ssia

Social Services Improvement Agency

Recording and Reporting against Personal Outcomes:

A feasibility study and pilot

February 2016

Pilot Study

The purpose of the pilot was to explore the feasibility of recording, reporting and aggregating progress towards personal outcomes for people who need care and support in Wales.

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1. Executive summary and recommendations

The Social Services and Wellbeing (Wales) Act 2014 introduced a requirement that care and support plans reflect the personal wellbeing outcomes that have been developed with people who need care and support. Part of the requirement will be for local authorities to record and measure progress against those outcomes. This report provides a summary of the findings of a pilot exercise to develop an approach to recording, measuring and aggregating the progress people make towards achieving their personal wellbeing outcomes.

The Social Services Improvement Agency (SSIA) were asked by the Welsh Government Technical Working Group on developing a national performance measurement framework to undertake a pilot with local authorities to develop and test such an approach. It was agreed that the pilot should draw on existing work across Wales and Scotland, including any relevant research to capture aggregated personal outcomes.

We worked across adults' and children's teams in 7 pilot authorities using an approach based on the 'pain score' widely used in the NHS.

NB: The pilot shows that it **is** possible to record, report and aggregate the progress made by people towards their personal outcomes. The recorded data tells us what people want, in their own words, and what they need to help them achieve their outcomes. It also enables us to understand how individuals are progressing towards their outcomes and to aggregate the information to a local, regional or national level.

However, the information collected is different from traditional performance management information. Its use lies in understanding the picture in terms of progress towards personal outcomes and how this varies between services, authorities and regions. By its very nature it is subjective as it is based on individuals' views of their own progress. Such data does not lend itself to traditional performance comparisons. It does provide an extremely rich source of data to support the more traditional and generally quantitative performance measurement indicators.

Learning from the pilot sites has also demonstrated the importance of a consistent and positive approach to setting and recording personal outcomes. Personal outcomes need to be meaningful and achievable for people. They also need to be considered within the purpose for the social care intervention. Cultural change and changing practice, to a more strengths based approach towards people, has been vital to achieving this. Good quality conversations mean good quality, achievable outcomes for people. It is clear, therefore, that there is real value in supporting professionals to understand what good outcomes are and promoting a culture within social care that empowers people to achieve their outcomes.

Overall, the pilot has been successful in demonstrating that progress against personal outcomes can be recorded and aggregated for the specific purposes set out in the Code of Practice, in relation to the impact social services are having on a person's wellbeing. However, we have identified a number of areas that would benefit from further development following on from the initial pilot if this approach were to be rolled out nationally and they are as follows:-

a) Developing national data

- The data collected as part of the pilot is very different to traditional performance information. For this reason we would recommend that the way in which the data is reported and used nationally be considered further.

- Timescales for reporting against progress must recognise that many people may take longer than others to identify what matters and to translate these into the outcomes which people want. The frequency of reporting this data should reflect that time is needed to develop a relationship with people to help them develop the outcomes that mean most to them and support the maximizing of their independence whenever possible.

- Work on definitional issues would need to be undertaken to ensure consistency e.g. to define 'progress' towards outcomes and to consider situations where maintaining a baseline score may be considered as progress.

b) Developing a variety of scoring tools for certain client groups

- The engagement methodology used by officers to engage with people and to evaluate progress towards their personal outcomes will need to differ according to the needs of individuals. A number of engagement tools are already in use and we would recommend that work is done to evaluate these further and consider their use. This will also ensure that the process of setting personal outcomes is as co-productive as possible and does not exclude any particular client group.

- The distance travelled approach of the NHS pain score as it was adapted for this pilot, is applicable and effective for social work cases which are held for a period of time.

c) Further develop way the data is recorded and collated

- For the purposes of the pilot, the authorities chose various different methods for holding the information gathered during the course of their conversations with the clients. Some authorities, like Denbighshire, saved scans of their paper forms on the clients' case files; while others, such as Bridgend, developed their software solutions so that they could enter the information directly into their current case management system. Whatever approach is adopted going forward, we will need to invest time in identifying and developing appropriate national approaches.

d) Develop a mutual understanding of setting personal outcomes

- The different conversation requires a culture shift where people have greater voice and control over their wellbeing, not only within social services but with other partners. Professionals who participated in the pilot told us that they needed to draw upon a different set of skills and support in order to help people to set outcomes that mean something to them. Some pilot areas are continuing to develop supporting guidance and training to help professionals change the way in which they work and make sure that change becomes embedded across everyday practice. At a national level, we would recommend there is guidance and support for professionals involved in developing the care and support plan on identifying and recording personal outcomes and understanding when is the right time to evaluate the baseline position and progress towards outcomes.

- People may meet with a range of agencies when receiving care and support. Different ways of working can affect the likelihood of people progressing against outcomes and conflicting approaches from professionals can impact negatively on a person's progress. It is important that consistent, positive support is given across the whole spectrum of their care. We would recommend, therefore, that information and guidance on the approach is developed nationally to communicate key messages around supporting people to progress towards their personal outcomes.

2. Welsh Government background and context for the pilot

The Social Services and Well-being Wales Act 2014 will see service professionals required to do things differently. Service professionals need to have different conversations with people to identify what matters to people and what their personal well-being outcomes might be. This will involve building on resources, including people's strengths, abilities, families and communities to develop a co-produced plan that is person centred and outcome focused. Evidence shows that this is a significant culture change and that organisations need to support the practice and system changes required.

The Code of Practice in relation to Part 4 of the Act requires that care and support plans measure the progress towards achieving personal outcomes. Services must co-produce a way to measure progress and achievement of personal outcomes in order to measure the impact of the care and support delivered. These personal outcomes will hook on to the national outcomes, set out in the national outcomes framework, and will ensure that services are securing well-being for people in Wales.

The Welsh Government Performance Measurement Technical Working Group began to consider the possibilities of recording, (including measuring and aggregating) progress towards personal outcomes. The group felt that the personal outcomes model should support service professionals to engage people in a dialogue or conversation to determine what well-being outcomes people wish to achieve as a part of care and supporting planning. It was felt that this will embed co-production into everyday practice and move away from a process-driven tick box approach to assessment and care planning, as per the ambition of the SS&WB Wales Act.

It was agreed that Social Services Improvement Agency (SSIA) would undertake a pilot to develop and test an approach to support this. It was agreed that the pilot should bring together existing work and research across Wales to capture aggregated personal outcomes. The recommendations of the group and scope of the pilot are discussed in the section below.

WG Performance Measurement Technical Working Group: Recommendations for the pilot

The following was agreed by the Technical Working Group and forms the basis for this pilot.

- Aggregated distance travelled data is considered to be an aspirational data collection that would set the performance bar high for service providers. It would require local authorities to report on what really matters to people and the difference the care and support they provide is having on people's lives.

- Aggregating will allow us to look at the percentage of agreed plan outcomes that are achieved for children and families – some of which are the well-being agenda outcomes that are not applicable for all people e.g. only some will need to be supported to be in work etc.

- The focus on supporting outcomes focused practice at an organisational level will drive a culture change and measurement would support this to transform services and support them to ensure people have real voice and control over their well-being. Including this in the performance framework now would not allow services time to prepare for the changes needed to record this information.

- This pilot will need to bring together existing work across Wales and existing research. The pilot will need to be informed by the Talking Points approach and http://meaningfulandmeasurable.wordpress.com/background/

- This pilot would need to be simple and targeted and test the developed approach in a minimum of 2 local authorities with specific user groups.

- SSIA will lead the pilot, in partnership with ADSS Cymru and WLGA, with technical support from the Local Government Data Unit. The work will develop and define the measures, pilot and refine the measures and then make proposals as to the feasibility the measures for formal inclusion within the code for outcomes, with the expected timeframe for adoption.

- This pilot would evidence how local authorities are responding to the well-being agenda and how local authorities implementing the principles in the Act.

- It is envisaged that this pilot will run for 15 months and begin in the summer of 2014 and through to until end of 2015. However, the data collection ran for 6 months. The code will be revised with guidance from pilot on its completion.

3. Methodology

Following acceptance of the brief from the WG TWG, the SSIA wrote to the 22 Directors of Social Services outlining the ambition of the project and inviting early expressions of interest to become pilot sites.

SSIA then linked to colleagues in Scotland on their 'Talking Points' and 'Meaningful and Measureable' initiatives. Those discussions helped with our understanding of the most effective way of delivering against the brief of the project, particularly in terms of the starting point. We agreed that we needed to put in place a skills development support package for those teams put forward by councils, as the evidence was very clear that ability to record and report against personal outcomes relied very much on effective conversations. The basis for the support was motivational interviewing.

We received expressions of interest from seven councils. Whilst we had originally agreed to test the approach on 2 sites, it was felt that we should build on people's desire to be work with us. Given that the overall window within which the pilot sites had to agree, record and report against distance travelled towards achieving personal outcomes an increase in the number of participating teams would allow for broader range of experience to be recorded. Resources were readjusted accordingly to support seven councils and nine operational teams.

A condition of pilot status was that senior managers and partners from that council, work with us over the course of one day to understand their roles and responsibilities in respect of operational outcomes practice and scoring concepts. Sessions were held which gave the pilots a chance to discuss the work with each other and members of the project team.

A working group was established to look at options and mechanisms to establishing and recording progress towards personal outcomes. Along with representatives of the pilot sites, membership of the group included CSSIW, WLGA, WG policy and performance, NWIS. Consideration was given to the inclusion of the 3rd sector in the pilot, however LAs felt that at this stage, they needed to properly understand the issues themselves before engaging the provider sector.

Note: It was necessary to accept that councils were at very different stages of developing outcomes based practice and so any tool and methodology developed had to work for everybody. The concept of working with a person to identify an outcome and then score in respect of progress towards achieving the outcome, was also new to the majority of pilot sites.

The group met between September and December to learn from the experience of others working in this area and to design the approach, which was based on the 'pain score' used widely across the NHS, as well as agreeing arrangements for front line skills support.

It was agreed that recording and reporting of the data would begin in the first quarter of 2015/16. The training support package was delivered between December 2014 and March 2015. Most councils began practicing this new operational approach immediately after having received the skills support, although scoring began on April 1st.

Given the diversity of the client groups covered by the pilot sites, it would not have been appropriate or effective to develop and issue an engagement tool within the available timeframe. Such an engagement tool would not have been appropriate for all individuals and would in a number of instances, have cut across existing approaches to operational practice.

Client group areas already have tried and tested methods of engagement which were either already in use or available for consideration and a number of the pilot sites already had their preferred tools.

During the life of the pilot, the SSIA and Data Unit brought together sites for learning events (held separately for adults and children).The Data Unit also held additional support workshops for performance measurement officers within the pilot sites during the course of the project and liaised with the lead data managers on each of the sites to ensure that the data could and would be reported consistently.   As part of the evaluation of the pilot, SSIA visited all the pilot sites to review and learn from their experience and that intelligence forms the basis of section 6 of this report.

The project Working Group will meet in January 2016 to review the learning and any recommendations arising from the pilot, before a final version of the report is submitted to the WG TWG.

4.   Participating Councils

We worked with a range of professionals across the pilot sites, including social workers, occupational therapists and support workers. They were based in a number of different teams, including teams, looked after children teams, integrated health and social care teams and Reablement. The participating teams are listed below:

- Flintshire Adults Services, Integrated Locality Teams
- Denbighshire Community Support Services (one north and one south cluster for adults acted as pilot sites) and Children and Family Service (intake, intensive family support, LAC, family placement and two foster carers)
- Bridgend Adults Integrated Community Services for Adults, West Network Team
- Blaenau Gwent Adult Services Community Care Integrated hub (East)
- Monmouthshire Adult Services - Abergavenny, Chepstow, Monmouth integrated teams and Community Learning Disabilities
- Caerphilly Children's Services, Bargoed and Rhymney Locality Teams
- Neath Port Talbot Afan Adult Community Network team and Cwrt Sart Community Children's Team

5. The pilot - Analysis of scoring and recording

5.1 The approach

Personal outcomes are, by definition, personal. Each individual will have their own view about the outcome/s that matter to them, and how far they have, or haven't progressed towards these. The working group concluded therefore that any approach to assessing and recording progress towards personal outcomes would need to accommodate the subjective views of the individual, or a carer in situations where the individual is unable to engage in such discussions. So, the chosen solution would need to provide a common approach whilst allowing subjective, individual assessment of the current position and of progress made.

In developing the approach, we had two key aims:

- to make it as simple as possible for both practitioners and clients to use and understand;
- to ensure that the measurement process does not overshadow practice i.e. it should form part of the discussions that practitioners will be having with their clients, not drive them.

We were also keen to ensure, as far as possible, that the chosen approach could:

- fit within existing care management processes;
- provide data to enable local analysis;
- allow practitioners to link the personal outcomes to the national outcomes;
- allow the practitioner's viewpoint to be understood as well as the client's; and
- be used across all client groups, including children.

Having looked at other 'scoring' methods, the 'pain score' approach used commonly in the NHS was proposed and adopted. Essentially, patients in pain are asked to describe their pain on a scale of 0 – 10, where 0 is no pain, and 10 is the worst pain you've ever had. Without any further explanation, patients can generally respond with a figure. Sometime later, often after medication has been administered, the patient will be asked 'so how is the pain now?'. Again, most can respond – in the main without any need to again describe the scoring approach.

We adapted this approach and piloted it with 0 being 'things are as bad as they could be' and 10 being 'things couldn't be any better'. Clients were asked where they think they are currently in relation to achieving each personal outcome – the baseline score – and where they'd like to be – the goal. The goal should reflect what is considered to be "good enough" in terms of the outcome being described. Periodically, this 'score' is reviewed and progress recorded. Crucially we did not define what each score meant – it is for each individual to consider this for each of their outcomes.

This approach was chosen principally because:

- it focuses on the clients views of their personal outcomes rather than the practitioners views or a pre-defined set of self-assessment statements;
- the information should 'fall out' of the conversation between practitioner and client rather than requiring an additional exercise to 'collect' the data.

In order to support the work of the pilot authorities, the Data Unit developed a spreadsheet which pilot sites could elect to use locally to record the necessary information. Alternatively, pilot sites could choose to use their own paper or electronic systems for local recording, as long as they were able to record and produce the necessary information to inform the pilot.

Some authorities developed the paperwork to allow clients to assess themselves against a 10 point scale and did not 'describe' the scoring. Caerphilly, for example, produced a bespoke recording tool that they used to engage with their child clients (see Appendix C), which allowed them to gather the relevant information.

The intention was that we could aggregate the information captured locally at a personal outcome level to allow us to report the following measures:

- the percentage of outcomes where progress has been made;
- the percentage of outcomes achieved;
- the percentage of clients who have made progress towards at least one of their personal outcomes;
- the percentage of clients who have achieved at least one of their personal outcomes.

All pilot sites provided the relevant aggregate data. As table 1 shows:

- 70% of clients across all pilot sites achieved at least one outcome during the period of the pilot;
- 64% of outcomes developed across all pilot sites were achieved during the period of the pilot with an additional 25% showing positive progress at the end of the pilot.

We have not provided comparative information about the number/percentage of clients that made positive progress towards at least one outcome as there were some inconsistencies in the interpretation of the data collected. Further clarity would resolve this issue should the collection be repeated in the future.

Table 1: Potential National Measures, pilot data

		Clients		Outcomes	
		Achieved at least one outcome	Made positive progress towards at least one outcome [a]	Achieved	Shown positive progress [b]
		%	%	%	%
Adults' services	Denbighshire	62		60	29
	Flintshire	81		72	21
	Neath Port Talbot	88		74	17
	Bridgend	39		32	38
	Blaenau Gwent	82		82	9
	Monmouthshire	44		42	52
Children's services	Denbighshire	36		21	69
	Neath Port Talbot	69		78	9
	Caerphilly	52		33	61
	All pilot sites	70		64	25

[a] Comparative data is not available

[b] These percentages are in addition to the outcomes that have been achieved

As table 1 shows, there is a big range in the percentage of clients that achieved at least one outcome (from 36% to 88%). Similarly there is a big range in the percentage of outcomes achieved (from 21% to 82%). There is less of a range in the percentage of outcomes that were achieved or saw positive progress, with most pilot sites reporting between 87% and 94% (Bridgend (adults' services) reported 70%). The figures are, however, a lot higher than we might have expected.

5.2 Evaluating the pilot: the data

The results suggest that the chosen approach makes it possible to measure and aggregate progress towards personal outcomes. Several of the pilot sites have elected to continue using the approach beyond the end of the pilot.

2 out of the 3 children's pilot sites, stated their intention to continue to use the scoring approach with children and their families where ever appropriate. The 3rd site had differing views within the team – some for and some needing to understand more about its application. For adult services, 3 out of the 5 sites will continue to use the scoring approach with their services users. 2 of those 3 will continue with the NHS pain score approach with the 3rd building on and developing their own local version. 2 of the 5 teams found the scoring tool unhelpful; reasons being it detracted from and interfered with the service user relationship and questioned the usefulness of the data. There continues to be difference of opinion across all the sites, as to whether the scoring approach could or should be used with all service user groups (see section 6 for further detail).

It is important, however, to recognise the purpose of this data and its limitations. It is very different to traditional performance information, being more suited to taking account of local progress than holding local services to account for their performance. Progress towards personal outcomes is very subjective and can be affected by many different factors, most of which are outside the control of a local authority. The extent to which progress is being made cannot therefore be used to judge how well an authority is 'performing'. The data should instead be used as an indicator of whether the personal outcomes approach is helping improve the well-being of social care clients.

Comment: One of the main considerations on adopting this approach is that councils have to make the shift to accepting that recording the service user/carer opinion is equally as valid as reporting that of their operational service delivers. In order for this to work effectively, social workers need to be confident that during any implementation phase, regulators, corporate centres, WLGA (elected members and leaders, WG performance and policy (for example), it is understood that distance travelled along a continuum can increase and decrease – in terms of a score. A reduction in score on the part of a service user, should not necessarily be viewed as a failure on the part of the service. Events for the better or worse, impact on progress towards achieving an outcome and often lead to outcomes becoming irrelevant and needing to be reprioritised. In more complex and long term cases (therapeutic social work), addressing say destructive behaviour, often needs insightfulness on the part of the individual which can necessitate a 'starting from scratch' in terms of moving forward and making progress.

The social care intervention may achieve a targeted outcome/s, as well as support the achieving of a wider, more well-being ambition on the part of an individual (the latter for which the social care may not see as their responsibility for delivering. *Case A4 was put forward by an Occupational Therapist in the Community Reablement Team. It refers to a lady who wanted her 'mojo' back. Although this was due to physical health problems, the impact of her low mood and self-esteem was having a negative effect on the whole family. The OT was able to work with the family to identify targeted outcomes to improve her sense of wellbeing, such as support to travel and visit the gym independently. By working toward the overall outcome of getting her 'mojo' back, the family have a much more positive outlook on their future. The traditional 'care package' applied was minimal and time limited.*

Case A9 was put forward by a Senior Practitioner Occupational Therapy in Adult Community Support Services. It refers to a gentleman who identified his primary outcome was a better relationship with his daughter, despite the referral being made for concerns around his mobility in the home. The professional's role was to allow the gentleman to discuss and reflect ways in which he could improve the relationship, which he took complete responsibility for by developing and working to his own solutions. This lead to improved mood and motivation, and progress against outcomes, without the need for any formal services.

5.3   Consideration of project timescales

Timescales for reporting against progress must recognise that some people may take longer than others to develop and review their outcomes. The frequency of reporting this data should reflect that time is needed to develop a relationship with people to help them develop the outcomes that mean most to them and support the maximizing of their independence whenever possible.

As Monmouthshire explain "It is difficult to identify and measure achievement in such a short space of time. […] the identification of outcomes is an iterative process that does change over time. It can take time to establish trust and a relationship whereby the person feels confident and comfortable to discuss personal outcomes."

Caerphilly comment that; 'Identifying the appropriate outcome for each child within a sibling group takes time. This can only work in a meaningful way when the child or young person feels confident enough in their relationship with the social worker. Achieving a longer term and hopefully sustainable result or outcome often takes much, much longer than timescales of the pilot allowed'.

This is evident in the pilot data where, during the course of our 6 month pilot, 73% of relevant referrals received across all pilot sites became part of the pilot. Of these clients, 17% had yet to develop any outcomes by the end of the pilot. Of those that had developed at least one outcome, 71% had reviewed their progress towards at least one of their outcomes.

This means that the national measures are based on just 59% (394 clients) of the clients in the cohort. Across the pilot sites this ranges from 36% to 67%. The smaller the cohort the more that any judgements based on it should be made with caution.

Further, the timescales involved in managing the process properly may mean that the outcomes change before they can be reviewed. As Bridgend note "The nature of the work (crisis, changing needs, quick deterioration, re-referred needs) also makes it difficult to report an outcome that may change very quickly."

However, according to the data we collected, very few clients across the pilot sites had outcomes withdrawn (4% across all pilot sites). Likewise, very few outcomes were withdrawn (4% across all pilot sites) during the course of the pilot. Consideration should be given here as to the short timescale of the pilot work.

Any future national indicators would need to be considered carefully. Work on definitional issues would need to be undertaken to ensure consistency e.g. to define 'progress' towards outcomes and to consider situations where maintaining a baseline score may be considered as progress.

As Monmouthshire note:

"*Positive progress towards one outcome in one case, could also counter balance with more than one negative scores on all other outcomes. Staying the same could also be seen as a positive outcome.*" [sic]

Denbighshire noted for example, that within mental health services, a person with significant issues - say around self-esteem – would see maintenance of a score as a considerable achievement. Similarly, progress from 1 to 2 will for a significant minority of individuals be as significant as somebody else moving from 3 to 8.

See also Bridgend case study A2 as case in point and the significance of the shift in score for the client from 0 -1.

5.4   Evaluating the approach

The validity of these measures and the extent to which they reflect progress towards personal outcomes also depends on the suitability of the measurement approach and the consistency in its application.

As part of the pilot we collected data that should also help us evaluate whether the approach we piloted is a valid approach for monitoring progress towards personal outcomes. Our analysis of this supporting information suggests that there was quite a lot of consistency in the application of the approach. For example:

- While the *percentage* of clients that had their progress reviewed ranged from 90% in Caerphilly (children's services) to 34% in Neath Port Talbot (adults' services), the *number* of clients that had their progress reviewed was fairly consistent across most of the adults' pilot sites and the children's pilot sites. Blaenau Gwent (adults' services) reviewed the progress of 196 clients, over 6 times as many as the next highest pilot authority. This was mainly due to the large volume of clients seen by their Community Resource Team (Occupational Therapy service). The outcomes for an OT service could be considered to be easier to state with often a beginning, middle and end to the intervention, thus possibly showing clearer outcomes.
- The majority of pilot sites reported between 2 and 5 clients per social work professional. Blaenau Gwent reported 15 clients per social work professional.
- Across most pilot sites clients developed an average of 2 outcomes. Clients in Bridgend (adults' services) had an average of 3 and clients in Denbighshire (children's services) had an average of 4.

However, as with the data, it is important to recognise the limitations of the approach.

5.5   Subjectivity and appropriateness (service user groups) of the scoring methodology

At the outset of the pilot we recognised that our chosen approach is a subjective way of measuring progress towards personal outcomes. Each individual will score their progress in their own way. It follows therefore that we cannot measure the aggregate progress being made in absolute terms, but we should be able to understand if progress has been made (or not) and if the outcome has been achieved.

Across all pilot sites just 7% of the relevant referrals were unable to engage with the process. However, Bridgend (adults' services) and Denbighshire (adults' services) reported that 39% and 20% respectively of referred clients were unable to engage. The majority of these individuals were adult clients with specific 'capacity' issues. Caerphilly also noted that they had decided to exclude some referrals from the pilot due to the severity of safeguarding concerns/family law issues and some of these families were highly unlikely ever to engage positively with services. However, it is also important to note that parenting assessments for court proceedings were felt to have been robustly supported by the outcomes and scoring approach, as social work professionals were able to clearly demonstrate engagement with the family.

As Blaenau Gwent noted "Staff found limitations with the use of numerical scores. Whilst progress and outcome achieved were recorded, some clients with capacity were uncomfortable stating a score and some situations were felt inappropriate for discussing scores." [sic]. However, BG also went on to state that with growing skills and confidence on the part of the social work professionals, they believed that no service user group or individual should be considered as inappropriate for inclusion in this approach. The engagement tool used to apply the scoring would be the critical element. Manipulation of the scoring methodology by individuals was raised by some teams. For example, some older people were felt to have been put under pressure to 'please' the social work professional and to score beyond how they really felt. Underscoring might also be seen as a way of retaining unnecessary services. Similarly in children's services, over-scoring might be seen as a way of bringing the involvement of social services in a family's life to a swifter end. The majority of the teams felt that some manipulation was unavoidable and the skill was to ask the question as part of the 'conversation' rather than as an add-on ie "what would good look like so that we will know when we get there?". Also to ask the question at the appropriate time and with confidence and understanding on the part of the worker.

Additional pilot site feedback about the measuring and recording of progress toward personal outcomes. We would suggest in response to this point, that this approach gives significant qualitative information from the perspective of the individual, in terms of the difference the sector is making to the specific as well as general well-being outcomes of the population who are engaged with social services.

Outcomes will change with circumstances within and outside of an individual's control. The strength of this approach is to focus with the individual on what outcomes are pertinent, realistic and achievable.

 "It still remains difficult to draw out assumptions and make aggregated comparisons across the scale. e.g movement up the scale from 2 to 3 is the same as movement from 1 to 10." [sic]- Monmouthshire

"The team expressed some difficulties in translating the support plan personal outcomes aims into the national aspects of wellbeing categories which seem high level." - *Bridgend*

Similarly, it has been noted by other social work professionals that the presenting issue or difficulty is often not the 'real' issue and so categorising early on in the engagement would seem at times unhelpful and ultimately misleading. In terms of the available categories, the Data Unit expanded on those reflecting the high level 9 well-being statements, but this would need revisiting, particularly if a categorisation of presenting problems were to be extended to the *first point of contact stage.

*First point of contact is used to describe that stage in an individual's pathway through Social Services, where an exploration of the issues might take place – the initial conversation. That might be via telephone or face to face dependent upon the authority's structure.

Appendix A

Key messages and learning from the Pilot Sites

The project team visited each of the pilot sites between mid October and early November to understand their experiences from participating in the pilot. The discussions focussed in the main but not exclusively, on the following areas:

1. ability to understand the concept of an 'outcome'
2. what was the experience of introducing a scoring concept
3. what were the challenges and benefits to outcomes focussed practice?
4. to what degree were structures and procedures changed to elicit the most from the pilot?
5. would the team be continuing to adopt this approach at the end of the pilot?

1. Ability to understand the concept of an 'outcome'

Overall the pilot sites made a good start in understanding and interpreting 'outcome' within the terms of the intervention. During the preparation sessions, people were encouraged to think of the interpretation of 'outcome' as being 'what matters', also that an outcome is not an action, a service or an output It would be fair to say that some social work professionals took the approach like "ducks to water". Those from a mental health background for example, felt this approach was quite similar to their existing practice model.

It would also be accurate to say that the practical interpretation of 'outcomes' and its application within social work practice does need time to be properly understood by frontline social work professionals, senior practitioners and managers at all levels.

Understanding, identifying and agreeing the outcome within the social work intervention, whilst also having taken an holistic examination of an individual's circumstances, did cause confusion for some. The holistic nature of an individual's circumstances (well-being) need to be understood so that their impact on the social work intervention can be managed, maximised and responded to appropriately. This must not be interpreted as the social work intervention needing to respond and resolve the entirety of an individual's ambitions.

It was also noted that the presenting outcome was often not what lay at the heart of an individual's issues. That outcome could more often than not only be identified accurately after a relationship had been built between worker and client.

All sites stated social work professionals needed the opportunity/mechanism to reflect on their conversations, helping them unpick difficulties. Many put peer review/support sessions in place to build reflective practice, whilst a move towards outcome focused supervision was also adopted. Without this time to reflect, issues became too difficult and there was a very real tendency to default to the service-led practice position.

2. What was the experience of introducing a scoring concept?

See main report on Data Analysis.

In addition the following points impact on effectively being able to report a client's score:

- The timing of the asking for a first score ie setting a base line, is critical
- Scoring can only be done once the outcome/s has been agreed with the client
- Scoring has to be against outcomes which are realistic and achievable

3.   Challenges and benefits to outcomes based practice

Partner agencies, other teams within the council – consistency of user experience. Systemic change needed along with and to support the front line. – need to expand this

All pilot sites stated that the shift in practice needed (identified by the project team and the evidence from colleagues in Scotland) could only be achieved with a focus on developing worker skills. . Below are some of the comments made by participants:

- *'Seeing the person and not the problem has been a key outcome guided by training.'* (Case A3)
- *'The training empowered me to facilitate the meaningful discussion with confidence.'* (Case A7)
- *'I felt the training influenced my work in regards to the fact I listened to what the service user wanted'* (Case A11)
- *'I feel the training gave me to confidence to adjust my approach to working with service users and allowed me the time to build up essential relationships to more fully understand what really matters to individuals.'* (Case A18)
- *'The training on collaborative communication skills was highly influential in adopting the outcomes approach. It enabled the social work staff to regain a focus on person centred social work and validated adopting a strengths based approach.'* (Case A20)
- *'Initially C's mother did not engage well with the social workers, but using the techniques covered in the training to have an outcomes-focused conversation did gain her engagement'.* (Case C5)

Managers from 7 pilot sites noted that an outcomes approach to practice was far more satisfying for their staff. This was reiterated by social works themselves. However it is not without its challenges; outcomes focussed practice can be more emotionally draining in a different way to previous practice. The training and subsequent coaching/mentoring are key to supporting individuals and teams to achieve and deliver a consistent service.

Many managers commented that the act of bringing their teams together to examine and explore outcome based practice in itself (and particularly their relationships with service users and each other) had been hugely beneficial to the team's morale.

3 sites felt that the limitation on numbers attending the training was not helpful and that being able to train all team members at the same time brought much added value and was what was needed.

- Every team stated that the shift needed to practice in this way should not be underestimated. One manager pointed out that the cultural shift had yet to happen and the pilot in itself hadn't achieved this. The pilot offered a start to this shift but it would only be achieved when systemic change had happened throughout the organisation.

All teams felt that effective outcomes practice was significantly limited by existing structures (IT systems, UAP process and some KPIs). The phrase 'square pegs into round holes' was used on a number of occasions.

Appendix B

Summary of operational case studies

Section 1:   Overview

As part of our work with pilot areas, we asked authorities to submit case studies in order to demonstrate how effective they felt the approach to scoring personal outcomes had been. Although the focus of the pilot was on the feasibility of scoring outcomes, we felt it was important to capture the breadth of experience and impact of changes to practice on both service users and practitioners.

We received 29 case studies in response, 21 for adult services and 8 for children's services and they are as you'd expect generally very positive, as participants were keen to take the opportunity to talk about/demonstrate their experience of the pilot. Responses were submitted by a range of practitioners including social workers, occupational therapists and support workers. They were based in a number of different teams, including teams, looked after children teams, integrated health and social care teams and reablement. A copy of each case study is attached at Annex 1. Each case study includes information on who submitted the case and the key themes identified within that case study.

Approach

We requested that each case study address a number of areas to help us understand and capture the full impact of this new approach. We wanted to hear about good practice as well as find examples of where there had been particular issues with any aspects of the pilot.   This included:

- How interventions differed from pre-pilot approaches

- Results for service users and families

- Impact for the practitioner and wider department

- Impact and effectiveness of training

- Working with other professionals

A number of common themes were identified from the case studies, and these have been summarised below. They give an indication of how developing and working towards personal outcomes has impacted on the lives of service users and families and the day to day practice for professionals. Many also demonstrate wider benefits for service providers. They highlight the barriers and enablers for supporting service users to progress against those outcomes and give an indication of what wider issues need to be addressed when moving towards a new way of working.

The cases studies received were overwhelmingly positive about the approach and the benefits for themselves, their department and the service users and families. There were also some difficulties highlighted which have also been included in the themes below.

- Person centred

In almost all cases, there is reference to the fact that service user wishes were at the centre of the approach. Some of the case studies make reference to the 'what matters' conversation and the importance of using the words of the service user in defining outcomes.

'I did find that it was easier to record the assessment by using Mrs C's own words.' (Case A1)

By putting the person at the centre, a number of case studies reported that they felt this had a positive outcome for service user. Designing and defining the outcome validated the situation for the service user and increased understanding among practitioners about the true needs of the service user and family.

'My approach needed to be person centred in order to establish a therapeutic alliance and to provide them with a sense of being listened to.' (Social Worker, Health and Social Care team: Case A10)

- Increased ownership and control

In determining their own outcomes, service users and families felt they had more ownership of their situation. This resulted, for many, in a greater sense of control over their situation and increased understanding of what was expected from them. In some cases, it also led to greater co-operation with social services reflecting how, in practice, the principle of voice and control underpinning the Social Services and Wellbeing Act can positively impact on the lives of people who need care and support

By not taking responsibility for the problems raised or imposing my own expectations, the family were able to identify the issues for themselves and work towards their own outcomes. (Childcare Team: Case C2)

'Mr L felt that his life was being taken over by Social Services, that he was losing autonomy, and consequently he became abusive towards the carers.' (Community Network Team: Case A19)

An increased sense of control over their lives also had a positive impact on mental health and wellbeing for a number of service users. (see 'Positive Attitudes and improved mental health and wellbeing' on page 5).

- **Better relationships with service users and their families**

A number of case studies reported an improvement in the relationship with service users and families. Some practitioners spoke of how service users responded positively when they felt they had been listened to properly. One also spoke of the benefits for them as a practitioner.

'Really listening to the citizen for the first time was so empowering' (Senior Practitioner Occupational Therapy, Adult Community Support Services: Case A9)

This particularly helped where the family were distrustful of social services and helped break down the barriers of 'us and them'.

'Another benefit is the positive reputation the department has in the eyes of Mrs C. and the family' (Integrated Community Network Team: Case A1)

The improved relationship also led to more open and honest conversations and built greater trust between practitioners and service users. That honesty meant that practitioners could address the real issues and less time was spent responding to issues that arose as a result of hidden problems.

The social worker described the non-challenging collaborative approach as "absolutely the only way we got in" due to the mother's existing prejudice against social services. (Social Worker, Children's Services: Case C7)

Being understood and listened to had a positive impact on the attitudes of service users.

'…the outcome was incredible powerful, with both individuals feeling their views and opinions had been listened to and validated by each other for the first time post-diagnosis'. (Adult Community Support Services, Locality Team Manager: Case A7)

- **Less services required**

Following the training, practitioners took a strength based approach when meeting with service users. Many case studies discuss how strengths were identified and how it helped service users to take action to address the problems they faced. Additionally, in agreeing the outcomes that mattered, practitioners found that there was less need to provide traditional packages of care; it wasn't what the service user wanted or would benefit from.

'Benefits for the department were that resources were saved in that there are no plans for respite, no plans for day service, and minimal service delivered in partnership with the family.' (Integrated Community Network Team: Case A1)

In one case study, through spending time listening to a service user, the practitioner found that she was making her own meals despite having a meals service as part of her package of care. There were other cases where it was found people were receiving services they simply didn't need whilst the real need remained unaddressed. In some cases, the initial time invested in conversations with the service user resulted in less need for long term interventions.

- Increased resilience

By taking an approach that focussed on strengths, service users demonstrated increased resilience. For some, this had a positive impact on their wellbeing and family dynamics. It also decreased any unnecessary dependency on services.

'We discussed the family's role in assisting her and identified that the family were unknowingly exasperating her condition by focusing on her difficulties and then completing all tasks for her.' (Occupational Therapist, community Reablement Team: Case A4)

One case spoke how the time invested in encouraging and enabling the service user to undertake tasks for himself had a dual benefit.

'…the outcomes show that the initial investment of time led to a decreased dependency on services and greater customer satisfaction' (Community Network Team: Case A19)

- Utilising support networks

A number of case studies commented on how their approach differed from pre-pilot approaches around support networks. By looking at the networks already in place, some practitioners were able to explore ways that the support network could help service users achieve their outcomes, as opposed to commissioning a service.

The family agreed that they would 'put the word out amongst the farming community'…they would check that Mr P was sitting in the kitchen where he 'always sat'. (Community Network Team: Case A21)

Where available, the network not only reduced a dependency on formal services but it helped families to look at their own strengths and limitations. It helped identify where wider networks were affecting a service user's situation and how it could potentially affect their progress towards their outcome/s.

'…the family were unknowingly exasperating her condition by focusing on her difficulties and then completing all tasks for her' (Occupational Therapist, Community Reablement Team: Case A4)

Within children's services, there was a case where the approach encouraged a mother return to living with her parents. By discussing and not prescribing, the mother was able to understand and decide for herself the value of support offered by her family and demonstrate good decision making for herself and her child. (Case C2, submitted by childcare team).

- **Encouraging positive risk taking**

Personal outcomes mean something different to each person. They are centred on the needs and wishes of the individual, which will not necessarily be around physical needs. In order to achieve the outcomes people identified, other professionals occasionally raised concerned about the risks involved. One case spoke of how it was particularly difficult to achieve one service user's outcome of wishing to remain living at home. Hospital staff had perceived risks around mental capacity and capability of the service user to manage. As the approach taken by the social worker was to have a more in-depth conversations with the service user, it gave a basis for reassessing that risk. For example, non-compliance with physio was an issue identified by health professionals but the social worker, after talking with the service user, found this was due to a lack of understanding of what he was expected to do. This risk wasn't what it was perceived to be and the outcome was achieved.

'…he has remained at home for several weeks despite the fear that his discharge would result in failure after a short period of time.' (Social Worker, Locality Health and Social Care Team: Case A18)

This was also true of children's services, where one case describes how '*the outcomes approach was particularly useful in this situation as it enabled the mother and other professionals to see that…the priority risk had been addressed and that the situation was good enough.'* (Social worker, Community Child Protection Team: Case C8)

- **Positive attitudes and improved mental health and wellbeing**

For some service users, the progression towards outcomes was a positive affirmation that their situation was improving.

'I saw him enthused and optimistic for the future now he could see a clear plan of what he really wanted to achieve.' (Senior Practitioner Occupational Therapy, Adult Community Support Services: Case A9)

In a number of cases, discussing what mattered to people helped uncover the stress and anxiety they were experiencing. This could then be acknowledged and addressed and removed a barrier to progression towards outcomes.

'The service user says she has got her mojo back' (Occupational Therapist, community Reablement Team: Case A4)

Mrs C. told me that she felt 'less anxious' and' less of a burden on her family' (Integrated Community Network Team: Case A1)

An increased sense of control over their lives had a positive impact on mental health and wellbeing for a number of service users. The impact of that loss of control on their wellbeing prior to the new approach was highlighted in some of the case studies.

'I no longer see the low mood and lack of motivation he had before, and his general mental health and wellbeing is improved.' (Senior Practitioner Occupational Therapy, Adult Community Support Services: Case A9)

We also saw positive progress for children in the case studies, with one example of a teenage boy's outcome improving dramatically from 1-10, as the intervention focussed on working to achieve that for him (Case C6, submitted by a social worker in Children's services).

- Impact on other professionals

Some case studies spoke of the positive impact of promoting an outcomes focussed approach had on other professionals. One social worker described this as 'passing on the ethos.' One also used the training to approach discussions with other professionals differently and felt it improved their working relationship and introduced a shared understanding of the service user's strengths and achievements.

'*The outcomes approach was particularly useful in this situation as it enabled the mother and other professionals to see that there were many positives.'* (Social Worker, Community Child Protection Team: Case C8)

There were, however, some cases where the personal outcomes approach conflicted with the approach other professionals wanted to take. Some felt that working towards some of the outcomes defined by service users presented a potential risk.

'*However, working in an outcome focussed way when other professionals were not, highlighted some conflict with other professionals'.*   (Social Worker, Locality Health and Social Care Team: Case A18)

- Scoring outcomes

There was little discussion about the use of the pain score to demonstrate progress. One mentioned they found the 1-10 scale 'really good' and there were some other positive comments.

'*The scoring tool was crucial to this, as is showed the gentlemen the progress he had made towards his goals and, by evaluating present strengths, showed him that the current situation isn't as low-scoring as perhaps first thought.'* (Senior Practitioner Occupational Therapy, Adult Community Support Services: Case A9)

In a small number of case studies, there was discussion about the difficulty some faced when asking service users to score their progress. Two mention mental capacity as an issue, but one overcame this by discussing the issue with the carer and having them score the shift in position. Two spoke of using scoring in a crisis situation and how it was inappropriate at this point, with one service user becoming quite offended by the approach.

'*I also asked her the 1-10 question and she was deeply offended'* (Health and Social Care Team: Case A17)

 One case study spoke of how they felt the service user scored highly in the belief it would mean an end to the involvement of social services.

'*…she has raised all her scores up to 10 in the belief that this will stop social services involvement.'* (Social Worker, Children's Services: Case C7)

- Difficulties with service users understanding of the approach

One social worker noted that, in some cases, she was unable to encourage service users to identify their own outcomes, based on what mattered to them. These service users were fixated on what they could be offered and did not want to explore their own strengths and set outcomes.

'Some people are fixated on what they feel will make life 'good enough' i.e. a stairlift or moving from their own home to a local authority tenancy. Despite using this approach and attempting to explore other ideas with them, they still state that this is what they need.' (Occupational Therapist, Locality Long Term Team: Case A5)

In some cases, due to mental capacity, some service users could not fully understand the approach. In a few cases, a carer or support network helped advocate for the service user.

'With no family involvement, the emphasis was placed on working with staff to find ways to achieve outcomes and changing some of the preconceived ideas and assumptions made about him.' (Locality Team, Older People: Case A3)

- Earlier identification of issues

Of particular note in many of the case studies from children's services, was that the approach helped identify problems earlier in the pathway. The focus on personal outcomes, leading to more open conversations, meant children and families were more willing to discuss issues at an earlier stage.

'(the approach) did help to identify the specific issues G felt strongly about at an earlier stage, made his outcomes the centre of the discussions and as such reduced the time taken for an intervention to take place'. (Social Worker, Looked After Children Team: Case C4)

In one case, this had a significant effect on the outcome for the family.

'The social worker felt that if she had not focussed on personal outcomes then the case could have escalated to Child Protection' (Social Worker, Children's Services: Case C5)

Section 3: Conclusions

Although the case studies can only give an indication, there are clearly factors that need to be considered and addressed when introducing an approach based around personal outcomes. There are clear barriers that can impact on progress against outcomes. These include

- Conflicting approaches with other professionals (particularly health professionals)
- Understanding the concept of personal outcomes, for both service users and professionals
- Attitudes to risk
- Difficulties in applying scoring in all situations

There are also some clear added benefits to the approach which should be noted, namely

- Improved relationships with services users and how this leads to a more co-productive approach to achieving personal outcomes

- Less need for formal services and a means by which to identify if the services in place really meet the needs of service users (including opportunities to explore and maximise the support than can be offered by existing support networks)
- The positive impact of a strengths based approach on service user/family wellbeing
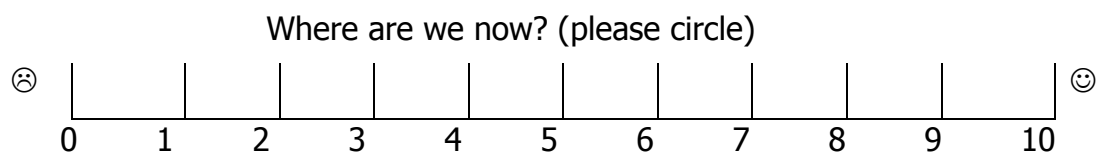
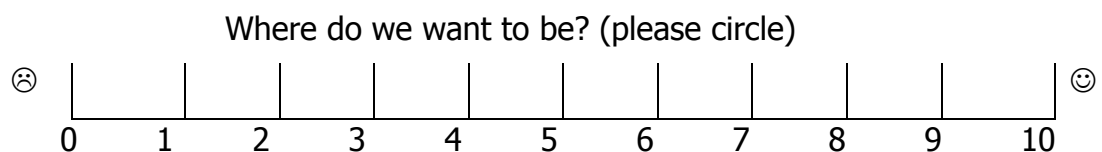# Appendix C – Caerphilly Recording Tool

Our Family Outcomes

Family Name:		Date:	

Outcome Number	Overall outcome that needs to be achieved

Statement of the problem:

(this statement needs to be behaviourally specific to what was observed or reported and the impact on the child/children)

Where are we now? (please circle)

☹ 0 1 2 3 4 5 6 7 8 9 10 ☺

What does this look like?

Where do we want to be? (please circle)

☹ 0 1 2 3 4 5 6 7 8 9 10 ☺

What does this look like?