



**‘WE’VE GOT TO TALK ABOUT OUTCOMES...’: A
REVIEW OF THE TALKING POINTS PERSONAL
OUTCOMES APPROACH**

Alison Petch

**IRISS (Institute for Research and Innovation in Social
Services)**

April 2012

Outcomes Important to Service Users

Quality of Life	Process	Change
Feeling safe	Listened to	Improved confidence/morale
Having things to do	Having a say	Improved skills
Seeing people	Treated with respect	Improved mobility
Staying as well as you can	Responded to	Reduced symptoms
Living where you want/as you want	Reliability	
Dealing with stigma/discrimination		

Outcomes Important to Carers

Quality of life of cared for person	Quality of life for the carer	Managing the caring role	Process
Quality of life for the cared for person	Maintaining health and well-being A life of their own Positive relationship with the person cared for Freedom from financial hardship	Choices in caring, including the limits of caring Feeling informed/skilled/equipped Satisfaction in caring Partnership with services	Valued/respected and expertise recognised Having a say in services Flexible and responsive to changing needs Positive relationship with practitioners Accessible, available and free at the point of need

Outcomes Important to People Living in Care Homes

Quality of Life	Process	Change
I feel safe and secure I see people I have things to do I live in a nice place I live life as I want and where I want I stay as well as I can I belong to a community	I am treated as an individual I am valued and respected I am listened to I have a say in decisions about my care and support I am supported to live well and plan for a good end of life My family and friends are involved if I want I can trust staff and rely on them to respond	My skills are improved My confidence and morale are improved My mobility is improved My health has improved or my symptoms are reduced I have settled in to where I am living

	My privacy is respected	
--	-------------------------	--

EXECUTIVE SUMMARY

This review of the Talking Points: Personal Outcomes Approach was asked to establish the nature of activity in respect of the approach across partnerships and providers across Scotland, in particular since an earlier review in 2008. It is based primarily on interviews with forty key informants (from partnerships, providers and national organisations) and responses from a sample of those already using Talking Points to a web-based survey. Talking Points is an approach which focuses on assessing the outcomes important to the individual, planning how they will be achieved and reviewing the extent to which they have been attained. The following points highlight the key conclusions from the review.

- The implementation of Talking Points provides an outstanding example of concerted action over an extended period of time to embed a personal outcomes-focused approach based on a robust evidence base. The commitment of two dedicated staff and the wider Joint Improvement Team has enabled both partnerships and providers to access detailed and ongoing support, providing expertise and practical assistance in the cultural transformation required to deliver an outcomes focus.
- Major strengths of the Talking Points approach were identified. These include the focus on the individual and what is important to them, identified through a conversational approach which allows them to articulate their hopes and preferences as part of the assessment, planning and review process. Talking Points was considered to be an example of the widely promoted strengths based approach, and one which chimed well with core social work values. It was judged to have major potential for recording and aggregating outcomes and for contributing in turn to outcomes-focused commissioning.
- Practitioners engaged with Talking Points endorsed the approach for its greater engagement with people who used services and carers. Individuals reflected on their needs and participated more fully in decision-making and there was a greater likelihood of identifying outcomes than in the past. Professionals expressed greater certainty in pursuing outcome-focused practice and considered there was greater consistency in assessment and review. Almost 90% expected Talking Points to become the mainstream model in their locality and endorsed the expectation of using individual level data to inform strategic planning.
- Respondents from the local partnerships outlined a variety of journeys in embracing the Talking Points approach, the concept of a journey being used frequently to describe the engagement with the approach. While the review process was often the starting point, the need to embrace assessment and care planning could then become evident. The relationship with the single shared assessment process preoccupied some partnerships and for others whether to work exactly to the 14 domains of Talking Points or whether to adopt a looser personal outcomes approach.

- Amongst the sample of provider agencies, informants spoke of the use of Talking Points as an opportunity to reflect, to refocus or to refresh. A further motivation was the desire to be responsive to commissioners and tenders, with at times the providers taking the lead in demonstrating the contribution of an outcomes focus.
- A key prerequisite for effective implementation of Talking Points is recognition of the concerted energy that is required over an extended period to embed the approach as mainstream practice. A focus on outcomes requires a change in both thinking and practice which comes easily to some but requires more extended engagement and coaching with others. It could also take time working with practitioners before they appreciated that an outcomes focus differed in critical ways from their current model of practice.
- Once an outcomes focus had been established, the recording and aggregation of outcomes emerged as a key challenge for both partnerships and providers. The appropriate balance between qualitative and quantitative measurement and the mesh with national performance measurement and the outcomes to be specified under the new arrangements for health and social care integration are currently the focus of activity by Talking Points leads and the Joint Improvement Team.
- The use of Talking Points presents an ideal opportunity to complete the commissioning cycle through a focus on outcomes-focused commissioning. Contracts can be specified in terms of the outcomes they are designed to deliver and gaps identified through the review process for individuals can provide intelligence on the nature of support provision that should be commissioned.
- There are a number of areas with major potential for further development and adoption of the Talking Points: Personal Outcomes Approach. These include consolidation of the use with carers, further work with care homes, and major expansion into the health arena.
- Both partnerships and providers spoke of the value of the support networks which had developed amongst those implementing Talking Points. Respondents valued in particular the reassurance from others that, for example, change did not happen overnight or that the nature of the approach could need reinforcement.
- Recommendations based on the findings of the review were drawn up by a group of key stakeholders. These are listed in detail in the report, grouped to the four pillars for the reform of public services put forward by the Christie Commission. They can be summarised as follows:
 1. A plan to spread the focus on personal outcomes in designing and delivering public services, including the use of the Talking Points: Personal Outcomes Approach, should be developed and agreed with all necessary stakeholders.
 2. A personal outcomes approach should be embedded across partnership working between health, housing and social care, in public, independent and third sectors; Talking Points provides the framework and methodology for the delivery of this approach.

3. The role of the Talking Points: Personal Outcomes Approach in promoting co-production, and preventing the need for services or formal support should be considered and developed.
4. In order to support improvements in performance and reductions in cost, the Talking Points Personal Outcomes Approach should be used to gather information about impact of services and support on personal outcomes, and this should be used to develop improvement measures at national and local level.

INTRODUCTION

This review of the Talking Points: Personal Outcomes Approach was commissioned by the Joint Improvement Team and conducted from September to December 2011. It builds on the earlier evaluation of the adoption of the User Defined Service Evaluation Tool (UDSET) in seven pilot sites across Scotland (Stewart, 2008). Following this evaluation UDSET became known as Talking Points and was reframed as an approach or framework rather than an evaluation tool.

Aims and objectives of the review

The overall aim of the review was 'to determine the spread, sustainability and effectiveness of the Talking Points: Personal Outcomes Approach'. In particular the review was expected to:

- Establish the extent and nature of activity relating to Talking Points: Personal Outcomes Approach amongst partnership and provider organisations across Scotland and beyond
- Determine the extent to which Talking Points has been mainstreamed as a sustainable approach within these organisations
- Establish the impact that implementing Talking Points has had in relation to:
 - Improving outcomes for service users and carers
 - Supporting staff
 - Supporting organisations to focus services and supports around outcomes for individuals, including use of information
 - Supporting organisations to meet broader policy goals, including: quality strategy, re-shaping care, dementia strategy, carers strategy, sds
 - Supporting inspection, regulation, processes and performance management requirements
- Identify barriers and supports to effective implementation of Talking Points
- Review progress in development and implementation of the approach since the Glasgow School of Social Work (GSSW) evaluation in 2008
- Make recommendations for future work to support the implementation of the approach, including ongoing evaluation.

It should be noted that this was a review rather than a formal evaluation, ie it was not charged with looking systematically at the outcomes for individuals of adopting a personal outcomes approach. Such an evaluation would require a longitudinal study and a robust research design. Likewise there was not the opportunity in this review for a cost benefit analysis or for securing the perspectives of those who use services.

DEVELOPMENT HISTORY

The evolution of Talking Points has been well documented (see for example the report from the Dunblane event of November 2008 and Appendix Three of the Practical Guide for Organisations (Cook and Miller, 2012)) and will be outlined only briefly here. It is rooted in a strong evidence base, developed initially at the Social Policy Research Unit at the University of York (Qureshi, 2001; Glendinning et al, 2006) and subsequently refined in the study at Glasgow University which led to the development of UDSET. The implementation of UDSET in seven pilot sites (Orkney, Angus, Midlothian, West Lothian, North Lanarkshire, East Renfrewshire and Glasgow (South West CHCP)) was the focus of the initial evaluation (Stewart, 2008). This highlighted the changing focus of UDSET.

'The UDSET was originally conceived of as a toolkit intended to incorporate the outcomes important to service users and carers in routine interactions between users, carers and health and social care staff. Over the past year, as the UDSET work has become associated with the Community Care Outcomes Framework, its role has evolved and expanded and current language also refers to the UDSET as an approach to practice based on user and carer outcomes. As both a toolkit and an approach, the UDSET has continued to evolve during piloting, providing a dynamic context to the views expressed.' (p3)

The context within which UDSET was being implemented is important. The Community Care Outcomes Framework was initially conceived as a national performance assessment framework prior to the Concordat agreement between Scottish Government and local authorities. Subsequently it developed in parallel with UDSET, with 16 measures designed to focus on delivery for the four high level outcomes: improved health; improved well-being; improved social inclusion; and improved independence and responsibility. Included in the 16 measures are six that refer directly to the experiences of people who use services and their unpaid carers. A review of the Community Care Outcomes Framework has been led by the Scottish Community Care Benchmarking Network (SCCBN), with a draft report in summer 2011; the statement on future plans for integrated working between health and social care and potential associated outcome measures was being awaited before deciding on the next stage for the Framework.

A second development in parallel with the emerging Talking Points was the National Minimum Information Standards (NMIS). Issued in July 2008, these set a range of minimum information requirements that assessment and care planning tools and electronic systems should be able to record. Work took place to try and ensure that there was consistency between UDSET and the NMIS in respect of user and carer feedback. The NMIS also related to the measurement of 10 of the 16 Community Care Outcomes measures.

A further important reference point is the Scottish Community Care Benchmarking Network (SCCBN), established following a meeting of

partnerships called on the initiative of the Joint Improvement Team and Midlothian Council in March 2009. Funded partly through Joint Improvement Team monies and partly, from the second year, through subscriptions from the partnerships, the SCCBN has focused on benchmarking performance activity around the Community Care Outcomes Framework. It has been particularly concerned to avoid a 'league table approach' and has sought to ensure a common understanding through basic training in benchmarking, a protocol for data sharing, and a code of conduct. The approach was modeled on the Scottish Housing Best Value Network formed in the late nineties. It was the SCCBN who were asked to lead on the review of the Community Care Outcomes Framework in May 2010. More recently they have acquired a data management system and benchmarking tool and started to upload national data sets. In the near future the intention is to be able to upload and compare local data sets. The Network is independent with an Executive Committee and there is a Network link person in each partnership.

THE ROLE OF THE JOINT IMPROVEMENT TEAM

Against this backcloth, the approach to the implementation and embedding of the Talking Points Personal Outcomes Approach offers an outstanding case study of effective research utilisation. There is an extensive literature identifying the preconditions for transforming research into practice (for example Nutley et al, 2007; Dill and Shera, 2012). This highlights in particular the inadequacy of a model of research use based solely on producing and disseminating research findings. Essential to long-term adoption is a concerted programme of engagement, repeated communication and the establishment of long-term relationships, the essence of the approach that has been adopted. A useful characterisation developed at IRISS is of four key elements for the achievement of evidence-informed practice: improving awareness and access to evidence; strengthening the evidence base; improving skills and confidence to use evidence; and embedding evidence in organisations. Activity relevant to the development and implementation of Talking Points has related to all four of these elements; that of the Joint Improvement Team particularly to the latter two.

The roll out and support of the Talking Points approach has been a core aspect of the work of the Joint improvement Team over the last six years. The work has been facilitated and nurtured through the employment by the team of Emma Miller and Ailsa Cook (the original Glasgow University researchers) who have developed a wide range of activities and resources designed to assist with the understanding and implementation of the approach. They characterise a number of phases to this work. The first three focused on the initial workshops, development work in three partnerships and the work on carers' outcomes that transformed the original research into the User Defined Service Evaluation Toolkit (UDSET) and was outlined in the Report of December 2007 (see listing at end of review).

Phase 4, as prefaced above, linked to the establishment of the Community Care Outcomes Framework and the funding and support of the early

implementers as reported in the GSSW review (Stewart, 2008) and the Dunblane learning event. The final phase, over the last three years, has seen the shift from toolkit to approach and an emphasis on an organisational approach to embedding outcomes. Activity, as detailed below, has spread across both partnerships and providers and has included piloting of an outcomes framework with people living in care homes. Associated with these developments, there has been the identification of a Talking Points lead in each of the 32 partnerships, the formation of a Talking Points Learning and Action Group, and the development of an on-line community of practice.

Full detail of this activity can be found in Chapter Two of the Practical Guide for Organisations (Cook and Miller, 2012), presented under the three core elements of engagement, recording and use of outcomes information. These elements have been identified through the development process as key to the effective adoption of the approach. It is worth noting the breadth and depth of this activity. It has embraced detailed practice-based sessions with partnerships and providers exploring how to think and work in an outcomes-focused way; a number of national events; the development of a range of readily accessible guides and other resources; fostering the sharing of skills, ideas and materials, including collaborative work with a range of national bodies; promoting the exchange model of assessment; and supporting communication as appropriate through the use for example of Talking Mats. Links have also been made with the parallel development of Better Futures by the Housing Support Enabling Unit. Guides have focused, for example, on Staff Support and Supervision for Outcomes Based Working (2010) and on Recording Outcomes in Care and Support Planning and Review (2011). Most recently, responding to the concerns detailed below around recording and measurement, a data retreat has been arranged to explore options for data management and use.

In the course of the interviews undertaken for this Review, respondents spoke very positively of the detailed support and advice that they had received from the Joint Improvement Team and in particular the JIT leads for Talking Points, Ailsa Cook and Emma Miller. People referred to their enthusiasm - 'I think she got them really enthused about it' [Pa6], their proactive approach – 'how can I help' [Pa12], and the value of their ongoing support.

'I do find that the Joint Improvement Team information is really, really useful and having like Emma and Ailsa, it has been really useful being able to contact them if I need to.' [Pr1]

'There's no two doubts, I know R found talking to Emma incredibly valuable and me talking to Ailsa I found incredibly valuable.' [Pr7]

APPROACH TO THE REVIEW

Web-based surveys

Survey data from two sources has contributed to this review. The Scottish Community Care Benchmarking Network (SCCBN) had been planning to undertake a survey of the SCCBN leads in each partnership to ascertain their use of the Talking Points framework. In order to avoid duplication, the opportunity was taken to link the review to this work and to add a couple of questions to the initial draft. A total of 68 individuals, including the SCCBN leads, were notified of this survey in early September 2011; following a reminder a month later, a total of 16 of the 32 partnerships completed the web-based survey.

A second web-based survey was specific to this review and targeted practitioners in those partnerships where use of a personal outcomes approach was deemed sufficiently progressed for the survey not to be confusing. The content of the survey was a replication of the UDSET Monitoring Tool (UDSET-MT), devised by Bob Hudson and used in the initial evaluation of the approach in 2008. It was updated to reflect the changed terminology. The link to the survey was passed to 18 organisations (14 partnerships and 4 providers), with the individual who had been interviewed (see below) asked to distribute it to approximately 10 practitioners working with the approach. There were 79 responses to the survey: 45 from individuals working in partnerships, 23 from providers, and 11 not specified. The 68 responses that specified an organisation embraced nine partnerships and four providers. Appendix Two details the questions addressed in this Talking Point Monitoring Tool (TP-MT); the findings are integrated as appropriate within the main text. It should be noted that varying numbers responded to specific questions.

Interviews

Lead contacts provided by the Joint Improvement Team were approached by email and invited to participate in a telephone interview to discuss the use of Talking Points within their organisation. Amongst partnerships, 13 of the 29 approached responded positively initially and a further seven after a reminder. Sixteen providers were approached: eight responded initially and a further two after a reminder. This resulted in 20 telephone interviews with partnerships, plus detail from one partnership from an earlier interview during the review of the Joint Improvement Team. The sample included all seven of the early implementers that were the focus of the earlier evaluation (Stewart, 2008). One contact responded positively but identified an alternative interviewee; there was no subsequent response. One further partnership indicated they had not yet implemented Talking Points. Ten interviews were completed with provider organisations that have worked with the Talking Points approach. Telephone interviews were also conducted with ten individuals with an interest in the approach at a national level and a group discussion was held with the JIT Associates.

It should be noted that Talking Points leads – and perhaps particularly those motivated to respond – are likely to be working with the detail of local implementation; national respondents may have a wider perspective on the relative profile of Talking Points amongst competing demands. The non-responders amongst partnerships would appear, from tracking information held by the Joint Improvement Team, to be those who have made less progress with implementing the approach. Two of the providers also got in touch to indicate that their use was insufficiently developed to merit an interview.

	Approached	Interviewed	Other	No response
Partnerships				
-Early Implementers	7	7		
-Other	22	13	1+1 ^(a)	8 ^(b)
Providers	16	10	2 ^(c)	4
National	10	10 (1 joint)		

^(a) one earlier interview; one response that not implemented TP

^(b) two undeliverable

^(c) two email responses

Of the 20 partnerships which were interviewed, ten (not necessarily the same person) had also responded to the SCCBN survey. There were six partnerships which responded to the survey but were not interviewed. It should be noted that while speaking for partnerships, both interview and survey respondents were primarily local authority based.

Limitations of the approach to the review

The reliance on a single interview respondent for each partnership and provider inevitably means that the perceptions are coloured by the particular role of the respondent, the extent to which they have a complete overview of the implementation of Talking Points in their area, and their own personal perspective on the approach. This in turn will contribute to the plurality of perspectives likely to be held by different stakeholders. The author of this review was aware of a number of instances where the interview responses did not fully accord with the accounts of those more directly involved in driving forward implementation from a national perspective. For example in respect of the use of Talking Points with carers, few respondents reported detailed progress, despite a number of initiatives which can be detailed by those involved in development work. Likewise, although there has been considerable debate at a national level around resolving challenges around the aggregation of data, at a local level the respondent may either be unaware of this or still wrestling with how to address the issue.

It is important to appreciate that a review based primarily on interview material is as much about perceptions as about accurate reporting. Considerable energy may have been put into a particular area or initiative but embedding knowledge and practice is a lengthy process, with the thresholds for engagement and adoption likely to vary from partnership to partnership based on a range of complex factors. This is a common challenge for those pursuing evidence-informed practice: the relationship between inputs and impact may not be linear; despite extensive programme provision a range of complex factors may inhibit the achievement of the desired progress. Moreover the implementation process is one of continuous but not necessarily predictable development.

It is worth responding at this point to the question of how many partnerships are currently using the Talking Points approach. Evidence from the Joint Improvement Team leads for Talking Points suggests that all partnerships are engaged to some extent. As will be detailed below, however, the nature of involvement will vary – and moreover can change fairly rapidly within a short timescale depending on leadership for taking forward the initiative. It is unfortunate that only half of partnerships responded to the survey sent out by the Scottish Community Care Benchmarking Network; of these 16 respondents, 11 confirmed that they were using the approach. As above, however, the knowledge of the individual responding to the survey may influence the response. As the use of the Talking Points Personal Outcomes Approach enters its third stage, it is anticipated that the Joint Improvement Team will use its network of associates to gather accurate baseline data for the position at Summer 2012. This will allow for more accurate tracking of the continued implementation of the approach from that date.

DEFINING TALKING POINTS

As detailed above, following the earlier review in 2008, Talking Points was reframed as an approach or framework rather than its earlier identity as an evaluation tool (as in the UDSET ie User Defined Service Evaluation Tool). Some of those who had been closely engaged with the evolving identity were familiar with these conceptual shifts; for others however there could be confusion as to the primary focus of the Talking Points approach. This was initially the case for example when Talking Points was discussed with the three test sites for self-directed support and there was initial resistance to any use – ‘some people saw it over there as something to do with evaluating the service rather than actually planning the support’ [N6]. Similarly, a provider commented

‘People are coming at it I think from the wrong end of the spectrum which is about evaluation and what I have been saying to people is yes of course the data is really valuable in helping to understand what is changing or not changing for people and why that might be the case, but it’s only as good as the conversations you start with, with the carer or with the service user, so you have to start with the practice because if you don’t get the practice

right, the data you are putting into the system isn't going to be that useful.' [Pr10]

The core focus on outcomes that is at the heart of Talking Points can increase the confusion if people fail to distinguish the individual focus of the personal outcomes approach from collective organisational outcomes.

'I think there are different strands of thinking around and about in relation to outcomes and there is a strand that sees outcomes very much in terms of performance measures, whether that is within individual practice or within one organisation or whether that's nationally. Not say that is a bad thing, but there is a risk if one is solely thinking around performance there is a potential loss of the other key strand of the approach which is the centrality of the service user and carer in our thinking and in our approach. The holistic nature of the approach can be lost within that slightly narrower performance thinking.' [Pa3]

A further observation was that Talking Points emerged during the latter stages of specifying the National Minimum Information Standards (NMIS) to be met during assessment and care planning. Tension between the two elements was never, it was suggested, fully resolved. As a result a jostling for supremacy between NMIS and Talking Points is perceived, rather than the clarity that could have resulted from a clear directive to implement Talking Points rather than NMIS.

'It dawned on us that we probably weren't promoting single shared assessment – we were promoting something much more specific, which was a Talking Points approach to assessment, care and support planning and review... and if we had had that conversation earlier on, we wouldn't have produced an NMIS.' [N2]

It was also suggested that while the SCCBN worked on the development of the Community Care Outcomes Framework, a parallel 'satellite' group to focus with practitioners on the development of a personal outcomes approach 'never really built up much momentum'.

Adding to the complexity – and potential confusion – of the various understandings is the distinction between the use of the specific domains of Talking Points (all 14 or a subset) or the adoption of a broader or parallel personal outcomes approach. One commented that 'any organisation taking this forwards they have to make it fit to their organisation' [Pr3]. Although the distinctions are often more complex, the variation can be characterised as at one end a measuring tool and at the other a conversational engagement

FORM LED

CONVERSATION LED



'its not good enough just to have forms and tick the boxes, you actually need to change the conversation' [Pa14]

The notion of a conversation was referenced frequently: 'to achieve an outcome you needed to have a conversation, a different kind of conversation' [Pa16]. But conversations can take different forms and there needs to be quality both in the listening and the recording. One respondent described how staff, in an attempt to get away from the assessment way of thinking, just recorded the conversation they had. Some are good; there are 'others that are too conversational and are too loose and don't have a professional feel about them' [Pa7].

For others, however, there was a clarity of purpose: succinctly, 'this is about an outcomes approach, it's about moving from service land to citizenship'. Moreover

'the opportunity to frame the personal outcomes or the personal outcomes agenda to me was invigorated by the UDSET which gave you the things that matter to people, your prompts to get on that journey'. [Pa16]

Recognising the challenges and diversions that uncertain definitions can create, the JIT leads for Talking Points have evolved a practice of ensuring clarity and consistency of definition in every report and presentation. Moreover, as demonstrated below (Table Two), implementation of Talking Points has led to greater understanding and clarity amongst staff as to what an outcomes focus can deliver.

MODELS OF IMPLEMENTATION

Table One highlights the responses recorded through the web-based survey on the various approaches that people had worked with. It should be remembered that the survey was targeted at organisations known to have implemented Talking Points. Around 90% had experience of outcome-

focused review forms and assessment forms for service users. In respect of similar forms for carers, the proportion was around 60%.

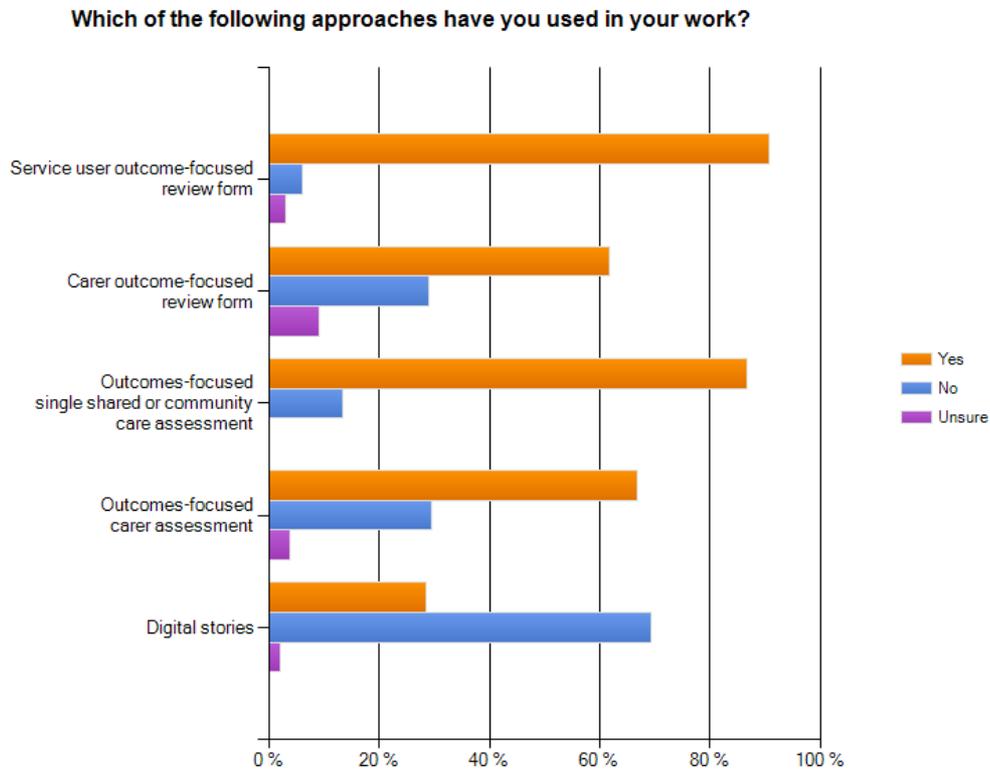


Table One: Response to TP-MT on use of different approaches (n=79)

Partnerships

Interview respondents from the partnerships outlined a variety of journeys in embracing the Talking Points approach; many described their organisation as still on that journey, ‘journey’ being a metaphor that was frequently employed. A rough categorisation can be offered.

Digging foundations

For three of the partnerships [Pa2; Pa18; Pa20] it was early days in terms of implementing a Talking Points approach, still exploring the preferred route and the links to the wider personalisation agenda, or making initial adjustments to the assessment or review process.

Applying a new coat of paint

Three of the partnerships [Pa8; Pa10; Pa19] had focused primarily on using the Talking Points approach at the review stage, one within social work only, one in the process of embracing health and one within an integrated context.

Refurbishment

In three of the partnerships [Pa1; Pa11; Pa14], the Talking Points approach had been introduced as a focus across assessment, review and care planning, building on the single shared assessment process. In one of these partnerships this extended across health, housing and social work; with the

challenges of responding in potentially diverse circumstances those involved in assessment and review were urged ‘don’t be blinded by the headlights of the tool, because every bit of that form will not be relevant to every client’ [Pa1].

Reconstruction

A number of partnerships [Pa3; Pa7; Pa12] had opted for redesign, moving away from existing single shared assessment schemes.

‘As we moved on in our thinking about personalisation and our thinking about social work values and how we could get that back into our care management model, we began to think that Talking Points were the way that we needed to go.’ [Pa7]

This same partnership admitted ‘we still have this slight feeling that we are being a little renegade because we are not doing single shared assessment.’ An earlier attempt to introduce an outcomes-focused assessment on top of the single shared assessment ‘became hijacked with IT’. The respondent for this partnership highlighted the evolving nature of implementation; moving onto self directed support, they were

‘at a kind of impasse until we free up budgets and people have an individual budget to go and spend on other ways of meeting their outcomes.’ [Pa7]

Another has introduced a suite of tools described as ‘the quick access, the outcome statement and the personal plan’; this partnership explained that

‘the relief in saying “away with SSA, we are bringing in something different” actually was a welcome relief for most people... We were saying “we are moving away from this needs-led assessment to a much more outcomes-focused way of working.”’ [Pa12]

Adding an extension

The approach in a couple of partnerships [Pa6; Pa17] can perhaps best be described by this category. In both, standardised assessment tools agreed across a number of partnerships restricted changes to the core assessment. One [Pa17] had therefore encompassed the Talking Points approach within an ‘aide memoir’ designed to prompt the assessment conversation: ‘what we’re saying is basically it’s an aide memoir to help people when they are carrying out an assessment to remember what’s important for people in their lives’. The other [Pa6] had initially incorporated the approach into assessments at three pilot sites. The advent of the standardised shareable assessment, which ‘doesn’t have any option anywhere to record outcomes on the paperwork’, led to the pilots being superseded but the decision taken of keeping outcomes within their internal systems: ‘we are still using the same outcomes as an add on to the shareable assessment’ [Pa6].

New build

In five of the partnerships [Pa4; Pa5; Pa9; Pa15; Pa16] implementation can be characterised as 'new build', adopting a range of more radical whole system approaches focusing on transformation to an outcomes-focused and assets-based approach. One in this group highlighted the motivation for this transformation: 'our whole approach is deficit led in order to get services, rather than services being a support to people'. Introduction to the Talking Points approach had been a revelation:

'moving to looking at the Talking Points agenda, the UDSET agenda, I thought this is the only thing, after all those years of me and others designing assessment forms and looking at what does assessment mean' [Pa16].

Another of the partnerships in this group detailed five key elements:

- review of the whole assessment framework – 'did the form have the capacity to capture a conversational approach'
- workforce development
- how to use the Talking Points information as a basis for the future commissioning and development of services
- engaging with major stakeholders, and
- addressing barriers to effective assessment, for example communication issues.

Those working in the 'new build' mode were conscious that their goal was transformation.

'We are moving to a new personalised way of thinking, this puts the person at the heart of things, this is not about needs, it's not about detriments, it's about positivity, it's about motivation, it's about encouragement to achieve rather than create situations where you are actually compounding people's needs by talking about them so much'. [Pa7]

They also recognised that time was a perquisite, that the journey was likely to be lengthy.

'I have never felt this is a quick fix and I think that's where my view, you know when I listen to others thinking all you are doing is changing the form, you won't change anything, you are just moving deckchairs around, so it takes much longer and we are still on that journey.' [Pa16]

Two outlined what could be seen as alternative frameworks to Talking Points, but similarly focused on outcomes. One of these had sought to 'get rid of a lot of the confusions, the repetitions and the disengagement' [Pa5], citing 30 different forms of assessment within a small partnership. The other had implemented a generic outcomes focus across children, adult and criminal justice services from an early date.

Sporadic development

This is the description best applied to the final partnership, one where a range of disparate pilot initiatives had been developed. These ranged from use of the Talking Points framework as an evaluation tool; application from assessment and care planning to review; and adoption of the Talking Points approach in a pilot of self directed support.

The range of options within these partnership responses can be summarised diagrammatically.



Early implementers

It is instructive to look at how the seven partnerships in the early implementer group have fared since the initial evaluation. Four (Pa8; Pa9; Pa11 and Pa16) can perhaps be considered the partnerships which are most advanced in the implementation of a Talking Points framework. Use of the framework is firmly embedded across assessment, care planning and review and across all care groups. One indeed, with a long history of promoting an outcomes-based approach which predated the implementer sites, has adopted the approach across their whole system, including children and criminal justice. Two of these sites use Talking Points in the context of integrated working across health and social care and both feed data from Talking Points directly into the Single Outcome Agreement. One of these partnerships highlighted the impetus that can come from an individual who drives the process: 'the biggest contributing factor to that was the enthusiasm and commitment that the team manager, who had been leading the work, had for the subject' (Pa8). Two of the four aggregate and analyse both quantitative and qualitative data. In the other three of the early implementers, progress has been somewhat slower. In two there has been an emphasis on the development of the single shared assessment process, with a focus on Talking Points primarily at review stage. In one of these partnerships its use is firmly embedded at this stage across all the integrated services – health, social work and occupational

therapy. The final site has weathered a number of substantive changes and development priorities which have somewhat submerged the learning from the initial pilot projects.

Providers

With providers also the journey metaphor was pervasive: 'I described it as a journey just because it has involved being very patient and determined and having to go back and check again and reiterate the key themes of what it is all about' [Pr3]. There was moreover a degree of commonality across the ten providers in their motivations for engaging with the Talking Points framework. Rather than classify into distinct groups, this summary will reflect on different elements highlighted amongst the providers.

Several of the providers were well established national organisations for whom the ethos of Talking Points fitted with their wider participatory culture.

'It just made utter common sense as an absolute moral argument, well of course you ask what they went through there, if they are getting a service off you, you have to ask people "what is it that you want"?' [Pr4]

It also met a practice need.

'Thinking about what kind of changes they want to make and what kind of things they want to achieve and then thinking about what some of the steps in that process would be and figuring out who is going to do what.' [Pr9]

Many of those responding on behalf of providers were knowledgeable about the approach and discussed at length the steps they had taken to embrace it, offering tough and detailed critiques on their progress.

'I think we are probably better at talking about capturing the impact the services have made in people rather than maybe being completely outcomes focused from the outset'. [Pr1]

For at least half of the providers, the approach offered the opportunity to **reflect**- with the individual on what they wished to achieve, or collectively, across individual experience, on the extent to which an outcomes focus was being achieved – 'gathering in stories'. For another provider of support for those with long-term conditions, use of the approach offered the opportunity for the individual to **refocus** – 'the patient has identified goals that they actually want to achieve.' For some the approach was very much in tune with long-established practice on person-centred support; it offered an opportunity to **refresh**. One provider, for example, spoke of a focus on 'what matters most' some ten years previously; another of 'realising as Talking Points has come in that we have probably been trying to do this kind of stuff anyway' [Pr1]. There was reference to combining a number of approaches, although this was not without the danger of overload or confusion.

'There's Talking Points, Talking Mats, Emotional Touchpoints and people just think this is another thing I have got to do and they do need a lot of reassurance around it's just something else that might help you, and a lot of the time the languages belie the fact that they are very simple ideas and simple techniques.' [Pr1]

A more pragmatic driver for the use of the Talking Points approach has emerged more recently, the desire to be **responsive** to commissioners and tenders. One explained how invitations to tender were

'looking for providers to give evidence of how they were working with Talking Points or how they demonstrated the outcomes for people' [Pr2].

This could also be motivating in persuading staff of the value of the approach. Likewise, another provider highlighted the value in having evidence, 'taking the initiative in having evidence at our fingertips when people question what it is we are doing' [Pr3].

'The Care Commission has been extremely impressed with the evidence provided by the Talking Points approach and the paperwork. At the last two inspections we have received excellent grading and that is being commented on.' [Pr3]

This could be problematic however if it started to distort the focus.

'There's always that dilemma between having to be evidencing things for inspections, so a lot of our paperwork was written from that point of view too and I sometimes wonder whether we have gone a wee bit too much to providing the evidence for other people that are checking rather than being truly outcome focused and person centred.' [Pr1]

In the current bruising climate, there were also tensions expressed in respect of the contract mechanisms.

'The big question in going forward is where it sits in relation to commissioners and funding bodies and councils. There is a huge tension there because we are pursuing 'excellent' and the message that we are getting in relation to services is well 'average' will do, we can only afford 'average'.' [Pr3]

A number of both partnerships and providers, as prefaced above, spoke of false starts, a realisation that their initial focus had led them into a cul de sac and that they needed to review their approach.

'We did things the wrong way around - it's easy to pick up on a form and change a form, but it's far more difficult to change the way that people actually think'. [Pa 10]

'We spent a few months in that working group developing the tools that would help the staff capture the outcomes that they were supporting carers to achieve, and then we did a development day with staff on the tool and use of the tools and launched the approach in January of 2009, and waited for the wonderful outcomes to roll in, and you can tell from the time of my voice that that didn't happen. We kind of scratched our heads for a few months going oh what's happening and what's not working here and we tweaked the tools... Eventually the penny dropped that the issue wasn't the tool, it was the practice and it was the fact that we were still very focused on outputs rather than outcomes, and we had to change our whole way of thinking, it took us around six months to kind of untick that...'. [Pr10]

Despite the extended timescales, respondents considered that such lengthy exploration could strengthen their understanding.

'We did get it wrong but we got it wrong for the right reasons, you know we made assumptions and we moved forward on those assumptions and then we realised those assumptions were flawed and we had to rethink it, but I am not sure how we could have done it differently.' [Pr10]

This last response raises a key question: to what extent do organisations need to work with and explore concepts on their own ground in order to implement them effectively or to what extent could there be opportunities for more collective clarification and progress.

Drawing across both partnerships and providers, there appeared to be a number of drivers that contributed to effective introduction of the Talking Points approach. These included one or more individuals in an organisation who took the initiative in driving developments forward, motivated very often by a commitment and passion for the approach. Being backed by support at organisational level was also important – or alternatively, as in several of the leading organisations, being sufficiently small to drive forward the initiative with key colleagues. Amongst larger organisations there were a number of respondents who expressed their frustration that their own enthusiasm for the approach and their strategy for its adoption had been sidelined or overlooked by other agendas. Indeed it is important to acknowledge that while Talking Points has been driven forward by a committed cadre of individuals, partnerships and providers, its profile across the wider health and social care community is as yet more limited.

Recognition of the concerted energy over an extended period required to enable people to understand and work in an outcomes focused way is also necessary. If the initiative is considered a quick fix or people are looking for rapid change there is likely to be frustration at the pace of progress, not least given the initial time investment required to understand and implement an outcomes-based approach. While initiatives can be developed and promoted to a high standard at national level, ultimately robust and enduring local adoption requires the co-operation of both senior management and direct contact practitioners.

STRENGTHS OF THE APPROACH

Both partnerships and providers were overwhelmingly positive with respect to the use of the Talking Points approach - 'it seems to have a genuine resonance for people doing the frontline work' [N2]. Indeed many respondents took it as read that the approach was fundamentally the right one; their concern was to maximise its adoption and to ease its spread and development wherever possible.

Focus on the individual and their personal outcomes

Typically, as described in the following quote, practitioners welcomed the opportunity to work in greater depth with individuals and to be liberated from what they saw as the constraints of form bound assessment procedures.

'They didn't feel the old style assessments really reflected the work they did with people because it was very tick box based, they didn't really find that it got to the heart of what they were doing and they actually wanted the opportunity to record more of the conversation if you like, and what they were doing for people and not just listing the services they were putting in place. We found that with all the teams that we introduced it to, there was really very little negativity about the whole process.' [Pa6]

There was little evidence of concerns at relinquishing more rigid assessment structures or fears that important elements could be overlooked.

Participatory conversations and shared responsibility

Moreover there was widespread support for the promotion of the conversational approach designed to elicit the hopes and preferences of the individual as part of the assessment, planning and review process. Such conversations seemed much more appropriate for a system designed to promote choice and independence and seeking to operate to a model of co-production. The logical extension of such an approach is a shared responsibility for achieving the outcomes that are identified. This argument for a shared responsibility for outcomes was well reported by one respondent.

'It was a young woman from a small learning disability charity at the last seminar we were at, she was saying, and I truly concur with this, that outcomes, this outcomes agenda really takes us back to why we should be doing this work in the first place, because in lots of ways although we are talking about recording and the need to report to local authorities, what it's really about is how we work with people and how we try and make sure that it's their voice which is coming through and it's their choices which are being met, rather than the boxes that we try and fit them into, and that really impressed me, I thought that was a lovely way she put it.'

Strengths based model

Several respondents framed the Talking Points approach in the vocabulary of a strengths-based approach - 'it's an assets model, rather than deficit model' [N4]. They acknowledged however that to switch from dependency and expectations of provision was a 'huge biggy'; 'that's a big, big habit that's been created' 'if you filled in strengths you wouldn't get access to the service' [Pa16]. Such a framing is highly relevant to the current emphasis on the promotion of strengths and assets based approaches, although this does not reduce the need for clarity of interpretation and discussion.

Core social work values

A common refrain from those who had worked in the field for some years was that engaging in a more detailed conversation with individuals recalled the practice for which they were originally trained. It had greater resonance, they suggested, with what they described as 'traditional social work values'.

'It just took me back to those core social work beliefs that kind of brought me in to the profession in the first instance I think, you know about working meaningfully with people, engaging, having a sense of what mattered to the individual from their perspective and planning alongside them in a very kind of core productive way.' [Pa15]

This sentiment was expressed not just by those working in the statutory sector; a provider commented that 'some people have actually come back and said do you know this is what we used to do years ago, how come we stopped doing it?' [Pr2]

Accessibility of core principles

Respondents also made reference to the 'common sense' principles that underpin the Talking Points approach. Although the evidence base may have been developed in the context of specific groups, the outcomes that are important to people are common across the population. This commonality gives the personal outcomes framework a resonance across both professionals and individual who access support. Moreover Talking Points has been shown to be accessible to a broad range of groups, including for example those with a range of communication needs through the use of Talking Mats. Moreover, as illustrated later in this report, the aspiration is for Talking Points to be used across the continuum of settings, from individuals living in their own home to those who are being supported in care homes.

Potential for recording individual and collective progress

A further strength of the approach, albeit with room for further development and refinement, is the opportunity to record and aggregate, both for the individual and across groups of individuals within a specific area.

'Look at whether the outcome is achieved or partially achieved or not achieved, aggregate from the Swift system – so over three months, x people had x outcomes, x fully achieved etc. Also with review documents, looking at whether around a number of areas there has been a big improvement, small improvement, no improvement, no change or not discussed.' [Pa7]

With an emphasis on the support of the individual as part of their local community and a renewed focus on community planning, the personal outcomes approach offers an ideal opportunity for an integrated approach to support planning and provision.

Potential for outcomes-focused commissioning

This in turn highlights a further strength, for the majority of areas a step to be taken in the future rather than a current reality. A logical development once outcomes for the individual are being routinely identified and reviewed is for outcomes to become the basis for commissioning. This provides an opportunity for the commissioning cycle to be explicitly linked to improving personal outcomes. Support and services can be commissioned on the basis of a contract to deliver the outcomes that have been identified. That may be on the basis of aggregate information about outcomes, or (through self-directed support) on an individual basis. Moreover greater attention to outcomes that remain unmet should contribute to more targeted and effective commissioning.

Strengths revealed through the TP-MT tool

Those involved in using Talking Points with individuals in care planning and review were also overwhelmingly positive in their response to the web-based monitoring tool. As demonstrated in Table Two, large majorities either 'strongly agreed' or 'agreed' with the six statements referring to improved engagement and experiences for people who use services and carers. There was considered to be greater involvement in decisions, more ability to reflect on needs, greater clarity amongst staff about what constitutes a good outcome, and a greater likelihood of identifying user/carer outcomes than in the past. It should be noted, however, that in respect of 'services and support are more person-centred than in the past' the endorsement was least strong, with a third of respondents dissenting.

Please enter your responses in respect of the following statements about user/carer engagement and experiences since the adoption of a Talking Points approach

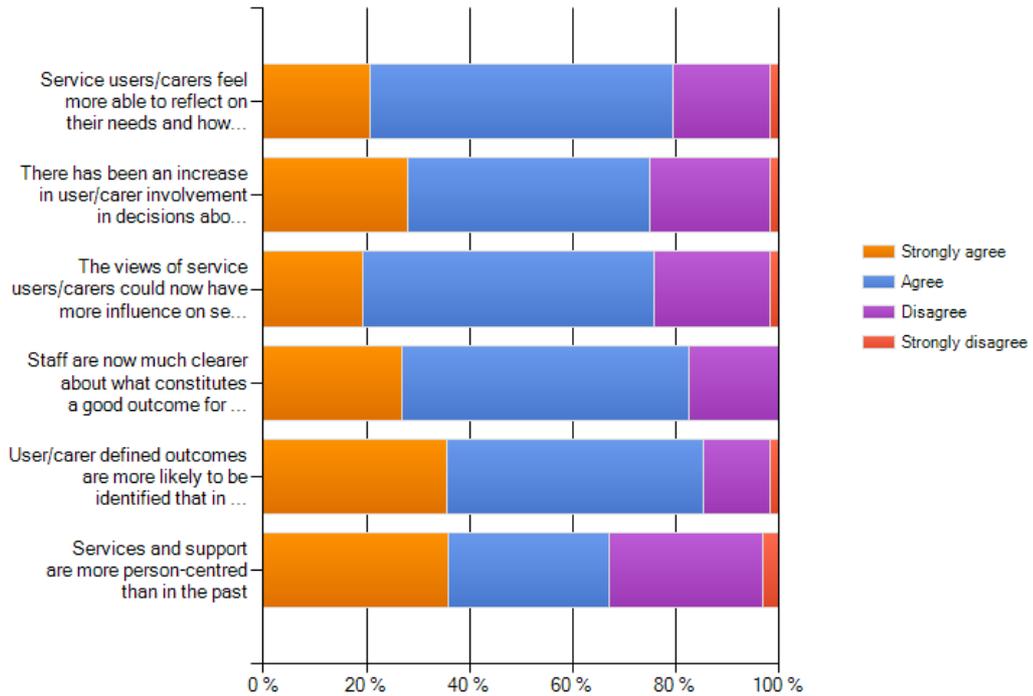


Table Two: Talking Points and the involvement of service users and carers (n=64)

Table Three summarises views on professional practice since the adoption of the approach. Again there is a very positive response to the development: practitioners much clearer about what constitutes a good outcome; better able to gain a holistic picture of an individual; a greater opportunity for meaningful dialogue; a greater level of consistency in assessment and review; and a view that the time invested in adopting the approach has been well invested. Opportunities remain for further improvement; two thirds for example considered that staff had been well trained and prepared to use the approach suggesting opportunities with the remaining third.

Please indicate your responses in respect of professional practice since the adoption of the Talking Points approach

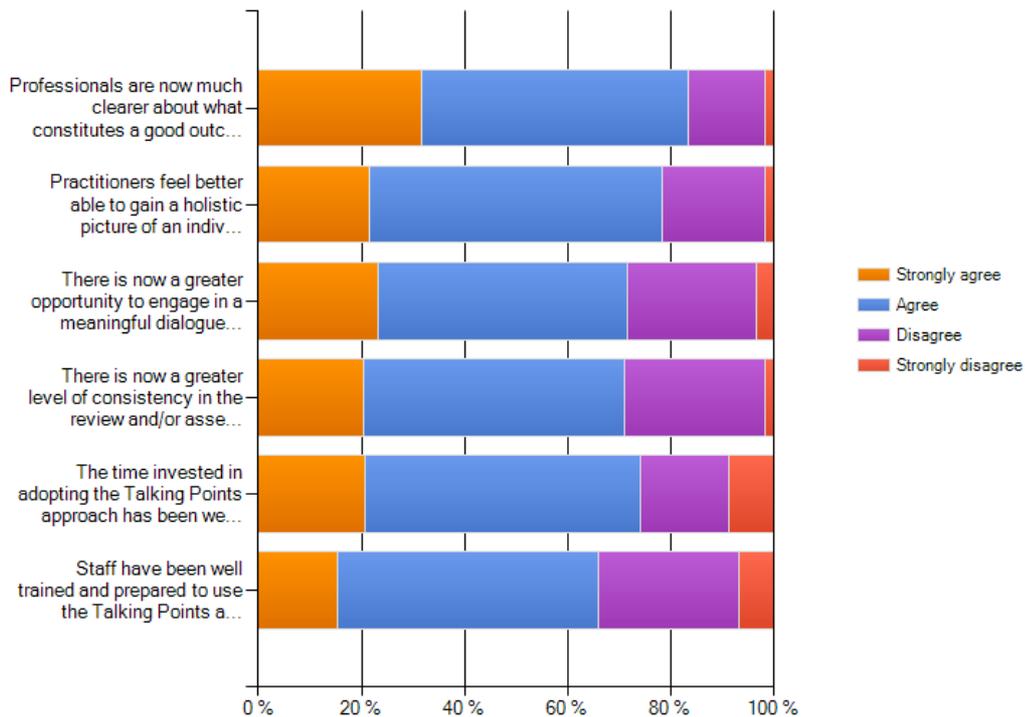


Table Three: Talking Points and professional practice (n=60)

Table Four is particularly striking. For example 87% of the practitioners expected the Talking Points approach to be the mainstream model in the locality. Large majorities considered Talking Points made them better placed to deliver on the National Outcomes Framework (84%), helped them to meet the National Minimum Standards for Assessment and Review (86%), and put them in a better position to develop our Single Outcome Agreement (84%). Respondents also felt that service managers had a much clearer idea of what is going on in local services, although not at quite so strongly (12% 'strongly agree', 59% 'agree'). Being better able to use individual level data to inform strategic planning was endorsed by 80%.

Please indicate your responses relating to data collection and organisational arrangements since the use of the Talking Points approach

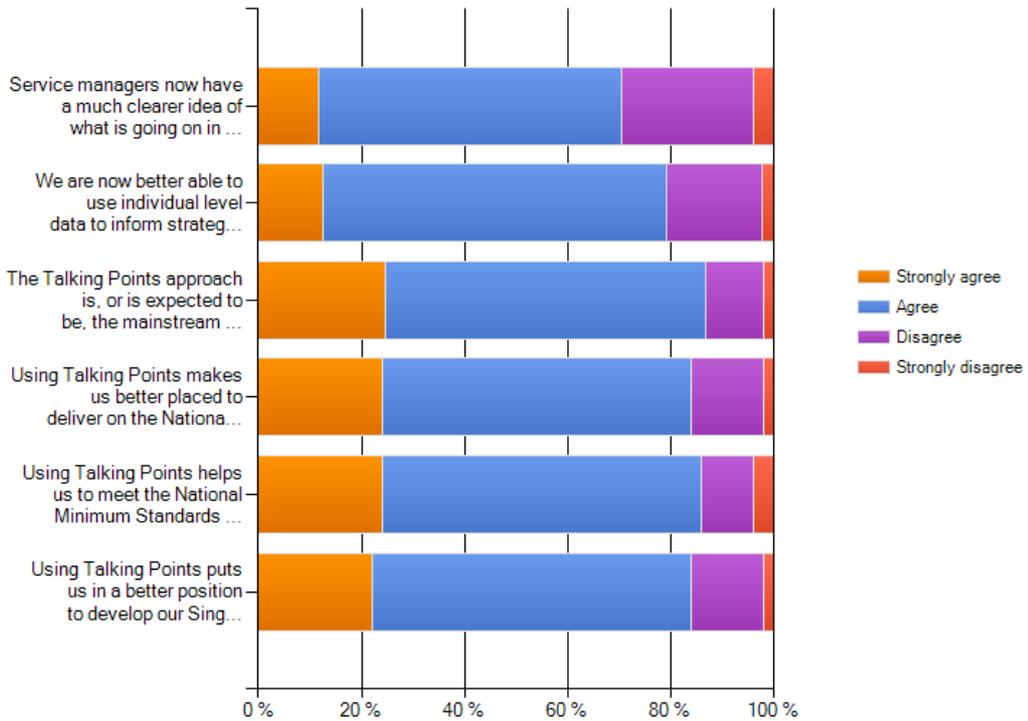


Table Four: Talking Points and data management (n=55)

A sense of the strengths perceived by those who have adopted Talking Points in their work with individuals can be gained from the first of the two word clouds at Appendix One. The two word clouds summarise the responses to questions asking about the positives and weaknesses of the Talking Points: Personal Outcomes Approach; for ease of presentation single responses have been excluded. Table A-One highlights the positives that respondents cited. Overwhelming is the person-centred nature of the approach, with associated features of greater user involvement and identification of service user and carer issues and concerns. The outcomes and the strengths focus were also strongly endorsed. The second word cloud, Table A-Two, summarises the responses in respect of weaknesses. It is significant, however, that the majority of these relate to the detail of local implementation, for example poorly designed forms or the wording of questions, rather than to the nature of the approach itself. These are issues that need to be addressed locally and should not undermine the strength of the approach itself.

ISSUES EMERGING IN IMPLEMENTATION

Notwithstanding the overwhelming endorsement of the Talking Points approach, a number of issues emerged in the course of implementation that were common to many of the partnerships. These should not be considered as in any way detracting from the strengths of the personal outcomes approach but as highlighting the issues that will need to be resolved in the course of implementation.

Doing all that

Several respondents described how initial attempts to present the Talking Points approach had been met with some indifference. In particular practitioners considered themselves to already be using such an approach and were wary of 'emperors' new clothes'.

'Staff, particularly in adult mental health, and to a lesser extent in the occupational therapy service, they actually felt that this was an approach that they were already using and had been doing for quite some time and didn't believe that this was anything new or that it was a new approach, and were pretty negative about the whole thing to a degree'. [Pa20]

Depending on their stage of engagement with the Talking Points journey, many had worked through to the point where practitioners had subsequently recognised that this was not the case.

'They said we have been doing this for years, this isn't anything new to us, and then when it actually came to the crunch it was a major cultural change for them.' [Pa11]

The need for sensitivity in responding to those asserting familiarity was recognised, together with the need for appropriate change management strategies.

'Taking time to really unpick that without making staff feel they've been wasting their time or they've not been operating they way they should have been is a challenge. So it has to be dealt with sensitively, I think you need to respect the professionalism of the staff that we have and the experience and the skills that they have and work with them to find a way that they're clear and we're clear with the approach that we want people to take.' [Pa14]

Time

A common initial response to the Talking Points approach is that it is likely to be time consuming, raising anxieties against a backcloth of work pressures. Again, however, several respondents acknowledged the potential trade off between initial time investment and longer-term effectiveness.

'The downside is that it takes much longer, their view continues to be it takes about twice as long as a sort of service-led review process and that is a bit of frustration, but to some extent it's not really any more because having said that they didn't like that it took longer, they unanimously also felt that it was better quality and that it was a better outcome in relation to the quality of the review and the information that was received, and it felt more like a piece of social work rather than a piece of kind of a tick box exercise.' [Pa8]

The concern with time was not just amongst those in partnerships; indeed for providers the apparent diversion from direct support activity can be more visible.

'There's less and less time to think about how you have these structured conversations with them, and the other thing that we are also conscious of is that because of the changes in budget, contact time is now seen to be a real issue... the time that you have got for writing up and administration and that can even be for team meetings, supervision, preparing self evaluations for the Care Commission...' [Pr6]

Indeed this respondent raised a particular dilemma, reporting that the message from the Care Commission was that staff should not be doing recording type work in an individual's house.

A number of respondents explained how, again as the journey unfolded, their perspective on the use of time changed, recognising the need to see past the initial demands - 'time spent on planning and planning effectively is more productive and more effective in the long term and gets results' [N1]. The approach offers the opportunity to change from the 'tick box functional approach of care management more concerned with efficiency than with effectiveness' [N4].

'How on earth can we possibly give this approach, you know we agree it's the right thing to do, but how could we find the time and I think I've shifted away from that thinking to much more about well you don't have to necessarily go out and spend two or three hours and do it all in one, you know it builds over time. It's not about the time you take. It's about the richness of the conversation that you have' [Pa14]

A couple of respondents spoke of some of the difficult conversations that could result from encouraging people to 'open out the conversation into where people are at emotionally', for example 'I want to be able to walk again' or 'I want my husband back again'. Support was provided initially to readjust to this perspective: 'social workers were having to start being social workers again rather than completers of forms about other people's detriments' [Pa7]. Discussions with carers could be particularly discomfiting, raising debate as to appropriateness:

'giving them permission to say I hate this and yes my life is completely restricted and yes it is not my choice and I feel trapped and all that stuff,

then of course the guilt sets in immediately and you have got this complexity of stuff that is going on and you can only stay for so long and you are leaving somebody to deal with all of this but the person they have got to look after is there and will be there until we get back and talk to them about it again. So we are learning to deal with that.' [Pa7]

'There have been some quite emotional review processes that people were saying there's no way they would have gone out and done a home care review and ended up two hours later with all these sorts of revelations.' [Pa8]

A further disquiet, particularly in the current uncertain situation, is that staff may pay only lip service to the implementation of the approach.

'We want to go through an entire kind of really robust review of what is it that we are providing people, is it making a difference, is it the 'just enough' support rather than the too much or too little. The danger for us is that people go and do that half heartedly and that they don't understand and what you get is a review of the existing support in the existing support plan fitted in under the headings of the outcomes and that's all that happens.' [Pr4]

Culture

The issue of time can be seen as part of the broader need for cultural change if the Talking Points approach is to be truly embraced - 'how do we shift so that our staff feel strong enough to make a referral to a church rather than to a day care centre'. Changing practice habits that have built up over many years does not happen quickly, and has to be supported at all levels throughout the organisation, including senior management: 'it's just trying to get buy-in, to be honest with you' [Pa1]. Respondents outlined a number of training approaches designed to explore with individuals the differences between inputs, outputs and outcomes. There was regular reference to the cake metaphor and to the outcomes card game developed by the Joint Improvement Team. One partnership outlined how they had appointed a champion for the outcomes-focused approach from each team; nonetheless:

'Staff struggle to indicate how to measure success "Mrs Alexander wants to feel safe and to live with other people", that's her outcome. And how we will measure success is that "Mrs Alexander will be feeling safe and living with other people". So this isn't actually adding any value.' [Pa7]

Respondents highlighted a number of strategies that they had employed when people were asserting that they already adopted an outcomes-focused approach. One, for example, explained how an attempt to explain the things that were important to people was met by 'well do you think we don't know that, we've been in this business for 21 years' [Pa17]; in response they were asked to reflect on the outcomes they had achieved for users over the past year. Another organisation which had previously introduced staff to the outcomes game, ran a further session of the game but drew on case file

examples from those purporting to be working with the approach. Their estimate was that only about 15% were outcomes rather than outputs. A respondent from a provider organisation explained that in piloting their outcomes approach they had deliberately targeted a manager they knew was very open to it and another who was resistant – ‘she actually thought this was like going back to the old tick box, the old Care Commission stuff, that we tick a box of what your needs are... and we will fit you in to this category’ [Pr6]. The individual was won over, however, ‘came back with a really delightful conversation... and she’s a real convert to it and she is now an absolute promoter’ [Pr6]. A final example is of a partnership which undertook a self-audit of cases as part of their improvement programme. Practitioners were asked to highlight the outcomes recorded in the case, the frequency of contact, and to rate them as to what had been done about risk. The cases were discussed at supervision, a sample was passed to the fieldwork manager, and a folder opened on the public drive where people could post issues. The possibility of peer auditing was being explored.

Others spoke of elements which had been particularly useful in generating a ‘light bulb’ moment as to the difference between outputs and outcomes: ‘the cake image is having a bit of a light bulb moment for staff’ [Pr1]; ‘I think the light bulb moment in so far as there is one is when the worker goes and attempts an interview using an outcomes-focused approach’ [Pa4]. Several referred to the lengthy implementation process overall, but also to the major variations in the time it took for individuals to understand the approach – ‘there is a light bulb moment from some people when you talk to them within ten minutes and a light bulb moment with other people is maybe a year down the line’ [Pr7].

‘I think we still have work to do on the culture change about flexible solutions, but some practitioners get it and some don’t. So that sort of person-led holistic outcomes view, rather than a service-led view. There is certainly... you can see elements of good practice, but I think there is still more work to be done on that’. [Pa5]

Again the challenge of asking practitioners to cast aside long established norms was acknowledged.

‘We have to focus on front line managers, we have developed them as gate keepers, we need to stop that gate-keeping mentality and encourage that creative and reflective dialogue and that does not happen overnight’. [Pa16]

At the same time the need to invest in managers was highlighted.

‘We have kind of given them responsibility to manage budgets and to keep things tight and then we are saying, by the way we actually want you to be quite delinquent now and be quite creative.’ [Pa16]

There were references to the development of outcomes-focused supervision, both at the individual and group (care home) level.

'Staff were saying that if we are looking to practice in this way it would be really valuable that our supervision encourages a focus on outcomes but also is itself structured in a way that models outcomes focused practice.'

This is an area which the Joint Improvement Team addressed in a publication in October 2010. A number of sample conversations are included.

At a national level, the SCCBN stress that they have always wished to focus on the 'whole systems approach', 'and by that we needed to look at not only systems and processes in relation to performance but also other aspects of culture and practice'. The scale of the cultural change needs to be recognised.

'People need to eat, sleep and drink this. We also found drip, drip, drip, drip does work; once isn't enough, twice isn't enough, briefing sessions aren't enough, it's constant. It's changing habits, it's constant reinforcement and use of language.' [Pa16]

Recording

Several respondents, both partnerships and providers, spoke of the dilemma in deciding how to record the outcomes that were identified and subsequently achieved, both at the initial assessment and at reviews. Some saw it as unproblematic – working with their existing record system to collect the data – 'we're going to be launching the framework in terms of the forms from the start of next year and by April 2013 we anticipate full year reporting on the data collection' [Pa14]. Others however had wrestled with the tensions between qualitative conversational recording and the use of proxy quantitative measures, however summary.

One provider for example detailed how they had initially thought of a numerical rating scale against which individuals could locate themselves. However they decided that this did not reflect the way that many people thought and seemed at odds with the conversational approach.

'This was about the quality of the conversation that you had with people and that if you were kind of in that conversation going okay so people are very intimate and difficult detail of their life, you go on a scale of one to ten, how would you rate that, so it just didn't feel right... it was about using that kind of reflective language to capture what were the priorities for the individual and what they wanted to work on and try to change. And then at review we use a very simple approach now, we have big improvement, small improvement, no improvement, worse. [Pr 10]

Another provider spoke of their thoughts around the need for some form of recording framework.

'The way we have thought about it, they can set as many or as few outcomes, and it can be whatever, as appropriate for the individual. But

they will still need to measure them... even if it's something "was this outcome met – fully, partially or not at all" something as simple as that – I am not going to over-complicate it with like numerical scales or anything. But I will need to get them to measure it.' [Pr8]

These discussions revealed a debate which has been around for some time and is key to the way in which the Talking Points approach is perceived and used by different stakeholders.

'Some of the group discussions I have been involved in the message that seems to come out is that sometimes you should just go away and do it and not worry too much about the recording part of it, you should just do it... I just think if you could record it you can then produce the hard evidence which can demonstrate to your purchasers that you are doing it, and which would also help your staff to see the distance travelled.' [Pr6]

A key consideration here is the extent to which the outcome domains are unique to the individual, are a formulation of the initial Talking Points categories, or reflect a somewhat different set of pre-defined categories. The latter was the case for a provider who spoke of their adoption of the 'ethos of Talking Points',

'thinking about what kind of changes they want to make and what kind of things they want to achieve and then thinking about what some of the steps in that process would be and figuring out who is going to do what', [Pr9]

and their use of the outcomes star. Ten dimensions had been identified and on the arm for each dimension there were ten divisions, allowing individuals to rate themselves from one to ten. The key dimensions for this provider were: motivation and taking responsibility; self care and living skills; managing money; social networks and relationships; drug and alcohol misuse; physical health; emotional and mental health; meaningful use of time; managing tenancy and accommodation; and offending.

Fundamental to much of this discussion is the balance between the reporting and the conversation and the danger that once a form has been produced it imposes its own structure.

In our workshop we are saying "it's not a form to fill in, it's a living document to record what people want and how you support people, what works, what maybe doesn't work because that can be shared, we can glean knowledge and learning.'" [Pr7]

Equally however, there could be the danger, as identified by one respondent, of the conversation becoming an end in itself and the identification of outcomes getting lost – 'what we didn't want was staff going out and having a blether with people we support and sitting with a clipboard and writing it down' [Pr6]. The respondent who reported that this whole area was a 'bit of a struggle' spoke for many; trying to equate what they are trying to achieve for individuals with the impact on the whole system and individual and agency

outcomes. Guidance on recording was published by the Joint Improvement Team at the end of 2011 and further detailed work is being progressed.

Aggregation

Defining a recording system is a natural precursor to consideration of how to aggregate outcomes across individuals. This was a further preoccupation for many, from both partnerships and providers, and was often an area for ongoing debate and experiment: 'I've just amended the forms, based on recommendations from A with a view to collating and gathering evidence both in a quantitative and qualitative way' [Pr3].

Frequently this concern only appeared at a later stage in the outcomes journey, emerging once the understanding and embedding of a personal outcomes approach had been progressed.

'Working out how to use the information that it gives us and developing a system that routinely collects that information and reporting systems for it and understanding what that's useful to us, so how we use it in service planning and how we use it in individual cases.' [Pa8]

Of those who had progressed to this stage, some had devised straightforward classifications and counts. For example one partnership [Pa17] described how they both count the number of outcomes fully met, partially met, not met and also obtain qualitative information on for example the outcomes individuals identify and why certain outcomes are not met. Another (smaller) partnership detailed manual aggregation to a spreadsheet, including outcomes in both qualitative and quantitative form. A range of opportunities for thematic analysis of these dimensions by team or locality is possible and, in this and other organisations, opportunities for benchmarking are generated. A provider outlined their system:

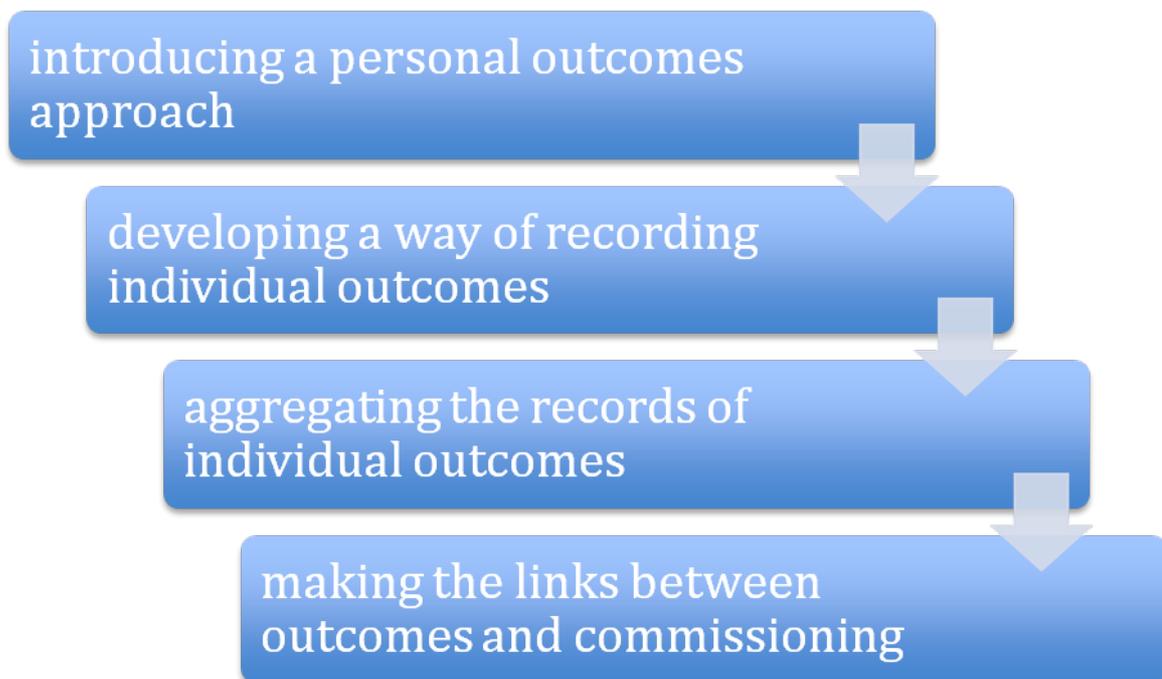
'In terms of the KPI, all the qualitative stuff for the review process, it will shape how the service is delivered for a person. We have sort of backed that up with a very brief overall score, we have asked people to give us very brief overall scores about how well we are meeting outcomes, or each outcome that's appropriate to them, and so that's just like a poor, good, very good, bit along that kind of scale. And it's those kind of very brief scorings that we put on through the KPIs, to start having a very top line thing, and to me all the real work has gone in to the qualitative work and service shape – that approach just seemed to me to be the best kind of balance between the qualitative bit and the number crunching bit'. [Pr2]

Others, however, were finding it challenging.

'I think you can devise a very simple system to aggregate individual data points or records, if that's the right term, but it won't be the same as anybody else's, and if you want to understand the nuances of the outcomes that are important to each individual, that's not straightforward at all.' [N2]

A couple of respondents made reference to a piece of work which is exploring the areas of commonality between Talking Points, the Indicator of Relative Need (IoRN), and resource allocation systems (RAS) [Pa15].

In this discussion of recording and aggregation it is perhaps useful to visualize a continuum



Performance measurement

The desire for aggregation is closely linked for many with an approach to performance measurement (and ultimately management). This may be at the local organisational level or within the national context. One local area reported that they had undertaken a self evaluation file audit on a cross section of 80 cases in each locality. Each case was scrutinised for an outcomes plan and for a sense of 'is the person there in the outcome'. SWIA (as it then was) was impressed and plans are in place to continue on a single agency basis once a year and also with partners once a year. Another partnership had initially adopted a 'traffic lights' system for recording and aggregation; subsequently they were moving to using a 'basket of measures' for performance measurement. Much of the discussion amongst respondents focused not so much on the practicalities of the approach to performance measurement but on the underpinning philosophy.

'What is the point of measuring when you haven't even embedded in the process to do it. You either go to measure and measure until your heart is

content and it means nothing or you take the time and the energy to embed the practice you want to change and then measure it.' [Pa16]

'I think there are different strands of thinking around and about in relation to outcomes and there is a strand that sees outcomes very much in terms of performance measures whether that is within individual practice or within one organisation or whether that's nationally. Not say that is a bad thing, but there is a risk if one is solely thinking around performance there is a potential loss of the other key strand of the approach which is the centrality of the service user and carer in our thinking and in our conversation. The holistic nature of the approach can be lost within that slightly narrower performance thinking.' [Pa3]

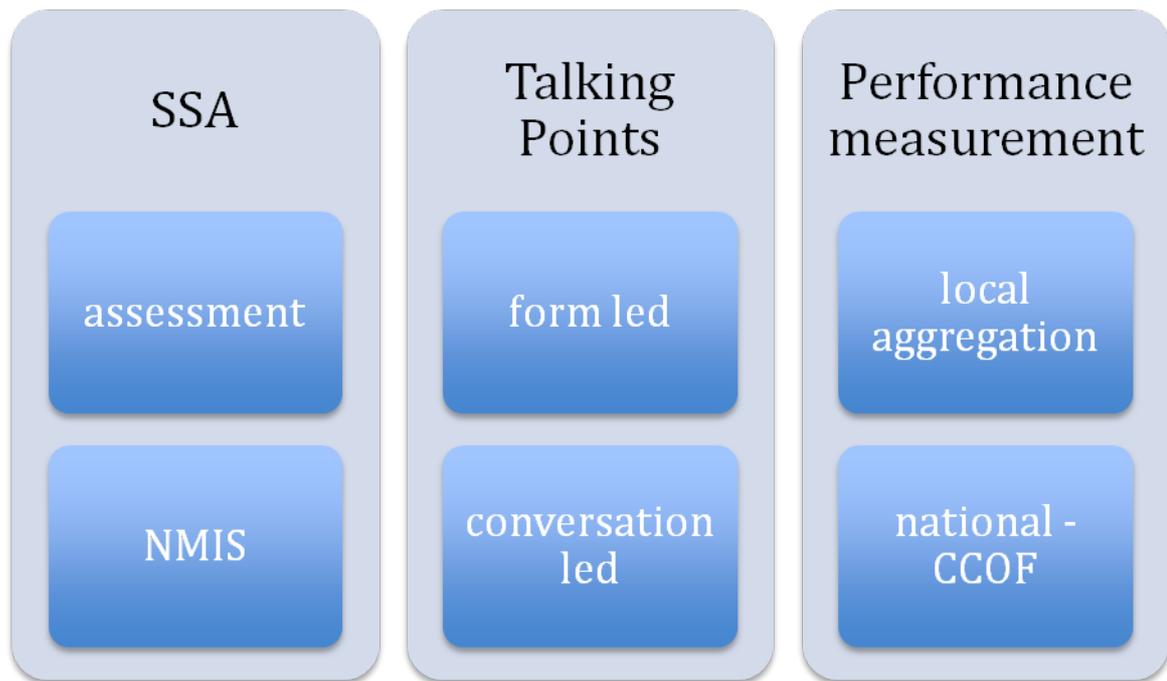
Others made the case that, however complex the reconciliation, a marriage between the achievement of individual outcomes and performance measurement had to be brokered.

'I think we have to make the links because if this were to sit apart from performance management, then it would never be mainstreamed in the way that we want it. So that's not to undermine the purity of the approach in terms of an outcomes focus but it is to say that if we're undertaking a certain way of doing things, then we have to be able to determine whether or not that is successful, both in and of itself, but also as a means of achieving greater goals.' [N4]

Some considered that a personal outcomes approach did not fit well with strategies for benchmarking; one respondent originally from a health background was particularly forceful in her views.

'I don't feel that the personal outcomes approach sits neatly with benchmarking... you can't have targets and outcomes mixed together... I think there's a desperation out there to try and link them together, but based on my experience working with health, mixing performance data and outcomes just simply induces adverse system behaviours.' [Pa17]

These key tensions can be presented diagrammatically:



Respondents were specifically asked how they saw the Talking Points approach relating to national initiatives such as the National Minimum Information Standards (NMIS) and the Community Care Outcomes Framework (CCOF). There were varied opinions on the degree to which the different systems meshed.

‘As far as the Community Care Outcomes Framework, I see Talking Points as being fundamental to the whole system. I think there has been quite a shift with performance managers and senior managers in moving away from just counting things, looking more at qualitative information and getting feedback from service users and understanding it is a total shift of the old way of just counting anything that moved.’ [Pa11]

‘The Talking Points cover these issues without people having to think about Community Care Outcomes I think, and I suppose at the end of the day we are not collecting stats on the achievement of Community Care Outcomes, what we are collecting is whether we are helping people achieve their own outcomes which are in line with the Community Care Outcomes, and it will always be about improving their safety or improving their quality of health or improving their quality of wellbeing, their quality of life as well as their quality of health.’ [Pa7]

Reference was made to the complicated landscape which surrounds Talking Points. The least favoured construct appeared to be the NMIS - ‘I think the NMIS is enormous and a huge burden actually, and I am not sure that I see it fitting very well with Talking Points’ [Pa8].

'I think there is so much duplication between the National Minimum Information Standards stuff and outcomes that one of them needs to get dropped, probably the National Minimum Information stuff. I would get rid of it.' [Pa4]

There were some concerns expressed that some of the information that was requested on a national basis bore little relation to the outcomes focus that was being promoted.

'I am also interested in some of the statistical information that we are being asked for from Scottish Government; it absolutely doesn't have an outcomes focus to it, and where it does have an outcomes focus, it's invariably organisational outcomes rather than outcomes for individuals.' [Pa15]

This reaction could be mediated depending on whether the collection of statistics was in the context of monitoring or whether it was in the form of the setting of targets.

'It's absolutely right the government want to know how they are faring against certain policies and because they set them and they want to know how successful they are in achieving them. I think that's right and it's fine to capture the stats around that, but not to set targets.' [Pa17]

Overall it was evident that there are a number of strands of opinion: some were struggling to reconcile individual and organisational outcomes, local and national frameworks; some wanted to integrate the national frameworks, particularly CCOF, more closely with the Talking Points approach; and yet others considered that the personal outcomes approach should be more dominant.

'People wanted to move even faster towards a personal outcomes approach and some people felt even more strongly that it should be all about personal outcomes and there shouldn't be so much about the kind of efficiency measures and volume measures in the framework.' [N1]

'So we have been very clear in our message that we do not want to have a Community Care Outcomes Framework which is separate, different or isolated from the bigger picture, it has to be a whole systems approach as we see it. So we want to minimise if not avoid duplication and actually be working in partnership.' [N1]

Commissioning

Aggregation of individual outcomes opens up the opportunity for partnerships to use data in the local commissioning process, to adopt an outcomes-focused commissioning model. Outcomes that are proving difficult to meet can be identified and potential gaps in services exposed and potentially met.

Many did not consider themselves to have reached this stage of the journey, although it was starting to appear on the horizon as a future possibility.

‘Early days for that sort of stuff. I mean we’re really trying to get our heads round the outcomes and measuring outcomes first and then, and then hopefully we’ll be in a position to say “well here’s the outcomes that we have been achieving and here’s a population, here’s our needs and here’s our gaps”’ [Pa17]

While the majority of partnerships were only beginning to grapple with outcomes-focused commissioning, a number of providers expressed an element of frustration.

‘I think for providers that probably one of the key issues is in relation to commissioning and the commissioning on outcomes approach when sometimes there’s limited understanding by the commissioning agencies, if you could put it that way, of what they are asking for, and so there’s a frustration I think on the provider network about yes we are trying to be outcome focused, we are really sincere in our attempts to be outcome focused, but actually we then get asked for what is basically outputs.’ [Pr10]

A small number of partnerships had progressed further. One, for example, explained ‘when people are tendering for services, we would be looking for an outcomes-focused approach... We’ve moved away from commissioning providers through hours and talk about individualised budgets’ [Pa9].

Risk

Only a small number of respondents made links between Talking Points and their approach to risk. Those who had considered this area offered detail of strategies that had been considered in some depth. Those who actively considered risk appeared to be doing so in a context of positive risk taking and risk enablement - – ‘what choices and risks are involved, highlighting them and discussing them and weighing them up, and especially if someone has got capacity it’s obviously much easier and then choosing to live with risk’ [Pa16].

‘It was all caught up in that bit about encouraging staff to think differently, be creative and innovative and if they’re going to do that, then they need support to do that. So they need to know that they come to a manager like me and discuss it and I suppose we talk about risk enablement.’ [Pa9]

Partnerships have devised particular mechanisms for integrating the recording of risk with outcomes. One for example explained that ‘the Keeping Safe bit, we have translated into a mini risk management plan’ [Pa7]. For any areas where potential risks are identified, a plan is devised, in part a response to a SWIA inspection observation on their previous policy of not always having a risk assessment, considering it not necessary for all cases. Another

partnership has embedded the link between outcomes and risk within their recording system.

‘What we have done in our screens is introduce a section explicitly on risk and risk management. We ask folk to grade the level of risk the person faces. That gets pulled through to the review screen... has the risk increased, decreased. It brings those two together and certainly from our point of view it makes explicit for the worker what I think is the intrinsic link between outcomes and risk.’ [Pa4]

Given the critical importance of risk enablement in achieving personalised outcomes, it is important that partnerships both acknowledge this link and work on its promotion. Indeed one respondent highlighted a tripartite relationship between outcomes, risk and chronologies: ‘I think those three bits about outcomes, risk and chronologies are so interlinked that you really can’t do one without stumbling across the other and then the other’ [Pa4]

A somewhat different aspect of risk was addressed by one respondent who suggested that it would be useful to undertake a risk analysis in respect of the use of Talking Points: does it miss anything and are there any risks to using the approach in assessment.

Carers

An element of the early work on UDSET (as it then was) at the Joint Improvement Team was the identification of a separate set of outcomes specific to carers (Miller, 2007; Miller et al, 2008), with detailed exploration and implementation in a small number of partnerships.

‘We organised a focus group of carers and there was discussion of what were the things that were important in relation to what they wanted and some of the things that already existed in UDSET they could relate to... but there was quite a number of differences as well from their perspective as carers.’ [Pr10]

Subsequently a number of areas have been working in partnership with the JIT Talking Points leads on developing their work with carers. In addition, outcome-focused carers’ assessments has been one of the areas selected as the remit for a sub-group of the SCCBN.

In interviews with respondents, this work was given less prominence. While several partnerships spoke of considering outcomes for carers, this was often within the more general context of an existing carers’ assessment rather than using a carers’ version of Talking Points. As demonstrated in Table One above, however, over 60% of the web-based survey respondents were familiar with the use of outcome-focused carers’ assessment and review.

The major exception to the generally secondary role revealed during the interviews has been the adoption of Talking Points by a key carer focused organisation; indeed the organisation had been a catalyst in encouraging the

development of a version for carers. Refinement of the approach has been ongoing – ‘recently we had a review of our outcomes and we started with four and then after the first year we increased that to six and now we are about to increase that to eight, not because we think we are just going to indefinitely multiply the number that we have, but just because what we are getting better at is recognizing the issues that carers are bringing to us and the changes that carers want us to help them make’ [Pr10]. One of the additional outcomes the organisation was seeking to add was around economic well-being, triggered by the financial disadvantage that carers often experience, the additional threats from the reform of welfare benefits, and uncertainties for carers with the development of self directed support.

Care homes

A number of respondents discussed the potential for the use of the Talking Points approach in care homes - ‘we have had a lot of debate about how useful the Talking Points is for people that are in care homes and maybe not got capacity. However they have had training on Talking Mats’ [Pa1]. One provider commented that use of the approach should be easier in a care home setting where there is more opportunity for interaction and exploration of preferred outcomes than in the less intensive home visit. Another national respondent reflected on the potential contribution of the Talking Points approach towards the end of life.

‘A lot of the Talking Points agenda had been framed around other client groups, where it was about maintaining levels of independence, helping people to progress the responsibility for their own lives. In that regard, could you, with a population of frailer, older people approaching the end of life, equally have an outcomes focus, and would Talking Points lend itself as much to that context of care, as it had done to other areas of adult care?’ [N5]

Some were aware of the year-long pilot which was conducted with three care homes in the Borders from April 2010 and was the focus of a report produced by the Local Steering Group in June 2011. Although early development was promising, this has been described as a ‘real struggle’ and has appeared difficult to sustain. Another partnership had considered using the Talking Points approach in a proposed care home re-provisioning to understand what would be important to individual residents in moving to a new care home. At the time of interview this had not progressed as the re-provisioning was on hold. Whatever the challenges in the care home context, a key national respondent argued that ‘we really need to crack it’ in order to ensure that the future agenda care homes were much more responsive to outcomes for individuals.

Health

A key area for a number of respondents was the potential for the use of the Talking Points framework in a health-led setting. One, arguing for the involvement of nurses and AHPs, observed that ‘if we think outcomes are

about the person's whole life, we can't only do it in the part of the system that serves them' [N2]. Several, however, debated the challenges of marrying the Talking Points approach with the somewhat different interpretation of outcomes prevalent in health.

'I know that within the health service they have themes again about improving outcomes and measuring outcomes, but they are a kind of slightly different understanding of outcomes... We've begun discussions about, well can we map our outcomes and your outcomes and see where the common ground is, can we work towards using one lot of outcomes.' [Pa8]

They acknowledged also, however, that a future of health and social care integration required such disparities to be overcome.

'If we want an integrated system of health and care and if there's only one part of this, if one part of the system's asking people about how they want to be supported and another part of the system isn't necessarily using the same concepts or indeed the same language. I mean the NHS has got their stuff about person centred care and all of that stuff, but you don't get the sense that it's the same level of radical thought or involvement of the individual.' [N4]

With clarity that health and social care partnerships will form the future configuration of the landscape, the importance of an integrated approach to the use of the Talking Points framework can only accelerate. It is interesting to note the high proportion of the early implementer sites which embraced an integrated approach.

Supporting networks

In working with the Talking Points approach, many of the respondents had made use of a variety of networks and individuals, both as a source of information and for mutual support - 'I was sort of pooling in all of my networks that you build up' [Pr2]. People were particularly appreciative of the inspiration provided through the Lothian Providers Group and through the Talking Points leads from the Joint Improvement Team. The Talking Points Learning and Action Group had also been a valued resource. Reference was also made to the early influence of the Assessment and Review Co-ordinating Group and to the Shared Learning and Practice Network, the latter perhaps with less of a high profile. As prefaced above, respondents were particularly heartened to be reassured as to the length of time it could take to embed a Talking Points approach and the struggle for some to recognise what was an outcome.

The range of resources available through the Joint Improvement website was valued - 'their website is brilliant, it's great for things like using supervision in an outcomes approach to that' [Pr6]. Individuals also identified a number of additional resources that they would like the Team to develop. A high priority was 'a simple system for recording this', a request that recurred on a frequent

basis: 'there was never a great deal of conversation about how you aggregate this and how you perhaps develop it further in terms of performance framework' [Pa6]; 'for me it's about the data capture and how we gather that in a meaningful way and in an easy way' [Pr5].

'How do we aggregate that information, because otherwise I think people will just feel they are on that treadmill again, like they were with the SSA... I'm really keen that this isn't just a paper exercise, that we can actually say "x amount of people went through the personal plan process, x amount of people through their outcome statement measured this amount of change benefit, this was the risk impacts etc". But also we can say "out of that percentage of people, this amount stayed at home."' [Pa12]

Other resources that organisations would welcome included a briefing note for individuals going through the process (one resource rather than 32 different ones); a focused day bringing leads together; and a catalogue of the resources on the website;

Moving forward

Compared to many initiatives that flourish and fade away fairly rapidly, Talking Points has exhibited a remarkable longevity, although an element of caution remained.

'I think the tipping point of talking about outcomes has been reached, but whether personal outcomes, which is what it really should mean, has sunk in with everybody who needs to get it, I am not sure.' [N2]

A key question must be the future trajectory for its development. A number of respondents highlighted the increasing profile of the Talking Points approach across the national agenda. The Carers' Strategy has as one of its action points that 'On an ongoing basis, in order to fully engage carers and deliver improved outcomes for carers, the Scottish Government will continue to promote and monitor the use of carer outcome evaluations through Talking Points'. The three Dementia Demonstrator sites have agreed to develop a common approach in using the Talking Points model for ongoing assessment for individuals during the progress of their dementia (*Scotland's National Dementia Strategy – One Year One*).

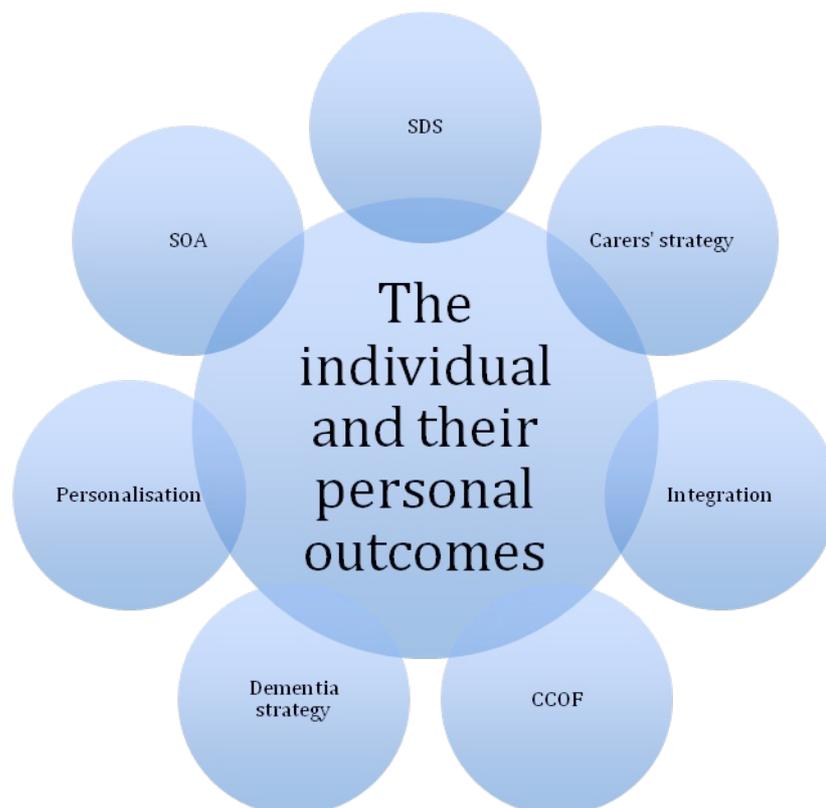
'It just seemed that this might be a tool that was actually far more people centred and would allow us to perhaps measure outcomes outside some of the other constraints that are often on the table once you start talking about it within the dementia field.' [N7]

Likewise the progression of self directed support is obviously closely bound with an outcomes approach. *Self-directed Support: A National Strategy for Scotland* makes specific reference to Talking Points as framework for developing a person-centred and outcomes-focused approach with individuals – 'we think the Talking Points approach is really central to the outcomes focused review that self-directed support has got to build on' [N6].

A number of respondents felt that the time had come for the common concern with the Talking Points approach to be reflected more clearly across policy agendas - 'the various workforce strands, whether it's for carers or ensuring care of older people or falls prevention, disabled children there's quite a lot of different workforce strands and they need to gel together' [N3]. A concern was expressed that Talking Points could be overly identified with one area of work - 'I would say there is a sense of it belonging to an area and not necessarily woven through the system... there is a group of people who are very much engaged in Talking Points and not necessarily them working together yet' [N6]. Indeed several argued that personal outcomes should be the binding core, that the ethos of outcomes-focused work should permeate everything - 'so everything sort of has a thread that follows through' [Pa12].

'One of the things it would be good to see into the future is a more comprehensive use of Talking Points, because clearly every partnership has a Single Outcome Agreement now, Community Care Outcomes Framework is increasingly used and we've got benchmarking facilities attached to that as well, so all of that has an energy behind it so I think we should ensure that Talking Points has a similar level of visibility and penetration across all of the partnerships.' [N4]

This suggestion is represented diagrammatically below.



As a further respondent argued,

‘You are speaking to people who are being given 10 or 12 strategies to implement along with legislation coming along and I think what we need to do is to begin to talk about the people in the outcomes rather than the 10 strategies and help people to realise that this is the hub of all these strategies, this is the focus for them all so it meets them all rather than people having ten different folk in councils all running off separately doing their implementation plans and never shall we meet.’ [N6]

The use of the Talking Points approach in health has already been addressed above, with the need to get the principles of choice and control into the NHS side. A further perspective is the role in the context of the emerging integrated health and social care agenda. More generally, ‘it is about holding fast and continuing with the creativity and innovation and thinking differently’ [Pa9].

‘This thing about the time has come, I think is true, and perhaps the combination of personal outcomes in our world and outcomes per se in the public sector and service sector, is cumulative.’ [N2]

This same respondent identified three key ingredients for successful adoption: a Director who understands the approach; leadership from senior management; and recognition of the need for time to be allocated.

CONCLUSIONS

This review of the Talking Points: Personal Outcomes Approach demonstrates the strong support which it garners amongst those who work with it. There is a common response that it targets the critical area of personal outcomes in a way that is both welcomed by the person accessing support and chimes with the core values of the professional. Although activity in a small number of specific partnerships is often highlighted in discussion of the adoption of Talking Points, there has been a steady growth both in the extent to which partnerships are incorporating the approach and in the profile it is being accorded within national policy developments. Indeed the longevity of the approach is of major significance given the tendency for initiatives to have a fairly short life before the next enthusiasm. As detailed above, this can be explained both by the strength of the initial evidence roots and the subsequent attention to the mechanisms for transfer to practice. This integration has no doubt been assisted by the relevance of the Talking Points approach at a period when a focus on outcomes has been increasingly dominant. At the same time, this synergy makes it even more important that the identity of Talking Points and its clear focus on personal outcomes is fully understood. Maintaining the integrity of outcomes was seen as critical by a number of respondents – ‘a wee bit worry that outcomes is becoming an overused word’ [Pa9].

'I suppose from my point of view, some concern that the outcomes was just becoming a bit of a mantra, but without people necessarily actually saying "well what does that mean? What are we talking about? What do we do differently if we are going to use an outcomes approach?"' [N5]

As the introduction and implementation of Talking Points has spread from the early implementers to both other partnerships in Scotland and to a range of provider agencies, a number of the issues highlighted in the 2008 evaluation remain pertinent. Current progress would suggest that there has been much activity on these more specific issues at a national level and with particular partnerships but that time is needed to embed this learning across the system. The 2008 report clearly identified a number of areas of concern: 'some confusion over the contribution of UDSET [as it then was] to the Community Care Outcomes Framework (CCOF) and to a lesser extent the National Minimum Information Standards (NMIS)' and the need to 'produce guidance material that situated UDSET data in relation to existing performance frameworks'; 'a significant challenge over how this data will be aggregated'; 'clarity over when and how this approach could be integrated to the whole assessment and care management process'; and similar clarity as to the potential use of the UDSET data in the commissioning process. The areas being highlighted in this current review sound very familiar to readers of the earlier review; indeed the focus of some of the recommendations outlined below has a similarity to those of the earlier review that illustrates the time required to achieve major cultural change. It is to be hoped that the major achievements in the spread of Talking Points achieved over the last three years will be succeeded in the near future by widespread resolution of the range of issues highlighted above.

It is essential that the use of the Talking Points approach moves forward to a phase where the focus is on embedding the approach in the new landscape of health and social care partnerships. Work is already in train on the extent to which Talking Points should mesh with agendas of single shared assessment, CCOF and NMIS and these need to be accelerated to a conclusion. More positively, work is also progressing on the recording and aggregation of data and this should be communicated widely. Likewise the introduction of the Talking Points approach within a number of national initiatives is a very positive move. It is essential that there is a period of concerted effort to both enhance the profile of the Talking Points approach across all partnerships, to introduce and integrate it with the agendas of health, and to resolve the number of enduring issues highlighted above. A number of respondents voiced a concern that the momentum of the approach could be dissipated, or potentially consumed in the ongoing tensions around national frameworks and performance measurement.

'The concern I have is that I thought it was tremendous that we bought in to Talking Points and really began to look at more meaningful community care outcome measures, but it seems to be going backwards again.'

[Pa16]

The recommendations detailed below are designed to ensure that the momentum is maintained and that outstanding issues are resolved. The current policy and practice environment is receptive, not least the implementation of self directed support and the delivery of integrated working, and the opportunity should be seized to ensure that Talking Points, with its history of being tried and tested over an extended period, is confirmed as the framework for the implementation of the personal outcomes approach.

‘One of the things I would love to see is that consistency in a framework across Scotland... my hope would always be that because it was the Joint Improvement Team then we would end up with something across Scotland that people would have a consensus it was a good framework on outcomes.’ [Pr4]

RECOMMENDATIONS

NB These have been developed following initial discussion with the Talking Points Action Group and a workshop in February 2012; they are grouped according to the four pillars for the reform of public services put forward by the Report of the Christie Commission.

A Public services are built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience

1. A plan to spread the focus on personal outcomes in designing and delivering public services, including the use of the Talking Points: Personal Outcomes Approach, should be developed and agreed with all necessary stakeholders.

This will include:

- Review of the Governance arrangements for promoting a personal outcomes approach at national level (1a)
- Development of a programme for national and local policy makers and key stakeholders to build capacity to work and think around the personal outcomes agenda (1b)
- Exploring routes to enhance and reinforce the skills essential to working in a personal outcomes focused way, and to develop the organisational culture to recognise and value and facilitate these skills (1c)
- A Talking Points communication strategy should be devised and implemented (1d)
- Specifically, the use of the Talking Points: Personal Outcomes Approach across all of a person's health and care journey, including acute hospitals, care homes and community hospitals, should be further promoted and developed (1e)

B Public service organisations work together effectively to achieve outcomes – specifically, by delivering integrated services which help to secure improvements in the quality of life, and the social and economic wellbeing, of the people and communities of Scotland

2. A personal outcomes approach should be embedded across partnership working between health, housing and social care, in public, independent and third sectors; Talking Points provides the framework or methodology for the delivery of this approach

Specific actions will include:

- The articulation of the Personal Outcomes Approach, Self Directed Support, and the Person-centred ambition of the Quality Strategy should be clarified and published (2a). As part of this,

1) The wider use of the Talking Points Personal Outcomes approach in NHS settings and teams should be promoted and developed (2b).

2) The use of improvement methodologies in implementing a personal outcomes approach should be considered, developed as appropriate and implemented according to a plan for “spread (2c)”

- With the move to Health and Social Care Partnerships, the place of the Talking Points Personal Outcomes Framework in the integration agenda should be clearly articulated in relevant guidance produced in the context of forthcoming legislation to integrate health and social care in Scotland (2d)
- Achievement of personal outcomes must be part of the national suite of outcomes for integration of health and social care (2e)
- Outcomes focused commissioning strategies developed locally building on use of the ‘Change Fund’ will be a vehicle for making change happen – we will continue to gather and share intelligence to inform proposals for Talking Points Personal Outcomes Approach to influence Joint Commissioning Strategies (2f)
- The links between the Talking Points Personal Outcomes Framework and eligibility criteria, Resource Allocation System and Self Evaluation Questionnaire should be freshly articulated in the context of a person’s “journey” (2g)
- The role of the Single Shared Assessment and the National Minimum Information Standards (Assessment, Care & Support Plans and Review) (2008) and fit with the Talking Points Personal Outcomes Framework should be reviewed; [assessment should be reframed in terms of co-production] (2h)
- 2i) The role and relationship of the Talking Points Personal Outcomes Approach should be clearly articulated in respect of all relevant policy frameworks for children, including Getting It Right For Every Child, SHANARI (the wellbeing indicators all children need to be Safe, Healthy, Active, Nurtured, Achieving, Respected and Responsible and Included)
- 2j) The role of the Talking Points Personal Outcomes Approach should be clearly articulated in all relevant policy frameworks for adults, including the Self Directed Support Act and associated Guidance, the Carers Strategy, Dementia Strategy, Mental Health Strategy, Sensory Impairment Strategy, and others that may arise.
- 2k) Regulation and inspection and improvement agencies should be familiar with the use of the Talking Points Personal Outcomes Approach and should look for its use in their inspections

C Public service organisations **prioritise prevention, reduce inequalities and promote equality**

- 3a) The role of the Talking Points Personal Outcomes Approach in promoting co-production and preventing the need for services or formal support should be considered and developed, building on the work of

e.g. Perth & Kinross Healthy Communities Collaborative, West Edinburgh Timebank, etc.

- 3b) Any formal evaluation of the Talking Points Personal Outcomes Approach should specifically consider its impact on reducing inequalities and promoting equality
- D All public services constantly seek **to improve performance** and **reduce costs**, and are open, transparent and accountable
- 4a) Building on the experience of the Community Care Outcomes Framework (2006 - present) the Talking Points Personal Outcomes Framework should inform the development and implementation of improvement measures at a national and local level
 - 4b) Guidance on strategies for recording and aggregating personal outcomes under the Talking Points framework should be widely circulated, and further developed on the basis of local experience
 - 4c) Carry out an evaluation of the Talking Points Personal Outcomes Approach that investigates its impact on the lives of people and carers, and provides information on the cost of working in this way; perhaps using a Social Return on Investment model. *

* subsequent addition from JIT

References

- Cook A and Miller E (2012) *Talking Points: Personal Outcomes Approach – A Practical Guide for Organisations*, Edinburgh: Scottish Government Joint Improvement Team
- Department of Health (2009) *Contracting for personalised outcomes: lessons from emerging practice*, Putting People First
- Dill K and Shera W (eds) (2012) *Implementing Evidence-informed Practice: International Perspectives*, Toronto: Canadian Scholars' Press
- Glendinning C, Clark S, Hare P et al (2006) *Outcomes-focused services for older people*, Bristol: Policy Press
- Hitchin S (2010) Midlothian Community Care Partnership – Talking Points: A Personal Outcomes Approach – An Evaluation of the Midlothian pilots
- Miller E (2007) *Identifying the Outcomes Important to Unpaid Carers*, Edinburgh: Scottish Government Joint Improvement Unit
- Miller E (2010) Can the shift from needs-led to outcomes-focused assessment in health and social care deliver on policy priorities? *Research, Policy and Planning*, 28 (2), 115-127
- Miller E (2011) *Individual Outcomes: Getting back to what matters*, Edinburgh: Dunedin
- Miller E, Whoriskey M and Cook A (2008) Outcomes for users and carers in the context of health and social care partnership working: from research to practice, *Journal of Integrated Care*, 16 (2), 19-26
- Nutley SM, Walter I and Davies HTO (2007) *Using Evidence: how research can inform public services*, Bristol: Policy Press
- Qureshi H (ed) (2001) *Outcomes in Social Care Practice*, York: SPRU
- Stewart A (2008) An Evaluation of the User Defined Service Evaluation Tool (UDSET) in the Pilot Sites, November 2008

TALKING POINTS: CORE DOCUMENTS

2007

Do Health and Social Care Partnerships Deliver Good Outcomes to Service Users and Carers? Development of the User Defined Service Evaluation Toolkit (UDSET) [AC, EM+MW]

2008

Talking Points: Personal Outcomes Approach (formerly UDSET): Sharing the Learning Workshop Report, 25 and 26 November 2008

2009

Talking Points Change Implementation Framework, August 2009

Talking points: Personal Outcomes Approach Support Pack for Staff [EM+AC]

Key Messages – Talking Points: Personal Outcomes Approach, September 2009

Philosophy and Principles Underpinning a Personal Outcomes Approach, November 2009 [EM, AC, WS]

2010

Talking Points: Update from Learning and Action Group Members, January 2010

Stirling Newsletter, July 2010

Talking Points Learning and Action/ Paper 2, September 2010

Staff Support and Supervision for Outcomes Based Working [JJ+EM]

2011

Key Messages – Talking Points: Personal Outcomes Approach, February 2011 [EM+AC]

Good Conversations: Assessment and planning as the building blocks of an outcomes approach, April 2011 [EM]

Reshaping Care of Older People Change Plans – Focus on Personal Outcomes, May 2011 [AC, CB, JF, SMcK, EM, MW]

Scottish Borders – Care Home Pilot April 2010 to April 2011, June 2011

Recording Outcomes in Care and Support Planning and Review, November 2011

2012

Talking Points: Personal Outcomes Approach – A Practical Guide for Organisations [AC+EM]

APPENDIX ONE: Talking Points Monitoring Tool (TP-MT)



Table A-One: 'Please give your views on the strengths of the Talking Points approach' (n=46)



Table A-Two: 'Please give your views on the weaknesses of Talking Points' (n=42)

APPENDIX TWO: TEMPLATE FOR TALKING POINTS MONITORING TOOL [TP-MT]

YOUR USE OF TALKING POINTS

IRISS (Institute for Research and Innovation in Social Services) is undertaking a Review of Talking Points for the Joint Improvement Team. As part of this Review, a number of practitioners identified by their organisations are being asked to complete the following brief survey. It should take no more than 10 minutes of your time. If you have any difficulty in accessing the survey please contact enquiries@iriss.org.uk.

1. What is the name of the organisation you work for?

2. Which of the following approaches have you used in your work?

	Yes	No	Unsure
Service user outcome- focused review form			
Carer outcome-focused review form			
Outcomes-focused single shared or community care assessment			
Outcomes-focused carer assessment			
Digital Stories			

3. Please enter your responses in respect of the following statements about user/carer engagement and experiences since the adoption of a Talking Points approach

	Strongly agree	Agree	Disagree	Strongly disagree
Service users/carers feel more able to reflect on their needs and how they can be met than previously				
There has been an increase in user/carer involvement in decisions about their own care and support				
The views of service users/carers could now have more influence on service planning and commissioning				
Staff are now much clearer about what constitutes a good outcome for service users/carers				
User/carer defined outcomes are more likely to be identified than in the past				
Services and support are more person-centred than in the past				

4. Please indicate your responses in respect of professional practice since the adoption of the Talking Points approach

	Strongly agree	Agree	Disagree	Strongly disagree
Professionals are now much clearer about what constitutes a good outcome for users/carers				
Practitioners feel better able to gain a holistic picture of an individual's situation				
There is now a greater opportunity to engage in a meaningful dialogue with users/carers				
There is now a greater level of consistency in the review and/or assessment process				
The time invested in adopting the Talking Points approach has been well invested in terms of the benefits				
Staff have been well trained and prepared to use the Talking Points framework				

5. Please indicate your responses relating to data collection and organizational arrangements since the use of the Talking Points approach

	Strongly agree	Agree	Disagree	Strongly disagree
Service managers now have a much clearer idea of what is going on in local services				
We are now better able to use individual level data to inform strategic planning				
The Talking Points approach is, or is expected to be, the mainstream model in the locality				
Using Talking Points makes us better placed to deliver on the Community Care Outcomes Framework				
Using Talking Points helps us to meet the National Minimum Standards for Assessment and Review				
Using Talking Points puts us in a better position to develop our Single Outcome Agreement				

6. Please give your views on the strengths of the Talking Points approach – the three best things about using Talking Points

- 1.
- 2.
- 3.

7. Please give your views on the weaknesses of Talking Points – the three aspects you find least helpful

- 1.
- 2.
- 3.

Thank you very much for completing this survey. The Report of Talking Points should be available on the Joint Improvement Team website early in 2012.