

Meaningful & Measurable

A Collaborative Action Research Project

Developing Approaches to the Analysis & Use of Personal Outcomes Data

FINAL PROJECT PARTNER REPORT

CITY OF EDINBURGH COUNCIL

November 2015



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.

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

This report shares the learning of City of Edinburgh Council.

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

City of Edinburgh Project Report



1. Introduction

Focusing on the outcomes important to people using services is a concern in current policy and practice in the City of Edinburgh and across Scotland. Practitioners and organisations need to engage with people to identify what matters to them in life, and record what matters so that the information can be used for service improvement and performance management.

In the City of Edinburgh Council the advent of the Social Care (Self-directed Support) (Scotland) 2013 Act has facilitated the implementation of new assessment and support planning tools to enable the capture of personal outcomes and support outcome-focused practice. The aim of our project has been to better understand the practice of recording of outcomes in assessment prior to and after the implementation of the Social Care (Self-directed Support) (Scotland) 2013 Act.

2. Where We Were

Since 2009, there have been two previous pilots in Edinburgh that attempted to capture personal outcomes through the assessment process. Across both these pilots there are common learning points. Firstly what was actually recorded was a mixture of inputs, outputs and outcomes suggesting that **not all practitioners understood outcomes**, even though they said they did. Also existing health and social care procedures resulted in issues of individual's risks and vulnerability being rationalised through **service led thinking**. There were competing demands on the practitioners involved in the pilot so while practitioners were asked to adopt conversational approaches to assessment/review, they were also under pressure to achieve assessments and review targets. Finally the **person's** (potential supported person) **ability to engage** in an outcomes focussed approach needs to be considered.

Alongside these pilots, there had been some development of outcomes recording within a diverse range of teams. For example, day care services for older people were piloting an 'outcomes diamond' which had four outcomes domains (continuing to be yourself; being physically fit; spending time with friends or people you like; feeling positive). Progress continues with developing the tool but it is intended to form part of the assessment and review process and will be carried out in discussion with the person which will generate qualitative data. Within Criminal Justice, individuals complete a questionnaire when they complete their community payback order, covering self-reported changes in quality of life indicators (e.g. family relationships, employment). These are collated quarterly and discussed at a managers meeting to inform supports offered to offenders. While these pockets of practice demonstrate a shift to outcome focused working, as yet the department has not managed to aggregate data on personal outcomes at this level.

The introduction of the Personalisation Programme in Edinburgh, to coordinate the implementation of self-directed support and its emphasis on personal outcomes, reinvigorated interest in outcomes focused approaches. Outputs included the development of a new assessment tool for implementing self-directed support, and a Health and Social Care-wide mechanism for recording personal outcomes is now in place. The outcome-focussed assessment is held on the SWIFT system, and is the database for the analysis of outcomes. However, it is recognised that solving the technical dimensions for recording personal outcomes are only part of the change required and that addressing workforce development and the organisational cultural conditions are also essential. In recognition of this a series of training for all assessors is in development that should help to support a shift in culture, practice and recording.

3. Our Intended Approach

There is considerable interest within the Council in outcomes-focused practice, and in using information on outcomes to inform assessments of performance as well as service planning and commissioning. From the perspective of those in a performance and research role, there was recognition that using outcomes information in this way presents considerable challenges which were neither well recognised nor fully understood.

We were keen to use the opportunity of the Meaningful and Measurable project to address this and to use the learning from our earlier pilots and the emerging outcomes-related practice. In order to achieve this, we developed the following research questions:

1. What data on personal outcomes are currently collected in assessments, service requests and case notes?
2. What is the nature of that data, in terms of understanding, consistency and depth?
3. What factors hinder and support the recording of personal outcomes data currently?
4. What can we do to support recording personal outcomes in the new system?
5. To what extent (understanding, consistency and depth) does the new system capture personal outcomes data three months in from implementation?
6. What are recommendations for future practice?

Our methodology has been qualitative and based on action research, with specific methods proposed that involved:

- Documentary Analysis (up to 100 cases pre and post implementation); and
- Sense-making with practitioners.

In phase one, we planned to:

- Collect and analyse an existing 100 cases via eAssess (the system used by both the Council and NHS staff, enabling assessments to be shared) and SWIFT that were sampled from across sector/mental health teams, made up of 20 staff x 5 cases.
- Produce key terms for analysis, through an initial sampling of 10 cases.

- Apply content analysis to data collected, examining text that captures information, such as ‘what’s important to me’/goals or aspirations expressed by person and any other information about how people are supported to realise these.

4. What We Did

Five staff from the Research and Information and Strategic Commissioning teams, with input from the University of Edinburgh, formed an analytical group and together organised the key tasks for the project.

Phase One

Phase one looked at outcomes recording prior to the implementation of the new assessment and support plan tools.

A download from SWIFT was taken for all people with a Health and Social Care assessment (with an actual end date) completed between October and December 2013. Twenty assessors were chosen from a variety of teams (hospital, sector, home care and addictions teams). We excluded any assessor who was involved in the new assessment pilot to ensure that our sample better reflect practice as it was before the introduction of the new outcome focused assessment tool. Ten assessments for each of these assessors were randomly selected and split among the five analysts. For each of these cases, the CARENAP form was downloaded which is the current assessment tool. To ensure as full a picture as possible, the assessment process and associated recording, service request forms and case notes recorded between October - December 2013 were also included in the analysis. No additional paper files or on other electronic systems were considered.

One of our initial tasks was to consider 3 specific ‘cases’ in order to generate an analytical framework. This process enabled us to consider how each of us were ‘reading’ the cases, what we were noticing, explore what assumptions we held and create a mechanism for analysing the cases we were to individually review. Given the time taken to go through some of the cases and the amount of data generated, we decided to only read 10 cases each. The group completed 53 cases using the framework we developed.

This sampling also generated substantial data, so we then agreed to focus on an additional, more in-depth analysis of a selection of 25 of these cases (the first 5 from each of the 5 lists) (see Appendix 3 for a profile of the sample). For each case we considered the type of case it was (location and urgency), details of person (age, capacity, informal supports) and then the level of recording - holistic picture of person, wording, style of writer, and finally what outcomes were recorded and where.

The detailed analysis of the 25 cases was then pulled together to generate our picture of outcomes recording.

Throughout the analysis

Throughout the analysis of the initial cases, we met as a group frequently to discuss our learning from the cases we were individually reviewing. We continued to make our analytic approach more consistent by developing our coding list to be more explicit and to ensure a shared understanding between analysts.

Phase Two

Phase two looked at outcomes recording after six months of practitioners assessing using a conversational approach and recording in the new tools. A similar download to Phase one was taken looking at assessments completed between October and December 2014. A total of 35 cases have been considered in Phase two to start to understand the changes in recording found with the new process and tool.

Future work

We intend to work with practitioners to review our analysis and identify any contextual factors that hinder/enable the recording of personal outcomes data that as non-practitioners we may not appreciate. The intention of this will be to work with practitioners to shape the learning from this analysis and consider these in relation to implementation of new tools and develop recommendations for organisational learning in relation to embedding outcomes in practice, management and reporting.

5. Findings

When we started out, we had low expectations of finding information regarding the recording of personal outcomes, however what we found both confirmed our expectations and challenged them.

During the process we noted that there are many factors, external to the assessment tools used, that impact on practitioners recording of outcomes. Local pressures and associated targets (for example, to help deal with high demand) as well as processes (e.g. requirements to provide specific information to support access to appropriate services) all impact on what is recorded.

In presenting our findings, we want to foreground our analysis by stating that we have undertaken this project in a way that we think is non-judgemental about practitioners approach to note taking and assessments. We are and were very conscious that we are non-practitioners and we are aware of the current challenging practice context. Our intent was to gain insight into the practice of recording and observe if the implementation of outcomes focused assessment as part of the requirements of self-direct support was leading to any shifts in the practice of recording personal outcomes.

What follows are the key themes that emerged from our analysis:

1. Tools and Process

In most of the Phase one cases we looked at there was some evidence of personal outcomes being recorded but this was in the range of documents we looked at and not necessarily the assessment.

The original assessment tool and process had a formal purpose to support requests for service and would be shared with others. This clear purpose for the assessment resulted in a service led focus for practitioners' recording. Specific data is required to request services and it was this that was recorded in the assessment and service request tools.

However, the role of case notes was significant. These informal, at times idiosyncratic, styles of documentation aided our understanding of the person, their situation but also interestingly, were illustrative of the raw practice experience and issues of competing systems pressures in the here and now. There is no formal purpose of case notes apart from to be used to note details within a case. This allows multiple voices to appear rather than the single author of the assessment. They span many points in time and as such provide a narrative over time, and so develop the story for the person being assessed, allowing the outlining of the conversation and people's opinions to be expressed. Over time this allows a more detailed picture of the person and what is important to them as well as more context about the conversations held throughout the assessment process to appear.

An example of this is a case note referring to family members who wanted to keep the person at home originally; the assessment does not refer to this, *"information on referral is family would feel she would manage at home with additional support"*. However, information in assessment is *"felt by all parties that this lady's needs would be best met in a care home placement"* (YG4). This highlighted that without the case notes, we wouldn't fully understand the situation or the change of decisions made.

There also appeared to be a practice of identifying a single solution to address the needs of a person. e.g. in the case of a person with dementia, direct payment for respite was provided as option to a carer, but there did not appear to be any options available for the cared for person in terms of strategies for living with dementia.

"Due to her changing needs I would request that her current two day allocation is turned into a DP so that carers can be hired to go walking with Mrs [D] or stay in the house. This also ensures her husband continues to get a break from a difficult caring situation. Without this LTC may be needed" (YG6).

However, this might be another impact of the service orientation of the documentation that is assessing need and providing a rationale for getting access to specific types of service interventions. Given pressure and demands on practice, this may have resulted in assessors self censor in the writing of formal documentation, that is, assessments, service requests meaning that although several options were considered or a wider ranging conversation was had, limited information and evidence is recorded and reflects service led thinking.

Apart from the tools it was recognised that the types of cases being assessed had an impact. For those practitioners who work with people who are experiencing crisis or have complex needs, these case specific factors affects the nature of outcomes focused conversations had and the extent to which personal outcomes can be recorded. We presume practitioners who are familiar with recovery approaches will use their professional judgement about the appropriate place in a person's recovery journey to explore outcomes.

The ability of a person to make decisions, especially as a result of dementia, emerged as an area of practice where it is challenging to engage in conversation to ascertain what is important to a person and then the role of carers or family in becoming a proxy for the person. The following quote highlights the challenge a practitioner faced but still persists with trying to inform the person about what was going on, *"I had a lengthy conversation with Mrs S. This was difficult, due to her inability to retain information, which necessitated me revisiting aspects of the conversation, to attempt to determine her ability to understand the discharge planning"* (YG7).

Another key issue appears to be the pressures associated with delayed discharge, which created in the documentation a sense of urgency and a focus on short term/interim solutions e.g. boarding.

'she [daughter] was approached by a doctor on the ward yesterday asking about progress in arrange a care home for her father and NHS need his bed back. This was very distressing ...' (19320105WD).

2. Differences in recording styles

There appeared to be differences in the information recorded by different teams. Where personal outcomes appeared to be evident was in the documentation of mental health and addictions practitioners, which made us think about the nature of the services and practitioners relationships with supported people. Also of interest was the goal orientation and very practical style of Occupational Therapists to recording. For example, in one case the OT captures the individual's outcome, "Mrs X would like to be able to access her bathing facilities safely and independently" (C6). The OT also describes how the person manages with issues rather than flagging them as problems, e.g.:

"Mobilises slowly with 1x stick at all times. Mobility is restricted by pain but observed to be steady, experiences shortness of breath on minimal exertion. Mrs X is overweight and advised that she feels this is making her mobility more difficult. Right leg can give way with no warning resulting in falls. Manages all transfers independently with increased effort. Takes her time but manages." (C6).

Whilst there were some personal outcomes that were very short term, narrow and functional in approach, there appeared to be an emphasis on recording using what might be called a

heuristic device familiar to the profession underneath this. Case notes enabled us through analysis to notice the nuanced differences in practice across teams, so for example, in situations where there is an emphasis on end of life outcomes and end of life care, there appeared to be practice that is very person centred. Also of interest is the recovery emphasis woven through the Alcohol/Drugs team approach to writing of notes.

There appeared on occasions to be contradictions when reading both case notes and assessments written by the same author, for example “[t]he problem has been partly identified in the assessment with one option presented to address the problem. However, the case notes show that there is even more to the story...” with the involvement of the family in discussing options for support being recorded (YG5).

On a more negative note, the differing approaches in some practice areas, meant that even with case notes, it was difficult to distil, even indirectly, personal outcomes. This occurred primarily in hospital settings.

3. Recording doesn't evidence the conversation

A key challenge that the team faced in analysis was that the documents they examined did not stand as a comprehensive record of the conversation, but instead were partial records reflecting different perspectives and outcomes.

The use of the passive voice made it difficult to determine whose outcomes were documented, for example, “at these times it is important that (his) feelings are validated and those supporting him allow him to express his frustrations” (EC03). It isn't clear from the record if this is important to him or important as a way of working.

We also noted that certain professional knowledge and particular professions were privileged in recording, primarily medical information and the authority of doctors. Whilst health information forms an important part of understanding a person's needs, other aspects of people's lives do not seem to have the same prominence in the documentation analysed.

We also observed through the documentation, situations, in relation to a person's input in hospital, where they went from being able to take part in conversations to what appears to be actively excluded. There were also instances of carers not being listened to.

‘It is the view of the multidisciplinary team and family that Mr X is no longer sustainable at home. He now requires 24 hour care and supervision in a care home placement’ (19320105WD).

Doctor: *‘clearly state to the son that Mr X requires’*. Son's point of view *‘stating it is his father's right to be able to return home if he wishes.’* (CS2)

4. Impact on Research and Information team

Throughout the analysis of the initial cases, we met as a group frequently to discuss our learning from the cases we were individually reviewing. We gained an understanding of the complexity of the cases that assessors are dealing with on a day to day basis.

We also reflected on our own reactions as they emerged during the course of reading, ranging from emotions of frustration, anger, sadness, concern and comfort. These responses may not be routine for experienced practitioners. Some of what was recorded in the assessments and case notes were very overwhelming. This led us to consider whether practitioners are self censoring in relation to the pressures and challenges they face, and whether the use of professional discourse and practice instruments distances the professional from their practice challenges and the person they are assessing.

We also acknowledged the distance from the actual conversation that we had - so we were reading a summary of a summary (i.e. the practitioner's summarises the conversation in their assessment and that conversation is a summary of the person's actual life). This limits our ability to accurately identify/interpret the extent to which an outcome based conversation/assessment was carried out. This has implications for us in attempting to use the recorded information for performance or planning purposes in terms of our confidence in its reliability and validity (recognising that there are similar challenges with the recording of quantitative information).

Finally we understood that there is a benefit in considering the whole picture of a person when looking at the recorded outcomes to get an understanding of how the outcomes recorded relate to the rest of the person's story. This has an impact on how we undertake outcomes analysis and reporting in future.

5. Phase Two - Recording of outcomes

In relation to the second phase of analysis of data from the new outcomes focussed assessment tool, our early analysis indicates that there is a change in outcomes recording within the assessment process.

There has been a noticeable improvement in the recording of personal outcomes throughout the assessment. Also, there is a specific field in the new assessment tool and database for recording of outcomes which adds to this improvement.

However, this field is not consistently filled and we are unsure if this is related to the way the database is structured which limits effective recording of outcomes, rather than the tool itself. We also observed that there are outcomes recorded in the actual assessment rather than the outcomes field, for example, there was evidence of outcomes being sought in the assessment and not recorded, such as an individual who was being admitted to a care home had a major outcome for her was to continue to see her brother and sister on a regular basis (YG05).

There was also the matter of what is recorded in the outcomes field not being an outcome, rather an output or an activity, with some assessors recording outcomes throughout the assessment and yet only recording outputs in the outcome fields, for example, “To contact the roads department to enquire about the possibility of a disabled parking space” whereas, a major outcome in the assessment was “[DD] is a very positive person and wants to maintain her level of independence despite her widespread severe osteoarthritis”. It would be difficult to link these up without reading the full assessment, assuming that they are linked (YG04).

Aside from the more explicit recording of outcomes, the new assessment tool appears to be fostering a more narrative style of writing about the person and their situation. One new assessment appeared to include direct quotes from the individual clearly stating his likes, desires and barriers to achieving these:

“Since being diagnosed with ME/CFS in 2003 I have found it impossible to work, engage in training or education but I have continued to maintain my interest in music and computing at a pace which does not over fatigue me. I try not to allow my diagnosis to limit my interests but I have to be realistic about how much I can do due to the debilitating nature of my illness. I am particularly keen to find ways to improve my diet and general health and I appreciate the support I receive from [agency name omitted] in helping me to plan and prepare nutritious meals but feel that I would benefit from having more of this. I would also welcome help from a support worker in helping me find ways to retain my present skills, offer me emotional and practical support when I am feeling low, and help me learn new skills.” (YG03)

There remains issues of single solutions only being evidenced in the assessment rather than consideration of other possible solutions (or even communicating that there were no other solutions). This led us to the view that there is still service led thinking shaping practice.

However, whilst we would argue that there is evidence of positive change, we are very mindful that that data we analysed was after only 6 months from when the tool was implemented and so practice change is still evolving.

6. What Difference Is This Making?

At this time the project has had limited influence beyond the Research and Information Team. Members of the Research and Information Team developed an appreciation of some of the pressures and challenges faced by practitioners, and of the range of approaches to recording case work and personal outcomes in particular. It is helping to inform the requirements for analysis of personal outcomes in the future. We anticipate that the evidence we’ve gathered will form the basis of joint work with practitioners to develop outcomes-recording practice. We have developed an understanding of the importance of joint work with practitioners in developing ways of recording and using outcomes data so that it is meaningful to them, as well as to us, as users of the data for very specific purposes. We plan to take this forward with our Workforce Planning and Development Colleagues and practitioners to ensure that sound

outcomes recording can be embedded in practice and in training in a way that is useful for all parties.

7. Challenges Faced, Implications and Learning

The time taken to do the analysis as a result of pressures on workload has influenced our expectations of the extent of analysis that could be feasibly undertaken given the amount of data generated. We identified that we have limited organisational infrastructure available for qualitative data analysis and so would benefit from specialist software to assist the analysis of qualitative data.

The experience has been interesting, enjoyable and time consuming. We do not spend enough time examining cases to enhance our understanding of what is happening at ‘the coal face’ of practice. However, we would do our analysis differently next time: we lost too much detail in summarising case notes and assessment notes into our analytical framework. There was too much of a gap in time between our analysis sessions, so we tended to lose track. We had different understandings of the key components in the analytical framework, which ended up not being as distinctive as they could be. We recognised the need for a code book and more work earlier on to ensure we all agreed the definitions and greater clarity from the outset.

We were conscious that we are removed from actual face to face practice and so our syntheses comprise a range of documentary sources (case notes, assessments and requests for services) produced by workers of conversations that they had had, that served a range of purposes and have a range of intended and potential audiences and we analysed and filtered this even further.

Our analysis showed the effect the tools and processes have on how assessors record personal outcomes. The new tool, alongside the outcomes focused training sessions, seems to be supporting the recording of outcomes but further work is needed to embed this with the culture of the department.

In relation to the organisational context, there is ‘talk’ and an aspiration of becoming outcome focused in practice, supervision and management. This is easy to say, however it is challenging in practice. In March 2011, the Scottish Government and COSLA published the three year review of the implementation of an outcomes approach as exemplified by the Single Outcome Agreement and the journey so far. This report recognised that “*the approach takes time and more effort is required to overcome inherent cultural and technical barriers within public services in order to maximise the benefits ...*” (Scottish Government, 2011:14). It is 2015 and we are still on that journey and barriers identified remain.

The following are a range of factors that we think can influence the extent to which personal outcomes data and information are gathered and used within the City of Edinburgh Council:

- Fostering the right conditions - that there is leadership at all levels across Health and Social Care, with the right incentives in place to support the cultural change required. A learning culture and appreciation of evidence-informed knowledge evolves.
- Setting realistic expectations - given performance management requirements (that is, targets for assessments and reviews) and the limitations of performance information as evidence of linear cause-effect relationships, modesty in expectations about the role of performance information is necessary. Given the service demand pressures, realistic demand for performance information and educating users of performance information takes place.
- Implementing to get buy-in and use - workforce and user/carer involvement in developing performance and evaluative information is embedded, as well as having a means to structurally link performance information and decision-making and create mechanisms for learning as well as accountability.
- Setting outcome expectations - given the need to move beyond outputs, there needs to be a means by which the organisation can assess its contribution and influence through the application of methods such as logic modelling, outcomes planning or contribution analysis.
- Selectivity - in order to avoid information overload, there needs to be a shared understanding of what data are truly needed and worth collecting and the organisation is aware of the transactional costs associated with measuring.
- Avoiding distorting behaviour - there are tensions with the approach to gathering personal outcomes and the existing performance management regime, that is, the approach requires time, to both gather and report, while performance management is focused on throughput. There needs to be a means by which measures are regularly reviewed, are actually focused on outcomes and counterbalancing measures are used, such as, the synthesis of a range of data sources.

Accountability for outcomes - when it comes to understanding and measuring progress as expressed in outcomes there is a realistic view of accountability. In particular, there is an understanding of what is under organisational control and what the organisation can directly influence. Given that outcomes can be the result of a number of partners and the person themselves, there needs to be shared understanding of accounting for shared and personal outcomes. There also needs to be great clarity of what is expected of practitioners in relation to recording in general and personal outcomes specifically, and a shared understanding of who can use the data generated and for what purposes.

