Meaningful & Measurable

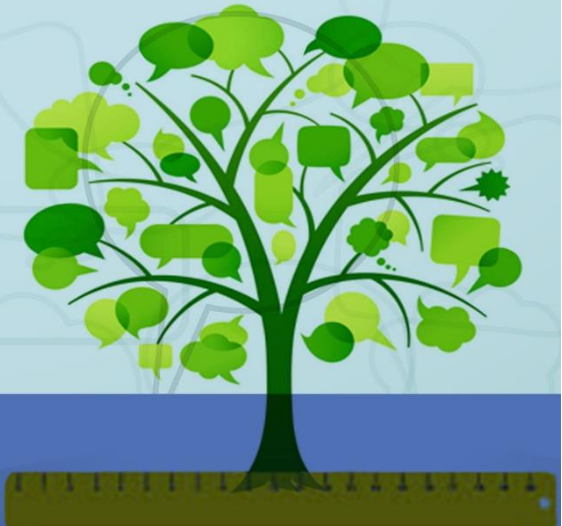
A Collaborative Action Research Project

Developing Approaches to the Analysis & Use of Personal Outcomes Data

FINAL PROJECT PARTNER REPORT

MORAY HEALTH AND SOCIAL CARE PARTNERSHIP

February 2013



About this Report

Meaningful and Measurable is a Collaborative Action Research project funded by the Economic and Social Research Council (ESRC). The project builds on an existing programme of work over several years in Scotland, involving all of the organisations to varying extents, in developing and embedding an outcomes approach to practice. The project itself was prompted because developing approaches to the recording, analysis and use of personal outcomes data has been found to pose challenges at all levels of organisations. Within this project, we are exploring the tension between:

- **Meaning**: the need for detailed, contextualised information on individual experience to inform individual planning and service improvement.
- **Measurement:** the need to aggregate information on personal outcomes to inform decision making at organisational and national levels.

All eight project partners have contributed to the findings of the project overall which will be reported separately.

Six project partners have also authored reports on their local projects.

This report shares the learning of the Moray Health and Social Care Partnership.

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PROJECT PARTNERS

- Angus Council
- Bridgend County Borough Council
- East Renfrewshire CHCP
- Edinburgh City Council
- Moray HSCP
- Penumbra
- Stirling Council
- VOCAL

ACADEMIC PARTNERS

- University of Edinburgh
- University of Strathclyde
- University of Swansea

STAKEHOLDER PARTNERS

- Joint Improvement Team
- Community Care Benchmarking Network
- Health & Social Care Alliance
- Social Services Improvement Agency Wales

Moray Project Report

1. Personal Outcomes in Telecare and Home Care

The focus for the Moray local action research project is to explore the use personal outcomes data in relation to telecare and home care visits of 15 minutes of duration.

This focus will aim to consider the extent which information on personal outcomes can support service improvement, performance management and the commissioning of services.

2. Where We Were

Following the recent joint inspection of Older People’s Services in Moray by the Care Inspectorate and Health Improvement Scotland (2014), the final published report judged that Moray delivered “***very good outcomes for older people and their carers***.”

It was considered that a significant contributing factor that led to this strong endorsement was Moray’s emerging personal outcomes approach.

The introduction of new electronic personal outcomes support plan and review forms in May 2013 was supported by an extensive outcomes training programme delivered over an 18 month period. For the first time both quantitative and qualitative personal outcomes data were able to be gathered via CareFirst.

Having embedded a personal outcomes approach within the Moray Adult Community Care Teams and having successfully developed a system of gathering both quantitative and qualitative data, the focus has now changed to how Moray can use personal outcomes data as a means of continuous improvement and the development of commissioning approach to services that uses personal outcomes data as part of its evidence base.

The Meaningful and Measurable project provided an ideal opportunity to explore how the personal outcomes approach can be further developed in Moray while contributing as a partner in relation to a national research project.

As a means of exploring the engagement, recording and reporting of personal outcomes data for service improvement, the Moray action research project focused on the following 2 areas of service provision;

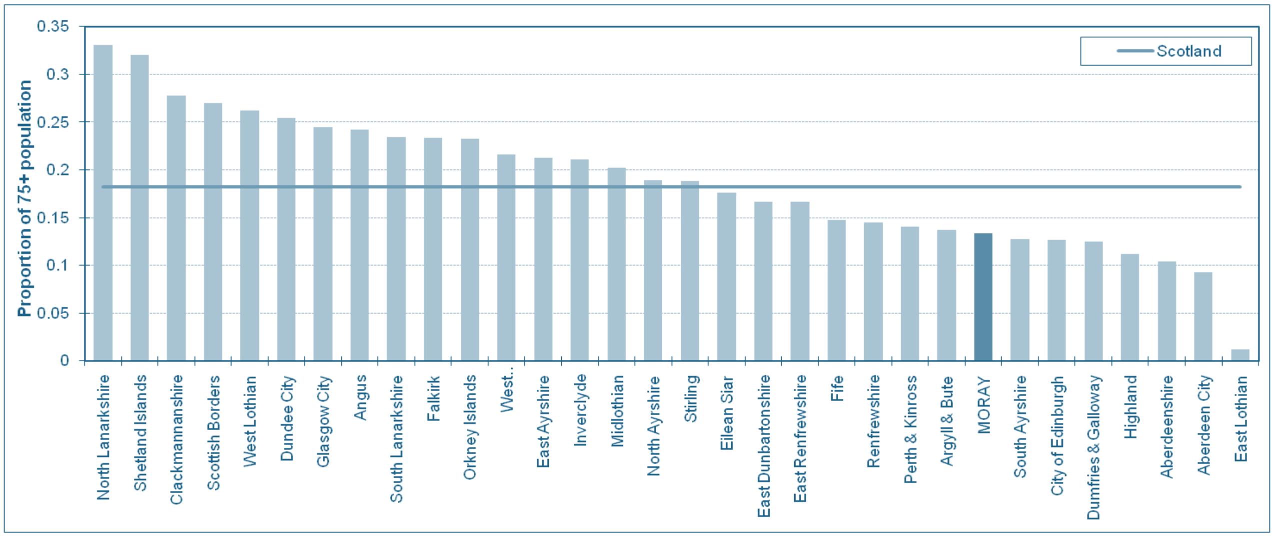
- the provision of telecare to support positive personal outcomes
- the ethics of delivering 15 minute home care visits

These themes emerged from discussions regarding Moray’s level of performance and future areas of improvement at the monthly Moray Community Care Performance Management Group Meetings. The underpinning premise for the selection of these themes is noted opposite.

Telecare

In relation to telecare, the following chart was discussed. The table illustrates the extent of the usage of telecare and community alarm equipment by each partnership across Scotland.

Table 1: Proportion of People 75+ with Telecare (2013)



The table highlights the significant variance across Scotland in terms of the use of telecare devices by each partnership area. This difference prompts the question:

> *What is the right amount of telecare equipment that should be provided by a partnership?*

Homecare

In relation to Homecare, the then Health Secretary Alex Neil, in May 2014, announced the Government's intention to end short home care visits of 15 minutes of duration. He stated:

> *"If a visit is meant to get somebody up and out of their beds in the morning, get them washed, dressed and shaved and give them their breakfast, there is no way on earth that can be done in anything like as short as period as 15minutes"* **(The Herald, 31 May 2014).**

The statement from the Health Secretary echoed, similar statements made by Moray Councillors following the publication of a report by the Equality and Human Rights Commission. The report stated that:

> *"There were many instances of homecare which caused us real concern, where human rights were breached or put at risk because of the way care was delivered*." **(Close to Home- An inquiry into older people and human rights in home care, Equality and Human Rights Commission 2013.)**

The human rights report and the subsequent statements made by politicians at a national and a local government level therefore challenged officers to evidence that the current practice of providing short homecare visits was indeed ethical.

Supporting a focus on personal outcomes

It was considered that the answer to both of these questions would require a consideration of the relevant personal outcomes data.

The insights gained from exploring these themes could then be used to inform the Meaningful and Measurable project and to contribute to a general understanding of how personal outcomes data can be captured, recorded and used for service improvement.

3. What We Started Out To Do

While the objectives for the Moray project have remained unchanged, the original plan was to include interviews with service users and unpaid carers along with social work members of staff.

After accessing data from the CareFirst system, examining case files and interviews with 5 care officers, it was considered that there was a sufficiently rich source of data to be explored without needing to interview service users.

Furthermore, the ethical issues relating to interviewing vulnerable members of the community also led to the conclusion that the methodology for the Moray project should be curtailed to conducting 1 to 1 interviews with social work members of staff and conducting a focus group with managers. These ethical issues related to the capacity of the vulnerable members to give consent given that many would be cognitively impaired.

4. What We Actually Did

As with a number of the other M&M local research projects it was originally proposed that it was necessary to interview 12 Social Workers and to hold mixed focus groups. It became clear that a substantial amount of data can be gathered from a relatively narrow focus on 5 case files. These case files were used as an important source of contextual information and in particular exploring the match between the scale measure and the narrative, the usefulness and appropriateness of the scale measure met, partially met and unmet and whether practitioners were identifying contributory factors in reviews.

Consequently by the second data retreat the scope of the project had been amended and the research questions had also been refined.

The primary questions addressed:

1. The match between scale measure data and narrative;
2. the usefulness and appropriateness of the scale measure met, partially met, unmet;
3. Whether practitioners were identifying contributing factors in reviews.

The various phases of the Moray methodology are noted below:

1. Analysis of personal outcomes data on care first (quantitative)

   Data relating to the recorded personal outcomes of Moray Adult Community Care Service Users was gathered from the local authority management information system. The quantitative data was assessed and from this sample, 6 individual cases were selected for further investigation (see stage 2 below).

2. Analysis of personal outcomes data and contextual information in selected case files (qualitative)

   The correlation between the score rating using the met/unmet scale. The findings of this stage helped to shape the general and specific interview questions for care officers (see stage 3 below).

3. Interviews with Social Workers and a focus group with Service Managers and the Head of Adult Community Care

   To further explore the issues raised from completing stage 1 and 2, interviews with Moray Adult Community Care Social Workers were undertaken and the emerging findings were then discussed at a focus group with the Service Manager and the Head of Adult Community Care Services.

In total 5 interviews were undertaken with Moray Social Workers. Each interview lasted approximately 50 minutes and no less than 35 minutes. The focus group was approximately one hour in duration. A consent form for staff was developed and signed by staff before undertaking the interviews.

The interviews were in 2 parts. The first part was based on a generic set of questions asked to all of the interviewees. The second part related to questions based on questions from case notes and CareFirst entries that the Social Worker had responsibility for.

The focus group was based on discussing the emerging themes from the 1 to 1 interviews with the 5 Social Workers.

The interviews were undertaken during August and September 2014 and the focus group took place in January 2015. Interviews and the focus group were recorded then transcribed.

5. Findings

The key findings are as follows:

1. There are recording issues. It was identified that there is often a discrepancy of the personal outcomes data recorded on care first with the paper file. For example, an unpaid carer stated being ‘happy with telecare’ (i.e. personal outcome being met) but does not feel ‘he can leave [his wife] on her own’.
2. Similarly, the categorisation of a personal outcome as being ‘met’, ‘partially met’ or ‘not met’ is not straightforward. There are ‘shades of grey’.
3. To date in Moray, the relative contribution of a range of factors and interventions is not identified when considering if a personal outcome has been met. For example, it

was unclear what the contribution of telecare is to meeting the outcome of 'feeling safe'. The relative contribution of friends and family, and respite support was not identified. This has implications in terms of the use of personal outcome data for the effective commissioning of services.

4. A 'bottom up' approach to the analysis of qualitative personal outcome data by front line members of staff was considered as a more effective way of gaining clear insights for the future commissioning of services. This approach would also support the micro commissioning of support in relation to Self-Directed Support (SDS).
5. It was not always clear what personal outcomes were to be achieved by short home care visits. In one case, it was agreed that short home care visits were inappropriately used as a surrogate friend for the lonely. It was identified that restoring the therapeutic role of social work and achieving outcomes within those family relationships was perceived as a more appropriate and effective approach to addressing social isolation. A community development approach in relation to social work practice was also identified.

Through the interviews and the focus group the following section aims to outline the evidence base for the above findings.

1. There are recording issues. It was identified that there is often a discrepancy between personal outcomes data recorded on CareFirst and on the paper file. For example, an unpaid carer stated being 'happy with telecare' (i.e. personal outcome being met) but does not feel 'he can leave [his wife] on her own'.

Everyone interviewed communicated a genuine commitment to the personal outcomes approach and noted that Talking Points does in their opinion lead to better outcomes for people than a traditional service led approach.

However, it was noted by managers that there are still challenges in the terms of the quality of the conversations that take place in Moray and that this contributes to recording issues.

The Service Manager, during the focus group, highlighted that there was still some way to go to get beyond the high level outcomes in Moray and into the more detailed and personalised recording that is required for more effective decision making. She commented:

> *"[Referring] back to the support plans that we read pretty thoroughly on Monday afternoon…We've got the bit in the support plan, which is absolutely right, about personal outcomes and it's, you know, feeling safe and having things to do. And seeing people. And I think these are the things that folk have identified as important if you're leading a, kind of, ordinary life. But my experience would be that they haven't really drilled down much further than that".*

2. Similarly, the rating scoring of a personal outcome as being 'met', 'partially met' or 'not met' is not straightforward. There are 'shades of grey'.

The Moray approach to personal outcomes was also reflected in an understanding of the perceived relative strengths and weakness of different ways of recording personal outcomes. For example, more than one of the Care Officers noted that categorisation of personal outcomes as either 'met', 'not met' or 'partially met' did not capture the shades of grey that reflect the complexity of people's lives. In relation to the measures in the Moray Outcomes based Support plans, one social worker commented:

“They’re very black and white. Where situations tend not to be. And sometimes, they are as good as the moment that you fill it in. And whereas it might not be met at any particular instance then you go back, you know. On your next visit you have that conversation again and the situation could be different. So I think they’re just... They’re very rigid, I find. I think it’s very easy to say that they’re not being met. I think the other two categories are slightly more difficult to evidence.”

Albeit that a limited number of personal outcome measurement approaches had been explored in Moray, there was a view from the social workers and the managers that there were always going to be relative strengths and weaknesses regardless of the approach chosen. While on the other hand the Outcomes Star approach was considered by some of the interviewees as having ‘visual appeal’, others considered it to be of limited use to more elderly service users with complex needs. Care Officers showed a willingness to adopt which-ever approach was deemed most appropriate.

3. To date in Moray, the relative contribution of a range of factors and interventions is not identified when considering if a personal outcome has been met. For example, it was unclear what the contribution of telecare is to meeting the outcome type ‘feeling safe’. The relative contribution of friends and family, and respite support was not identified. This has implications in terms of the use of personal outcome data for the effective commissioning of services.

There was little or no significance placed on considering contribution in relation to the factors influencing whether a personal outcome had been met. Care Officers responded by saying that their interest was primarily in knowing if a person had their outcome fulfilled. An example of this situation was the contributing factors of telecare, friends making contact and respite provision in relation to the feeling safe outcome. As the social worker commented:

“I don’t think I can actually put on one particular thing, what it was that was keeping her safe. Apart from being in her own home. That was... That was the main thing.”

4. A ‘bottom up’ approach to the analysis of qualitative personal outcome data by front line members of staff was considered as a more effective way of gaining clear insights for the future commissioning of services. This approach would also support the micro commissioning of support in relation to Self-Directed Support.

All Care Officers identified that the narrative was essential to developing an evidence base for the commissioning of services. While measurement through categorisation of personal outcomes as met or not met was important, this was considered by the interviewees as less important than a meaningful understanding of the personal outcome narrative.

Echoing the previous statement about the Moray approach to personal outcomes as still being in development, the focus group managers expressed a desire to gain a better understanding of interventions. Considering commissioning at an individual level and by social workers themselves was seen as important as opposed to service led commissioning approaches:

“Should we still be pursuing them? [Service-led commissioning approaches]. My own view is now let’s stop looking for that. Let’s stop thinking that somehow or other we’ll find it. You know, like technology. Somehow or other we’ll find a gadget, or even a dozen gadgets, of which we’ll provide, you know, a menu, and people will be able to say, like, “One of them is going to make you safe.” Not necessarily. And I kind of feel that with social work as well. If we’re actually just talking about social workers just going back to being social workers. And understanding their job is to understand people, get them to talk about their lives…it’s actually just saying, “Well, get back to talking to people about their lives. What they want and how they want it, and how we can help you do it.”

5. It was not always clear what personal outcomes were to be achieved by short home care visits. In one case, it was agreed that short home care visits were inappropriately used as a surrogate friend for the lonely. It was identified that restoring the therapeutic role of social work and achieving outcomes within those family relationships was a more appropriate and effective approach to addressing social isolation.

In one case it appeared that the recommendation of regular home care visits for application of E45 cream for an individual, was perhaps based on an underlying concern to obtain company for someone who was lonely. The dilemma was explained by a social worker:

> *"I suppose we are trying to meet people's basic needs first. [Support Plans] come with budgets for instance….the problem is that if you put it on the support plan, sometimes socialisation is the one that is pulled first".*

The social worker then went on to explain the approach she used to address the challenge of supporting someone who was lonely when this was not a priority area for support:

> *"Well I tend to put it in. If they're receiving it anyway for medication, then I may put it on as an add-on….As a result of this…the person also has a good relationship with the carers, for instance."*

When discussed at the Focus Group, both managers were in agreement that the use of home care to support people who are lonely is not appropriate. The Service Manager speculated that the social worker might think:

> *"That's one that I can get out the bag fairly easily, fairly quickly, get it on a support plan. It'll come in under budget and the team manager will sign that one off. So that could be a quick fix. I think it's probably not the right fix for someone who's socially isolated and lonely. Because, I mean, I think the home carers are magic at developing relationships if that's what they're in to do, but it's still a paid relationship for potentially 15 or 30 minutes in your day".*

An alternative approach, which emphasised restoring the therapeutic role of social work as a means of refocusing on the quality of life, was proposed by the Head of Service:

> *"Another approach is to look at families and how families work. I wonder how many of these people – and this is something that would be interesting, because if a social worker was doing this then they could… They could probably delve into this level of detail. How many of those people are saying they're lonely, but they have families … There are people then that, on paper, you would say they should be able to have a meaningful relationship. And there should be a discussion with… With them to say, "Listen, folks, you know, I'm lonely. What can you do about it?" And social work should be able to convene, if you like, that forum. Where people can say that and hear it and then respond to it. In a way that, hopefully, actually, you know, meets that person's need. I don't think we kind of see ourselves as doing that as social workers anymore".*

The managers also thought that a community development approach was also required to maintain a focus on the broader quality of life outcomes.

6. What Difference Is This Making?

The above findings are still to be formally presented to staff within Moray CHSCP. Informally, they have been discussed with the Head of Adult Community Care Services, Service Managers and Officers within the Commissioning & Performance Team.

7. Personal Accounts

The Head of Adult Community Care Services when informed of the overarching findings of this research project took a particular interest in the justification for home care services as articulated in the support plan for individuals who are socially isolated. She noted that she wanted to use this report to challenge her managers to ensure support plans accurately record the personal outcomes to be pursued. If personal outcome statements are not accurately stated, this will impact on how we deliver services.

In the context of integration, the report will also be used to focus on a more bottom up approach to engaging with qualitative personal outcomes data with front line members of staff and more consideration being given to how personal outcomes data can support a SDS micro commissioning approach.

8. Challenges and Opportunities

The focus on the national health and wellbeing outcomes as part of the integration agenda presents an excellent opportunity to promote a personal outcomes agenda in Moray. Indeed, a joint outcomes group has been formed to progress and further embed the personal outcomes approach across the Partnership. However, on the other hand the continuing cultural impact of a biomedical approach cannot be underestimated.

9. Implications and Learning

Positive

- I have a better understanding and appreciation of the amazing amount of work and commitment my fellow social work colleagues have committed to progressing the personal outcomes approach in Moray.
- Through having a better understanding of the strengths and weaknesses of different personal outcomes measurement tools, I am more tolerant to alternative approaches.
- It is such a rewarding experience working with academics and practitioners from across Scotland and Wales and I'll miss the cerebral stimulation of the data retreats.
- Although my tutor had a demanding workload, I was always grateful for Ailsa's guidance, encouragement and support.
- Receiving the typed up transcripts was very helpful.

Negative

- I didn’t fully appreciate how much work such a project requires and ideally would have liked to dedicate a whole staff team to this worthwhile and fascinating project. Coming from a small partnership we have limited staff resources that we can commit.
- The ethics application didn’t really work for me. I think the wrong conclusions were drawn from the statements I made and time was also lost considering the application. I would treat this element of a similar project with caution.

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