
Outcomes for Disabled Service Users

Department of Health Final Report

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Executive Summary

Social service provision to younger disabled people is not often at the forefront of policy debate. However, the Government recognises the distinct contribution that disabled people make to the economy and the waste of potential that ensues when key services do not assist them. Often the type of assistance that younger disabled people require needs to be more flexible, or of a different type, than that offered by social services. For example, people may require assistance with making decisions concerning work, both paid and voluntary, or in parenting.

This study explored ways of incorporating these and other types of assistance into assessment processes. In the study these were called 'outcomes' and they were incorporated into new assessment documents for use by a multi-disciplinary team of professionals. These professionals were trained to use a new approach to assessment based on outcomes. The design of the study was explorative and rested upon co-producing the outcomes tools with professionals and service users. An extensive period of consultation was undertaken to ensure that the outcomes approach best suited the requirements of disabled service users.

The new outcome-focused approach and documents was found to be useful, workable and an improvement on the original needs-based system. For the professionals, using outcome-focused tools meant assessment was far broader than was possible under the original needs-based system. As a result, some professionals talked to service users about areas of their lives that they had not previously covered (particularly, education/training and employment). In using the outcomes approach some professionals found it challenging to change to being a facilitator or assistant rather than expert or assessor.

Service users valued the outcomes approach because it was clear and they could exercise choice and control over service provision. Professionals valued the outcomes approach because it put service users' views first and allowed them to be creative and imaginative in their work.

The findings demonstrate that the outcomes tools are viable for use with disabled people of working age and that they are compatible with the spirit of the social model of disability. The outcomes tools are also in line with the policy imperative of the recent Green Paper on Adult Social Care (2005), and in particular, with its recommendation for individualised budgets that will increase choice and control.

Chapter 1 Introduction

1.1 Project background

The project that forms the basis for this final report aimed to develop and test ways to incorporate an outcome focus into assessment and review with disabled people between the ages of 18 and 65. The focus of the project was specifically upon disabled adults who experience physical or sensory impairments or chronic illness. The project detailed in this report forms the first attempt to test the value of the outcomes approach in direct work with disabled people undertaken by social services staff.

During the previous Department of Health programme, the Social Policy Research Unit (SPRU) developed a conceptual framework for understanding social care outcomes based on research with staff, managers, disabled service users and carers. This research distinguished between maintenance, change and process outcomes, and identified a number of broad aspects of quality of life which service users sought to achieve or maintain through service input (Qureshi *et al.*, 1998; Bamford *et al.*, 1999). Building on this framework, subsequent research and development work with a partner social services authority succeeded in introducing outcome ideas into assessment with older people (Qureshi *et al.*, 2000), and into an equipment and adaptations service (Bamford, 2000).

The project detailed in this report built directly upon these foundations by exploring and testing ways to incorporate a focus on outcomes into routine assessment, review processes and documentation within a Disability Service. The outcome-focused documents and practice approach incorporate concepts synthesised from the social model of disability (Oliver, 1990; Oliver and Sapey, 1999). Thus, the importance of addressing and confronting social and environmental barriers and discrimination was central to the process of developing the outcomes approach and documentation used in this project.

The project ran from January 2002 to December 2004 and received core funding from the Department of Health.

1.2 Contextual literature

Policy context

The NHS and Community Care Act (1990) introduced the principle of 'needs-led' assessment and specified financial responsibilities and charging arrangements that formed an attempt to clarify rights to services. Although this Act underpinned

important reforms in services for older people, it was criticised by younger disabled people for failing to clarify rights and entitlements to services or provide an adequate framework for social work practice with this group, (Oliver and Sapey, 1999). The Community Care (Direct Payments) Act (1996) gave local authorities the power to give disabled people cash to purchase their own services, should they so desire. Take up of direct payments is patchy to date (Pearson, 2004), however, under these arrangements, social services staff are still responsible for the assessment of 'care needs' and retain some responsibility for overseeing the arrangements (DoH, 1996).

The flexibilities of the Health Act (1999) became available to health bodies and local government in April 2000. These offer opportunities to pool budgets, develop integrated provision and lead commissioning arrangements to ensure that service commissioning and delivery can respond in a holistic way to peoples' needs.

Modernising Social Services (Department of Health, 1998) acknowledged the importance of an outcomes focus in providing services, but noted that changes in service provision up to that date had concentrated largely upon structure and process rather than on outcomes (*ibid*: 2.2). *Modernising Social Services* also contained an explicit focus upon the importance of case review.

Fair access to care services - guidance on eligibility criteria for adult social care (Department of Health 2002) (Local Authority Circular(2002)13) was issued to councils in 2002, with implementation to occur by April 2003. This guidance provided councils with a framework for setting their eligibility criteria for adult social care. The framework is based on individuals' needs and associated risks to independence, and includes four eligibility bands - critical, substantial, moderate and low. When placing individuals in these bands, the guidance stresses that councils should not only identify immediate needs but also needs that would worsen for the lack of timely assistance. The guidance explains how assessments and subsequent care planning should be carried out, in proportion to needs and in good time. The importance of reviews to determine continued eligibility is stressed.

In *Independence matters an overview of the performance of social care services for physically and sensory disabled people* (SSI, 2003 405) an inspection report issued to professionals in 2003, the Government claimed that physically and sensorily disabled people should be benefiting from the modernisation of social care along with other service users. This report found evidence that although some progress was being made, it was slow and patchy and too many disabled people still did not have the opportunities they sought and the support they needed to live independently and take control over their lives.

Practice context

Clarity about intended outcomes has been identified as a key element in recording of care management, but one that is often absent (SSI, 1999). User groups and

disabled authors have seen a focus on user-defined outcomes as central to user-led approaches to assessment and the development and improvement of standards of quality (Morris, 1997; Turner, 2000).

A range of obstacles to being explicit about outcomes has been identified in the literature including professional and organisational culture, conceptual problems and anxiety about the level of personal or organisational performance (Qureshi, 1998). Research in the previous SPRU programme undertaken with older people suggested that, once professionals have a clear understanding of the concept of outcomes, then the identification of agreed intended outcomes during assessment helps to focus intervention on the desired aims of services and the aims and preferences of users. It also provides a clearer basis for care planning and briefing providers (Qureshi *et al.*, 2000).

There are however, clear problems in extrapolating and transposing practice wisdom from routine practice of care management with older people to practice with disabled people of working age. Obvious differences concern differing agendas owing to life stage such as parenting, childcare and employment (Wates, 1997). There are also differences in social service practice and service provision modes. Challis *et al.* (1998) found that care managers working with disabled people of working age have slightly lower caseloads on average than care managers working with older people and also that expenditure ceilings per case were, on average, higher for younger than older people. Until recently, greater choice about provision, in the form of Direct Payments, was offered exclusively to younger disabled people. In addition, there is some limited evidence that younger disabled people may be more interested in self-assessment and self-review, although there is also some evidence that unsupported self-assessment can lead to an understatement of needs (Kestenbaum, 1993). The amount of information given to service users, the choices of services available, and the degree of control service users can exercise over the decisions that are made, are all important factors that affect service user empowerment (Morris and Lindow, 1993; Stevenson and Parsloe, 1993).

The *Single assessment process for older people* implementation guidance (Department of Health 2003) was introduced in April 2004. Although the Guidance covers services for older people (and is therefore outside the remit of the professionals and service users in this report), the standardisation of working practices, IT solution and accreditation of assessment tools had a bearing on the work of the Disability Service as a whole. The single assessment process, introduced in the National Service Framework for older people, aimed to make sure older people's care needs are assessed thoroughly and accurately, but without procedures being needlessly duplicated by different agencies.

Achieving change in practice

Many innovations, even the most effective ones, fail to become mainstream practice even when national and local policy support them. Furthermore, the way in which new approaches to practice, or new procedures, are introduced can influence whether or not they are adopted (Smale, 1996). The degree of professional and organisational change involved in the introduction of outcome concepts should not be underestimated. In the previous SPRU programme barriers to successful introduction of outcomes included conceptual confusion, professional and organisational culture, and lack of resources (Qureshi *et al.*, 2000). Literature on change and innovation suggests that the probability of success is enhanced if innovations solve problems recognised as such by those who have to implement them, they do not require large investment of resources (unless there is already a recognition of the need for this) and they fit in well with existing practice or planned changes which are already moving in the same direction (Egan, 1993; Rogers, 1995; Smale, 1996). It is recognised as important to engage key players and achieve their ownership of both the product and the process of development. This approach requires a collaborative process in which ongoing dialogue with stakeholders can inform developments. The researched development process used in this project incorporated this collaborative approach and conforms to the first three of the four phases of the cycle of innovation as described by West (1997):

1. **Initiation** - Setting the agenda, identifying the problem, recognising the need for change.
2. **Planning** - Identifying what needs to change, matching plans to organisational needs.
3. **Trial Implementation** - Systematic testing of the innovation in the local context and refining and restructuring plans and procedures as necessary to fit local needs and resources.
4. **Routinisation** - Transfer to mainstream activity.
(West, 1997)

Key principles guiding the project

The social model of disability (Oliver and Sapey, 1999) is the key principle guiding the project. The social model draws attention to the ways in which social structures and the behaviour of individuals and groups create disadvantage for disabled people and prevent the fulfilment of valued social roles and realisation of potential. The original version of the social model conceptualised disability as context-dependent, and created by environmental, attitudinal and structural barriers (Oliver, 1990). However, recent thinking moves on from this position, acknowledging that some impairments have consequences which are not created by social structures and that the new challenge is to include recognition of impairment within the social model (Morris, 1993; Crow, 1996). Furthermore, in Disability services in general, there is a great need for heightened awareness of barriers to service provision (such as incorrect format and media when providing services to Deaf people) (Harris and

Bamford, 2001). Most recently, Swain and French (2000) asserted that what is required for the new millennium is an ‘affirmation model’ which: ‘addresses the limitations of the social model through the realisation of positive identity encompassing impairment as well as disability’ (Swain and French, 2000: 569).

Although some authors have claimed that the social model may have outlived its usefulness in certain respects, (Shakespeare and Watson, 2002), there is still widespread agreement within the disability movement that the core principles of addressing and removing disabling barriers and discrimination are of central relevance to disabled people’s lives. It is also acknowledged that despite impressive progress made by the disability movement in achieving mainstream recognition from service providers for the social model of disability as a useful and workable concept, the effects are slow to be seen in front-line service provision (Oliver and Sapey, 1999).

The social model of disability has guided the researchers at all stages of the project from design of the proposal through to the production of this final report. Crucially and importantly, stringent efforts were made to avoid research practices that disrespect disabled people. These efforts apply to all situations, and especially pertain to the use of non-disablist language and behaviours. The outcomes practices and documentation developed as tools from this project are congruent with the core principles of the social model of disability.

1.3 Methodology

Design

The project had three distinct phases. These are detailed below:

Phase	Objective
1. Consultation and Development	To produce an outcomes approach and outcome-focused documentation that would be acceptable to practitioners in the Disability service
2. Researched Trial Implementation	To develop and trial the approach and documentation with all stakeholders, whilst researching the process
3. Comparative Test	To understand how practice changes by comparing practice and documentation before and after introduction of outcomes

Each phase was designed to build upon the field relationships and innovations developed in the former phase. The three phases were each conducted in separate areas of Derbyshire and the areas conform to social service boundaries.

The design of the project conforms to the principles of qualitative methodology (Mason, 1996) in as much as it was primarily designed to yield data on process, rather than to attempt to quantify actions or produce tools for measurement of outcomes. The outline design of the study was modelled upon that of Qureshi *et al.* (1998), which was successfully used in their study of older people's services. The method involves developing assessment tools in collaboration with stakeholders in the setting, (phase 1) trialling the tools with a selected group of professionals (the Researched Trial Implementation), and finally testing the tools against those used originally in the setting (the Comparative Test). These broad principles were adopted in this study, although it differed in key respects from Qureshi *et al.*'s (1998) work, especially in relation to the centrality of service-user focus adopted and adherence to the social model of disability principles. Thus the methodology of this project was built upon the foundations successfully established in the first outcomes programme.

Aims

The design of the study as a whole was iterative and therefore evaluation of acceptability and usage from each stage informed the one that followed. The aim of the development phase was to produce an outcomes approach and outcome-focused documentation that would be acceptable to practitioners in the Disability service and that could be used for routine assessment and review with disabled service users. Following West's (1997) principles, the design stipulated that the majority of effort would be spent on negotiation, careful documentation of process and incorporation of key ideas into practices and documentation for each following stage. Thus development of the outcome-focused tools was a matter of co-production with stakeholders.

The aim of the Researched Trial Implementation was develop and trial the approach and documentation with all stakeholders, whilst researching the process. It was further intended to study the usefulness of the outcome-focused tools to stakeholders in the setting.

The aim of the Comparative Test was understand how practice changes by comparing practice and documentation before and after introduction of outcomes. Rather than run a test in which outcome-focused practice and documentation was introduced in one area and not another for the purposes of comparison (which the local authority resisted on ethical and practical grounds) this phase evolved to take the form of a 'before and after' test. This involved interviewing all staff involved concerning their current practice and collecting their original assessment documents for a six-month period prior to commencement of the outcomes training. Professionals once trained, used the outcome-focused documents for six months,

after which they were re-interviewed, focussing on the perceived difference that using outcomes had made to their practice. By this means, both documentation and practice were compared. Ethical approval was sought and obtained for the study from the Derbyshire Social Services Research Ethics Committee.

Sampling

A total sampling strategy was used which aimed to achieve 100 per cent coverage of all professionals working within each distinct area of the local authority. In consultation with the Disability Service Manager, it was decided that each of the three phases of the project would be undertaken in a different social services area¹.

Hence, the Pilot was undertaken in South Derbyshire, the Researched Trial Implementation took place in the west, (High Peak and Derbyshire Dales), whilst the Comparative Test took place in the east (Amber Valley and Erewash). This strategy was beneficial in ensuring that each cohort of professionals implemented the outcomes approach from scratch.

Originally it was intended to implement the outcomes approach with only Care Managers(CM). However, initial contact with the social services demonstrated that there were low numbers of this professional group working in the local authority. It was thus decided that the best and most pragmatic means of introducing the outcomes approach would be to adopt a 100 per cent staff group as the sample in each social services area². Thus the professional groups covered were Disability Service Manager, Manager, Care Manager, Social Worker/Care Manager (SW/CM), Social Worker Sensory/Visual Impairment (SW), Occupational Therapist (OT) and Community Care Worker (CCW).

The main duties of Care Managers are to assess, coordinate services and the Care Plan, negotiate and liaise with various agencies, commission and procure services and ensure the Care Plan is carried out. The role of Social Worker/Care Manager overlaps with the duties of the Care Manager, but they also carry out care management functions. The Social Worker Sensory/Visual Impairment has the same function, although works with people who have sensory or visual impairment. The duties of the Occupational Therapist are to enable disabled people to remain at home through provision of major adaptations and equipment, to use assessment skills in relation to the environment and to undertake complex cases. Community Care Workers carry out less complex cases, undertake assessments to enable disabled people to remain independent and assess for technical aids and provide advice. The professionals participating in each project phase are shown below.

¹ The boundaries for these social services area were also redrawn during the development phase, which complicated the sampling and training procedures.

² Owing to the two reorganisations that took place during the first two stages of the project, a larger number of staff were trained in use of the outcomes approach than eventually trialled it. These staff were transferred to Older People's services. The numbers of staff trained are detailed in each chapter.

Table 1.1 Staff participating in each project phase

<i>Participating staff</i>	<i>Pilot</i>	<i>RTI</i>	<i>CT</i>
Disability Service Manager	1	1	1
Manager	1	2	2
Care Manager	3	1	7
Social Worker/Care Manager	0	0	3
Social Worker Sensory/Visual Impairment	0	0	1
Occupational Therapist	3	6	10
Community Care Worker	0	5	7
Total	8	15	31

Research and development questions

The research and development questions that the study was designed to address are detailed below.

1. To what extent is it possible to develop an outcome-focused approach for incorporation into routine practice with disabled people that will prove practical and useful from the perspectives of service users, practitioners and managers?
2. Which aspects of outcome-focused practice are most valued by disabled service users, professionals and managers?
3. Can outcome-focused case review tools be developed for routine use with disabled service users?
4. Does use of an outcomes approach affect the outcomes achieved compared with conventional methods?

1.4 Development work (Phase 1)

Searching for suitable agency partners

In making a decision concerning a suitable site for the project, the following criteria were deemed important:

- a) The Social Services must have an established service for disabled people of working age.
- b) The site must be amenable to research (particularly in respect of geographical location).

- c) The site should have a good reputation for its work with disabled service users (in comparison with others in the national league tables).

Four sites were investigated but only one proved to comply with all three criteria. For this reason, that local authority (Derbyshire Social Services) was approached and agreement to form a working partnership was eventually secured.

A series of meetings with senior management in the local authority was undertaken in which the parameters of the projected work were established. Following these meetings, a draft partnership agreement was secured which set out the responsibilities of both the SPRU research team and the local authority social services. The partnership agreement³ therefore formalised the arrangements between the research team and Derbyshire Social Services.

Project Advisory Group

The Project Advisory Group (PAG) advised the researchers, supported the research effort as a whole and provided advice from their experience of working with disabled service users. Members of the PAG were drawn from local and national organisations and were invited for their expertise in working in the fields of social care, health and disability studies. The PAG met three times per year.

Discussion at the PAG was far-ranging and included topics such as ensuring the project dovetails with policy developments (including the Single Assessment Process, Fair Access to Care, Better Care, Higher Standards and the National Service Framework for long term conditions).

Local Implementation Group

The Local Implementation Group (LIG) comprised the research team and key individuals from Derbyshire Social Services. The LIG expanded over the life of the project to incorporate additional key staff involved in the implementation of the project. The working brief of the LIG was to enable the project to function effectively at a local level and to provide a communication link between the staff in the local authority and the research team. The LIG was involved in all areas of project planning and implementation. In addition the LIG proved to be a source of information and support particularly with respect to the on-going reorganisation of Social Services and the implementation of national policy developments (such as the Single Assessment Process). In effect the LIG acted as a decision-making body at local level. It met eight times over the course of the project.

³ A copy of the partnership agreement appears in Appendix 2.

Service user participation

The research team were concerned that service users contributed to all stages of the project. Early in the project it was decided in consultation with PAG and LIG that flexible and multi-faceted means of ensuring service user participation would be used rather than having a service user panel comprising a small group of service users with a fixed-membership meeting throughout the life of the project. This decision was taken because the latter strategy was potentially unrepresentative and geographically difficult in the local authority. It was therefore, pragmatic and more inclusive to seek service user participation through a variety of methods.

Service user consultation and participation took a variety of forms:

- a) Presentations to partner organisations and groups.
- b) Formal seminars or meetings if preferred by service users.
- c) Mailings, either by post or e-mail in a format of the service user's choice, including project up-dates and findings as well as documents for consultation and response.

Over the course of the project many groups gave their views on the innovation of the outcome focus. This included the pre-existing social services Service Users Panel, Derbyshire Coalition for Inclusive Living, South Derbyshire Local Disability Focus Group, Campaign for Tackling Acquired Deafness (CAMTAD), Deaf Equality Forward, Derbyshire Association for the Blind, Spotlight Group and the Deaf-Blind Focus Group. In addition links have been maintained with the national organisation of service users Shaping Our Lives. These groups contributed their memberships' opinions on questions concerning the introduction of procedures that affect service provision, such as acceptability of documentation, user-friendliness of forms and preferred means of introduction of innovations. During the Comparative Test phase a member of the research team joined three service user groups and undertook an extensive period of involvement to identify service user views on outcomes and the best means of giving service users information on the outcomes approach. This work is reported in Chapter 3.

Initial development work

It was felt important that significant time and resources were committed to ensuring all stakeholders have a voice in the development of the project. To that end a number of events and meetings were held between January and August 2002.

In the initial stages of the development phase a seminar was held that drew together key individuals from national service user groups such as *Shaping Our Lives* and professionals from social services to address the question of the compatibility of user-defined outcomes and the original outcomes framework (Bamford *et al.*, 1999). Key messages from this seminar were incorporated into the orientation materials for

the project. Further details are available in the report that was published from the seminar (Morgan and Harris, 2002).

Before the project commenced the research team attended a workshop⁴ held by Derbyshire Social Services on developing outcome approaches across the adult service sector. Eighty participants including senior managers from social services and health, project and planning managers and front-line professionals attended the workshop.

An intensive programme of meetings with key members of staff in the Social Services department was commenced, which included managers representing the local areas for the development work and members of the Training Team, who were involved in discussion about taking over the outcomes training at the end of the project. In addition, team meetings for front-line workers were attended on a regular basis to consult and inform professionals of project developments.

A series of three half-day introductory sessions for staff were held on the 6th and 7th March 2002 in Erewash, Matlock and Chesterfield. The aim of these sessions was to introduce the project, discuss the part staff would play and to give participants the opportunity to ask questions and raise issues. Invitations were sent via service managers to all staff who work with disabled adults. Thirty-four staff participated in the introductory sessions including social workers, community care workers, occupational therapists, care managers and service managers. In addition a number of meetings were held with staff at a locality level across the county.

Document-devising and outcomes training sessions

Two half-day document-devising and outcomes training sessions were held at Willersley Castle on the 23rd and 24th April 2002. The workshops were open to all staff involved in assessment, care planning and review with disabled people of working age and invitations were circulated via service managers. Fifty-eight members of staff attended over the two sessions, comprising representatives of all professions and from all eight districts within the local authority:

⁴ 'Getting the best from services – Developing outcome approaches in the adult service sector' Derbyshire Social Services Workshop, November 2001. Jennifer Harris gave a plenary speech titled 'Social care outcomes in practice'.

Table 1.2 Professions participating in document-devising and training

Care Managers	6
Community Care Workers	12
Domiciliary Service Organiser	1
Physiotherapist	1
Occupational Therapists	23
Rehabilitation Officer	1
Sensory Development Worker	1
Social Workers	6
Staff Development	1
Team/Service Managers	6
Total	58

The focus of the Willersley Castle workshops was practical, looking in detail at current practice (and particularly the use of the original documentation) and seeking to identify potential barriers to the implementation of outcome-focused practice and the introduction of outcome-focused documentation. The workshops were conceived as outlets for all staff ideas that would contribute to devising new outcome-focused documentation, with the emphasis upon retaining domains that staff considered to work well, whilst introducing a focus upon outcomes. Staff were invited to discuss in small groups the relative merits and demerits of the original assessment documents set and their preferences for deletions and additions of categories. There follows below a summary of main themes that the participants raised in these ‘document-devising sessions’.

Participants echoed the general comments made about current practice at the introductory sessions. It was found that assessment tools were not standardised across the local authority area. Despite the fact that Derbyshire had an official set of assessment and review documents, their use varied between localities and professions. A large amount of information gathering was felt to be either repetitive or unnecessary. General support existed amongst professionals for greater standardisation of practice and documentation as long as it allowed for local flexibility and remained responsive to other developments, such as the Single Assessment Process and the recent Best Value review of adult assessment. Staff did not want to lose perceived current good practice.

Professionals were keen to emphasise the ‘first principles’ of assessment-that it is a person-centred process of building enabling relationships with service users rather than being service-led. Therefore documentation was viewed as a tool within assessment rather than driving the process. The need to distinguish assessment as

a process separate to service provision and care plans was highlighted as important in maintaining needs-led rather than service-led provision. A significant number of the participants said they would welcome greater clarity about professional roles in relation to assessment and about the scope of assessment. There should be a basis of trust between professionals within and across teams in respect of each other's assessment and professional judgement. It was suggested that this would require clearer delineation of different professional competences.

It was important to participants that any new documentation was concise and straightforward to complete and that the level (depth) of assessment should be congruent with the level/duration of service users' involvement with social services. Also highlighted was the irrelevance of some sections of the existing documentation for terminally ill service users. Many professionals expressed frustration at what they perceived to be the requirement that all sections of forms are to be filled in regardless of relevance. There was general agreement that the original experience of assessment was not always an empowering one for service users. In particular professionals pointed to the detailed nature of information requested as part of the Community Care Assessment document regardless of the nature/extent of the service user's involvement with social services. There were a number of questions professionals felt uncomfortable asking and that some service users refused to answer. Participants felt there was greater scope for professional judgement in deciding what level of information gathering was necessary. It was also felt important for service users to determine what information they felt different workers and service providers should have.

Participants were clear that they wanted an outcomes approach to be integrated into recording tools, not additional (summary) documents. There was some concern about how specialist assessment would be incorporated into outcome-focused documentation. This was particularly the case for occupational therapists and community care workers in assessing for aids/adaptations or specific areas of assessment relevant to service users with sensory impairments. The Community Care Assessment was felt to be the most appropriate place to begin an outcome-focused approach. It was felt important to have space to record the link between outcomes and the services to be provided, to show the 'working out' of why a particular service or action had been agreed.

Adequate guidance was seen as vital to the successful implementation of an outcomes approach. There were a variety of suggestions concerning what form this could take including checklists based on the outcomes framework or on the Southampton Centre for Independent Living's (CIL) 12 'needs' (SCIL 2005).

The importance of providing information that was accessible and that was also culturally and age appropriate was highlighted. Concerns were raised about the availability of information and documentation in alternative formats and languages.

Concern was expressed about the length of time taken for documents such as Care Plans to be copied to service users.

Most participants were clear that their role was to facilitate the empowerment of service users and while there were concerns about raising expectations that could not be met there was a general recognition that the task of a Disability Service was to raise the expectations of disabled people and support aspirations as well as day to day functioning.

Final production of the outcomes documents

Following the sessions, new outcome-focused documents were prepared by the research team that incorporated all staff suggestions and findings from the consultations with service user groups (Morgan and Harris, 2002) included the addition of the outcomes framework in the Community Care Assessment (CCA)⁵, and the two categories of outcomes and smaller outcomes in the Care Plan (CP). The Care Plan Review (CPR) and Personal Service Plan (PSP) documents were also altered to reflect the addition of the outcomes to the previous documents⁶. These documents were taken to the LIG and PAG for approval, before a further consultation with the staff group. This set of documents was taken forward into the Researched Trial Implementation.

Development of the outcomes framework used in this project

The original outcomes framework devised in previous SPRU work with disabled service users (Bamford *et al.*, 1999), was amended and incorporated into the Community Care Assessment and Care Plan documents. The work on the framework made the language more conversant with the social model of disability (that is, focussing on access and environmental and social barriers to community participation). The outcome domains in Bamford *et al.*'s (1999) framework were transformed into four main outcomes sets; autonomy outcomes, personal comfort outcomes, economic participation outcomes and social participation outcomes, with more specific outcome domains in each. Further work was undertaken on language to make the documents service user led and to direct professionals to work in a facilitative and assistive style, rather than as an expert assessor.

⁵ The Community Care Assessment document was used for the initial assessment of a service user. Under the original practice guidance, the CCA was the place to detail what the needs of the service user were at assessment. The Care Plan which followed documented how the needs of the service user were to be provided for by social services. The Care Plan Review was a document that reviewed what had been provided and the extent to which the needs had been met. The Personal Service Plan was used by staff who were not the first social services staff to be involved in the case and which detailed the intervention of that member of staff (the format was very similar to the Care Plan).

⁶ A Personal Service Plan Review (PSPR) document was newly devised for the Comparative Test as staff in that area utilised the PSP in their everyday practice and the new PSPR thereby provided a means reviewing work undertaken using the PSP document.

1.5 Operationalisation

Pilot study

The purpose of the small-scale pilot was to test out the process of using the newly devised outcome-focused assessment and review documentation. The documents had been produced as a synthesis of a period of extensive consultation therefore it was anticipated that at this stage the evaluation would focus on the practicalities of using the documentation. The pilot took place in South Derbyshire. It involved a group of 12 service users and the members of staff assigned to them. These professionals were three Care Managers (CM) and three Occupational Therapists (OT). Professionals were trained at two training sessions held in South Derbyshire. Five of the six pilot participants attended⁷. The aim of the session was to train front-line staff in the use of the outcome-focused documents. Five of the pilot participants had previously attended an outcomes consultation and training session, therefore only a brief overview of the outcomes framework was provided. The bulk of the session was devoted to the practicalities of using outcome-focused documentation. This involved using the new pack of documents and practice guidance. The case studies in the practice guidance were used to illustrate how outcomes could be recorded under the new headings.

Evaluative focus groups were held separately (for logistical reasons) with two Occupational Therapists⁸ and the three Care Managers. Professionals in general were positive about the newly-devised outcome-focused documentation and had used them over the previous three months with service users. Although the Occupational Therapists had a few reservations about the documents (as the existing official documents were already perceived to be 'too social work oriented' and to exclude some aspects of physical functioning, and the new documents were built upon the existing ones), they largely endorsed all three outcome-focused documents. The Care Managers complained of repetition between the Community Care Assessment and Care Plan as the outcome domains from the former, run through into the latter (in order that the service user may continue to trace progress on each domain) and the extra work entailed in writing these out. The general feeling was that the outcome-focused documents were an improvement on the existing set, and that they were more user-friendly.

1.6 Conclusion

The development work including the Consultation Period, document-devising days and small-scale pilot produced a number of findings concerning staff preferences, particularly in relation to the affected documentation; community care assessment,

⁷ One member of staff was unable to attend due to illness.

⁸ One of the Occupational Therapists left the service mid-way through the pilot.

care plan and care plan review. It is important to note here that professionals were not utilising a common set of documentation at the outset of the project. The senior management of the Disability Service therefore viewed the introduction of the outcomes focus as a watershed juncture in which professionals would henceforth all use standardised outcome-focused documents.

Following synthesis of the findings from the consultation programme, the existing documents were reviewed with a view to the incorporation of the outcomes focus. Those elements, which professionals claimed worked well on the existing forms, were retained (mostly these pertained to lay out). Minor adjustments were made in response to current policy imperatives such as the Single Assessment Process (SAP) which although not introduced to work with disabled people of working age, was considered by the local authority partners to hold some benefits in terms of congruence with practice across the county. This resulted in very minor changes only (for example, a category box for 'ethnicity' was inserted) mainly because the suggested tools for SAP are at variance with this project's commitment to the social model of disability.

The main differences between the existing documentation and the outcome-focused documents revolve around the inclusion of the criteria 'summary of service user's desired outcomes (goals)' and 'smaller outcomes (sub-goals) to be met'. The latter were developed in response to comments made by professionals at one of the consultation events, who wished to have some way of defining and specifically detailing the work that goes into the achievement of the outcome.

The original outcomes framework devised in previous SPRU work with disabled service users (Bamford *et al.*, 1999), which had been approved by staff during the consultation and document-devising periods, was amended and incorporated into the Community Care Assessment document. The changes made the framework more consistent with the language of the social model of disability, that is, by restructuring the domains to reflect a primary focus on access.

Changes to the Care Plan were more extensive in terms of departing from the existing documents. The structure was radically overhauled to provide an outcome-focused care plan in which progress and responsibilities for delivery on aspects of the agreed outcomes could be tracked by the service user. Alterations were made to the language on the forms to reflect a service-user led process. For example, 'summary of presenting situation' had the words 'as seen by the service user' added. Other changes in this vein reflect the more active role of the service user in achievement of the desired outcomes and details persons with responsibility to assist in this process. These changes were designed to give service users the lead in their assessment and to direct professionals to act in an assistive and facilitative style (see Appendix 5 for outcome-focused tools).

It was deemed important by both professionals and management that the structure of the new forms mirrored closely the existing documentation wherever possible. This had obvious benefits in reducing the amount of extra training that staff would require in using the new forms but also added to a sense of security and confidence.

Following this work, plans were put in place for the commencement of the Researched Trial Implementation, a training day was arranged for all staff in the new geographical area and all staff were ready to utilise the outcome-focused approach and documents with immediate effect. A programme of regular monitoring meetings was established with the service managers. All professionals involved in the Researched Trial Implementation attended these meetings and their line manager was present. The researchers monitored staff progress in using the new documents at these meetings. Plans were put in place to offer an interview to all service users who receive an outcome-focused assessment (and possibly review). Additionally, interviews were arranged for the end of the Researched Trial Implementation with all front-line staff and senior managers using the approach and documents. A collection strategy was put in place locally for all outcome-focused documents produced by the professionals during this period.

During the development phase it became clear that Social Services were about to be radically altered by a reorganisation. In actual fact, there were two reorganisations which took place during the first two years of the project. The first reorganisation had the effect of altering line management structures across social services. In consequence, some of the senior managers that were working with the research team were unsure as to how many staff they would inherit or lose from their teams, and most of the frontline staff were extremely anxious for their jobs throughout this period. In terms of the project management, one unavoidable consequence was that the managers could not effectively compel frontline staff to adopt the new outcomes procedures and documents.

Chapter 2 Researched Trial Implementation (Phase 2)

2.1 Context

The aim of the Researched Trial Implementation was develop and trial the approach and documentation with all stakeholders, whilst researching the process. It was also intended to study the usefulness of the outcome-focused tools to stakeholders in the setting.

The Researched Trial Implementation period was November 2002 to June 2003. The initial two months were spent in making arrangements for document collection and staff training. The professionals began using the documents immediately after training and in total used them for six months (January to June 2003 inclusive)⁹.

A total of 37 staff were trained in a one-day outcomes training session: one Disability Service Manager, two Managers, 12 Care Managers (CM), nine Occupational Therapists (OT) and 13 Community Care Workers (CCW). The training covered the outcomes approach, practice examples, case studies and introduction to the new outcomes documentation. The session was attended and supported by all operational Managers.

During the Researched Trial Implementation, the local authority underwent two major reorganisations and a sizeable proportion of the 37 trained staff were moved into the Older Peoples Division (which was not implementing the outcomes focus). Following the reorganisations, the remaining 15 staff in the Disability Division who trialled the outcome-focused documents and approach were as follows: one Disability Service Manager, two Managers, one Care Manager, six Occupational Therapists and five Community Care Workers. Staff were split across two local sites. These staff were responsible for implementing the outcomes approach at the local level and trialled the three new outcome-focused documents, the Community Care Assessment (CCA), the Care Plan (CP) and the Care Plan Review (CPR). The staff had worked for Social Services for varying lengths of time. Four staff had worked there for three years or under, six staff had between three and ten years' service and five staff had over ten to 23 years (maximum) service. Managers were asked how many staff they were responsible for and these figures were 25, 10 and 13 staff respectively.

On-going support and clarification of arising issues was provided through monitoring meetings, which were timetabled to coincide with monthly staff meetings (six in total)

⁹ Document collection period ran from November 2002 to June 2003, although very few were received during the start up period (November and December).

at each local office. Issues raised in the groups ranged from the very practical, such as the best means of producing a printed version of the electronic forms and how to produce them in larger fonts to issues of the legal status of the forms and necessity for service users to sign these to demonstrate agreement in principle to the work. Field notes were taken from the monitoring meetings, although the primary purpose was to support staff, answer on-going implementation queries and clarify intentions from the research team's perspective. All participating Managers and front-line staff who trialled the outcomes approach and documents were interviewed at the end of the Researched Trial Implementation, as were a group of 11 service users who self-selected into the project and had been through an outcome-focused assessment.

The staff and service user interview data were subjected to qualitative data analysis using a computer program (Atlas.ti). Data presented in the remainder of this chapter comprise analyses of staff interviews, service user interviews and outcomes documents.

2.2 Staff Interviews

User-friendliness of the outcome-focused documents

The vast majority of the staff made positive comments about the outcome-focused Community Care Assessment (CCA) document. However a few professionals thought that it was 'long to complete' and 'repetitive'. Complaints of length and repetitiveness were made by a small number of staff throughout the Trial, however, these were subsequently found to relate to a type of practice within which the CCA was used as a 'check-list' (all the domains were being used as questions, whether or not they were applicable to the case) rather than completing only those domains applicable to this service user (as directed in the training). When used in this way, the length of time taken for each assessment considerably increased. The 'repetitive' complaint was related to practice prior to outcomes introduction in which the professional would record virtually the whole assessment at the end of the CCA, often not using a Care Plan. Under the standardisation of assessment processes and outcomes introduction, these professionals had to use the Care Plan also, which resulted in claims of repetitiveness.

A few professionals were concerned about 'raising hopes or expectations' by using the new CCA. This 'raising hopes' theme, recurred in various guises throughout the Trial and related to professional fear that the service user will somehow be let down if outcomes they identify are subsequently not resourced. However, no professionals described being challenged in this way during the Researched Trial Implementation.

Domains that caused confusion were 'access to peer support' where the professional did not know how to find out if it is required and 'citizenship' in which the research team anticipated that professionals would explore service users' access to voluntary

work or other community participative activities.¹⁰ Two Managers commented that the new CCA is 'very simple to understand' but claimed that some staff had struggled owing to general poor recording practice prior to the introduction of the outcome-focused documents. Managers also foresaw benefits in using the outcomes approach in terms of the facility to more closely monitor staff assessment practices and in terms of 'forcing' staff to realise their accountability to the service user and to social services management:

The new outcome-focused Care Plan met with virtually unanimous approval from all the professionals. Professionals also commented that the new Care Plan was 'clear') 'easy to fill in', 'more specific than the previous Care Plan, easier for people to look at, better for people with specific communication need' and 'easy for assessor and service user to understand'. Staff also commented that the Care Plan was the 'most useful' of the new set of documents. These comments demonstrated clear support for the new Care Plan as superior to the original version. One Manager thought that the Care Plan should be made 'more Braille friendly', but that it is easier to produce on audio tape than the original form.

The vast majority of the professionals believed the outcome-focused CPR was an improvement on the original version. Staff commented favourably on the 'user-centredness' of the summary of presenting situation and thought it assists in making the process transparent for all parties. Not all OT staff were convinced of the necessity to undertake a formal review of every case, although other (CCW) staff who previously reviewed by telephone were 'pleasantly surprised' by ease of use.

General comments on usefulness of outcome-focused documents

Professionals were asked to comment on the usefulness of the outcome-focused documents to their work. Most comments were positive reflections:

OT1. It's more useful for complicated, more high intensity cases whereby you're assisting the service user to differentiate between what help they require, what service you can offer, because it does sub-divide their needs so that you can try and work on them on more of an individual basis.

These comments support the general opinion of the process aiding clarity and improving transparency in communication between service user, professional and management:

CCW1. There's quite a lot of information from somebody on that [outcome-focused documents} it's quite clear and they understood, he [service user] understood it and I went through it a lot easier.

¹⁰ The research team provided clarification at monitoring meetings concerning definition and intended areas of assessment covered.

M1. I actually think it's a damn sight easier to use because in its simplistic form it's almost there isn't it, it's guiding you all the way through, you shouldn't actually have a problem doing it.

Another Manager voiced some general concern about the appropriateness of (continuing) use of the term 'Care Plan' in work with service users with sensory impairment. However, it was claimed that the focus on outcomes was a significant improvement on 'needs' in respect of moving away from the more paternalistic aspects of service provision which are so disliked by this group:

M2. They've found the documents user-friendly. We do have some comments about sensory impairment and 'care' - they are just issues around the 'care' bit, that's all.

Applicability of the outcomes approach

Most professionals were clear that the outcomes approach was applicable to their work. In speaking about applicability, one professional (OT1) raised concerns about discussing some domains, particularly in relation to 'training' and 'education' where:

OT1. ... as an Occupational Therapist I didn't feel trained enough to give that information.

This comment demonstrates that if the outcomes approach is to work well, staff must feel confident in referring to other services (such as educational establishments) when the outcomes specified by the service user fall outside their professional expertise. There are staff training implications here.

In adopting an outcomes focus from scratch, there are also major implications in terms of availability of local resources. Moving from a mode of practice that was needs-led (and therefore easier for the professional to control) to one that is outcome-focused (in which service users have more control) is potentially unsettling. It takes time for professionals to build up an array of information of local community resources and services that may be of use.

The Managers were similarly enthusiastic about the applicability of the outcomes approach to the work of the Social Services department. One anticipated that the outcomes approach may increase referrals but foresaw they may be of a different type, time-limited pieces of discrete targeted intervention, with a clear, agreed purpose, which is seen as an improvement on current practice. This Manager also claimed that the outcomes approach forms a 'useful tool in supervision and monitoring' and that it would lead to the development of 'interesting kinds of services in the area'. The resulting ideas that have filtered through the paperwork had given this Manager a better idea of the types of service that disabled people require 'that are not day centre based'. The outcomes approach had therefore assisted

management to identify goals that service users wish to pursue within mainstream provision.

Usefulness of the outcomes approach to cases

Staff were asked to give examples of cases where the outcomes approach had proved useful and not useful. Some believed it was 'too detailed' in some cases and that possibly 'learning disabled' clients 'couldn't be bothered'. Another Occupational Therapist (OT2) commented that:

OT2. I did have one chap who, when I was asking him about returning to work thought I was trying to stop his benefits and I think that was a bit unfortunate.

Comments such as these demonstrate the sensitivity of these topics in service users' lives and the considerable communication skills that professionals must use in negotiating them. It also clearly demonstrates why, within the outcomes approach, professionals should adopt an assistive and facilitative style, allowing the service user to lead the conversation and they should not use the documents as check lists.

Some staff had concerns about the utility of the outcomes approach in cases of terminal illness:

OT3. One lady with MND ... the end is in sight, I just couldn't bring myself to go through those things and I know I could have written it down but then – then they see that document and ... I just think that's the last thing they want to get involved in.

The difficulty the research team had in this case (terminal illness) was disentangling whether the Occupational Therapist was against using the outcome-focused documents in these cases, or using *any* documents in these cases. Clearly this is an area that requires great professional sensitivity, but it is not clear from the data why these professionals believed that this could be enhanced by a lack of documentation.

Other staff claimed it was difficult to use the outcomes approach with terminally ill people because it was perceived that using outcomes expressed a 'positive future'. The research team persisted in encouraging staff to think more creatively in these cases about for example, assisting the service user with targeted outcomes that they may still want to achieve within the given time. Others were concerned that there was the possibility of 'talking about areas that are quite upsetting to them'. The comments made concerning terminal illness then, appeared to show that the breadth and width of the outcome-focused documents were sometimes considered too extensive, with some domains (such as training and employment) inappropriate. However, it is clear that if these professionals were operating a service-user led assessment as encouraged by the documents then this concern would be obviated, (as if they were inappropriate the service user would not raise them).

Some professionals explained that the approach was useful for service users with learning difficulties because:

CCW1. They do need more time and they don't like the approach to be quite as forceful so you need that time ... so they were quite good for that.

Others believed that the approach was most useful in situations where the service user had a clear aim:

OT6. The lady that's actually been re-housed – her primary aim or outcome was to have an adapted property so that was very, very straightforward and very clear.

Professionals also described being surprised to find that the outcomes approach was useful in opening up topics that were not in the original referral:

OT3. I had to turn the chap down for what he actually asked me for but his needs were more about everything else that was going on in his life, because he was asking for a shower and he didn't fit the criteria for that and there were some family difficulties and what he needed was something to do with his life so he ended up going on a computer course and we took him there. ... And so that would be something I wouldn't have done and perhaps he wouldn't have done if we hadn't used that paperwork

Managers also acknowledged that the outcomes approach had usefully uncovered many subsidiary needs in service user's lives that would previously not have been covered:

M3. ... an Occupational Therapist ... had her own ranking in her head of the things that would have been most important to him but because ... she approached it through the lens of an outcome focus, began work on a range of things that were very, very different to what she'd traditionally have focused on and ... it was more about the acquisition of additional money through a welfare rights approach than changes to the bathroom. He took on more responsibility - he was the one who accessed the Housing Association to sort out a shower rather than the Occupational Therapist so it was a different type of service.

In terms of applicability to specific cases then, most concerns were addressed towards terminal illness, although practice change to a service user-led approach (which was not always evident) would obviate many of the concerns raised about delving into inappropriate areas or upsetting service users by discussing certain topics. It was also evident that the broader focus given by the outcomes approach opens up professional practice, allowing for discussion of topics outside the original referral.

Advantages of using the outcomes approach

Staff were asked what advantages and disadvantages they saw in using the outcomes approach compared to their usual practice. In terms of advantages, some staff claimed it raised their awareness of the capacity to measure intervention and track progress.

The Care Manager thought that the outcomes approach was advantageous as it promoted a wider assessment and gave the chance for service users to be clear about what they want out of the service. The Community Care Workers said the new format was clearer and gave the ability to assess more in-depth, and one thought the outcomes approach was 'fairer to the service user because it doesn't let you forget anything, so they get a better service'.

The Managers stated it was a much nicer tool, that the process was more participative, promoting dynamic, creative thinking and that the advantages were the focus upon service user involvement. One claimed a significant advantage was that the approach stimulated the professional to focus on the service user's desired outcomes, not their own interpretations.

In terms of disadvantages, a few staff felt the outcomes approach produced 'a little more paperwork' and that it was 'bit more constraining really' owing to the size of the form and also that service user expectations may be unrealistically raised. Two professionals thought that the outcomes approach was not particularly difficult but more time consuming, possibly requiring more visits.

Main differences in practice

Staff were asked what the main differences were that they had noted between using the outcomes approach and their original practice. Some claimed that the layout of the outcome-focused documents is similar to the original but better (clearer and wider approach). Other staff believed it had moved practice from a service-led to a needs-led focus.

The difference in practice of 'allowing' service users to lead the assessment clearly proved to be a major professional challenge as the following two quotations demonstrate:

CM1. The assessment was on a man who doesn't have the capacity to lead the assessment for lots of different reasons and therefore I've had to do it in conjunction with a multi-disciplinary team of people and primarily his parents, which doesn't really seem to fit with, again, the service user led approach and it's [on the form] more my interpretation of the situation based on the information I've gathered from the different professionals and I don't see any way around that and also you know, whatever format was being used it would be the same anyway.

OT6. [This] is a lady that I met on the home visits with the hospital Occupational Therapist last week and I didn't have the time or feel it appropriate to sit down and talk to them about the outcome that this lady wanted. I'm going to fill in most of the form myself and then I've got to go out again so I'm going to complete it then, but I felt like I should have done it at that visit, so I felt under pressure to complete it, but it wasn't appropriate.

The first quotation demonstrates the professional's disinclination to write their personal interpretations on the forms. In the second quotation, the professional had not offered the service user this opportunity. This juxtaposition exposes differences in levels of training and perhaps of professional confidence in responding to the challenges posed by the introduction of the outcomes approach. The issue of 'filling it in myself' may or may not be significant, depending on whether the information is that given by the service user, or is the professional's interpretation. In the case of the former, the professional might be operating a service-user led assessment, whilst the latter could be interpreted as an attempt to retain 'expert power'. The significance of these two quotations is that the first demonstrates the professional moving toward a service-user led approach and the second does not.

Some staff noticed that using outcomes allowed for concentration on 'peripheral issues' which may have not been seen as important under the needs-led approach, so practice became more 'balanced'. It also made them seek out colleagues for advice and promoted lateral thinking. Others saw no difference from the original approach but said the outcomes approach has led to a focus on some domains previously not addressed (employment and education). Yet others found the changeover to be 'stretching (in a good way)', that the outcomes approach gave a wider assessment and entered new domains for Occupational Therapy. The facility to 'break down the goals' was seen as useful, but overall the paperwork took longer.

The Care Manager (CM1) did not feel that they were picking up areas previously uncovered but that they were going into them in more depth (described as 'a good thing'):

CM1. I'm sitting down and going through each area more with the service user rather than before I'd go and have a general chat and then the assessment would be my interpretation, there's more sitting down with people face to face which is an improvement in practice.

One Manager felt the main difference was that staff work processes were more transparent and that using the outcomes approach assists in supervision and monitoring and 'forces' staff to 'justify their visit'. Thus the whole process was felt to make staff accountable to their Manager and to service users. A different Manager said the outcomes approach is 'a much more social approach rather than a disability approach' and was preferred to a focus upon 'care'.

Starting to use the outcomes approach

Staff were asked to comment on how easy or difficult they found it to start using the outcomes approach. Some professionals were confused over the 'big' and 'small' outcomes and how to record these at first. Others thought that initially the problem was how much to put in each box (which 'comes with time'). Some felt the paperwork took longer but less with practice. Another was confused about 'citizenship' and how to ask questions of the service user on this domain. Some Community Care Workers were confused about the use of the 'financial security' and 'emotional well-being' domains. One Manager thought some staff found it taxing emotionally because it 'challenged almost their view of the world' (although they benefited from this) and that the outcomes approach would 'weed out staff that perpetuate service user dependency'. In terms of easiness, it felt it was useful for getting out of a rut and the process of beginning work on outcomes was stimulating, it was simple to use the outcomes approach and that sensory impairment staff found it much easier to use than the original system.

Benefits for service users

Professionals were asked whether using the outcomes approach was more or less beneficial to service users than the original assessment system. Some staff felt that there were no perceivable benefits yet. One said that the outcome-focused Care Plan had proved to be beneficial to service users and was convinced enough to want to continue its use after the research ended. Others thought the service users would benefit as more information will be available from this process and hoped it would flag up unmet need. Some were convinced service users benefited from use of the outcomes approach because it promotes a more holistic assessment (providing care is taken not to 'raise expectations'). All Managers believed the outcomes approach was more beneficial for service users than the original system, stating that they believed that the staff feel more engaged and service users feel more involved, and that they get a 'better deal' from the outcomes approach.

Summary of main themes in staff interviews

Most professionals were positive about the outcome focused documents although a few felt the set as a whole were repetitive. Professionals feared raising service user expectations, but this was unfounded.

The professionals found the outcome focused documents useful for their work and they were particularly user-friendly for service users with sensory impairment. Although most professionals thought the outcomes approach applicable to their work, they requested more training to enable them to work with service users on education and training domains. In changing to the outcomes approach, professionals need time to build up an array of community resources.

The outcomes approach was useful in most cases, although some professionals had reservations concerning terminal illness. The outcomes approach was thought

particularly useful for service users with learning difficulties, for expanding the assessment into areas outside the original referral and for prioritising service users' outcomes. The advantages of the outcomes system were that it gave a much wider assessment, was more creative for professionals and led to greater service user involvement. Disadvantages were that it may produce more paperwork and be more time consuming. The perceived main differences in practice were that this moved from a service-led to a needs-led approach and in many cases allowed service users to lead the assessment. Perceived benefits for service users were the more holistic assessment possible and the facility to be more engaged with the process.

2.3 Service user interviews on outcome-focused assessment and review

Context

All participating staff were asked to circulate an informed consent document (Appendix 2) to all service users who had received an outcome-focused assessment during the Researched Trial Implementation period (December 2002-June 2003). Participants were offered a choice of venue for the interview; all selected to be interviewed at their home. An interview schedule was produced and piloted with three service users outside the target area (Appendix 3). The interviews followed a semi-structured format. Eleven (self-selecting) service users were interviewed. All service users were disabled people of working age (16-64), five were male and six female. The majority had physical impairments (two had sensory impairments). The interviews took place at different stages of the assessment process. The majority of service users were 'between' the Care Plan and review stage.

Referral and assessing staff

Nine of the service users referred themselves (or were referred by their partners). All of the service users who had previously been involved with social services had re-referred themselves. One service user was an internal referral from a welfare rights officer and one had been referred by Health as part of hospital discharge. The service users varied in whether they had a fixed idea about what they wanted from social services. The 'repeat' service users all contacted social services with a particular goal in mind, usually a piece of equipment. Those service users who were first time users of social services were less specific about what they wanted from social services. A number had recently acquired impairment or their condition had significantly deteriorated and these service users tended to be approaching social services with a more general interest in what assistance may be available. Three assessments were undertaken by two Community Care Workers and six were undertaken by three Occupational Therapists. One assessment was undertaken by a Specialist Sensory Impairment Worker and one by a Care Manager, (totalling 11 assessments).

Outcomes assessment

Service users were positive about the potential of an outcome-focused assessment. They felt that the approach had helped them focus on broader and more long term issues especially when they had approached social services with a clear idea of what they wanted (usually an aid or adaptation). Some service users stated that the assessment had raised issues they would not have otherwise considered and that staff had played a useful role in facilitating the identification of outcomes.

Some of the assessments appear to have prompted creative thinking about 'what will be done' although some service users and staff seemed to remain constrained by 'what is available'. Some staff appear to find this type of creative thinking easier than others, and this was also the case for some of the service users who also often thought in terms of available services. A particular concern of many of the service users was that any action or provision of equipment should 'fit' with their family and lifestyle and they were prepared to either pay to ensure for example a piece of equipment suited their home or lifestyle or to accept 'less' service if it were more flexible.

The distinction between the outcome and 'what will be done' seemed to offer greater clarity in situations where a service user did not meet an eligibility criteria or the sort of support they required was not available from social services. Service users responded positively to being encouraged to identify outcomes that would be achieved through the actions of others outside social services (whether the service user, their family or other agencies) recorded in their Care Plan. Service users expressed this in the following ways:

I wanted her (Occupational Therapist) to see that I was helping myself.

It's everything that you've gone through and done what you've already achieved and what you're aiming for. It's all there in black and white in front of you and you know where you're up to on each thing.

Comparison with previous assessments

Some service users who had participated in a previous assessment came back to social services with a clear idea of what they wanted. In this way their assessments were different to their previous assessment (usually their first) which tended to be more comprehensive. This meant that one service user felt the initial assessment had been more outcome-focused (although this was not the language used) than the most recent one. Another service user felt that the outcomes assessment was more formal and covered more areas than the earlier assessment. One service user felt the outcomes assessment was more useful as it resulted in a more flexible form of service provision.

Accessibility and appropriateness of the outcomes documentation

All except two of the service users had received a Care Plan at the time of the interview. All the service users in this group felt it was an accurate reflection of their assessment. Indeed as one service user commented:

If they wrote a lot more forms in ways that people understood, in plain English instead of all these whys and wherefores you'd be a lot better off.

One service user was 'slightly surprised that it was all set out so officially' although they were happy with the content of the Care Plan. Another service user commented:

It were spot on ... he set out projects you know, like one, two, three ... it was good ... it's simplified and spot on.

In general the Care Plan was felt by all to be an accessible document that was clearly laid out. None of the service users required or requested an alternative format, although these were available (Braille, large print, audio tape, video tape).

General observations

Several service users said that they looked to social services as a source of 'expert' or 'specialist' knowledge. The professionals appear to have acted in a reactive mode to what the service user raised, rather than being proactive. This was particularly the case with aids and adaptations). As one service user pointed out:

We've muddled through really, its been quite difficult trying to find out about things. Nobody tells you unless you ask or some other disabled person says 'why don't you ask them about so and so' and I think they should come out with suggestions of where to go and what to do because its very hard if you haven't been disabled all your life.

A number of service users felt they had only found out about an option by chance for example through another disabled person, and that there was a certain amount of each service user having to reinvent the wheel in terms of what worked and what was available. Many service users stated they were prepared (and some were happy) to organise things themselves but wanted initial support especially around information provision.

Summary of main themes from service user interviews

- Most service users were positive about the outcome-focused assessment process.
- Some service users found the necessary 'creative thinking' within the outcomes approach easier than others.

- Services users valued the increased breadth of coverage offered by the outcomes approach.
- Service users valued the plain English within the outcome-focused documents.
- Flexibility of the outcomes approach was valued by service users.
- Service users were concerned that equipment should 'fit' with their family and lifestyle.
- Service users responded positively to having outcomes recorded that were to be achieved by the actions of people other than Social Service professionals, (self, family, other agencies).
- Most service users were prepared to organise the achievement of their desired outcome themselves, but wanted initial support (especially provision of information) from social services.

2.4 Outcome-focused documentation

Outcome-focused documents from 52 cases were collated as part of the Researched Trial Implementation phase of the project (November 2002-June 2003).¹¹ In the majority of these cases, copies of the CCA and Care Plan were collated. Many of these cases were due to be reviewed outside this phase of the project while others were not, according to the staff member involved, due to be reviewed.

Community Care Assessment

Basic information

Some staff struggled with the 'ethnicity/culture' and 'religion' sections, which despite guidance was used to record factual information, that is, 'white/British' or 'Catholic' rather than details that may be pertinent to the assessment or future service provision. Most staff seem to have used the 'communication/access requirement' section where relevant although they tend to record negatively, that is, 'x cannot read', rather than positively stating the service user's access requirements, that is, 'x requires information on audio tape'.

Summary of presenting situation as seen by the service user

Staff did not record the reason for the referral or the service user's view of this reason if someone else had made the referral. Only two members of staff habitually recorded the reason for referral. Recording in this section was prone to being largely descriptive (that is, of the service user's condition) without providing (explicitly) a sense of how the service user saw their situation. Some members of staff appeared to record the whole assessment in this section, including details of action to be taken. Very few staff recorded the summary from a service user's perspective.

¹¹ Seven extra service users were known to the researchers (since they returned an informed consent form which indicates they have been part of an outcomes assessment) but no documents for these service users were passed to the research team.

Outcomes assessment

Many of the assessment sections were descriptive and focused on limitations, (for example, 'Mrs X cannot use the stairs') rather than on outcomes. Very few of the documents gave any real sense of what outcomes the service user wanted to achieve and where it was recorded it was often implicit. Some assessments recorded the input to be provided, for example, under 'safety' one Community Care Worker had recorded 'bath board required'. It was not always clear why information was recorded as in some assessments much of the descriptive information provided appears unnecessary.

Some staff used this section to record their own opinions and judgements. This was particularly the case with the 'emotional health' domain. It was not always clear what information had been provided by the service user or carer and what the member of staff had chosen to record. Others, however, clearly stated whose opinion they were representing and the differences or conflicts of interest that existed.

Summary of outcomes

In some of the documents there does not appear to be a 'flow' of recording, that is, outcomes were identified on the Care Plan that were not raised in the CCA and vice versa. There was a tendency amongst all staff to use the 'smaller outcomes' section to record 'what will be done'. Although the division between the assessment and care planning (identification of inputs) stages is clearly stated in the recording policy (and reflected in the CCA and Care Plan forms) it is evident that staff were continuing their original practice of identifying inputs at the assessment stage. Several staff struggled with this practice change throughout the Researched Trial Implementation.

Summary of assessor

The use of this section varied between staff. Many used it to confirm their support for the outcomes identified earlier. One Care Manager used this section to provide their professional opinion on complex cases often involving child protection issues and other agencies as well as recording potential areas of disagreement or conflict with the service user.

Care Plan

As at the assessment stage there remained confusion between outcomes and inputs although many of the inputs described as 'smaller outcomes' in the CCA were moved to the 'what will be done' section. Apart from this, staff had least difficulty in recording in the Care Plan.

Care Plan Review

A relatively small proportion of reviews had been carried out by the end of the Researched Trial Implementation. More complex cases were less likely to be due for review during this period which meant that the reviews completed tend to reflect more straightforward and limited-focus cases, that is, provision of equipment. The

confusion between outcomes and inputs noted at the CCA and Care Plan stage were replicated in the review documents.

2.5 Conclusion

Overall, in terms of implementation, the Researched Trial Implementation can be viewed as successful. Staff from all professions managed to use the outcome-focused documents and learn the outcomes approach during the life of this phase of the project, although many experienced challenges to practice established over many years. Management and most staff gave unremitting, extensive support to the introduction of the outcomes approach and it is very unlikely that the Researched Trial Implementation would have been successful had it not been for their enthusiastic support.

The Researched Trial Implementation was detrimentally affected by a sudden and unforeseen reorganisation of the Social Services department. This had severe consequences on both the staff and the research project. It is fair to say that these conditions were far from ideal for the trial of the outcomes approach. Despite these detriments, the majority of staff who used the outcome-focused documents found them to be useful, workable and an improvement on the original documentation. Many Occupational Therapist staff who were initially very apprehensive and even hostile to the introduction of the outcomes approach, had been 'converted' by the end of the Researched Trial Implementation.

Some staff thought that the outcomes approach was repetitive, however, these staff were found to be using the outcome-focused documents as a 'formula' or checklist (asking service users questions on each of the domains on the documents rather than using the domains as a guide only). Some staff expressed concerns about using the outcome-focused documents with terminally ill service users. It was not possible to establish exactly whether these staff were resisting using any documentation in these cases, or had particular concerns about the outcome-focused documents. It was clear that a few of these staff believed that the outcomes approach expressed a positive future that was problematic in such cases. However, many other staff used the documents with this group without concern.

The time allocated to training staff was one day for the Researched Trial Implementation and it was clear from the data that staff would appreciate a longer initial training period, with more time given to examination of the outcome-focused documents, case studies and explanation of guidance. It also became clear that, at project outset, many staff were not using the official Social Services documentation

or adhering to official recording policy. This detrimentally affected the project in as much as these staff had to adapt to two sets of changes¹².

Due to problems with the evolving line management structure, it was not possible to gather all outcome-focused documents used by all professionals during the Researched Trial Implementation, although the final set was approximately 90 per cent complete. There were some problems with faxing documents to the research team and it would have been better (but geographically impossible) to instigate a personal collection system. Management expressed some concerns with anonymisation of outcome-focused documents, although all research team members are bound by Department of Health and University of York codes of confidentiality.

At the end of the Researched Trial Implementation it was decided that in the Comparative Test phase all participating staff should receive a longer initial training period (two days), followed by monthly support meetings. This initial training should cover use of the official recording policy, as well as an extended examination of the outcome-focused documents, case studies, guidance and discussion. In the Comparative Test training, staff should be encouraged to use the outcome-focused documents as tools for discussion with service users, not as checklists or as a formula for questioning. This should eliminate the complaints of repetitiveness. The research team should carefully consider the issues raised by staff in relation to use of the outcome-focused documents with terminally ill service users and instigate discussion with Managers in the Comparative Test area concerning applicability to these service users. Finally, a system of personal collection of outcome-focused documents should be introduced for the Comparative Test and any requirements for anonymisation required by the Social Services department fully implemented.

¹² This eventuality was entirely unforeseen as the outcome-focused documents were built upon the official documents, upon the presumption that all staff were using them.

Chapter 3 The Comparative Test (Phase 3)

3.1 Context

The aim of the Comparative Test was to understand how practice changes by comparing practice and documentation before and after introduction of outcomes. The Comparative Test took place in a different area to the Researched Trial Implementation. Staff participating in the Comparative Test are shown in Table 3.1 below.

Table 3.1 Participating staff in the Comparative Test

Disability Service Manager	1
Manager	2
Care Manager	7
Social worker/carer manager	3
Social worker	1
Occupational therapist	10
Community Care worker	7
Total	31

The staff were drawn from one (new) social services area but were managed as two, broadly comparable, teams each headed by a Manager. The timetable for the Comparative Test is presented below:

Table 3.2 Timetable for the Comparative Test

<i>Activity</i>	<i>From</i>	<i>To</i>
'Before' documents collection (original documents)	01/04/03	01/10/03
'Before' interviews	11/03	
Outcomes training and beginning outcome-focused document use	12/03	
Outcomes approach practice and monitoring (the 'After' period)	01/01/04	01/07/04
'After' interviews	07/04	

All participating staff underwent a two day training course during which the outcomes focus was introduced via presentations and case studies for discussion in small groups. The aim of the training course was to introduce the concept of outcomes and the new documents to the staff, present case scenarios and talk through recording issues that may arise in practice.

The comparative test was of ‘before and after’ design. In terms of professional practice, this meant that staff utilised the old documentation and practice (based around the identification of ‘needs’) up to the first day of the training course, were trained in the outcomes focus and then commenced work utilising the outcomes approach and documents for the following six month period. The outcome-focused documents were immediately introduced to the service on the final day of the training course. In order to compare practice change over time, all staff were interviewed before the training course and subsequently re-interviewed at the end of the ‘after’ period. All assessment documents used by staff for the prior six month (‘before’) period were collected and these were compared with the outcomes assessment documents produced by staff in the ‘after’ period.

Following the training course, research staff joined the monthly staff team meetings in order to assist staff, answer queries and monitor progress. Fourteen team meetings were attended during the designated monitoring period (seven at each site). The service manager of each team, with the exception of one meeting, attended each meeting. All professionals had the opportunity to attend and most meetings were well attended.

The results of the Comparative Testing phase (phase 3) are presented below. These comprise three data sets; the ‘before and after’ staff interviews; the comparative document analysis and findings on service user views of the outcomes concept.

3.2 Before and after staff interviews

The staff interview numbers in the Comparative Test are displayed below:

Table 3.3 Staff interviewed ‘Before’ and ‘After’

	<i>Before</i>	<i>After</i>
Managers	2	2
Care Manager (CM)	7	6
Social Worker/Care Manager (SW/CM)	3	3
Social Worker (SW)	1	1
Occupational Therapist (OT)	10	10
Community Care Worker (CCW)	7	6
Total	30	28

NB. In the ‘After’ period, one CM missed the interview appointments and one CCW had died.

The interview topics reviewed comparatively below include use and applicability of original and outcome-focused documents, issues of routine practice, perceived

usefulness of domains, advantages and disadvantages of use, documentation targeting service user goals, issues of suitability for the work, professional satisfaction and service user response to practice approach and documents.

Use of documents

The documents in use in the setting (the 'original set') before the project commenced comprised the Community Care Assessment (CCA), the Care Plan (CP), the Care Plan Review (CPR), and the Personal Service Plan (PSP). The outcome-focused documents were built directly onto the original set and a new document, the Personal Service Plan Review (PSPR), was devised especially for the project. In the 'Before' interviews a total of 20 professionals said that they always used the original Community Care Assessment (CCA), with a further three reporting they sometimes used it and five never using it. All 28 professionals reported that they used the Care Plan (CP). Ten professionals reported using the Care Plan Review (CPR) in practice. Only five reported they used the Personal Service Plan.

Practice had substantially altered in the 'After' period in terms of standardisation of document usage, with all 26 remaining professionals using the entire set of outcome-focused documents in routine practice. All had used the CCA and 25 had used the new CP. The new PSP had been used by 15 professionals (nine of whom were OT), with three using the new Personal Service Plan Review (PSPR).

Applicability of documents

In general, the professionals agreed that the original system of documents was applicable to their work. Comments from all professionals and both managers indicated that the original CP was the most applicable document in practice, while reservations and/or suggestions were raised about the CCA, CPR and PSP. One OT stated:

We use [CCA] as routine, but probably the OT do less of these than other people because we're not that often the first person involved so it would have been done by somebody else in many cases. I find it difficult to fill in because there's a lot of repetition. (OT10)

Among the five professionals who did not use the original CCA, were three sensory and visual impairment workers. Lack of use was due to the perception that it was not applicable to the nature of their work which tended to be very short-term and highly focused:

It's [CCA] so long for the type of work we do. If I'm going in because somebody's having problems hearing the telephone, the door and so on - half of this is irrelevant. They'd wonder why I was asking all these questions, they're so personal. (CCW2)

The other two professionals who claimed not to use the original CCA were both OT and suggested it was due to the discipline specific nature of their roles and negative responses from service users.

The original Care Plan (CP) was used by all professionals and perceived to be the most applicable to their work primarily because it clarified the issues to address; provided a clear and an explicit agreement with the service user; encouraged a sense of ownership and provided a basis for review.

The ten professionals who reported using the original Care Plan Review (CPR) in practice did not use it very often. Only one OT claimed to use this document. OT reviews under the original system were undertaken by telephone and not formally documented. Those professionals who used the CPR, but only rarely, suggested that this was due to the short-term nature of their involvement with service users. Both Managers agreed that in the 'Before' period, staff were not routinely using the CPR to review cases, the exception being Care Managers for complex and extended intervention cases.

The five professionals (4 OT, 1 CCW) who used the original Personal Service Plan (PSP) agreed that this document was useful and applicable when they were not the main professional involved and when an assessment had already been completed. In some cases it was used instead of a CP, in others both a PSP and a CP were completed. The remaining professionals who claimed not to use the PSP represented the full range of professional groups. Most reported that they used the CP instead.

In the 'After' interviews, the Managers felt that the new outcome-focused documents were applicable to the work of every staff member but one mentioned that the broader focus given meant that staff should be careful to tailor the level of assessment to that required by the service user. The OT staff were split on the issue of applicability. Comments ranged from 'very applicable' to being concerned that the documents do not 'cover the areas we cover'. Some OT staff were concerned that the broad focus was not always appropriate for limited assessments that concentrate purely on the provision of a functional item and others thought they were not easy to use and it was not easy to decide where items should be written. A few OT staff believed the economic participation outcomes were inappropriate for some disabled people.

The new CCA was described as much 'wider' than the original document - this was valued by some staff who believed it merely formalised good practice, but not by others who viewed completing it as an increased pressure within their work. The Community Care Workers (CCW) expressed the greatest amount of concern about the applicability of the outcome-focused documents to their work. They thought that the documents were both too broad and deep in coverage for their more functional

role and not specific enough in a few categories (such as access to all areas of the home). The CCW were also concerned about the terminology within the forms, particularly in relation to more sensitive issues on the CCA such as 'desired level of cleanliness', 'autonomy' and 'citizenship'. Only one CCW thought the documents were 'very applicable' and 'very relevant'. The outcomes Care Plan met with broad acceptance from all professionals.

Care Managers in general considered the new documents applicable and 'client-focused'. The Care Plan was thought to be a considerable improvement on the original version. In general they welcomed the focus on economic participation, although not all felt that there were sufficient existing links with the employment service. The Social Worker/Care Managers (SW/CM) felt that the new documents were 'more respectful of service users' and that they usefully move away from a focus on 'problems'.

Covering all or selecting domains in practice

Twenty-five professionals commented on covering all or selecting domains in the 'Before' interviews. Twelve professionals tended to work through all the domains during assessment and write-up of the CCA. The reasons given for this practice were the in-depth nature of work, to ensure that no blank spaces were left. Thirteen professionals tended to select those domains that they felt were appropriate in the circumstances. This practice was related to the nature of work (for example, discipline-specific assessments). This may be an indication of the fuller type of assessment undertaken by CM, and that the OT considered large sections of the original CCA inappropriate to their discipline.

A substantial practice change had occurred by the time of the 'After' interviews with most professionals filling in only those categories they felt appropriate and recording 'not applicable' or 'not discussed' in other places on the outcomes documents. The rise in the practice of selecting domains appears to be related to the increased breadth of assessment given in the new documents, particularly the CCA, and reported pressure on practice owing to backlogs.

Usefulness of domains within documents

The professionals provided details about particular domains on the original CCA perceived to be useful. In the 'before' period no particular patterns by distinct professional group were evident. Generally, the most useful domains included personal assistance, physical health and communication and domestic assistance, significant life events and technical aids/equipment. Other domains nominated included information needs, housing, financial and summary. Relevancy depended upon whether the work was discipline-specific, or related to particular service user group such as issues relevant to those with visual impairment. Only three professionals mentioned the importance of social and recreation, and employment and education issues. Domains perceived as rarely used and/or difficult to use in the

'before' period included culture, mental health, personal counselling, significant life events, personality and preferences, employment/education, social/recreation, essential priority information, transport and financial and technical aids. On the whole, 'culture' was often not seen as relevant due to the dominance of white service users in the area. The 'mental health' domain was reported by some members of all professional groups to be rarely used or difficult to approach in an assessment.

At the 'After' interviews, the Managers thought that all categories on the outcome-focused documents that concerned the home, personal comfort, health and environment were useful and one specifically thought that the 'summary of presenting situation as seen by service user' performed an important role in setting the correct outlook for the whole assessment. The majority of the professionals agreed. Five professionals mentioned specifically that the new focus on parenting had been useful and one Care Manager felt that the outcomes approach legitimated the work having a broader focus, particularly in relation to leisure and social outcomes.

Outcome domains on the CCA that were not thought to be useful included the 'desired level of cleanliness of home'. 'Citizenship' caused some confusion as to what should be recorded and 'emotional well-being' (which replaced 'mental health') and 'personal hygiene' were noted by some staff as sensitive concepts to record and address with service users. Overlap between the categories 'safety' and 'security' was problematic for many staff, and several OT felt that the 'access to all areas of the home' and 'physical health' domains were too large and unspecific for their work. More specifically, some OT described finding it difficult to 'fit' their assessment on the outcomes documents.

The 'training' and 'employment' domains caused problems for a few CCW who continued their practice of not addressing these areas. In general the CCW described using the economic and social participation outcomes least of all the professions. The 'emotional well-being' domain in the outcomes documents (that replaced 'mental health' in the original CCA) remained a difficult area to address and to document.

It is noticeable that by the 'After' period, no professionals were describing social/recreation as not useful which reflects the increased emphasis given within the outcomes documents to this area, management support for this line of work and increased funding opportunities given through *Fair Access to Care Services*. However, 'training' and 'employment' were still seen as not useful by some staff in the 'After' period. In contrast to the contentious nature of the CCA domains, the Care Plan and Care Plan Review domains in both original and outcome-focused states, met with broad professional approval.

Advantages and disadvantages of the whole set of documents

Professionals were asked to identify the main advantages and disadvantages of the original and outcome-focused sets of documents. The original set of documents was viewed by many professionals to be comprehensive. Professionals felt that they yielded an accessible information source, which could be of benefit to practice. The documents provided copious background information which was useful for information sharing in joint working. For many professionals, the original set of documents provided consistency and routine. Professionals valued the way in which the original documents summarised and clarified the identified needs and exactly what was to be done and identified who was to take responsibility for the work.

The advantages and implications of having a written agreement was a further theme that emerged from professional comments and this had particular relevance to the CP. A written agreement facilitated a shared understanding and ownership of the process and what was agreed; avoided misunderstandings between professional and service user and provided an opportunity for the service user to reflect on the agreement. However, four professionals implied that a written agreement sometimes presented difficulties when trying to decide how to record information of a more sensitive nature. This was particularly difficult when issues had not been discussed openly with the service user, but simply observed by the professional (for example, in relation to mental health). In some instances, professionals preferred not to commit sensitive information (for example on domestic violence) to a written document and used a more informal exchange of information with others involved.

In terms of disadvantages in the original documents, a number of professionals perceived the system as too generic (in particular, the CCA). This was raised predominantly by occupational therapists and involved a concern about the under-emphasis on discipline-specific assessment processes. Two professionals who were not occupational therapists raised similar concerns about the generic nature of the CCA and its failure to 'fit' the nature of the work. Both these examples related to sensory and visual impairment. The original system (particularly the CCA) was seen as intrusive. The CCA was sometimes perceived to be too personal or off-putting. This could create barriers between the professional and the service user. A contrasting view suggested that if the relationship and rapport between the professional and the service user was attended to, then intrusiveness could be avoided. Some comments suggested that the original system, (and in particular the CCA) was repetitive. Professionals drew attention to the negative impact this might have on the service user. The time consuming nature of completing the original set of documents (both the process of assessment and the process of documentation) was also seen as a disadvantage.

In terms of the 'After' state, the advantages of the outcomes document set were as follows: Managers felt in general that the documents were useful in prompting professionals to assess on broader life issues than those concerned only with

immediate mobility around the home, and for moving away from a focus on 'problems'. Many staff commented that the main advantage was the broader focus than previously existed in the department.

The combined effects of the *Fair Access to Care Services* (FACS) criteria and the outcomes focus were noted as advantageous by several professionals, with the latter driving the attention to social and economic participation, and the former providing the legitimisation and funding. Several professionals talked of the outcome focus positively affecting their practice and getting them back to their 'core values', particularly in terms of social work, as well as increasing reflexivity. The 'aspirational' nature of the approach was perceived as advantageous generally but the largest concurrence concerned the primacy of the service user's perspective in the documents. Other perceived advantages were that the outcome focus aids clarity, gives a strong structure for the assessment process and the facility for the service user to prioritise the outcomes. Others valued its 'respectful' nature, its comprehensiveness and thoroughness. The majority of the staff who appear to perceive the most advantages were Care Managers or Social Worker/Care Managers, although many OT were similarly enthusiastic. However, it was noticeable that none of the CCW thought that using the outcome documents was advantageous.

In terms of disadvantages, the majority of these comments were made by the CCW staff who felt that the process of completion was 'time consuming'. Some CCW described spending almost half a day on in-putting one assessment, and stating that previously this process would only have taken around half this time.¹³ A further dislike was reiterating outcomes detailed in the CCA on the CP. Other areas of perceived disadvantage were in using this broader focus with people who are terminally ill. There was also a perceived disadvantage in using a broader focus in that it appears too 'big' for very targeted and straightforward work, such as that undertaken by CCW when providing one item of equipment. Two staff mentioned 'jargon' as a disadvantage and one was concerned about ease of 'flow' between younger and older people's services (as the Single Assessment Process was being introduced into the latter).

Comparison of the perceived advantages of the original and outcomes document sets, shows that professionals believed the originals were consistent, clear and complementary. Comments on the outcomes documents concerned the benefits of the 'broader' whole life focus and their aspirational nature. Furthermore, benefits for service users were mentioned such as their 'respectful' nature; that they provide a

¹³ It must be noted at this point however, that the change to computerised self-input was brought in by the department on the same day that the outcomes documentation was introduced in the Comparative Test area and it is difficult therefore to isolate complaints concerning time to complete documents from time to input data. The situation was further complicated since the professionals who felt the least enthusiastic concerning outcomes, also appear to be those who struggled most with computer input.

strong structure for assessment; that they give the advantage of service user prioritisation to the work and support core professional values. They were also thought to be clear, thorough, comprehensive and give benefits to the team from standardisation of practice. In combination with FACS, the outcomes documents were believed to broaden provision of support and crucially, to allow professionals to access sufficient resources to achieve the service user's desired outcomes.

Comparison of perceived disadvantages, of the original and outcomes documents reveals that the originals were seen as generic, intrusive, repetitive and time-consuming by many staff. The outcomes documents (being built onto the originals) also attracted criticism for being time-consuming and repetitive, and were also said by a few staff to be problematic for work with terminally ill people, too big for targeted work, possibly creating a problem in terms of 'flow' between younger people's and older people's (non-outcome focused) services and suffering from jargon.

Documents targeting service user goals

Eight professionals thought the original set of documents targeted service user goals. A further nine suggested that the original set did assist in targeting service user goals, but that this was primarily due to the professional's skills and experience.

Nine professional staff and two Managers thought that the original set did not assist in targeting service user goals.¹⁴ Within this group, three suggested the reason was that the original system was service-led. Three others suggested it was because the original set of documents focused on needs not aspirations.

The vast majority of professionals in the 'After' period interviews felt that the outcomes documents targeted service user goals. There were only three dissenters to this general perception (1 SW, 2 CCW). In general the professionals were very positive about the prospective benefits to service users available in using the outcomes approach. The following quotation demonstrates the targeting process:

I think it's quite a lot more service user focused really in terms of the paperwork. I think the other thing is ... starting it off in the light of, 'This is for you to ... I'll sort of ask you a few questions but this is for you to tell me about any difficulties you're having - what sorts of things maybe your disability's stopping you from doing, you can start off on that kind of note and then it sets the service user off thinking like that as well, and maybe sort of leads them into focusing on themselves a little bit more rather than being scared to death of having this professional in their house doing an assessment. (OT)

The professionals were also asked whether they could recall cases that demonstrated the more targeted approach. The following case example highlights

¹⁴ One professional (CM) was unsure and another (CM) did not comment.

an area of work that would be unlikely to have been resourced by the department under the original system:

A guy who had really quite serious back injuries ... he was only a young man and he was totally isolated in his house, he couldn't get out ... he was actually quite depressed and I think because we used that [outcomes], I was able to say 'OK, ... we'll try and get somebody of similar age to take you out to fly your planes with you' ... So I think that, in that way, yes, that was where that came out quite well because - it may have been overlooked, let's put it that way. (SW/CM)

Only three staff felt that there was no difference in targeting levels between the outcomes and the original systems. In comparing the before and after sets on targeting therefore, it was found that 17 of the 30 professionals and managers thought the original documents targeted the service user's goals, whereas 25 out of 28 thought the outcome-focused documents perform this targeting function.

Clarity

Professionals were asked whether the original assessment system assisted service users to clearly understand the purpose of the intervention. A total of 11 professionals thought the original system did facilitate service user understanding about the purpose of intervention. A further 11 professionals also thought so but this was not straightforward and dependent on professional skills in interpreting the documents. Five professionals perceived that the original document set did not, or at least did not always, facilitate service user understanding and one was uncertain.

However, in the 'After' interviews, the majority (22) of the professionals believed that the outcomes approach made the purpose of the work clear to the service user. Some professionals thought that the key to understanding how this takes place is in thinking about the service user as exercising control over the direction of the work:

I think because you're involving them in a different way and you are actually saying 'What is it you want to achieve?' then they hopefully should see the purpose of any intervention far more clearly than if you're just saying 'Well OK, you're having a bit of trouble with this so we're going to do this for you' ... if they're being asked what they want to achieve and you're sort of on their side and helping them to achieve it, then they'll see the purpose for the intervention that you're offering. (OT)

Several professionals talked of the clarity that comes because the approach allows for the outcomes to be 'broken down' (into smaller outcomes or small tasks) and this was perceived as beneficial in enabling the service users and professional to 'track' progress and recognise achievements (and barriers to achievement), but also in terms of what the department has agreed to do. Increased clarity therefore has communication benefits for the department:

I think it's clearer doing an outcome ... and I think it's how most people if you asked them would want us to work. (OT)

Other comments about clarity of the outcomes focus related to the fact that the outcome is clearly stated at the start of the document, and all subsequent work should be directed towards the achievement of the service user's desired outcome. This then works in a clear, targeted way, driven by the service user. A small group of professionals (4 OT, 4 CCW) thought that the outcomes approach was less clear.

In comparison of the 'Before' and 'After' positions, although the original assessment system was perceived to be clear for service users by about a third of the professionals, a similar number thought that professional interpretation was needed and a further small group thought the documents were unclear. The majority of the professionals (18 out of 26 responses) believed the outcomes approach was clear. It was seen as advantageous that the outcome is 'up-front' on the documents and all other work and recording is directed towards its achievement and that the approach allows work to be broken down into small tasks that accumulate in the achievement of the outcome.

Documents suited to intervention

Professionals were asked whether the document sets were well suited to the intervention. Responses on the original set suggested that there were issues depending upon whether the work involved simple or more complex cases; younger or older people; or particular service user groups such as those with visual impairment. In some instances, professionals agreed that the original system was, or at least should be applicable across all age and service user groups. However, professionals from all groups used their own discretion to ensure that the set of documents did suit all service users.¹⁵

Where professionals spoke of the original set of documents not necessarily being applicable across service user groups, three themes were evident. Firstly, they were perceived to be more applicable to complex situations and often too comprehensive and time consuming for the simpler or more straightforward situations. Secondly, they were not thought to necessarily suit independent people who want to remain self-sufficient. Some professionals also believed that younger people engaged more easily with the system. Thirdly, they were less suited to assessment of people with visual impairment, due to their independent lifestyle and outlook.

In terms of the 'After' state, in general staff believed that the outcomes documents and approach suit service users who are motivated and interested in change, and those who are generally pro-active in their approach to life. It was also well suited to

¹⁵ This was also the view of one of the Managers.

very complex cases where the 'fine tuning' was important to service users and carers:

It was *how* we put in the care and *how* we actually wrote down exactly what was needed. It's not 'he needs his teeth brushed', and I found it really good for that, to actually break down ... yeah, I think it was very appropriate in that case ... we need these smaller bits, it's not a case of just brushing his teeth he needs somebody to hold the back of his head, it's fine tuning'. (SW/CM)

Opinion was split between a Manager and a SW/CM on whether outcomes documents suited crisis situations:

A young man with diabetes and ... he was directed when he was 20 to go to a day centre ... and using the outcomes focus at a time when there was a crisis at home [we started] to look at alternatives and goals and alternative lifestyle and possibly independence. So using that as a tool to work towards these different goals and to try to support him to have higher aspirations and higher quality of life rather than centre his future around his disability and the dependence, and I think it was a very good tool to look in that positive way ... and I think using the outcomes was central to supporting him to look outside. (SW/CM)

In relation to situations where the outcome focused documents are not well suited, these largely seem to comprise cases where service users asked for a specific piece of equipment and expected that the professional will provide this and leave. One Manager was concerned about suitability in cases where there were 'vulnerable adults':

... perhaps if somebody's at risk, maybe they've put themselves at risk 'cos they don't want a particular piece of equipment. I suppose you could get some conflict there, or maybe a disabled woman whose husband was abusing her but she's not wanted to sort of take any action and well - those issues could be quite difficult ... 'cos we've got a different agenda. (Manager)

The core issue here concerns risk, either where the service user is intentionally taking a risk with their well-being, or another person is putting this at risk. In these cases, as the Manager describes, social services have a different role which is further towards the 'control' end of the spectrum of social care. This role does not sit easily with the social model of disability or with the outcomes focus since it conflicts with the ethos of the centrality and primacy of service user rights.

Comparison of the 'Before' and 'After' sets reveals that both the original and outcomes documents were thought to be well suited for complex cases and too time consuming for very targeted work or 'simple' cases. Some problems and issues noted within the original set include not being suited to work with younger disabled people and not appropriate for work in the field of sensory impairment owing to

'independent lifestyle' and the inappropriateness of intrusive questions. The original set were also difficult to use in cases involving 'sensitive information'. The outcomes documents were seen to be well suited for those service users who have aspirations of independence and improvement in quality of life, and suiting those who are well motivated and interested in change. The outcomes documents were not well suited to 'equipment only' assessments and possibly to situations where there may be a conflict of interests between the service user view and social service role (in work where there is a 'monitoring' or 'control' aspect) or where the service user may be seen as a 'vulnerable adult' perhaps taking risk with their own or others' well-being. This latter feature arises because it is an area of potential conflict with the primacy and centrality of the service user view within the outcomes approach.

Professional satisfaction and dissatisfaction

Professionals were asked about their overall level of satisfaction with the original and outcome-focused systems of assessment and documentation. The majority of professionals (22) and both Managers were positive and generally satisfied with the original system of assessment and documentation, although there was some acknowledgement of deficiencies in the original review system. Three professionals were more ambivalent as they thought the assessment was reasonable but the review system was unsatisfactory. Two others were not satisfied and one was unsure. Professional satisfaction with the original system tended to be related to the positive benefits of having a system that yields good information, as well as legitimacy and clarity. However, within the group of generally satisfied professionals, there were two key qualifications. Firstly, professionals thought more emphasis and attention should be given to a systematic review process, particularly for OT but there were perceived problems owing to capacity. Secondly, professionals highlighted the time consuming nature of the original documentation system, which could exacerbate waiting times and create competing demands. Professionals who were dissatisfied with the original system tended to highlight pressures on practice as a key issue, rather than the system of assessment and documentation itself. For example, two professionals drew attention to the lack of staff resources as a reason for being less satisfied with the original system. In these examples, professionals described working in a service-led mode as a way of coping.

Professionals were asked whether they were satisfied or dissatisfied with the outcome-focused assessment system in the 'after' interviews. The results are displayed below:

Table 3.4 Satisfaction with the Outcomes system

	<i>Satisfied</i>	<i>Neutral</i>	<i>Dissatisfied</i>
Managers	2		
Occupational Therapists	8	2	
Social Worker/Care Managers	3	1	
Care Managers	6		
Community Care Workers	2		4
Total	21	3	4

The results demonstrate that all professional groups with the exception of the Community Care Workers were satisfied with the outcome-focused system.

Professionals expressed satisfaction with the outcomes approach in as much as it presents opportunities to incorporate a focus on service user rights to the work and ‘not to see them as disabled’ and ‘how we should have been thinking anyway - looking at what people want and not what we think is best for them’ (SW/CM). It was also thought that the breadth and coverage will lead to ‘a much better service and a much fairer assessment’ (SW/CM), that the work being fully and formally documented gives the professional ‘protection’ (OT), that it gives the facility to ‘track’ service user progress through the assessment system and gives benefits in joint working between professionals. Furthermore, the outcomes system ‘really fits’ with *Independence Matters* (Manager), it is orderly, clear and a good system, and using the document set creates the right conditions for ‘aspirational’ work with the service user. Professionals expressed satisfaction that their work is far more ‘creative’ and ‘imaginative’ than under the original system (CM) and that the additional clarity and transparency of the process is welcome. Others expressed satisfaction that the outcomes assessment system is ‘respectful to service users’ and:

It’s a constant reminder of our values. Every time we fill out the form we’re reminded that this is about service users and what they want, not about organisational needs which in a large bureaucracy are meant to be the focus far too much. (SW/CM)

Professionals were asked to register any dissatisfaction with the outcomes approach and comments ranged from feeling that the overall approach is ‘a very good idea’ but the CCA form is disliked (OT), concern about how the adoption of the outcome-focused assessment system would ‘fit’ with the Single Assessment Process (SAP) and the possibility of being ‘left behind’ in that respect (SW/CM). There was also a feeling that the system is too broad for the type of work undertaken and that outcomes are more time consuming (CCW).

Service user response

Professionals were asked about their perceptions of service user response to the original and outcomes systems. Overall, professionals believed that service users responded quite positively to the original system of assessment and documentation. Several thought that a positive response was related to skilful management of the assessment process. This included paying attention to how the service user was informed about the assessment process; genuinely including the service user in the process; and prioritising relationship and rapport building. Two Care Managers reported that service users could be confused and concerned about the original assessment process. In other examples, timeliness of service provision was thought to influence service user experiences with the original system.

In the 'After' interviews, some professionals gave accounts of a positive 'shift' in social service provision:

I think generally it's been a very positive response. They perhaps now see you as coming on board with them and actually working with them a lot more ... [in the past] some people perhaps haven't contacted Social Services [because of] the way in which they will be received and hopefully this will change some of that. So we're moving away from the idea that we will prescribe [to] you, and we're now working with you to look at what you want to achieve. I mean certainly my experience has all been positive, but I think generally you almost get a bit more respect really when you come in with that attitude if you like. (OT)

A different professional commenting on service user response contrasted the social model features of the outcomes approach with the diagnostic style of professionals using the medical model:

Well my chap with all the problems, he really came on board really well with it, because I think all of his life ... it was all about - the doctor will tell me this is what's wrong with me and this is what we'll do. And then somebody else will come along, district nurse, and say 'I need to do this, and this is what I'm going to do' and suddenly somebody comes along and actually says to him, 'Well I'm not actually going to tell you what to do, I'm going to hopefully work with you to look at ... what you want to achieve and if I can help you to do that then I'll help you to do that' and I think he really liked that, he responded very well to that. (OT)

Six other professionals felt that service users responded to the outcomes approach positively and many welcomed the 'ball in their court' as a positive change in approach. A few professionals did not know what service users felt or believed they would not know any difference from the previous system. Others claimed that the outcomes approach has 'opened the doors' with some service users, as they are more inclined to accept assistance from social services.

Summary

In comparing the 'Before' and 'After' positions, it is noticeable that professionals believed service users were positive about both systems. However, it does seem evident that professionals had to work to render the original process accessible for service users, and a certain amount of skill was required. The benefits of the outcomes systems noted were that it is not an 'expert' approach and the professional has the opportunity to work 'alongside' the service user. The 'non-prescriptive' style of the outcomes approach was valued in terms of increased respect for service users and the centrality of the service user steering the work. The more positive focus was seen as valuable to professionals in perhaps 'opening doors' so that service users were more likely to accept assistance from social services.

Satisfaction with the original system was related to providing legitimacy and clarity but there were concerns over time-consumption and service availability. Those who were dissatisfied with the original system mentioned lack of staff resources as contributing to backlogs and pressure of work. These, it was claimed, led professionals into service-led practice as a way of 'coping'. The outcomes system elicited satisfaction from the professionals for its focus on the centrality of service user rights and views in assessment, that the individual is 'not seen as disabled' thereby enabling the professional to make the cognitive shift towards social model practice and that the majority of the professionals admire the ability to be 'creative' and 'imaginative' within a system they perceive as 'clear', 'transparent' and 'orderly'. However, the CCW group registered the highest levels of dissatisfaction because the outcomes approach was seen as too broad and time-consuming for their work.

3.3 Document analysis

All assessment documents completed by professionals during the Comparative Test phase were examined in order to compare the nature of practice 'Before' and 'After' the introduction of the outcome-focused approach. The specific aims of the document analysis were to compare the content of service user need statements documented by professionals before the introduction of the outcome-focused approach and the content of service user outcome statements documented by professionals after the introduction of the outcome-focused approach; and describe and compare the intervention statements documented by professionals during the 'Before' and 'After' periods. A further aim was to examine the 'After' (outcome-focused) documents in more detail to describe service user outcome statements; and intervention statements associated with different professional groups.

Data sources and analysis

All statements of service user need, service user outcome and intervention documented by professionals during the two periods were transcribed verbatim from the original record into an Excel spreadsheet. Table 3.5 includes a description of the

data sources. The 'Before' analysis was based on 557 statements of need and 624 statements of intervention extracted from documents, while 465 statements of outcome and 765 statements of intervention were extracted from the 'After' documents. Need, outcome and intervention statements were often recorded on more than one of the documents. In each case, documents were reviewed to make sure all statements were included but not repeated. An inductive process of coding was conducted (Mason, 1996).

Table 3.5 'Before' and 'After' data sources

<i>Data sources</i>	<i>'Before'</i> (Service users = 188) <i>N</i>	<i>'After'</i> (Service users = 186) <i>N</i>
Documents	242	321
CCA	68	149
CP	162	140
CPR	11	3
PSP	1	28
PSPR	0	1
Need/outcome statements	557	465
Intervention statements	624	765

The content of service user need and service user outcome statements

The need and outcome statements categorised for the 'Before' and 'After' periods are presented in Table 3.6. The 26 categories reflect the key content areas of service user need and service user outcome statements documented by professionals for the two periods. Table 3.6 provides an opportunity to consider the content of need and outcome statements across the two periods; the diversity of need and outcome statements documented by professionals; and the relative emphases placed on different types of needs and outcomes. Overall, the analysis indicates some degree of limited diversity in the content of need and outcome statements documented by professionals for the two time periods. For example, nine of the 26 categories (personal care and comfort, access in and around the home, transfers, domestic/activities of daily living, communication, equipment/aids, financial, social/leisure/recreation and independence) account for a substantial proportion (75.2 per cent) of all the needs and outcome statements categorised (n=1022) for both the 'Before' and 'After' periods.

Table 3.6 Percentages of service user need and service user outcome statements categorised for the 'Before' and 'After' periods

Category	<i>Statements of need and outcome (%)</i>	
	'Before' (n=557)	'After' (n=465)
Personal care and comfort	15.1	18.7
Access in/around the home	14.0	20.0
Equipment/aids	7.4	3.2
Transport	3.6	0.4
Financial	4.7	5.2
Transfers	8.6	10.3
Physical health/well-being	5.6	2.1
Domestic/activities daily living	9.3	5.4
Mobility	2.1	0.6
Communication	9.2	5.4
Visual	4.3	
Cognitive	0.7	
Safety and security	0.7	1.9
Housing/accommodation	2.3	1.7
Carer issues	2.7	0.4
Employment/education/training	0.9	4.1
Social/leisure/recreation	2.3	6.4
Information/advice	0.9	0.9
Care package/hours	1.6	1.3
Parenting and relationships	0.9	1.3
Emotional well-being	0.3	1.5
Independence	0.9	7.1
Referral other professionals	0.7	
Legal	0.2	
Access community	0.9	1.7
Citizenship		0.2

A small number of categories account for a substantial proportion of all need and outcome statements categorised within each period. For example, for the 'Before' period, seven categories (personal care and comfort, access in and around the home, domestic/activities of daily living, communication, transfers, equipment/aids and physical health and well-being) account for 69.2 per cent of all need statements. Similarly, seven categories (access in and around the home, personal care and comfort, transfers, independence, social/leisure/recreation, communication and domestic/activities of daily living) account for 73.3 per cent of all outcome statements categorised for the 'After' period. Furthermore, the analysis of need and outcome statements within each period also suggests that compared to other categories, personal care and comfort and access in and around the home are two key areas of concern to service users as documented by professionals. Personal care and comfort represents 15.1 per cent of all needs categorised for the 'Before' period and 18.7 per cent of all outcomes categorised for the 'After' period; while access in and

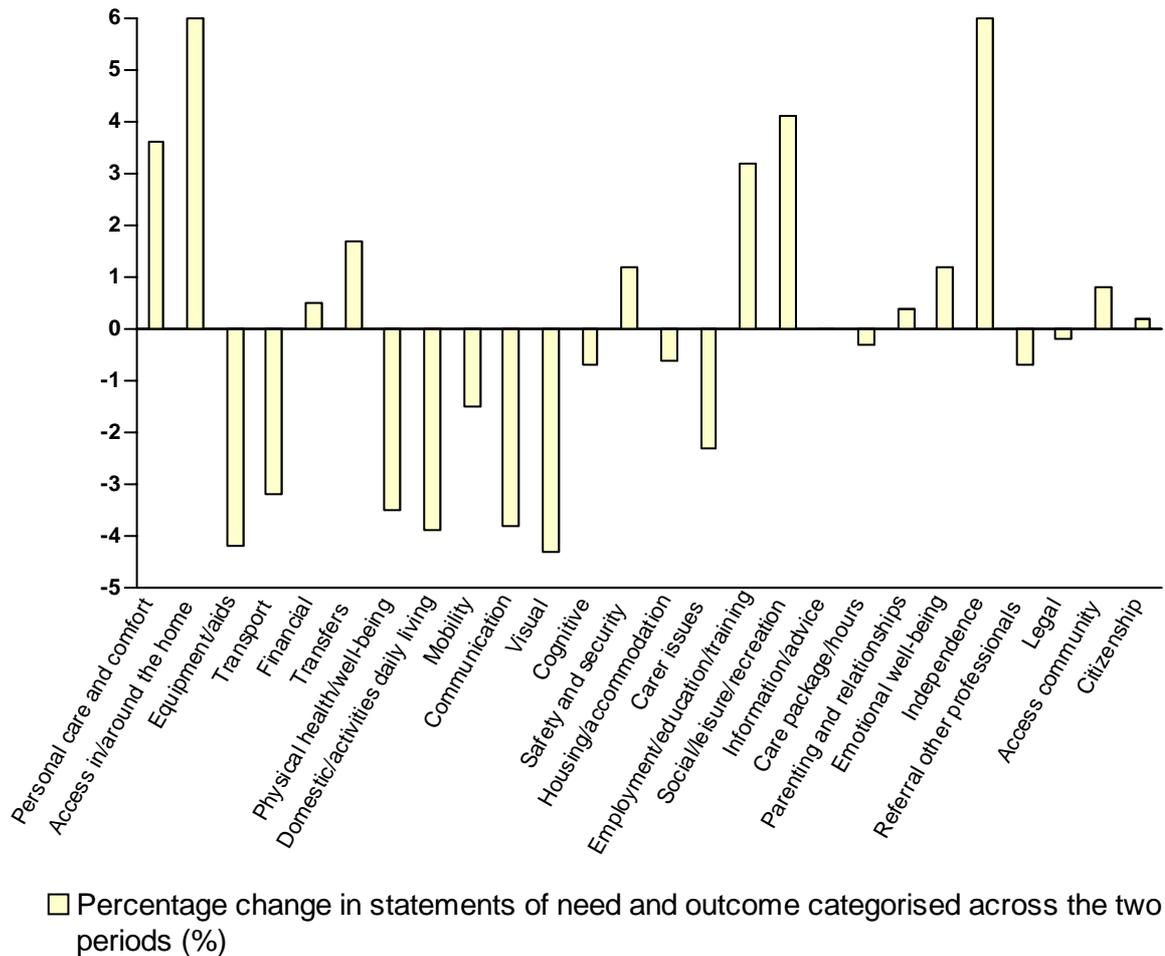
around the home represents 14.0 per cent for the 'Before' period and 20.0 per cent for the 'After' period.

The analysis of need and outcome statements categorised within each time period also provides some insight into the types of issues that are emphasised and under-emphasised. For example, the emphasis during the 'Before' and 'After' periods appears to be on practical and individually focussed self care tasks (e.g. personal care and comfort, domestic/activities of daily living, communication) and negotiating the physical environment of the home or place of residence (e.g. access in and around the home and transfers). During the 'After' period increases are noted in categories concerning the individual's social roles and participation, and community access (e.g. social/leisure/recreation, employment/education/ training, parenting and relationships and independence), reflecting the increased emphasis upon these within the outcomes approach.

Figure 3.1 shows the percentage change in statements of need and outcome categorised across the two periods. As shown, there is an increase in relative percentage terms across the two periods in 12 of the 26 categories indicating that these issues were more evident in documentation during the 'After' period compared to the 'Before' period. On the whole, however, the relative percentage increases were small with only two categories, access in and around the home (6.0 per cent) and independence (6.2 per cent) showing a greater than 5.0 per cent increase across the two periods. The increase in access in and around the home across the two periods further reinforces this as a key area of concern of service users across the two periods. Further, given that independence represented only a small percentage (0.9 per cent) of all statements of need categorised during the 'Before' period, this change across the two periods is of particular interest. Although a small increase is demonstrated for citizenship (0.2 per cent), this increase occurred in the 'After' period since no statements of need were categorised in citizenship for the 'Before' period.

From Figure 3.1 it is also evident that a decrease in relative percentage terms over the two periods occurred in 13 of the 26 categories, although changes were not substantial for most categories. The greatest decrease across the two periods is demonstrated by the categories visual (-4.3 per cent), and equipment/aids (-4.2 per cent). For the visual category, this change was substantial given that no statements of outcome are categorised for the 'After' period. This is a similar pattern for the categories, cognitive, referral to other professionals and legal. There was no change in the category information/advice across the two periods.

Figure 3.1 Percentage change in statements of need and outcome categorised across the two periods



Given the focus in community care on provision of practical assistance with personal self and home care tasks (Barnes, 1998), the primacy of individually focused self care tasks (e.g. personal care and comfort, domestic/activities of daily living) and negotiating the physical environment of the home or place of residence (e.g. access in and around the home, transfers) across the two periods is not surprising. Yet the change in content of need and outcome statements across the two periods, albeit slight, suggests there is some shift in orientation.

Types of interventions documented by professionals before and after the introduction of the outcome-focused approach

Table 3.7 shows the relative percentages of intervention statements categorised for the ‘Before’ and ‘After’ periods. There are 31 intervention categories comprising a range of descriptors. Among these are equipment/aids, housing/accommodation (housing adaptations, housing referrals and transfers), financial referral/applications (e.g. Direct Payments, maximisation of benefits, disability living allowance), care package/hours (e.g. recommendations for a care package appropriate to need or a reduction or increase in care hours) and a range of referrals to allied professionals

(occupational therapists, social professionals and physiotherapists); sensory impairment professionals (ophthalmologists, opticians, audiology); medical professionals (rehabilitation consultants, general medical professionals); visual impairment services (e.g. guide dogs, blind association, visual impairment clinics); domestic/activities of daily living services (home help, meals on wheels); employment/education/training services (e.g. job centre referrals); and emotional/support and counselling services (e.g. psychologists, art therapy). The professional support category captures the more intangible processes of support provided by the professional undertaking the assessment.

Table 3.7 Percentages of intervention statements categorised for the 'Before' and 'After' periods

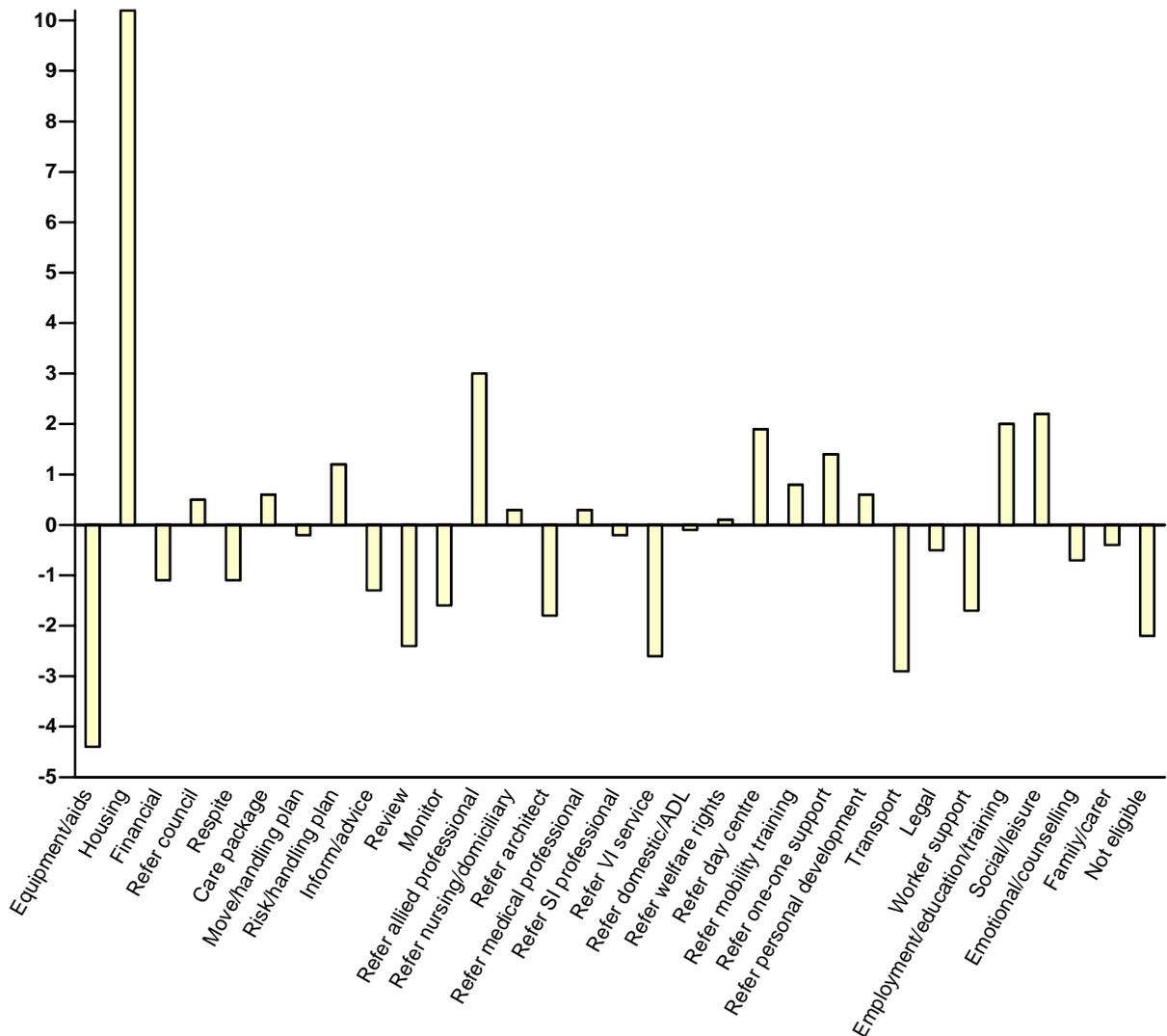
Category	<i>Statements of intervention categorised (%)</i>	
	'Before' (n=624)	'After' (n=765)
Equipment/aids	41.3	36.9
Housing/accommodation	4.6	14.8
Financial referral/application	8.5	7.4
Referral/liaise council	0.5	1.0
Respite	1.4	0.3
Care package/hours	4.5	5.1
Moving/handling plan	0.5	0.3
Risk/handling assessment		1.2
Information/advice	5.1	3.8
Review	3.4	1.0
Monitor	2.4	0.8
Referral allied professional	1.8	4.8
Referral nursing/domiciliary service	1.3	1.6
Referral architect	2.4	0.6
Referral medical professional	0.6	0.9
Referral SI professional services	0.6	0.4
Referral visual impairments services	3.0	0.4
Referral domestic/activities daily living	1.0	0.9
Referral welfare rights	0.2	0.3
Referral day/resource centre	0.2	2.1
Referral mobility training/services		0.8
Referral one-one support services		1.4
Referral personal development course		0.6
Transport	3.8	0.9
Legal	0.5	
Professional support	7.8	6.1
Employment/education/training		2.0
Social/leisure/recreation	0.5	2.7
Emotional/support/counselling	0.8	0.1
Family/carer	0.5	0.1
Not eligible	2.7	0.5

A small number of intervention categories account for a substantial proportion of all interventions categorised (n=1389) for the 'Before' and 'After' periods. These are equipment/aids, housing/accommodation, financial referral/application, professional support, care package/hours and information/advice categories. Within each of the two periods a similar pattern is also evident. For example, for the 'Before' period, equipment/aids, financial referral/applications, professional support, information/advice, housing/accommodation and care package/hours account for 71.8 per cent of all intervention statements categorised for that period. Six intervention categories (equipment/aids, housing/accommodation, care package/hours, financial referral/applications, professional support and referrals to allied professionals) also account for the substantial proportion (75.1 per cent) of all intervention statements categorised for the 'After' period.

Equipment/aids is the most common intervention for both periods, representing 41.3 per cent of all interventions categorised for the 'Before' period and 36.9 per cent of all interventions categorised for the 'After' period. The substantial increase in emphasis upon housing/accommodation, employment/education/training, social/leisure/recreation and referral to day centre, along with referral to other professions, (mobility training services, one-to-one support services and personal development course) show the profile of interventions changed under the outcomes approach.

Figure 3.2 presents the change in relative percentage terms for each intervention category across the two periods. Of the 31 intervention categories, 14 show an increase in relative percentage terms across the two periods, whilst the remaining 17 show a decrease. With the exception of one category (housing/accommodation), the degree of change for any one category across the two periods is less than 5.0 per cent. Although equipment/aids demonstrates a decrease of around four per cent (-4.4 per cent), the relative percentages for this intervention for each period suggests it remains a core focus of professionals' intervention strategies. Housing/accommodation on the other hand shows an increase of 10.2 per cent across the two periods. This change reflects an increase in the number of statements concerning referrals to housing associations and requests for adaptations to the property documented by professionals for the 'After' period.

Figure 3.2 Percentage change in statements of intervention categorised across the two periods



□ Percentage change in statements of intervention categorised across the two periods (%)

Overall, equipment/aid interventions are consistently high across the two periods compared to any other type of intervention despite evidence of some diversity in the types of interventions categorised for the 'After' period (e.g. inclusion of referrals to day/resource centres, one-one support and employment/education/training).

Professional groups and statements of outcomes after the introduction of the outcome-focused approach

Using the outcome-focused documents only, statements of outcomes categorised for the 'After' period were examined in more detail to identify the types of outcomes associated with different professional groups. This analysis was based on the 465 statements of outcomes drawn from 321 documents. For the purposes of this analysis, professionals were assigned to one of four professional groups, community

care workers (CCW, n=7), occupational therapists (OT, n=10), social workers and social worker/care managers (SW/SWCM, n=4) and care managers (CM, n=7).

Table 3.8 presents the percentages of 'After' service user outcome statements categorised for each professional group. A substantial proportion (44.7 per cent, n=208) of the 465 outcome statements categorised for the 'After' period were documented by the CCW group. In comparison, the OT (26.2 per cent, n=122), SW/SW/CM (20.0 per cent, n=93) and CM (9.0 per cent, n=42) groups documented far less of the overall service user outcomes categorised.

From the analysis, the CCW group tends to document more outcomes relating to personal care and comfort (30.7 per cent) and access in and around the home (25.0 per cent) compared to other outcomes. These two categories represent a substantial proportion (55.7 per cent) of all the outcomes documented by the CCW group. Transfers (11.0 per cent) and communication (10.6 per cent) outcomes are also most noticeably emphasised in documentation by this group. These four categories make up 77.3 per cent of all statements of outcome categorised for the CCW group.

Similarly, the OT group documents more statements of personal care and comfort (10.6 per cent), access in and around the home (30.3 per cent) and transfers (19.7 per cent) compared to other outcomes. These three categories make up 60.6 per cent of all outcomes documented by this group. However, whilst access in and around the home represents one-quarter of all the outcomes documented for the CCW group, it represents almost one-third of all those documented by the OT group. The OT group also demonstrates a higher propensity to document transfer outcomes (19.7 per cent) compared to personal care and comfort outcomes.

Almost half (47.6 per cent) of all the outcomes documented by the CM group involve four types of outcomes. These include personal care and comfort (11.9 per cent), physical health and well-being (11.9 per cent), domestic/activities daily living (11.9 per cent), and social/leisure/recreation (11.9 per cent) outcomes. The analysis also indicates that this group documented financial (9.5 per cent) and independence (7.1 per cent) outcomes.

Table 3.8 Percentages of ‘After’ service user outcome statements by professional group

<i>‘After’ service user outcomes by professional group</i>				
Category	CCW (n=208) %	SW/SWCM (n=93) %	OT (n=122) %	CM (n=42) %
Personal care and comfort	30.7	5.4	10.6	11.9
Access in/around the home	25.0	2.1	30.3	4.8
Equipment/aids	2.9	1.1	5.7	2.4
Transport		2.1		
Financial	1.9	5.4	9.0	9.5
Transfers	11.0		19.7	2.4
Physical health/well-being	0.5	1.1	2.4	11.9
Domestic/activities daily living	8.2	1.1	1.6	11.9
Mobility	0.5	1.1		2.4
Communication	10.6	2.1		2.4
Safety and security	1.9		4.1	
Housing/accommodation	1.0		3.3	4.8
Carer needs		2.1		
Employment/education/training	1.0	11.8	3.3	4.8
Social/leisure/recreation	1.4	19.3	3.3	11.9
Information/advice		3.2	0.8	
Care package/hours		4.3		4.8
Parenting and relationships		4.3	1.6	
Emotional well-being		5.4	0.8	2.4
Independence	2.9	22.5	2.4	7.1
Access community		4.3	0.8	4.8
Citizenship		1.1		

The SW/SWCM group demonstrated a higher propensity to document social and economic outcomes compared to others such as personal care and comfort, or access in and around the home. Over half (53.6 per cent) of all outcome statements documented by the SW/SWCM group concern independence (22.5 per cent), social/leisure/recreation (19.3 per cent) and employment/education/ training (11.8 per cent). In this group, statements were identified for 19 of the 22 outcome categories, demonstrating that these professionals cover the widest spectrum of outcomes.

The results demonstrate the differing emphases between professional roles and work undertaken across the multi-disciplinary team.

Professional groups and patterns of interventions ‘after’ the introduction of the outcome-focused approach

Analysis of the ‘After’ intervention statements categorised for the four professional groups was undertaken to identify whether particular interventions were associated with different professional groups and to describe the types of interventions emphasised and under-emphasised within each group. An overview of percentages of ‘After’ intervention statements categorised for each professional group is shown in Table 3.9. A substantial proportion (40.9 per cent, n=313) of all interventions categorised for the ‘After’ period were attributable to the CCW group. The OT and SW/SW/CM groups accounted for similar proportions of all the interventions categorised (26.4 per cent, n=202 and 26.1 per cent, n=200 respectively), while the CM group was associated with the least number of interventions categorised (6.5 per cent, n=50). Four categories of interventions (equipment/aids, housing/accommodation, professional support and care package/hours) accounted for a substantial proportion (70.3 per cent) of all interventions categorised for the four professional groups.

Table 3.9 provides some insight into the orientation of each of the four professional groups when responding to service user outcomes. Equipment/aids and housing/accommodation account for a substantial proportion of all interventions documented by the CCW (78.6 per cent) and OT (60.8 per cent) groups suggesting these are common intervention strategies for these two groups. More importantly, both groups demonstrate a higher propensity to document equipment/aids compared to any other type of outcome, although this is more pronounced for the CCW group (55.3 per cent of all interventions), than for the OT group (45.5 per cent of all interventions). These results also suggest, however, that there is some degree of limitation in the diversity of interventions documented by the CCW and OT groups.

The CCW group shows some indication of referral to other types of interventions, such as financial referrals (4.1 per cent) and information/advice (3.2 per cent). Overall, however, these represent only a small proportion of all interventions categorised for this group. For the OT group, the analysis also suggests that financial referrals (8.9 per cent) and information/advice (4.9 per cent) are documented but similarly, less so compared to other types of interventions.

Table 3.9 Percentages of ‘After’ intervention statements by professional group

Category	<i>‘After’ interventions by professional group</i>			
	CCW (n=313) %	SW/SWCM (n=200) %	OT (n=202) %	CM (n=50) %
Equipment/aids	55.3	7.5	45.5	4.0
Housing/accommodation	23.3	3.0	15.3	6.0
Financial referral/application	4.1	9.5	8.9	14.0
Referral/liaise council	1.3		2.0	
Respite		0.5		2.0
Care package/hours	0.6	14.5	0.5	14.0
Moving/handling plan		1.0		
Risk/handling assessment		4.5		
Information/advice	3.2	3.0	4.9	6.0
Review	0.6	2.0	0.5	2.0
Monitor		3.0		
Referral allied professional	2.9	9.0	2.5	10.0
Referral nursing/domiciliary	0.6	0.5	4.0	2.0
Referral architect	0.6		1.5	
Referral medical professional	0.3	1.0	2.0	
Referral SI professional	0.6	0.5		
Referral VI services	0.6	0.5		
Referral domestic/ADL	0.3	1.5		6.0
Referral welfare rights			0.5	2.0
Referral day/resource centre	0.3	3.5	2.0	8.0
Mobility training/services		1.5	1.5	
Referral one-one support	0.3	5.0		
Personal development course		2.5		
Transport	0.6	1.0	1.0	2.0
Professional support	2.2	11.5	4.4	16.0
Employment/education/training	0.3	6.0	1.0	
Social/leisure/recreation	0.6	7.0	1.0	6.0
Emotional/support/counselling	0.3			
Family/carers		0.5		
Not eligible	0.6		1.0	

With nine categories, (professional support, financial referral/application, care package/hours and referral to allied professionals, referral day/resource centre, housing/accommodation, information/advice, referral domestic/activities daily living and social/leisure/recreation) accounting for the substantial proportion (86.0 per cent) of all interventions documented by the CM group, there is also evidence of some degree of limitation in the diversity of interventions documented. Moreover, four of the nine (professional support, financial referral/application, care package/hours and referral to allied professionals) make up over half (54.0 per cent) of all interventions

categorised for this group. This implies that these are core areas of work for the CM group.

For the SW/SWCM group, seven categories (care package/hours, professional support, financial referral/application, referral to allied professionals, equipment/aids, social/leisure/recreation and employment/education/ training interventions) account for 65.0 per cent of all interventions categorised. Of particular note is that interventions concerning employment/education/training and social/recreation/leisure make up a reasonable proportion (13.0 per cent) of all interventions categorised, as do referrals to one-to-one support, day/resource centre and personal development courses (11.0 per cent of all interventions categorised). Interestingly, this is the only group where intervention categories such as referrals to personal development courses, family/carer interventions, moving/handling plans and risk/handling assessments were identified. This finding demonstrates that the SW/CM group had the widest range of interventions of all the professional groups.

3.4 Service user views

Background

Service users were involved at all stages of the project and gave their views in a variety of ways. During the Comparative Test however, a number of service user groups participated regularly in the project. The key findings from these groups are reported here.

A member of the research team joined three existing service user groups which met regularly throughout the Comparative Test period. Service user groups were identified through contact with managers in Derbyshire Social Services. The aim was to find service user groups who could provide input into the project on a regular basis. Three ideal pre-requisites were identified: that the groups comprise of members using the Disability Service; that group members are aged 18-65 years; and that the groups were not located in the areas of the Comparative Test.¹⁶ Three service user groups were identified. These were one group of deaf blind service users¹⁷ and two disabled service user focus groups encompassing people with a variety of impairments.

Membership comprised between four and eight service users, and two and eight staff members and carers per group. All three groups met regularly, Group One meeting

¹⁶ The service user groups were not in the CT area to ensure that service users giving their views would not feel that their service levels might be jeopardised by participation in the project. The design of the CT phase incorporated this as a means of gauging service user opinion on outcomes (rather than through interviews as in the RTI). Service user involvement in the CT was intended therefore to be more practical in focus as well as more intensive.

¹⁷ Although the group of deaf blind service users was made up of people in an area involved in the Comparative Test area, it was deemed important to include the membership since their views are rarely canvassed.

every two to three months, Group Two every two months and Group Three every one to two months. Group One was visited five times, Group Two four times and Group Three twice.¹⁸

The aim of participation in the groups was to discuss and explore the concept of outcomes, the user friendliness of the Care Plan, and the best means of providing information about the new outcome-focused service. The purpose was to permit service users' ideas to influence the development of the outcomes concept and to ensure user-friendliness and acceptability of the outcomes approach and tools. Notes were taken at the meetings and key issues that were found important to service users were as follows;

- Service users were concerned that the outcomes approach may lead to more paperwork for professionals to complete, about being passed between services and delayed responses.
- The service user can be 'lost' between services in transitions between life stages.
- Issues surrounding the availability and accessibility of information were raised. A one stop place for information would be helpful. Electronic technologies could be used more to convey information and could improve accessibility for visually impaired and Deaf people.
- Knowing how to access services was an important issue that recurred across the groups and throughout the meetings.
- Continuity of service was important and could avoid the same questions being repeated at assessment.
- Coordination was thought to be a stumbling block to delivering services, with organisations being unaware of what each did. One key person should be identified for each service user to lead them through the assessment process.

The outcomes approach

There was general agreement across the groups that the outcomes approach was useful. It was pointed out that it is a useful approach because it takes into account how the service user wants to achieve their outcomes, rather than this being based on professional assumptions.

It was suggested that service users may need assistance, or even training, in how to identify their outcomes. Group members were able to easily identify and talk about outcomes they wanted to achieve. They thought about what they had achieved and what they would like to achieve. Examples of outcomes achieved included making the kitchen a safe environment. It was also suggested that a person's upbringing and background has an effect on how they think about their outcomes and aims. It was felt that individual life experiences impact on aspirations. A person's stage in the

¹⁸ Time constraints led to the omission of Topic Guide Two for Group Three and the adaptation of Topic Guide Four to be sent for the group to self-administer.

process of becoming a service user was thought to have an effect, with it being harder to say what your outcomes are in the early stages of becoming a service user and this may become easier with time. There was a suggestion that some people prefer not to look ahead if their impairment is worsening.

One member spoke about individual confidence levels and how difficult it can be to adjust to visual impairment. A factor aiding thinking about outcomes was the importance of having a clear picture of past achievements and aims for the future. This links in with the idea of service users having time to think about their outcomes before an assessment. One group suggested getting assessment questions in advance or a pre-visit questionnaire conducted over the telephone.

The groups also discussed outcomes using a fictional case study. Members identified a number of outcomes the case study character might wish to achieve. A range of technical, emotional and practical outcomes were identified by service users.

The members¹⁹ identified the following as characterising a good assessment:

- Continuity.
- Pre-assessment.
- One person responsible to make referrals to other agencies and check tasks have been completed.
- Copy everything to the service user.
- Ask about passing information on to other people.
- To be given an idea of how long things will take and be told 'we'll get back to you' even if it cannot be done.
- Accountability of agency (complaints process) and workers actively taking responsibility for their actions.
- Sensitivity.
- Positive frame of mind.
- Time and genuine caring approach.
- Service users must really be listened to.
- Service users need to be given more time for thinking in advance of meetings with professionals.
- Professionals and service users need to be clear about what they are going to achieve.

The outcome-focused care plan

Themes relating to the Care Plan fell into three clusters around issues of language, process, and format. With regard to language, there was a general indication in two groups that service users did not understand the abbreviation FACS (Fair Access to Care Services). One service user was unclear about the term 'Care Plan

¹⁹ Groups One and Two only contributed these ideas.

coordinator'. Some found the term 'outcomes' obscure and thought 'goals' was better but others thought that 'outcomes' was preferable. Responding to a professional's suggestion that the word 'care' belongs to the medical model of disability, a service user suggested renaming the Care Plan, 'support plan'. It was suggested that using the word 'needs' made service users feel needy.

Other points related to the process of completing the Care Plan. It was felt that outcomes listed on the Care Plan would need to be explained in person by the professional to the service user. Another suggestion was to record the start, rather than completion, date of the work. Other members valued the sections 'who will do it' and 'cost to service user'. It was considered important that the service user is asked that they fully understand and agree with the Care Plan. This last comment also relates to general comments in which service users talked about the issue of having sufficient time.

Layout and accessibility were issues raised in relation to the Care Plan format. Service users felt it important that the Care Plan was received in an accessible format. This had not always been the case for existing service users. The Braille copy was not straight forward to read and could be made more accessible in the following ways: keeping to lower case or capital letters only; using a standard format with headings rather than the box format; and writing words in full rather than using abbreviations.

Members discussed the printed version of the outcome-focused Care Plan. It was found that the data protection box is faint when viewed in large print. Care should be taken when using shading in the boxes as this affects legibility.

Time was raised as an important general issue to members. There was concern that social services may not have the skills or time to effectively discover service users' outcomes. Some commented about insufficient time for meetings and reviews. It was felt that Care Plan Reviews were rushed and did not allow enough time for service users to absorb the information.

The main themes emerging from the discussion of the Care Plan were:

- Professionals should ensure service users are receiving the Care Plan in the most appropriate format.
- Braille versions should be standard formatting; in class one or class two, depending on which is most appropriate for the service user.
- The data protection box should be moved to the end of the form where it does not disrupt the flow of the document.
- Shading should be avoided.
- Use of full text, rather than abbreviations.
- Consideration of the use of the terms, 'Care Plan' and 'outcomes'. Alternatives suggested were 'support plan' and 'goals'.

- Allow enough time for Care Plan Reviews to take place.

Changing to an outcome-focused service

A discussion was held about what service users would need to know about changing to an outcome-focused service. Discussion centred on current practice and service users' preferences for receiving information. Linked themes were notification timescales and who should be informed. Finally, discussion also touched upon the benefits of receiving prior information on assessment and understanding outcomes.

In discussion of making changes to assessment processes, service users said they would need to know how it is different, why the process has been changed and what advantages and disadvantages this change may bring. There was also concern about what will be removed as a result of changes. Currently service users in the groups learn about changes through contact with professionals, or via a third party, for example social services contact the service users' partner or relative to convey information to the service user. One member stressed the importance of picking the appropriate time and way to inform service users of changes with the emphasis on being treated as an individual. Service users need to be told about things to know what is available. In some instances, professionals were telling service users about things they thought would interest them.

Service users made a number of suggestions (not specifically about outcomes) about how they would like to learn about changes. Being informed by letter was suggested, ensuring that information is provided in the appropriate format. Great importance was placed by Group One upon using the right format for the individual and this was echoed by Group Two who suggested the use of large print and taped information as required. Letters were seen as beneficial because they provided concrete evidence about decisions and actions. Letters were also felt to provide consistency, with everyone being told the same thing. However, it was also felt that not everyone would read the paperwork they were sent. Sending a copy of the outcome-focused form prior to assessment could be beneficial, as this would provide time to understand and consider the assessment questions. Informing service users of changes by telephone was seen as impractical.

Essential points to remember when conveying information included: providing times, dates and contact telephone numbers and providing information in the most appropriate format. This may be in Braille or large print, keeping information simple and concise, and providing time to absorb information. Suggestions about where to place information about outcomes included: doctors' surgeries, hospitals, the post office and libraries.

Some members felt that notification of changes would need to be given one to two weeks before the change occurred, but others felt the service user could be told at assessment. The service user was generally regarded as the most important person

to know about changes to service. It is important that support workers are informed of changes in service focus in advance so that they have time to explain these to the service user.

The benefits of receiving information were to provide a chance to think about the assessment in advance, and it was felt this would also save time at assessment. The concept of outcomes was thought to be easy to grasp once explained.

3.5 Conclusion

The 'Before' and 'After' interviews offered the professional perspective on practice change following introduction of the outcomes approach and documentation. Overall professional satisfaction levels with the outcomes approach were high across all professional groups, with the exception of the CCW group, who viewed it as too broad and possibly too time-consuming for their work. Professionals were concerned that the original system had deficits in time-consumption, service availability, pressure of work, backlogs and lack of staff resources, leading some professionals into 'service-led' mode of assessment as a way of coping. The outcome-focused approach, whilst not solving these issues, did elicit satisfaction for the centrality of the service-user's view, enabling professionals to move into social model practice and for the increased job satisfaction that arose from being 'creative' and 'imaginative' in direct work. Many noted the timely introduction of FACS that had provided the funds to underpin the social model intentions of the outcomes approach. In combination with FACS, the outcomes documents were believed to broaden provision of support and crucially, to allow professionals to access sufficient resources to achieve the service user's desired outcomes. Overall, the results were encouraging, suggesting that very few professionals had reservations concerning applicability to their work, or appropriateness for the assessment procedures.

The main benefits noted were the centrality of the service user's perspective and the facility for the professional to work 'alongside' the service user as an assistant rather than as an 'expert' or assessor. Many professionals noted an increase in service user receptiveness and decrease in hostility to the service as a whole which arose from working in this way. Some professionals noted benefits for joint working in the full recording practices on the outcomes documents and others thought that the approach reminds them of their 'core values'.

In the comparative documentary analysis it was found that statements of need and outcome concerning broader social roles, social participation, and community access were less evident in professionals' documentation than individually focussed issues focusing on practical, and personal self and home care tasks, and negotiating the physical environment within the home. Key areas of need and outcome included personal care and comfort, access in and around the home, transfers, domestic/activities of daily living, communication, equipment/aids, financial,

social/leisure/recreation and independence. Access in and around the home is consistently a key need and outcome. The latter category and independence recorded the greatest change across the two periods. These areas were found to be centrally important to professional practice.

Equipment/aids was the most common intervention documented by professionals across the two periods. With the exception of housing/ accommodation related interventions, which increased substantially, the degree of change in all categories across the two periods was not great. Compared to other outcomes, personal care and comfort and access in and around the home represented a substantial proportion of all the outcomes documented by the CCW. The OT outcome statements had a similar profile being dominated by personal care and comfort, access in and around the home and transfers. Almost half of all the outcomes documented by the CM group involve personal care and comfort, physical health and well-being, domestic/activities daily living and social/leisure/recreation outcomes, whilst over half of all outcome statements documented by the SW/SWCM group concerned independence, social/leisure/recreation and employment/education/training. This shows that professional practice at both time periods was largely discipline-driven.

Equipment/aids, housing/accommodation, professional support and care package/hours account for the substantial proportion of all interventions categorised for the four professional groups. The core intervention strategies documented by the CCW and OT groups were found to be Equipment/aids and housing/accommodation. The CM intervention strategies were more diverse and a far broader spread of intervention strategies was evident in the SW/SWCM group. The limited diversity of needs, outcomes and interventions documented shows the continued dominance of equipment/aids and housing/accommodation issues within the service, although there is evidence of subtle shifts in emphasis towards the increased inclusion of social/recreation and education/employment/training as professionals operationalised the outcomes approach.

The service users in the study viewed the introduction of outcomes positively. Service users were concerned that information about changes to service such as the introduction of the outcomes focus took place within a context of genuine information-sharing and that key personnel would guide them through their interaction with social services. The importance of continuity and coordination between the services involved in their support was also important.

Service users had no difficulty identifying and discussing a broad range of outcomes for themselves and others. However, they felt that assistance could be given in the form of questions in advance of assessment. Some of the characteristics identified by service users for a good assessment were continuity, pre-assessment, one responsible professional and sufficient time to think about outcomes.

In introducing an outcome-focused service, prior information provision was seen as beneficial to service users because it permits planning and preparation. The preferred way of learning about service changes was by letter. Use of the internet and telephone were less preferred ways to inform service users about change. Opinion was split about when to tell people about changes. There was general consensus that the service user is the most important person to keep informed. A consistent theme was the importance of providing information in the most accessible format.

Chapter 4 Report Conclusion

In this chapter, the research questions are reviewed and evaluated in the light of the data collected. The aims of the study were to produce an outcomes approach and outcome-focused documentation that would be acceptable to practitioners in the Disability Service (the Development phase); to develop and trial the approach and documentation with all stakeholders, whilst researching the process (the RTI); and to understand how practice changes by comparing practice and documentation before and after introduction of outcomes (CT). Each of these phases was undertaken in a different social services area, following the principles of 'researched development' previously used by Qureshi *et al.* (2001).

Key findings

The majority of staff from all professional groups found the outcome-focused approach and documents to be useful, workable and an improvement on the original (needs-based) system. The majority of staff believed that the outcomes approach and documents were applicable and appropriate to their work and suited their professional role.

The outcomes approach and documentation was successfully routinised into the practice of the multi-disciplinary team. There are positive benefits to focusing upon outcomes for service users. These comprise greater clarity (in approach and documents) and enhanced choice and control in the assessment process.

Professional satisfaction levels were high in every profession excepting the CCW, who saw the introduction of outcomes as radically changing their practice away from a focus on functional items towards a whole life focus. Professionals reported increased ownership of change for service users and increased empowerment, choice and control.

Use of the outcome-focused tools offers a far broader assessment than is possible under the needs-based system. Increased 'breadth' of coverage brings issues for professional assessment practice such as tailoring the 'level' of assessment to the service user's requirements. Utilising the outcomes system involved some professionals moving into areas of work that they were not previously familiar with (particularly, education/training and employment). Many professionals expressed the need for further training on outcome areas that were less familiar (particularly employment and training).

Professionals valued the user-centred nature of the outcomes approach and that using it allowed them to be creative and imaginative in their work. There was evidence that some professionals since using outcomes had adopted social model

inspired practice, taking an approach that centred upon barrier-removal, access to mainstream services and facilities within the context of service user rights.

Service referral patterns did not radically alter in the comparative test although there was some evident increase in use of employment services and increased referral to other professions.

The move towards acting as a facilitator rather than assessor appears to pay benefits in increased service user receptiveness and reduction of social service stigma. In the document analysis it was found that the CCW role was dominated by personal care/comfort, access in and around the home, transfers and communication. The main focus of the OT role was similar apart from communication, whilst additional areas of the CM role were physical health and well-being, domestic/activities of daily living and social/leisure/recreation. The SW/SWCM group focus was mainly independence, social/leisure/recreation and employment/training.

Service users viewed the introduction of outcomes positively. They had no difficulty identifying and discussing a broad range of outcomes for themselves and others. Prior information provision was seen as beneficial.

Revisiting the research questions

The first research question was:

To what extent is it possible to develop an outcome-focused approach for incorporation into routine practice with disabled people that will prove practical and useful from the perspectives of service users, practitioners and Managers?

The empirical evidence provided by the project demonstrates that this objective was achieved in all general respects. Although the development of outcome-focused tools for use in such contexts necessitated a lengthy period of development work, the benefits of an extended period in the field accrued in enhanced fieldwork relationships with professionals and managers. This enhanced the extent to which all stakeholders had opportunities to influence the development of the outcomes approach and outcome-focused tools and ensured that those devised proved to be practical and useful.

In a general sense, very little dissent to the introduction of outcomes to services was noted and there were many cases of enthusiastic support from service users. Service users whose views were collected had little or no difficulty in identifying outcomes, or understanding the purpose of using the outcomes focus. Practicality and usefulness of the outcomes focus for service users was evident.

Support from management for the introduction of outcomes was generous at all stages of the project and it was unlikely that it would have been successful without it.

Managers perceived the introduction of outcomes as pivotal to the refocusing of social services in line with the social model of disability, in which service users would exercise control and choice and the professional role would radically alter to one of assisting the service user to achieve their desired outcome. The timely introduction of the *Fair Access to Care Services* policy in the Comparative Test provided social services with the necessary funding to underpin the desired outcomes identified by service users and the ethos of this policy and the outcomes focus proved complementary. The *Green Paper on Adult Social Care* (2005), with its recommendation for individualised budgets increasing choice and control has distinct resonance here.

Professionals regarded the introduction of outcomes in general as an improvement on the original focus on needs. Many professionals (particularly OT) experienced difficulties during the RTI owing to the reorganisation which had the unfortunate effect of obscuring the extent and nature of the effects due to the introduction of outcomes. The greatest amount of professional dissonance was noted in the Comparative Test and came from the Community Care Workers, who believed that the outcomes focus was too broad for the targeted intervention work they undertake and that the documentation was too comprehensive for their requirements. However, the majority of the OT in the Comparative Test and the CCW in the RTI did not experience adverse reactions. This finding suggests that time of introduction, extent of other changes taking place in the organisation and professional culture all influence successful introduction of the outcomes focus (Qureshi *et al.*, 2000). The professional groups that supported the outcomes focus introduction most consistently throughout the project were the Care Managers and the Social Worker/Care Managers. This suggests that the professional outlook and culture of these professions is most in tune with the ethos of the outcomes focus, and possibly least threatened by the social model of disability features. In a general sense, those professionals that preferred to the original style of service that was performed in a 'functional' mode (focusing on highly practical items such as equipment and aids/housing adaptations) experienced more dissonance with the outcomes focus than those who embraced the new style service ethos and who supported the increased emphasis upon social participation, leisure, education and employment. It seems highly probable that the reason that the Care Managers and Social Worker/Care Managers experienced the least dissonance with the outcomes focus was that the latter items already formed a core focus of their work under the original scheme. In general, very few professionals had reservations concerning applicability to their work, or appropriateness of the outcomes focus for the assessment procedures. These formed the correct conditions for acceptance of innovation described by Smale (1996). It is known that barriers to successful introduction of outcomes include conceptual confusion, professional and organisational culture, and lack of resources (Qureshi *et al.*, 2000). Although each of these affected the project in some way, professional enthusiasm largely overcame the worst of their effects.

The second research question was:

Which aspects of outcome-focused practice are most valued by disabled service users, professionals and managers?

Service users valued the 'respectful' nature of the outcome-focused practice and that the professional takes the role of assistant in achieving their desired outcome, rather than taking the role of expert assessor. Service users also valued clarity and openness in relation to the provision of information. This applied at all stages and even before the assessment process commenced. The provision of clear information on the introduction of any service change, and particularly the introduction of outcomes, given in an accessible format was a key necessity.

Professionals valued the respectful nature of outcomes and the centrality of the service-user's view, enabling professionals to move into social model practice. They also appreciated the increased job satisfaction that arose from being 'creative' and 'imaginative' in direct work. Increased service user receptiveness and decreased hostility to the service as a whole following outcomes introduction was also valued. Some professionals noted benefits for joint working in the full recording practices on the outcomes documents and others thought that the approach reminds them of their 'core values'. Finally professionals valued increased ownership of change by service users and consequent increases in service user empowerment, choice and control.

Managers in general valued the increased transparency of process brought through the fuller recording given in the outcomes documentation. This proved beneficial for supervisory purposes and had added benefits in highlighting areas where staff required further training. Although not an objective of this project, the use of the outcomes documentation for monitoring purposes by management was also reported to be beneficial.

The third research question was:

Can outcome-focused case review tools be developed for routine use with disabled service users?

The data collected for this project demonstrates that outcome-focused case review tools can be developed for routine use. Successful development of tools of this nature (as described in Chapter 2) depends crucially upon achieving ownership of change from the outset and throughout the course of tool introduction. Achieving this within a multi-professional and multi-disciplinary setting however, is not without challenges and complications. Issues of difference in professional culture and discipline-specific requirements impacted upon the development of the tools. In relation to West's (1997) four stages (reviewed in Chapter 1) the project achieved all four stages, moving from initiation and planning, through trial implementation to routinisation of practice and document usage.

The final research question was:

Does use of an outcomes approach affect the outcomes achieved compared with conventional methods?

The document analysis provided some findings concerning the pattern of service provision and how this changed following the introduction of the outcomes focus. The data provides a professional focus on this research question, in as much as it can only be viewed as what the professionals recorded as the nature of the issues (outcomes) and the nature of their intervention. With these provisos, from the Comparative Test data it is possible to see that the service was gradually changing, with a diminishing of equipment/aids as the main focus of the work of the service, to an increased emphasis upon social/recreational and education/employment, and an increase in referral to a wider group of service providers. It seems clear therefore that using the outcomes approach increased the emphasis on these areas of professional practice and assisted professionals to move towards social model inspired practice. These changes occurred during the life of the project, and it is impossible to know how sustainable they may prove to be in the future.

Policy relevance

In terms of 'fit' with relevance to policy, it seems clear that the outcomes approach dovetails with and in many respects complements both the spirit and the intention of *Fair Access to Care Services* (FACS) (Department of Health, 2002). This is because in many key respects, the introduction of FACS opened up the funds to the social services that were necessary to underpin the outcome-focused service. Crucially, the focus within FACS of the individual's eligibility for service as contingent upon the risk to their independence, fitted perfectly with the outcomes focus themes of access to mainstream services, employment, education to gain employment and training, as well as social/leisure/recreation. These were all lower priority areas within the service prior to the introduction of outcomes. The FACS guidance states:

The most appropriate and cost-effective help should be determined by matching services to eligible needs through the use of statements of purpose. Councils should assess an individual's presenting needs, and prioritise their eligible needs, according to the risks to their independence in both the short and longer-term where help not to be provided. Councils should make changes in their practice to take a longer-term preventative view of individuals' needs and circumstances. (Department of Health, 2002: 1)

Clearly, the outcomes documentation fitted the 'statements of purpose' envisaged in this policy. Furthermore, the centrality of preventive work and the preservation and maintenance of independence in the policy formed key underpinnings to the outcomes focus. The timely introduction of FACS meant that social services could fund the arising desired outcomes and use it imaginatively to produce services that were truly user-centred.

Stephen Ladyman, MP, Parliamentary Under Secretary of State for Community, stated in a speech in November 2004 concerning the new vision for adult social care:

I think that it is time to take a long hard look at what we want out of social care and question some of the assumptions that have underpinned how it's operated for the last 50 years. People have tried this before. But pretty well all of those attempts have ended up focusing on systems, processes, structures and organisational change - even if they didn't start there. Well that is not where I have started from and not where the Green paper I am working on will start. I have started, instead, by looking at the outcomes that people using services and their families want. What are the outcomes that we as potential customers and taxpayers want from social care? (Ladyman S, 2004)

The Social Care Institute for Excellence was subsequently directed to co-ordinate responses concerning the New Vision for Adult Social Care (SCIE, 2004). Interestingly, a number of the key findings from their report resonate with the ethos and practice of the outcomes focus utilised in this project. Firstly, the determination to pursue 'person-centred responses to need' (*ibid.*, point 4.7) is echoed in the outcomes focus as a central organising principle. Secondly, it is envisioned that:

Adult social care cannot implement a new vision alone or independently of what resources already exist within local communities. It will require skills and resources that extend well beyond those traditionally exercised in social services departments. We need to clarify the respective roles and responsibilities of 'universal' and adult social care services. (SCIE, 2004: 11)

The intention here is to create a new form of social services practice that is more extensive in utilising all available resources. The outcomes focus used in this project utilises exactly these resources in the explicit acknowledgement of the role of the service user, carer, professional and other sources in the achievement of the desired outcome. Similarly, the direction towards an increase in referral to other sources rather than direct provision, so central to the outcomes approach, is heralded in the above statement.

The third area of strong overlap between the new vision and the outcomes approach is the clear steer on the identification of outcomes:

The next round of consultation should give more attention to and indeed, start from, clarifying what outcomes people requiring support want. We could readily draw on the considerable amount of evidence about this issue. This exercise could then drive decisions about the strategic framework of roles and responsibilities necessary to secure those outcomes. (SCIE, 2004: 11)

Clearly the Government agenda for the new vision of adult social care includes a strong emphasis upon outcomes and the core questions addressed by this research project. The Government are determined to introduce this vision which has a central

emphasis upon the outcomes that service users and their families want to achieve (Department of Health, 2005). The new vision will therefore encompass issues that form the key messages from this research, the primacy of the service user's choice and control.

References

Bamford, C. (2000) Surveying outcomes of equipment and adaptations, *Research Works*, Social Policy Research Unit, University of York. Available at SPRU website <http://www.york.ac.uk/inst.spru>.

Bamford, C., Vernon, A., Nicholas, E. and Qureshi, H. (1999) *Outcomes of social care for disabled people and their carers*, Outcomes in Community Care Practice, Number Six, Social Policy Research Unit, University of York, York.

Barnes, M. (1998) Whose needs, whose resources? Accessing social care, in M. Langan (ed.), *Welfare: Needs, rights and risks*, Routledge, London, pp. 81-126.

Challis, D., Darton, R., Hughes, J., Stewart, K. and Weiner, K. (1998) *Care Management Study: Report on National Data Social Services Inspectorate*, Department of Health, London.

Community Care (Direct Payments) Act (1996), HMSO, London.

Crow, L. (1996) Including all of our lives: Renewing the social model of disability, in C. Barnes and G. Mercer (eds), *Exploring the Divide: Illness and Disability*, The Disability Press, Leeds.

Department of Health (DoH) (1998) *Cm 4169. Modernising Social Service: Promoting independence, improving protection, raising standards*.

Department of Health (DoH) (1996) *A Guide to Receiving Direct Payments*, DoH, London.

Department of Health (DoH) (2000) *Modernising Social Services: A commitment to people: The 9th Annual Report of the Chief Inspector of Social Services 1999/2000*. Available at: <http://www.doh.gov.uk>.

Department of Health (2000) *Guidance Circular EL (97) 62*. Available at: <http://www.dh.gov.uk/assetRoot/04/05/76/04/04057604.pdf>.

Department of Health (2002) *Fair Access to Care Services Guidance on Eligibility Criteria for Adult Social Care*. Available at: <http://www.dh.gov.uk/assetRoot/04/01/97/14/04019714.rtf>.

Department of Health (2003) *Independence Matters: An overview of the performance of social care services for physically and sensory disabled people* (SSI 2003 405). Available at: http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsInspectionReports/PublicationsInspectionReportsArticle/fs/en?CONTENT_ID=4094321&chk=zF8/xU.

Department of Health (2003) *Single Assessment Process for Older People*, implementation guidance. Available at: http://www.dh.gov.uk/PublicationsAndStatistics/LettersAndCirculars/HealthServiceCirculars/HealthServiceCircularsArticle/fs/en?CONTENT_ID=4003995&chk=JHcEP%2B

Department of Health (2005) *Independence, Well-being and Choice: Our vision for the future of social care for adults in England*. Social Care Green Paper. Available from Department of Health website: <http://www.dh.gov.uk/consultations>.

Derbyshire Social Services (2004) *Recording Manual*, Derbyshire Social Services, Derbyshire.

Egan, G. (1993) *Adding Value*, Jossey-Bass, San Francisco.

Harding, T. and Beresford, P. (1995) *What Service Users and Carers Value and Expect from Social Services Staff*, NISW/Open Services Project, Report to Department of Health.

Harris, J. and Morgan, H. (2002) *Outcomes for Disabled Service Users Interim Project Report*, Working Paper No. DH1924.11.02JH/HM, Social Policy Research Unit, University of York/Department of Health.

Harris, J. and Bamford, C. (2001) The uphill struggle: Services for Deaf and hard of hearing people; issues of equality, participation and access, *Disability & Society*, Carfax, London, pp. 969-79.

Health Act (1999), HMSO, London.

Kestenbaum, A. (1993) *Making Community Care a Reality: The Independent Living Fund 1988-1993*, Independent Living Fund, Nottingham.

Ladyman, S. MP, Parliamentary Under Secretary of State for Community, 9 November 2004: *Shaping the Future of Adult Social Care*. Published: November 2004. Speech given at the Social Services North West Conference. Available at http://www.dh.gov.uk/NewsHome/Speeches/SpeechesList/SpeechesArticle/fs/en?CONTENT_ID=4095575&chk=AITyUa.

Mason, J. (1996) *Qualitative Researching*, Sage, London.

Morgan, H. and Harris, J. (2002) *Shaping Our Lives/Social Policy Research Unit, Social Care Outcomes Seminar: Issues for Professionals and Service Users*, Working Paper No. DH1904 10.02 HM/JH, Social Policy Research Unit, University of York, York.

Morris, J. (1997) *Community Care: Working in partnership with service users*, Venture Press, Birmingham.

Morris, J. and Lindow, V. (1993) *User Participation in Community Care Services*, Community Care Support Force, NHS Management Executive, London.
NHS & Community Care Act (1990), HMSO, London.

Oliver, M. (1990) *The Politics of Disablement*, Macmillan Education, Hampshire.

Oliver, M. and Sapey, B. (1999) *Social Work with Disabled People*, 2nd edition, Macmillan, London.

Pearson, C. (2004) Keeping the cash under control: What's the problem with direct payments in Scotland?, *Disability and Society*, 19, 1-3.

Qureshi, H., Patmore, C., Nicholas, E. and Bamford, C. (1998) *Overview: Outcomes of Social Care for Older People and Carers*, Outcomes in Community Care Practice, Number Five, Social Policy Research Unit, University of York, York.

Qureshi, H., Bamford, C., Nicholas, E., Patmore, C. and Harris, J. (2000) *Outcomes in Social Care Practice: Developing an outcome focus in care management and user surveys*, Department of Health Report DH1738.6.00HQ, Social Policy Research Unit, University of York, York.

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

SCIE, Social Care Institute for Excellence (2004) *The New Vision for Adult Social Care: Responses to a survey conducted by the Social Care Institute for Excellence Commissioned by the Department of Health*, Department of Health, London.

SCIL, Southampton Centre for Independent Living, (2005) '12 needs' http://www.southamptoncil.co.uk/basic_needs.htm.

Shakespeare, T. and Watson, N. (2001) The social model of disability: An outdated ideology?, *Exploring Theories and Expanding Methodologies: Research in Social Science and Disability*, 2, 9-28.

Smale, G. (1996) *Mapping Change and Innovation*, HMSO, London.

Smale, G., Tuson, G., Ahmad, B., Darvill, G., Domoney, L. and Sainsbury, E. (1994) *Negotiating Care in the Community*, Practice and Development Exchange, National Institute for Social Work, HMSO, London.

SSI (1999) *Recording with Care: Inspection of case recording in social services departments*, Department of Health, London.

Stevenson, O. and Parsloe, P. (1993) *Community Care and Empowerment*, Joseph Rowntree Foundation, York.

Swain, J. and French, S. (2000) Towards an affirmation model of disability, *Disability and Society*, Carfax Publishing, London, 15, 4, pp. 569-82.

Turner, M. (2000) *"It is what you do and the way that you do it"*. Report on user views on the introduction of codes of conduct and practice for social care workers by

the four national care councils, commissioned from the Shaping our Lives User Group by the Office for Public Management, London.

Wates, M. (1997) *Disabled Parents: Dispelling myths*, NCT publishing, Cambridge.

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