the standards it aspires to, and the limits that overall resources and fairness in distribution may dictate.

The concept of 'before and after' measurement, which is applied in considering change, is not relevant to maintenance or service process outcomes. Service process outcomes are by definition measurable only after services have been received, although there is undoubtedly a case for repeated measurements if continuous monitoring is intended. Similarly a department can assess whether an acceptable quality of life is being maintained by specifying target standards and comparing the person's actual state with the desired standard. Such measurements can also be repeated over time, but the 'outcome' is not the difference between measurements over time but the difference between the standards achieved and those which would be achieved without input from services. Often, it will not be possible to directly observe this difference, only to make judgements about it.

Using these findings in assessment and care planning with older people

Initial attitudes of stakeholders

From our initial consultations with staff and managers it seemed that there were a number of areas where potential benefits were envisaged from a better understanding (and communication) both of intended outcomes, and user and carer preferences. Middle managers, responsible for staff who undertook assessment, had commented that links between needs (in the assessment) and the service response (in the care plan) were not always clear, and that in home care objectives rarely went beyond the very general, such as keeping people at home. It was felt by managers that this failure to record specific objectives might omit to demonstrate good practice which was in fact occurring, or equally, might suggest that there was at times too unthinking a leap between 'needs' and services. In addition, both staff and managers observed that this lack of clarity sometimes meant that valuable information gleaned during assessment, about the purposes for which services were to be provided, was not being communicated to provider managers or, subsequently, to provider staff. However there was no wish to change assessment in any radical way because considerable effort had already been devoted to agreeing and implementing an assessment system across the authority, which was used by social care staff in community and hospital settings.

Care managers in the stage one research, while they recognised the legitimacy of demands for accountability, did not immediately perceive a practical use for an outcome focus in assessment. They regarded individual situations as too varied, and often too complex, to clearly specify general outcomes to be sought. Thus it became clear that without opportunities to discuss the concept in some depth, and to relate to a conception of outcomes which they recognised as appropriate to their situation, the introduction of a requirement to summarise intended outcomes at assessment would be likely to generate confusion and resistance.

To achieve credibility among care managers it was important to recognise that assessment is where the agency agenda and the user agenda meet and have to be reconciled (Richards, 2000). This tension at

the heart of assessment is not the only source of potential conflict, as Smale *et al* (1994) noted:

... conflict often exists between the demands and needs of referrers, carers and dependent people; between different 'users' of services and between other people in the 'client's' family and wider network. Undertaking assessments and care management has to be **negotiated** within these conflicting needs, attitudes, expectations; as have definitions of the 'problem', and its 'solutions', to arrive at, and maintain a workable and good enough package of care, as defined by users. (Smale *et al*, 1994, p.3)

16

As a consequence, assessment can involve the negotiation of complex and difficult paths through conflicting expectations and requirements, although the underlying aim for most social workers, as expressed in our initial focus groups, was around preserving individual autonomy in adverse circumstances:

'it's allowing someone to still have control of their life and make decisions for themselves and live their life as they see fit without others imposing their own [views on] what they should do' (care manager - discussion group)

The development process

The process of developing and testing a form for recording intended outcomes in assessment took the following form:

- Five meetings of a working group
- Two workshops for 17 staff who undertook assessments.
- A trial implementation involving 30 assessments by 12 members of staff

Each of the above is discussed in more detail below:

The *working group* consisted of two researchers, one principal care manager (with responsibilities for assessment 'paperwork'), one home care manager and two care managers. The brief was to develop initial documentation which would: embody the findings of the first stage SPRU research about perceptions of outcomes; be

designed to fit with existing, or planned, recording; minimise demands for additional paperwork; underpin and extend good practice in care management with older people.

No older users or carers were involved in this group. We took the view that this stage of the project largely concerned matters of relevance to the department and the improvement of its own procedures. There had been considerable user and carer involvement in initially developing the outcomes framework which we were attempting to integrate into practice. The users consulted had not expressed interest in the contents of their records, but rather in having opportunities to feedback their evaluative opinions to people with sufficient power to act on them. This aim was being pursued in other development projects (cf. Patmore, 2001). Goldsmith and Beaver (1999) similarly found that older people were not very interested in what was held in their records (para. 4.2).

SPRU's agenda in the development work was to find a way of ensuring that intended outcomes were recorded, as well as considering the user or carer preferences which might affect the achievement of process outcomes. In addition, SPRU researchers believed that it would be important to record anticipated changes that were likely to influence the duration or kind of services needed, if that were possible. The care managers in the working group were positive about outcome ideas, and believed that the existing 'needs summary' as it stood was not an adequate conclusion for the assessment. However their primary concern in developing new documentation was that it should more accurately reflect (especially in complex situations) the good practice which they believed was being undertaken. The manager wanted to coordinate all the proposed changes in assessment, deriving from a range of management concerns across the department, in order to ensure that changes were introduced simultaneously in a planned and coherent way.

In many ways these concerns were mutually reinforcing, and in our view led ultimately to a new summary (with supporting documentation) which was well linked to our outcome concerns, clearly relevant to practice issues in assessment, and likely

to be adopted because of its links into other departmental changes. The only downside from the research point of view was that the multiple changes happening together made it more difficult to conduct a distinct evaluation of the use of outcome summary per se. Although our evaluation forms asked specifically for comment on the summary, frequently workers responded with comments about the other changes, and their impact (or problems). Although all feedback was valuable to the department, this experience suggests there may be some tension between 'adoptability' and 'researchability' in undertaking researched development, because seeking to link a specific development to other compatible changes makes for difficulties in subsequently focusing data collection on the precise impacts of one specific change.

The *workshops* were conducted half way through the working group's operation, by SPRU staff in collaboration with the department's training section, and were designed to: outline the SPRU findings; discuss and comment on draft documents produced by the working group; and affirm and build on current good practice in care management. The workshops comprised a mixture of presentations, plenary discussions, work in pairs and work in groups. When we presented findings from the first stage of the programme, there was some relief that 'outcome' which had seemed to some an unnecessarily mystifying piece of jargon, could be interpreted within a framework which they recognised, and which had added credibility because of the extensive user consultations which had been conducted locally. While we are confident that some staff can summarise outcomes without extensive training or opportunities for discussion, there are many others who benefit from, and enjoy, the chance to hear and discuss research findings and improve their confidence about the concept of outcomes and its fit with their work. Our future intention is to build on our existing materials to develop and test training resources to assist departments with such a process. In the light of feedback and questions raised in these workshops, the documentation was revised and, at the request of staff, a prompt list of outcomes was prepared which could be used by them as an aide memoire. Once this process was completed, a limited trial implementation was set

up to test the use of the assessment summary and prompt list in practice. The content of these documents is outlined below:

- The *assessment summary* emerged as a one page document (two sides of A4) which comprised a structured set of headings. The previous longer 'summary of needs' was reduced to a brief pen-picture to set the scene. Two further headings on the first page reflected SPRU's initial interests: 'expected changes (relevant to service delivery)' and 'agreed outcomes to plan for'. Subsequently the first of these two has been retitled 'looking to the future' and a review date is requested if needed. The second page summarises the options discussed for reaching the agreed outcomes (services can be mentioned here), the views and preferences of user and carer (separately) about services and priority outcomes, and the 'assessors conclusions' about the way forward which summarise what has been agreed as a basis for the care plan. This set of headings reflect recognised good practice and recognition of the complexities of negotiation which may be involved in reaching an agreed set of outcomes and care plan.

Following the pilot the authority has decided to add a set of tickboxes to reflect common outcomes, with a view to generating some aggregatable data about outcomes sought. The precise wording of the headings is not the key issue, indeed in our view it is important that wordings are used which fit well with local requirements. The important concepts are: a brief picture of present issues relevant to eligibility for services; a perspective on the future and likely changes; agreed outcomes to plan for; options discussed with the user and or carer; users expressed preferences about service delivery (or outcomes); carers expressed preferences about service delivery (or outcomes); assessor's conclusions. One of the care managers on the planning group was particularly interested in the 'exchange' model of assessment, developed by Smale *et al* (1993), in which the user is regarded as the expert on their own situation, the worker as an expert on available services and negotiating problem solutions, and the process of assessment is regarded as an exchange of information: this last in contrast to a 'questioning'

model for the interaction. Although this model was not specifically advanced or discussed in the subgroup, nor necessarily held by other practitioners who contributed their expertise, the emphasis in the outcome summary on agreeing outcomes, discussing options, eliciting user and carer priorities, and the assessor's responsibility for summarising conclusions, are evidently congruent with this approach.

- The *prompt list* (see Box 2) summarised common outcomes for older people and carers. It was intended to support staff by providing a suitable vocabulary to describe commonly sought outcomes. The following extract indicates the way in which maintenance outcomes for older people were described. The remainder of the prompt list contained an introduction for staff and examples of outcomes for carers, and change and service process outcomes. The full prompt list is reproduced as an appendix. (page 14)

In preparing the prompt list it became clear that the maintenance outcome dimensions were only useable in practice if the level to be aimed for was specified. There is obviously a difference between aiming only to relieve severe isolation, as opposed to aiming to achieve full social participation. The standards were inferred by the researcher from knowledge of existing practice, because standards in this form were not specified by the social services department. It is our belief that outcome-related standards of this kind are readily understood by service users, and could form a basis for eligibility criteria, in that a person would be eligible for services if ill health or disability meant that their quality of life was, or risked becoming, below the specified standards.

The *trial implementation* involved 12 staff: seven social worker/care managers, two senior practitioners, and three home care organisers. Half of those involved worked in hospital settings, half in the community. Staff were recruited and briefed by the two care managers who had been on the planning group. The original target was that each assessor would complete four assessment summaries and give structured feedback, via a self-completion form, on the experience of doing so. The assessments, in anonymised form, were to be

Box 2	
MAINTENANCE OUTCOMES : common domains of outcome and description of a standard for each domain (These outcomes have to be maintained in a continuing way although the level of services required to achieve this may vary over time. They may be maintained in the short term, during recovery or rehabilitation for example, or in the long term, perhaps where deterioration in the person's condition is expected)	
The older person	
Personally clean and comfortable	An older person who is not able to carry out their own personal care is personally clean and comfortable, presentable in appearance, has a nutritious and varied diet, and is in bed or up at appropriate times of day.
In a clean and comfortable environment	The immediate environment is clean enough to avoid harm to health and prevent deterioration in morale.
Safety	The older person feels as safe and secure as they wish to be AND the worker is satisfied that the risk levels are acceptable or the client prefers to continue to accept the risks involved.
Contact and company	The older person is able to access sufficient contact with significant others and opportunities for wider human contact and social participation (to avoid isolation).
Keeping active and alert	The person is able to pass their time in activities which interest and stimulate them, at home and outside the home (if wished).
Control over daily life	In so far as the person is able to express preferences, they feel that they have control over, and can plan, their daily life and routines. (Can also apply to carer)

made available to SPRU, whose task was to analyse the completed summaries, and the assessors' diary sheets, and feedback preliminary results of analysis as part of a workshop to exchange information with participants. In the event, not all participants reached the target numbers, but a total of 30 assessments were completed, which was judged sufficient to draw some conclusions about the experience of using the tools.

In feedback the most frequently mentioned difficulty was the time required, although in all of these cases it was not the length of the summary required which posed the difficulty but the complexity (and unfamiliarity) of the thinking required:

More time consuming due to need to separate threads of what was needed and why

Trying to separate issues and put them into the right sections was difficult. Took a lot of thinking and time

In one comment on difficulties there was a suggestion that the thinking became easier with practice:

Initially I tended to jumble up outcomes with services but this became easier as subsequent forms were completed

In contrast to these difficulties, the majority of positive comments reflected more general perspectives on the effects of a focus on outcomes on the assessment process as a whole, and indicated that the intentions of the summary were being realised:

Good - it made clear the rationale for the service being provided.

Clearer indication of the aims of support.

This was a very clear cut case so there was no ambiguity about intended outcomes. However, having to state outcome so precisely helped to put any risks into context.

(User) has a complex family situation and

conflicting views between family members. I thought this form helped to highlight why a particular path had been chosen and offer important info to nursing home on family situation and views held therein.

One worker commented on a possible benefit to users of a summary of intended outcomes instead of 'needs':

An easier way of sharing the assessment with users without the negative aspects of their abilities being highlighted.

This last comment is reinforced by literature from the user movement and by disabled people (Turner, 2000; Morris, 1997) who have argued for a greater focus in assessment on what is to be achieved (as well as how), and have indicated that an exclusive focus on 'needs' runs the risk of seeming to concentrate on inabilities and deficiencies on the part of the user.

The diary sheet also directly asked workers whether the assessment summary and prompt list had made any difference to: the assessment process; the care plan or planning process; the way the package was implemented or delivered; the way the package was reviewed. Because some workers had filled in only one diary sheet for several assessments we had a total of 17 responses. However the answer 'yes' was given in relation to assessment (seven times); care plan (eight times); package delivery (nine times); review (seven times). One illustrative comment about review was:

Yes, because an important indicator became whether (user) had experienced discomfort or not, and not merely whether nursing needs were being met.

A comment on the care plan was:

Yes, care plan geared towards rehab goals.

Analysis of the completed assessment summaries revealed some variation in the extent to which outcomes had been clearly identified. An example of clear identification in an assessment by a hospital based social worker was:

1) For (user) to return home. 2) For help to be clean and comfortable and to have a varied diet at suitable times of the day. 3) For (user) to feel safe in the home. 4) For there to be sufficient human contact through day and night. 5) For user to have, as far as possible, choices in relation to who provides support. 6) For risks in relation to pressure areas to be minimised. 7) For user to be transferred in a way that reduces the risk of physical harm to herself and others. 8) For (user)'s confidence and morale to be improved.

Another example, reflecting mental health concerns and intended changes for a carer, was:

20

Reduction in level of depression - improved mental health. Improved coping skills and confidence. Independence with self-care - regain skills and capacities. Reduce carer involvement.

In the subsequent de-briefing meeting the issues raised were discussed at greater length and views exchanged on possible improvements and changes. After receiving a report on the pilot, the implementation group decided that the assessment summary should be introduced in work with older people throughout the authority. This is now in progress.

Conclusion

The identification and summary of intended outcomes is *not* another method of assessment, and not intended to replace or supplant existing assessment documentation or procedures. We believe this enhances its adoptability. Rather it is an explicit recognition of an essential step between assessment and the construction and implementation of a care plan.

Given the reported issues that this project was intended to tackle, i.e. making ends/means connections more explicit, our main concern was that intended outcomes should be better demonstrated in recording, because this was important in itself from the point of view of performance management, provider information and structuring of subsequent reviews. From this point of view, simply to replace the existing open-ended summary of needs which previously

concluded the assessment, with a more structured summary which included identification of intended outcomes, was sufficient for success. The reports back from the pilot suggested that there might also be improvements in practice in terms of focussing the assessment process, providing summaries which were more positive and forward-looking from a user perspective, and ensuring that the process of negotiation and information-giving, which led to the assessors' decisions about how to deploy agency resources, was clearly evident. However the process would have to be subject to considerable further testing, to establish whether such benefits were widespread, and whether they extended to improving actual outcomes for older people and carers.

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APPENDIX

OUTCOMES PROMPT LIST**Social Policy Research Unit
University of York****Guidance notes for staff**

The Outcomes Prompt List has emerged from research and development work undertaken by SPRU in partnership with social services staff within the Outcomes Programme. During SPRU's research, staff indicated that a great deal of the work of social services involved providing support continuously, day after day. Much work undertaken by home care is of this kind. The 'outcome' is that a person's day-to-day needs are met, and continue to be met. **Maintaining quality of life** in this way involves outcomes such as personal cleanliness and comfort; clean environment; personal safety; having social contact and company; having interesting or stimulating activity; having control over everyday life and routines. Sometimes maintenance is needed short term (perhaps during recovery or rehabilitation), but frequently no specific end-point for services is envisaged, indeed an increase in services may be anticipated if the person's condition is deteriorating.

Of course it might sometimes be necessary to improve someone's quality of life before it is possible to reach the situation where it can be maintained. In contrast to continuous maintenance, services sometimes actively work towards **changes or improvements**, which if achieved, mean that there is a possibility that fewer services will be needed, or that future services will be able focus on maintenance. Changes for the better result from tackling barriers to achieving quality of life, or reducing risks. Examples mentioned were: improving the person's functioning (ability to get about, confidence, skills, feelings, behaviour); eliminating risks, improving access to benefits; improving relationships with family members or carers.

Finally, once services are being delivered, there are **service process outcomes** which are the results or impacts of the ways in which services are delivered. One such outcome is the extent to which the user feels that assistance from services fits well with other sources of assistance, and with their own life choices or cultural or religious preferences. Other impacts of services reflect the ways in which people are treated by staff, and the extent to which people feel they have a say in services.

During the training courses some people said that a checklist of the kinds of outcomes which might be relevant would be helpful. The following is a list of common examples, it does not include every possible outcome, and the outcomes themselves are expressed in quite general ways. Sometimes people will wish to list more detailed or specific outcomes for a particular person. The list which follows is meant as a reminder of some of the more common possibilities.

'MAINTENANCE' OUTCOMES : common domains of outcome and description of a standard for each domain

(These outcomes have to be maintained in a continuing way although the level of services required to achieve this may vary over time. They may be maintained in the short term, during recovery or rehabilitation for example, or in the long term, perhaps where deterioration in the person's condition is expected.)

The older person	
Personally clean and comfortable	An older person who is not able to carry out their own personal care is personally clean and comfortable, presentable in appearance, has a nutritious and varied diet, and is in bed or up at appropriate times of day.
In a clean and comfortable environment	The immediate environment is clean enough to avoid harm to health and prevent deterioration in morale.
Safety	The older person feels as safe and secure as they wish to be AND the worker is satisfied that the risk levels are acceptable or the client prefers to continue to accept the risks involved.
Contact and company	The older person is able to access sufficient contact with significant others and opportunities for wider human contact and social participation (to avoid isolation).
Keeping active and alert	The person is able to pass their time in activities which interest and stimulate them, at home and outside the home (if wished).
Control over daily life	In so far as the person is able to express preferences, they feel that they have control over, and can plan, their daily life and

The carer	
Maintain health and well-being (physical, mental, emotional, spiritual)	Negative impacts of caring on health and well-being minimised; able to have sufficient sleep, exercise and some fulfilment/satisfaction within their life.
Able to have a life of their own	Can enjoy free time, leisure activities or is able to keep employment, friends or social/community links, or meet other obligations.
Supported in the caring role	Feels that services offer appropriate help, emotional support, information and share responsibility for the quality of life of the older person.
Peace of mind	The carer is free from excessive or persistent anxiety about the well-being of the person they care for.

CHANGE OUTCOMES: changes which result from tackling barriers to achieving quality of life, or reducing risks

(An end point to the intervention can be defined, at which the intended improvement can be said to have been achieved, or partly achieved, and the level of services required can be reduce, or the focus of continuing services becomes maintenance.)

24

Recovery or Rehabilitation outcomes	
Regaining skills and capacities (for independent living)	Only an outcome of services if social care staff are explicitly working on specific activities which are designed to help people to re-acquire skills and capacities.
Improving confidence and morale (older people and carers)	Regaining the confidence to deal positively with changed life circumstances, and/or personal and societal attitudes towards ill health and disability.
Improving ability to get about	Become more able to get around freely within the home or outside. (Many possible methods: equipment, adaptations, therapy, mobility training)
Reducing symptoms (for example of depression or anxiety)	(May be a joint outcome of health and social care services.) Experiencing fewer symptoms, feeling less depressed or anxious, sleeping better, relating better to others.

Other examples	
Reducing or eliminating risk of harm	Modifying the environment, averting homelessness, dealing with possible physical abuse or injury (if risks are being reduced and kept at lower levels by continuing service input then maintaining personal safety is perhaps more appropriate than this category).
Maximising benefit income	Could be a one-off aim, but if managing finances on a continuing basis were involved this would become a maintenance outcome.

Family and carer related	
Improving significant /close relationships	Enabling people to see each other's point of view, reducing tensions within relationships; mediating between conflicting interests.
Enhancing motivation or capacity to give care	Reducing distress or improving satisfaction in caring for carers, leading to caring being experienced as more manageable or rewarding.
Improving confidence and sense of expertise in care giving	Helping carers to make informed choices and feel confident and equipped to provide care; increasing knowledge and skills.
Reducing carer involvement	Enabling carer to draw boundaries about what they will do, or to give up altogether.

PROCESS OUTCOMES: the results or impacts of the way in which the package of services is provided

Services 'fit' with (or support) other sources of assistance and life choices

'Good fit' with cultural and religious preferences	The person feels that services take account of preferences about relevant issues, such as the way in which domestic tasks are performed, expectations of family members, staff characteristics, language skills and the nature of appropriate food and activities.
'Good fit' with family and other assistance	The person feels that services are delivered in ways that fit in well with their ideas about appropriate roles for family members, and support choices about care giving and receiving.

Influence over services, and impact of interactions with staff

Having a say over personal and domestic assistance	The user or carer can, if they wish, influence tasks performed, timing or personnel involved, in order to achieve their desired outcomes
Feeling valued and treated with respect	The person feels accepted despite symptoms or difficulties; treated as someone with legitimate right to services; treated as a fellow human being (with some warmth and friendliness); treated as someone different from others, with individual needs; their privacy and confidentiality are respected

Note: Within the Outcomes Programme, the above list of *process outcomes* did not form part of the prompt checklist used in the pilot implementation. Service process outcomes were discussed in the workshop and generated some interest. In retrospect we feel it is valuable to include them, as they do have relevance to the way in which the individual package is structured and delivered, so may need to be considered during care planning, even though they cannot be measured until after services have been received, and generally measurement is 'after only' rather than 'before and after'.

