Developing Outcome-Focused Practice: Examining the Process

Elinor Nicholas was a Research Fellow (currently an associate) at the Social Policy Research Unit (SPRU) at the University of York,
Hazel Qureshi was Professor of Social Care and Assistant Director of SPRU until the end of 2003.

Abstract
The idea of outcome-focused practice has gained momentum within social care in recent years and is a prominent feature of many current policy initiatives in the drive to deliver best value and generally improve services. However, the question of how to achieve this, or what it might involve is rarely considered. This paper briefly explores the complex nature of change entailed in developing both cultural and practical reorientation towards outcomes. It then examines in more detail the process of bringing about that change. The discussion offers an experiential perspective with illustrations from a range of development projects undertaken within the Outcomes Programme in collaboration with social care agencies. These experiences are related to the wider literature on change, innovation and research utilisation. While recognising the pressurised contexts and timetables in which multiple changes must be introduced, the article highlights the value of taking a longer term, and considered approach, with realistic assessment and planning around both the opportunities and the obstacles. A range of strategies are discussed including linking outcome-focused initiatives to others priority developments, working with the enthusiasts but engaging all stakeholders in agreeing what needs to change and how. The development of a new resource pack is also highlighted.

Keywords: Outcomes, change, management, care management, social care, adult services

Introduction

Can outcome-focused practice become a meaningful reality in the pressurised worlds of social care and health, amidst their contexts of multiple change, conflicting demands and expectations and limited resources? A range of recent policy initiatives has stressed the importance of maintaining a focus on outcomes when designing, delivering and evaluating social care, for example: the Single Assessment Process (Department of Health, 2002), Intermediate Care (Department of Health, 2001a), the 2000 Carers and Disabled Children Act (Department of Health, 2001a) and Best Value (Department of Health, 1998). However, there is ample evidence from various studies to indicate that meaningful application of outcomes in practice is a rarity (Goldsmith and Beaver, 1998; Qureshi, 2001; Warburton, 1999). The Outcomes Programme (1996-2000) undertaken by the Social Policy Research Unit (SPRU), and funded by the Department of Health, aimed to address this issue. The particular aim of the Outcomes Programme was to find practical ways in which the outcomes valued by older people, disabled adults and their carers could become more central to core activities in social care, such as assessment, care management and local evaluative surveys. On the basis of in-depth consultations with users, carers, practitioners and managers a conceptual framework for understanding outcomes was developed, reflecting the distinctive role of social care in maintaining as well as improving quality of life (Qureshi and Nicholas, 2001). A series of five researched development projects, undertaken in partnership with two social services departments, served to demonstrate both the feasibility and the value of introducing these ideas into various aspects of individual and agency practice, with the assistance of tools designed to fit with the local context. The projects focused on the development and trial implementation of:

- An assessment summary to assist recording of intended outcomes for older people and their carers.
- A briefing sheet for home care providers to remind them of intended outcomes and user preferences.
- Tools to assist a focus on the carer's perspective of outcomes in assessment, care planning and review.
- A programme of outcome-focused evaluative interviews by senior and middle managers' with a sample of older home care users
- A rolling survey of outcomes for adult users of occupational therapy, assessment and adaptations service.

The first four of these projects were undertaken in conjunction with Bradford, and the fifth with York, Social Services. The results of these projects, descriptions of the tools, their use and their impact on practice are reported elsewhere and will not be

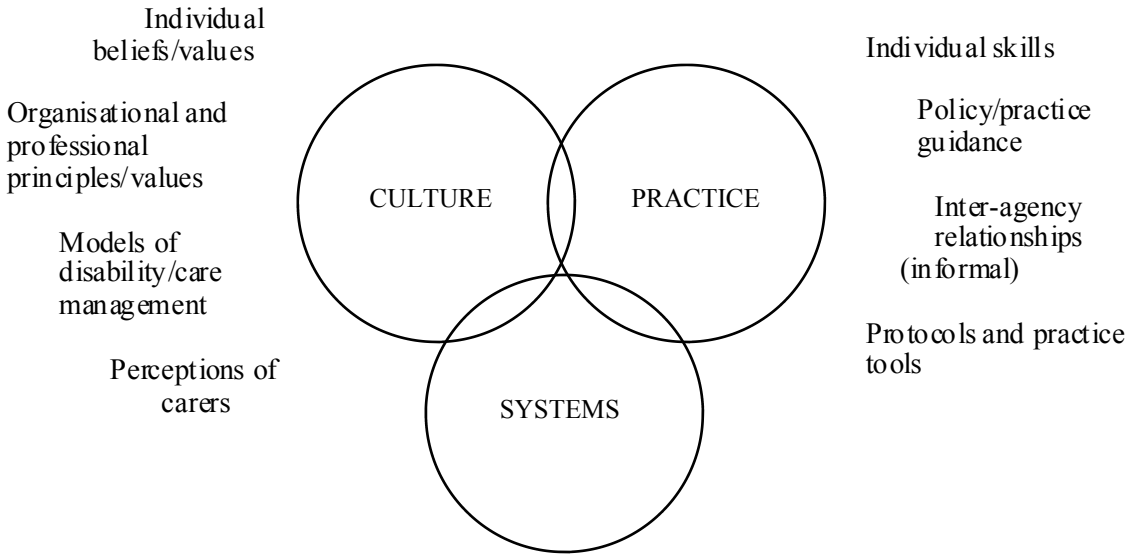
elaborated upon here (see for example, Nicholas, 2003; Patmore, 2001; Qureshi (ed), 2001, Qureshi and Nicholas, 2001; Heaton and Bamford, 2001; also http://www.york.ac.uk/inst/spru/).

The main focus of this article is the *process* of implementing or applying outcome ideas. In order to move beyond statements of policy intent, there is a need to address the practicalities: where to begin, who to involve, what are the time and resource implications? Furthermore, evidence suggests that the *ways* in which new forms of practice or procedures are developed and introduced can significantly influence whether or not they are adopted (Smale, 1996). Our purpose here is to offer some reflections and observations from our own experience as 'change agents' and evaluation of the development processes within the five outcomes projects. The discussion will be illustrated with examples from the Outcomes Programme, and set in the context of the wider literature relating to change, innovation and research utilisation.

The Nature of Outcome-Related Innovation and Change

The journey undertaken by SPRU with partner agencies in the process of translating research findings into useful practice approaches is likely to be mirrored by others who wish to apply outcomes ideas in practice. This is not a quick or straightforward journey and merits some signposting. SPRU's work on outcome-focused care management indicates the different, but inter-related dimensions of change which may be involved (See *Figure 1)*. Targeting any one dimension can have implications for the others. At the same time, it will not be possible to tackle all dimensions at once, and our experience suggests that relatively small changes in one area can have positive results, whilst highlighting where else change efforts may need to be directed.

Figure 1 Dimensions of change affecting outcomes focused care management



For example:
Duty/intake systems
Information/IT
Training/professional support/supervision
Planning/quality improvement mechanisms
Interagency relationships (formal)

This complexity is reflected in the literature on research utilisation, and on change management. A recent review of the management of change literature by Iles and Sutherland (2001) usefully summarises some of the key conceptual approaches, which may be helpful background for those embarking on outcome-related innovation and change. For example, change can be either ***planned or emergent***: it can involve conscious reasoning and effort, or it can unfold or emerge as a result of factors outside the control of those affected. They stress that while organisational change is a process which '*can be facilitated by perceptive and insightful planning and analysis and well-crafted, sensitive implementation phases*', there is also likely to be an important emergent element within it (Iles and Sutherland, 2001:14). The latter can occur either in response to a number of disparate management decisions apparently unrelated to the change, or in response to internal or external factors and influences in a particular context (for example, economic, political, power of different interest groups). A distinction is also made between ***episodic*** and ***continuous change*** (Weick and Quinn, 1999; cited by Iles and Sutherland, 2001)**.** Episodic change is deliberate but infrequent and time-limited, often involving replacement of one strategy or programme with another. In contrast, continuous change is evolving and incremental, characterised by people constantly adapting ideas acquired from various sources. They point out that at a collective level, a process of continuous and simultaneous adjustment across units can amount to substantial change. A further distinction relates to the extent and scope of change. With reference to the work of Ackerman (1997) they outline three types: **developmental, transitional and transformational change**. **Developmental change** can be planned or emergent and is incremental generally involving improvement of an existing situation (for example, skill or process). **Transitional change** is episodic and radical and involves movement from an existing state to a new known state, with management of an interim transitional state for a given period. **Transformational change** is also radical. It requires a shift in basic assumptions held within the organisation, and can result in the emergence of a very different state of being (for example, culture, structure, processes) which is not known until it takes shape.

While a focus on outcomes is an explicit policy intention, there is currently a lack of clear imperative and guidance from central government on when/how this should be implemented by local agencies. This may not be a bad thing, given the multiplicity of change facing social and health care agencies, but it implies that change initiatives directed towards outcome-focused practice are most likely to be 'developmental' and 'continuous' as defined above – that is, focusing on improving individual practice and related processes, involving adaptation of ideas to suit circumstances, experimentation on a small scale, and incremental learning. It is conceivable however that with planned and sustained effort, such incremental initiatives could have a 'transformational' impact in time.

Within the current policy context, joint development agendas for example implementing intermediate tier services such as the single assessment process and intermediate care, can provide important opportunities for integrating an outcome focus, but this poses further challenges. '**Whole systems thinking**' reflects an increasing awareness that resolution of many health and social problems, and indeed achieving positive outcomes for patients/service users and carers, lie beyond the ability of any one practitioner or agency. There is recognition of the need to develop systems for provision of 'seamless care' for patients within and between agencies. Systems however are complex networks of inter-relationships rather than chains of cause-and-effect relationships (Iles and Sutherland, 2001). Organisation theory tells us that systems have a tendency towards maintaining the status quo or 'equilibrium' and thus are resistant to change. This is true whether or not the system is experienced as healthy, or a good place to be, as the current equilibrium will be fulfilling a function for the system as a whole in as far as it is 'the best solution' the system is currently deploying to cope with demands (Bingley-Miller and Crawshaw, 2002). In addition, individuals within the system will all have their own view of the system's function and purpose. Similarly Rogers' work on the diffusion of innovations suggests that it is the *perceived* newness of an idea, practice or object, which constitutes the definition of an innovation and determines how an individual reacts to it. Adoption of innovations is seen as a social process

in which a variety of roles or stances played be individual stakeholders can influence progress either positively or negatively (Rogers, 1995).

Increasing evidence on research utilisation underlines the need to take on board these complexities if we are to find more effective ways of implementing evidence based practice (Nutley et al, 2002). In their systematic literature review Walter *et al* point out that strategies to enhance research impact may address any point on a continuum '*from raising awareness of findings, through knowledge and understanding of their implications, to changes in behaviour*' (Walter et al, 2003:11). 'Conceptual' use of research which brings about changes in levels of understanding, knowledge and attitudes, is much more common than 'instrumental' use resulting in change of behaviour (Weiss, 1987; cited in Nutley et al, 2002). Getting outcomes thinking embedded in practice will require both types of change. However the leap from conceptual to instrumental use is both considerable and critical. The review identified a number of helpful practices that support effective impact, many of which resonate with SPRU's experience. For example, it highlighted the value of partnerships between researchers and practitioners; opportunities to discuss findings, and to test them out; individualised educational strategies and those which allow interaction with colleagues and experts; supportive opinion leaders (expert and peer); and adequately resourced facilitative strategies. Several examples of research-practice partnerships now exist – for example, Research in Practice (RIP), Making Research Count (MRC), and the Outcomes into Practice Network run by SPRU and agency partners – which assist research-based learning and experimentation. Other key features of successful practices were tailoring or adapting findings to particular contexts which is vital to ownership; individual enthusiasts who can help to 'sell' new ideas and practices; contextual analysis to identify specific barriers and enablers to change; credibility of evidence linked to strong and visible leadership particularly at senior level, which can help to motivate, legitimise and integrate findings within the organisation. Ongoing support (financial, technical and emotional) for those implementing changes was found to increase the chances of success, with dedicated project co-ordinators being central to several successful initiatives. Later in this article we provide some specific examples from collaborative work conducted by SPRU indicating how working with local enthusiasts, analysing the context for change, and local adaptation of findings helped considerably in getting outcomes ideas incorporated into thinking and practice.

Involvement of all stakeholders, and integration within organisational activities and systems, also help to support and maintain research impact activities (Walter et al, 2003). The involvement of stakeholders is not just about achieving 'ownership', important though that is, but also reflects the essential contribution that their knowledge of local context can make to finding appropriate ways to apply research results. We would go further and argue that the process of adaptation and reconstruction, which is essential for application, is also an occasion for further learning. One concern may be to learn about the factors which may enhance or inhibit application in other contexts. However, the process is not just a matter of 'applying' knowledge which already exists: the attempt to apply findings may lead to modification, or new understanding, of the original findings. New conceptualisations of the production of knowledge criticise the belief that knowledge transfer is hierarchical, and emphasise that new knowledge is generated in the context of specific problem areas (Gibbons et al, 1994).

Mindful of the challenges of introducing outcome-focused practice and the competing demands and priorities facing social care managers and their partners, SPRU were keen to make the messages of the Outcomes Programme as accessible as possible. This task was greatly assisted by an ongoing partnership with managers and trainers (participants in the 'Outcomes into Practice Network'), who had already begun to find creative ways of utilising the research findings within their localities. Exchanges of experience and mutual learning through the network's periodic workshops have supported these activities, and also assisted us greatly in translating the findings of the Outcomes Programme into working models, principles and practical resources (for example, presentations, small group exercises, handouts) which now comprise a resource pack (Nicholas et al, 2003).

Some of the training materials included have been created, and refined through use, by managers themselves.

The remainder of this article explores how the complexities of introducing outcome focused practice can be tackled within local agencies.

Managing the Complexity

As indicated above, there are many ways of thinking about and approaching innovation and change. The particular approach adopted may be less important than an awareness of the complexities and the factors that can help and hinder, along with a robust approach to project management. SPRU's approach to development was greatly influenced by, amongst others, the work of Gerald Smale, which drew on the diffusion of innovations theory, as well as a decade of research and practice within the Managing Change and Innovation Programme of the former National Institute for Social Work (Smale, 1996, 1998). The latter involved innovative managers from social services, health and voluntary sectors. Smale suggests that while innovation and change can be messy and complex processes, and not entirely controllable, it is nonetheless possible with careful planning to map a way through the complexity, avoid the worst of unintended consequences, and anticipate and positively tackle obstacles. He also argues that there may be advantages in reframing innovation as a problem solving process. This can help to clarify how different stakeholders define both the problem and its solution; maintain a focus on the *purpose* of change, thereby avoiding 'change for change's sake'. In addition it provides a different criterion for measuring the success of any innovation: that is, whether it is an effective solution to a recognised problem, *not* simply whether it is adopted. Taking time to clarify stakeholders' existing concerns and criteria for success, and a maintaining a clear focus on purpose are also important initial steps in the Systematic Approach to project management, another influential model in some of the outcomes projects. This latter project management model has been widely used in all sectors but adapted specifically for use by non-profit organisations (The Management Centre, 1995).

A core part of Smale's approach derived from the Managing Change and Innovation Programme is the 'Innovation Trinity'. Recognising the complexity of the real world, this highlights three fundamental and overlapping dimensions of development activity relating to the problem being addressed: mapping all the significant people; analysis of the innovation; and understanding the context of change. These activities will hopefully lead to 'a convergence of thinking and action between key people about what changes and what stays the same' (Smale, 1998: 97). However, initial convergence of thought and action can quickly dissipate in an environment where agendas, priorities and personnel may all change over the project's life. Early understandings and agreements reached need to be revisited and refined as new information and insights emerge over time (The Management Centre, 1995). This can in turn encourage mutual reflection and learning and enable innovations to remain focused and well integrated with other developments. Smale's 'Innovation Trinity' provides a useful framework for discussion of some key process issues involved in introducing outcome-focused practice.

The first dimension, understanding the context for development is as important for in-house change agents as it was for SPRU researchers as outsiders. Change does not take place in a vacuum: it 'takes place relative to other changes in the social and physical context' (Smale, 1996: 39). Even for the keenest managers, introducing a focus on outcomes is likely to be just one amongst many important areas for development, and one which may not be seen as a major priority, in comparison to more pressing policy or legislative requirements. It is therefore vitally important that change strategies take account of the real world. It makes sense to link outcome-related initiatives where possible to other planned or prioritised changes, thus aiming for a more coherent, integrated and manageable approach that harnesses rather than competes for available time, energy and resources. Some current opportunities for integrating an outcome focus in practice/systems may include: implementing the single assessment process; practice development in line with the Carers and Disabled Children Act; training programmes in relation to either of the above; designing patient/user surveys; reviews of current arrangements for care management and/or

management information systems; Best Value reviews.

As well as identifying the opportunities for development it is important to anticipate any obstacles or problems associated with introducing an outcome focus in practice. If the latter are made explicit sooner rather than later, they can be positively addressed, or at least acknowledged, rather than emerging in an unexpected way to block or impede perceived progress. They may also be important for determining the scope of the project, and assessing realistically what is possible to achieve. For example, in one agency there was an opportunity for introducing an outcome focus as part of a planned review of their assessment forms. We also discovered that much time and attention had previously been invested in establishing a consistent assessment format and in training staff in a 'needs-led' approach. This meant that managers and practitioners were reluctant to accept change to the current assessment documentation in any radical way. However there were a number of recognised local problems that meant they were open to minor amendments. For example, managers were keen to have a means of providing clearer evidence to differentiate between good and bad practice; clarify the basis of decision-making in care-planning and review; improve the skills of care managers working with older people; focus service effort (more specific objectives for providers). On the other hand, practitioners' wariness about outcomes and their applicability to social care was a potential barrier, along with their existing workloads and pressures arising from parallel time-consuming developments. The former was largely overcome by providing 'time out' in training and development workshops to explore the issues in relation to their practice. This in turn enhanced motivation as it enabled them to make the connection with their own desire to improve practice. In another authority, there was general support for the idea of developing postal questionnaires for collecting information about the outcomes of Disability Support Services. This was linked with a strong commitment to quality improvement, and significant dissatisfaction among some staff with the existing system based on user satisfaction with services. At the same time, initial discussions highlighted that potential obstacles to development might include staff anxieties and cynicism about how information collected would be used; the need for additional resources for administration and analysis; competing demands and priorities; staff reservations about the validity of user views. Awareness of these contextual factors helped to determine what was done, how, and with whom.

Other important aspects of understanding the context include the culture of the organisation(s) and the different occupational groups within them; the relationships between the organisation(s) and their environment, and between significant people within and outside them. Culture may be difficult to pin down, and incorporates both explicit and implicit beliefs and values, held by individuals or groups, and those expressed within policy documents which affect how things are done, or help to account for why they are not done. Creating safe, structured opportunities for honest dialogue with, and between, different stakeholders to explore their perspectives can help to tease out these different dimensions of organisational culture. Such dialogue can also enhance mutual understanding and the cooperation necessary to any change initiative.

Collaboration was a key aspect of SPRU's work on outcomes, both in terms of defining the meaning of outcomes within the social care context, and in working out how to apply this understanding within particular contexts. Although involvement of users, carers and staff in the research phase gave us some credibility as change agents, a collaborative approach to development was considered essential to achieve a sense of ownership of any practice tools developed, and maximise their perceived usefulness and relevance within the local context. *Mapping all the significant people* is considered the central dimension within Smale's Innovation Trinity. This involves recognising the part played by all key people in making change happen (or indeed preventing it from happening). Understanding the different roles people can play and the associated behavioural characteristics is an important aspect of mapping. Drawing on the extensive research of Rogers (1995) which is confirmed by his own experience, Smale identifies a range of significant roles: for example, product champions, early adopters, late adopters, laggards, opinion leaders,

gatekeepers, opponents, close collaborators, network entrepreneurs (see Smale,1996 for full list and explanation). Right at the beginning of the development phase of the Outcomes Programme, a stakeholder mapping exercise was undertaken within the research team to identify from initial consultations the range of stakeholders within each partner authority, their actual or anticipated interest in taking forward outcome-focused initiatives, and any compatible agendas to which our development work might be linked. This proved very helpful in beginning to identify some key players, in particular the 'close collaborators': the individual managers, trainers and practitioners with whom we could explore initial ideas and later work with closely to plan strategies for development and trial implementation. This exercise was repeated at a later stage with some of the planning groups in specific projects.

Working with local enthusiasts, or 'product champions' as they are sometimes called, was a deliberate strategy used within the outcomes projects as evidence suggested this can assist more rapid diffusion of new ideas or ways of working (Stocking 1985). '*Product champions' are defined as 'crucial early adopters, being people who not only adopt new methods, but take up the cause of spreading the message to others*' (Smale, 1996: 62). A variety of local enthusiasts were vital to the outcomes projects. They played key roles in progressing the development and implementation process and in 'championing' the products (outcomes tools and approaches) in ways we, as 'innovators' could not do alone. For example, in the projects aiming to develop outcome-focused care management, enthusiasts at a senior management level were helpful in legitimising the projects and the products emerging from them; making links with the broader strategic developments and keeping outcomes on the agenda at a senior level. Committed middle managers were essential to support staff involved in trial implementation and enabling the transition to routine practice achieved in some projects. They also helped to keep the project grounded in practical realities and tackle obstacles at a local level. Given the degree of scepticism among practitioners about the usefulness of outcomes in practice, engaging enthusiastic practitioners was particularly important to ensure links with good practice and local procedures. In one project, several individuals took a lead role in training/ briefing sessions that helped to 'sell' the project and the tools to their peers.

The involvement of a number of user and carer enthusiasts (in some preparatory workshops and planning meetings) was very helpful in challenging certain assumptions and current practices. Through sharing their own experiences, including trial use of tools in some instances, they were able to address directly particular issues and concerns raised by staff (for example, in the case of carers' questionnaires, whether these might be too time-consuming or intrusive).

Identifying the range of people who are likely to be involved or affected by the outcome-related initiative, should be accompanied by some analysis of what action needs to be taken with whom. This might include work to prepare the ground, engage certain people more fully, build alliances, and create support mechanisms for those who will be implementing change. In addition key players need to be engaged in weighing up for themselves the positive and negative implications of the proposed changes to practice. This brings us to the third dimension of Smale's Innovation Trinity, *analysing the innovation.* The diffusion of innovations research (Rogers, 1983; Rogers and Kincaid, 1981) cited by Smale (1996) highlights five attributes of innovations that enhance their adoptability: relative advantage, compatibility, complexity, trialability and observability. With reference to the first three of these attributes, implementation, even on a trial basis can be greatly assisted if the implementers perceive the new ways of working to be better than those which precede it, and compatible with prevailing values, notions of good practice, goals and tasks. In short, does it help them as individuals to do their job?

Understanding the agendas and concerns of various stakeholders, and how these fitted with our own, required detailed negotiations which took time, but this was essential to ensure sufficient compatibility for change to happen, even with relatively straightforward innovations. For example, within the planning group developing an outcome-focused assessment summary for use with older people, it became clear that the researchers, practitioners and

managers involved all had slightly different purposes and concerns. Researchers were keen that the new record included a summary of intended outcomes (distinguishing between change and maintenance outcomes), users' and carers' preferences for ways of achieving these, and any anticipated changes which might influence future provision. Care managers, though positive about the proposed outcome focus and dissatisfied with their existing 'needs summary' were concerned to ensure that the new summary better reflected existing good practice particularly in complex situations. Thus the summary form needed to reflect the actual flow of information gathering and decision-making and should therefore be easier to complete. Managers on the other hand were keen to have a means of recording outcomes that could contribute to performance management, and to ensure consistency and simultaneous introduction with other changes to assessment. These agendas were, on the whole, mutually reinforcing but ongoing communication and co-operation were essential at each stage of development and testing, to ensure that mutual understanding was maintained and respective purposes fulfilled. The result was a new summary that was well linked to our outcome concerns, and, according to feedback from stakeholders, relevant to practice and management concerns. This summary was eventually adopted within mainstream practice across older people's services within this agency (Qureshi and Nicholas, 2001).

Regardless of how complex or straightforward new ways of working might appear, objectively, it is important to clarify the degree of *perceived* complexity from the point of view of those who will be implementing them to ensure this is not a hidden obstacle. Even the more straightforward outcome-focused approaches can involve significant shifts in thinking or action, which may require extra time and effort, at least initially. Providing time out to think, opportunities to check out, and try out new ways of doing things helps to build confidence and overcome perceived difficulties. However, apparent understanding and even enthusiasm for outcome-focused approaches demonstrated within a workshop setting does not necessarily mean that application will follow. Amidst the usual pressures and demands it is much easier to revert to old and familiar ways. Strategies may be needed at individual, team and organisational levels, to support people in their work setting both to begin, and maintain new ways of working. On a more positive note, most practitioners reported that 'thinking outcomes', using the new tools, and finding the right words for recording purposes, became easier with more experience. Motivation was also greatly assisted by the perceived benefits to their practice and opportunities to meet with their peers for reflection on practice, hear others' experiences and to air difficulties as they arose (Qureshi, 2001).

Within the Outcomes Programme, the more straightforward outcomes tools were those which were more readily adopted into mainstream practice, for example, the assessment summary for use with older people (Qureshi and Nicholas, 2001), and the briefing sheet for providers (Patmore, 2001). At the same time widespread implementation in these instances was greatly assisted by being well integrated with broader changes within the department. The more complex the innovation, or different from usual ways of working, the more preparation, training and ongoing support will be required to assist wider implementation. With more complex changes to existing practice, it can be helpful to separate out the component innovations involved to identify who sees what as 'new' or potentially difficult, in order to determine what forms such support should take (Smale, 1996). For example, introducing an outcome-focused carer assessment and review in one authority represented fairly substantial changes to existing practice and culture according to practitioners and managers within the planning group. In this project the approach required different ways of thinking, including: understanding outcomes from the carer's perspective; promoting and maintaining the carer's expertise; a focus on satisfactions and coping strategies, and not just problems (Nolan et al, 1998). Changes in practice incorporated a range of new self-completion questionnaires aimed to assist an informed discussion with carers about desired outcomes within different levels of assessment, and review, and a short summary form for recording conclusions. This was a more structured and systematic way of undertaking carer assessments than most practitioners were used to, aiming to actively engage the carer in the process. More

preparation was required to facilitate understanding of the underpinning philosophy, to provide opportunities for project participants to practice using the new forms, feed back their concerns and explore the issues involved. The extent and full implications of the perceived novelty in this approach only became apparent as a result of experimentation. The greater emphasis on listening to the carer's perspective and enabling them to have their say, alongside the user, were changes which were welcomed by most as being in line with good practice. However this also created some tensions with existing organisational arrangements and priorities, for example, when and where carer assessments were done, which carers should be prioritised and which staff should do them (see Nicholas, 2003, for further details). Drawing on the work of Watzlawick et al (1974), Smale describes such changes as 'second order' changes involving renegotiation of tasks, methods, roles and relationships between people (first order changes being limited to renegotiating tasks and methods). When introducing new ways of working it is vital that their impact is recognised and that provision is made within the planning and/or review process to renegotiate arrangements (Smale, 1996).

Such negotiations may also mean being prepared to modify the proposed innovation, as we found necessary in all the outcomes projects. But adaptability to local circumstances can be positive and in our experience, in most instances it enhanced the end results and made adoptability more likely. Evidence from the diffusion of innovations research suggests that as ideas are taken into practice they are adapted to fit the ideas and self-perceived needs or problems of those who are taking them on board. Smale argues that such adaptation is not only inevitable but also desirable as it helps to give the innovation meaning in the local context:

> *For many innovations it is more important that ideas and concepts are communicated rather than full prescriptions for practice. The idea of roundness and axles may be more helpful than fully designed wheels.*
>
> (Smale, 1996: 21)

In the case of outcome-focused practice, this would appear to indicate caution against the understandable appeal of ready-made tools, although existing tools such as those developed in the Outcomes Programme can provide useful examples as a starting point from which to build.

The remaining two attributes affecting the adoptability of innovations are *trialability* and *observability* (Smale, 1996). These raise some important considerations in relation to outcome-focused practice, especially for managing the transition from trial implementation to routinisation. (West, 1997, describes the cycle of innovation as consisting of four main phases: initiation, planning, implementation, routinisation). Being able to experiment and try out innovations can be very important in developing understanding of what works and what may need adapting for mainstream use. Practitioners involved in the care management projects particularly stressed the value of having opportunities to try out new ways of working and to reflect on their individual practice. Even for experienced practitioners focusing on outcomes represented a considerable culture shift, as one practitioner commented: 'It's a different way of thinking about things, and thinking is the crucial word'. But 'pilot' or special projects of this sort can have their pitfalls and may create barriers to routinisation in the longer term (Smale, 1996). In order to avoid resentment, suspicion or even resistance developing round the proposed innovation it may help to maintain 'low walls' around the project, so that those not directly involved in the experiment, as well as actual participants can be regularly reminded of what it is intended to achieve, links to other agendas, progress to date, evaluation process and timescale, opportunities to hear about results and influence change.

If the positive learning from a 'pilot' project is to be taken forward into mainstream practice at the end of the project or experimentation period, the same detailed preparation, planning and project management will be needed at this stage to ensure the wider range of stakeholders involved are identified, engaged and supported over the routinisation process. Initially, both SPRU and our partner agencies underestimated how long it would take to reach the point of routinisation. In most of the outcomes projects it took approximately two

years to progress through initiation and planning to trial implementation (including evaluation). It is not surprising that many pilot projects run out of steam at this stage, or suffer from lack of clear direction and purpose, perhaps due to changes of personnel or priorities. This makes it all the more important to develop positive strategies to maintain momentum and interest beyond those immediately involved and to ensure the results, or lessons arising from experimentation are given due consideration in the relevant forums and progressed to decision-making and action. The degree to which the results of an innovation are visible to others is another key attribute affecting adoptability. In addition to informal feedback from participants throughout the experiment (for example, through progress reports, newsletters or presentations to wider audiences) a more systematic evaluation and review of the results is one way of increasing visibility, and providing a more informed basis for decision making. To avoid evaluation becoming an afterthought, it is worth considering at the start of the experimentation period how the innovation will be evaluated and at what stage(s), to whom do the results need to be made visible, and how and when the results should be recorded and communicated towards this end?

Conclusion

Getting 'outcomes into practice' is not simply a matter of finding the right tools and training people to use them. Although practice tools and training are both important, we have argued in this article that *the process* of re-orientating practice towards the outcomes people value, is more complex and requires careful consideration and planning. It is important to recognise that this process takes time, and can involve changes to roles, relationships, culture and systems as well as individual practice. This will need energetic leadership at a senior level and also detailed project management. Although more research is needed to assess the impact of introducing an outcome focus to practice, evidence from the Outcomes Programme suggests it is a journey worth embarking on. Starting small, working with the enthusiasts and linking outcome-related initiatives to other development agendas (such as the single assessment process) can all help to make the task more manageable, bring about positive results and lay firm foundations for further development.

On this journey, there are many obstacles to be overcome, not least the culture change required at all levels of the organisation. While the term 'outcome' trips off the tongues of many managers and policy makers, few may have considered the real implications for practice of an outcomes-focused approach.

Furthermore, the idea of 'outcomes in practice' may appear to have little relevance to most front-line practitioners, who may fear further entanglement in management bureaucracy and control mechanisms that do not reflect the skilled and complex nature of their work. Increasing evidence from research suggests that the effectiveness of research-impact and change-management activities depends on collaboration with stakeholders. Our own work underlines the value of engaging managers, practitioners, service users, carers and other partners in reflecting on the meaning and relevance of outcomes, the need for, and purpose of change, and in shaping and evaluating new ways of working. In our experience this involves mutual learning in which practice wisdom and user and carer experience can contribute new insights into how best to integrate a focus on outcomes within a particular setting; it can also enhance motivation for, and ownership of the new ways of working, which will assist implementation. To assist the development task, there is now an increasing body of research evidence, practical experience from the Outcomes Programme and other development initiatives, and a resource pack to assist agencies in making the transition from policy intention to practical approaches which are meaningful and useful to all concerned.

Further Information

- *An important complementary programme of work, the Outcomes of Social Care for Adults (OSCA) initiative, also funded by the Department of Health, included thirteen studies concentrating more on issues of definition, evaluation and measurement of outcomes (Henwood and Waddington 2002).*

- *For more information on the Outcomes Programme, Outcomes into Practice Resource Pack, or Outcomes into Practice Network, please contact: spruinfo@york.ac.uk or see SPRU's website: http://www.york.ac.uk/inst/spru/.*
  The resource pack (Nicholas et al 2003) has been developed collaboratively with managers and trainers who participated in the Outcomes into Practice Network. This process was funded by the Department of Health. The pack is intended as a tool to assist agencies' development and training activities towards introducing outcome-focused practice. It offers research-based guidance, and a range of resources which can be photocopied and adapted, including sample programmes, PowerPoint presentations (on CD), exercises for group work, handouts and examples of practice tools.

References

Ackerman, L. (1997) 'Development, Transition or Transformation: The question of change in organizations', in D, Van Eynde, J. Hoy and D. Van Eynde (eds), *Organisation Development Classics,* San Francisco: Jossey Bass.

Bingley-Miller, L. and Crawshaw, M. (2002) *Force Field Analysis Briefing Notes for Making Research Count workshops (Day 2)* York: Department of Social Policy and Social Work, University of York.

Department of Health (1991) *Care Management and Assessment: Managers' Guide*, London: HMSO.

Department of Health (1998) *Modernising Social Services, Cm 4169,* London: Department of Health

Department of Health (2001a) *Intermediate Care, HSC 2001/001: LAC (2001) 1*

Department of Health (2001b) *A Practitioner's Guide to Assessment under the Carers and Disabled Children Act 2000* London: Department of Health, p.10, para 22 and p.11, para. 29.

Department of Health (2002) *The Single Assessment Process guidance for local implementation, Annexes,* London: Department of Health, p23

Gibbons, M., Limoges, C., Nowotny, H., Schwartzman, S., Scott, P. and Trow, M. (1994) *The New Production of Knowledge: the dynamics of science and research in contemporary societies,* London: Sage.

Goldsmith and Beaver (1998) *Recording with care* - SSI inspection Report, (para1.11) London: Department of Health.

Heaton, J. and Bamford, C. (2001) Assessing the outcomes of equipment and adaptations: issues and approaches, *British Journal of Occupational Therapy*, 64(7): 346-56.

Henwood, M. and Waddington, E. (2002) *Messages and Findings from the Outcomes for Social Care for Adults (OSCA) Programme, Final Report Executive Summary* Leeds: Nuffield Institute for Health, University of Leeds.

Iles, V. and Sutherland, L. *Managing Change in the NHS: Organisational change, a review for health care managers, professionals and researchers,* London: NHS Service Delivery and Organisation R&D.

Nicholas, E. (2003) An Outcomes Focus in Carer Assessment and Review: value and challenge, *British Journal of Social Work,* 33: 31-47.

Nicholas, E., Qureshi, H. and Bamford, C. (2003) *Outcomes into Practice: Focusing practice and information on the outcomes people value. A Resource Pack for managers and trainers,* York: Social Policy Research Unit, University of York.

Nolan, M., Grant, G. and Keady, J. (1998) *Assessing the Needs of Family Carers: A guide for practitioners,* Brighton: Pavilion Publishing

Nutley, S., Walter, I. and Davies, H. (2002) *From knowing to doing: A framework for understanding the evidence-into-practice agenda (Discussion Paper)* St Andrews: Research Utilisation Research Unit, University of St Andrews.

Patmore, C. (2001) Improving home care quality: an individual-centred approach, *Quality in Ageing,* 2(3): 15-24.

Qureshi, H. (ed) (2001) *Outcomes in Social Care Practice, Outcomes in Community Care Practice Number Seven,* York: Social Policy Research Unit, University of York.

Qureshi, H. and Nicholas, E. (2001) A new conception of social care outcomes and its practical use in assessment for older people, *Research, Policy and Planning,* 19(2): 11-25.

Rogers, E.M. (1995) *The Diffusion of Innovations* (4th Edition) New York: The Free Press.

Rogers, E.M.and Kincaid, D.L. (1981) *Communication Networks: Toward a paradigm for research,* New York: The Free Press/Macmillan Publishing Company.

Smale, G. (1996) *Mapping Change and Innovation,* London: National Institute for Social Work, HMSO.

Smale, G. (1998) *Managing Change through Innovation*, London: National Institute for Social Work, The Stationery Office.

Stocking, B. (1985) *Initiative and Inertia: Case studies in the NHS,* London: Nuffield Provincial Hospital Trust.

The Management Centre (1995) *Project Management Handbook,* London: The Management Centre. Adapted from Taylor, M. (1982) *Coverdale on Management,* London: Butterworth/Heinemann.

Walter, I., Nutley, S. and Davies, H. (2003) *Research Impact: A Cross Sector Review: literature review,* St Andrews: University of St Andrews, Research Unit for Research Utilisation, Department of Management.

Warburton, R. (1999) *Meeting the Challenge: Improving Management Information for the effective commissioning of Social Care Services for Older People: Handbook for Middle Managers and Operational staff,* London: Social Care Group, Department of Health.

Watzlawick, P., Weakland, J. and Fisch, R. (1974) *Change: Principles of Problem Formation and Problem Resolution,* New York: Norton.

Weick, K.E. and Quinn, R.E. (1999) Organisational Change and Development *Annual Review of Psychology,* 50: 361-86.

West, M. (1997) *Developing Creativity in Organisations,* Leicester: British Psychological Society.

Acknowledgements

This article is based on work which was undertaken by the Social Policy Research Unit which receives support from the Department of Health; the views expressed in this article are those of the authors and not necessarily those of the Department of Health. The authors wish to thank all who participated in the research and development phases of the Outcomes Programme and members of the Outcomes into Practice Network, whose enthusiasm, commitment and creative thinking has been inspirational.

Notes on Contributors:

Elinor Nicholas was a Research Fellow (currently an associate) at the Social Policy Research Unit (SPRU) at the University of York, where she worked on the Outcomes Programme between 1997 and 2003, including coordination of the 'Outcomes into Practice' network. Her background is in social work, training and development within social care.

Hazel Qureshi was Professor of Social Care and Assistant Director of SPRU until the end of 2003. She has published widely on social care including a book on the Outcomes of Community Care for Service Users and Carers (with Andrew Nocon). She led the Department of Health funded programme of work on outcomes on which this article is based.

Address for Correspondence:

Elinor Nicholas
Social Policy Research Unit
University of York, Heslington
York, YO10 5DD
Telephone: 01904 433608
Fax: 01904 433618
E-mail: en2@york.ac.uk