



Midlothian Community Care Partnership

Talking Points: A Personal Outcomes Approach An Evaluation of the Midlothian pilots

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Executive Summary

This report describes a study of the way in which Community Care practitioners and their managers have engaged with *Talking Points: A Personal Outcomes Approach* (Petch et al, 2007) through a pilot project within Midlothian Community Care Partnership. Semi-structured interviews with staff and a focus group with service users were used to explore people's perceptions of the approach and understanding of its underpinning principles as well as the ways in which it had been used in practice.

Findings suggest that staff engage with the approach in different ways according to their understanding of its purpose, the context in which they are working and the circumstances of the service users themselves. Further to this, individuals' understanding of the principles of Talking Points is likely to affect its capacity to promote outcomes focussed practice and improve outcomes for service users. The study also found that its additional purpose in relation to performance measurement has potential yet is problematic in relation to translating qualitative data into quantitative measures.

The evaluation's findings suggest a number of key messages:

- It is crucial that practitioners and their managers have an in depth understanding of the philosophy and principles of Talking Points in order to use the approach effectively and achieve outcomes focussed practice.
- The more time consuming nature of outcomes focussed assessment must be recognised and accommodated within teams and practitioner workloads in order to support outcomes focussed practice.
- Training or staff development opportunities should incorporate opportunities for sharing current good practice and peer support.
- Organisational change is required in order to develop more flexible ways of planning and commissioning services.
- Recording formats will have to be developed in such a way as to accommodate two key features: Firstly, flexible exploration of service

user outcomes and secondly, the recording of data which can be used for performance measurement, planning and reporting purposes.

- Further work is necessary to build on progress already made in developing outcomes focussed performance measurement. This should incorporate both qualitative and quantitative measures.

Contents

	Page
Executive Summary	3
Introduction	7
Notes on Terminology	7
Chapter 1: The Context	8
1.1 The Policy and Practice Context	8
1.2 Research into Outcomes	10
1.3 Talking Points: Personal Outcomes Approach (formerly UDSET)	12
<i>Table 1: Service User Defined Outcomes</i>	13
1.4 Theorising Outcomes	13
1.5 Conclusion	14
Chapter 2: Research Design and Methods	15
2.1 Research Questions	15
2.2 Methodology	15
2.3 Methods	16
2.3.1. Preparation	16
2.3.2. Data Collection	16
2.3.3 Participants	16
<i>Table 2: Staff Participants</i>	17
<i>Figure 1: Age range of Staff Participants</i>	18
<i>Figure2: Number of Times Talking Points Approach Used.</i>	18
<i>Table 3: Focus Group Participants</i>	19
2.3.4 Analysis	19
2.4 Reflections on the Methods and Methodology	19
Chapter 3: Findings and Discussion	21
3.1 Receptiveness to Talking Points/UDSET	21

3.2	Taking More Time	23
3.3	Understanding of Talking Points/UDSET	24
3.4	Working with the Service User Defined Outcomes	26
3.4.1	Outcome Domain 1: Quality of Life	26
3.4.2	Outcome Domain 2: Process	30
3.4.3	Outcome Domain 3: Change	31
3.5	Training and Preparation	35
3.6	Adapting Forms	37
3.7	Using Talking Points With People Who Have Dementia	39
3.8	Potential Impact On Service Users	41
3.9	Performance Management	45
 Chapter 4: Conclusions and Recommendations		 52
Appendix 1: Outcomes Focussed Review Form		54
Appendix 2: User Defined Service Evaluation		
	Questionnaire-Telecare	60
Appendix 3: Pilot Site Information		61
Bibliography		63

Introduction

In September 2007, the Midlothian Community Care Partnership became one of the seven early implementers in Scotland developing the implementation of the National Outcomes Framework for Community Care. The partnership identified the need for a shared outcomes focussed approach and saw involvement in the User Defined Service Evaluation Tool (UDSET) project as an excellent opportunity to take things forward. Starting in April 2008, the approach was piloted at nine sites across the partnership. This evaluation includes seven of the pilot sites as two came on stream at a later stage. Details of the included pilot sites can be found in Appendix 3.

This report is structured as follows: Chapter 1 provides a summary of the context in which the UDSET approach (later Talking Points) was developed. Chapter 2 describes the methods used to undertake the evaluation. Chapter 3 offers an analysis of the findings and attempts to explore whether the core aims and objectives of Talking Points were achieved through its application in the pilot. In Chapter four conclusions and recommendations for effective implementation within the partnership are made.

Note on Terminology

In 2009 The User Defined Service Evaluation Tool (UDSET), along with the Carer Defined Service Evaluation Tool (CDSET) was rebranded as '*Talking Points: Personal Outcomes Approach*'. As the pilot took place while it was still called UDSET, many of the evaluation participants knew it by this name. As a result both terms will be used throughout this document and are understood to refer to the same approach.

Chapter 1: The Context

1.1 The Policy and Practice Context

The NHS and Community Care Act (1990) (NHSCCA) and subsequent Care Management policy have had a transformational impact upon the way in which social work services are delivered (Sharkey, 2000). As well as heralding a revolutionary shift from residential to community based support, the policy aimed to make more efficient use of public funds (Huxley, 1993, McDonald, 2006, Lewis and Glennerster, 1996). Parallel developments in Health policy and practice have also emphasised a shift toward community based provision, multi agency working and patient involvement (Scottish Government 2007 & 2009b, NHS Scotland 2009b).

The subsequent impact of policy on the way in which practitioners, working in Social Work, undertake the Care Management role has been widely documented. There has been recognition that Care Management tends to focus on the procedural stages rather than on relationship building or therapeutic intervention (Jones, 2001; Postle, 2002; Webb, 2006). This was echoed by the 21st Century Social Work Review in Scotland, which found;

“Services and professionals overwhelmed by bureaucracy and systems, often gathering information for local and national use which is of little value”

(Scottish Executive, 2006)

Although many practitioners have tried to resist this trend, it has also been argued that managerialist responses have led to a shift away from professionally defined responses to problem solving towards procedural approaches and the deskilling and de-professionalisation of social workers. (Lymberry, 1998; McDonald, 2006)

In his book: *Social Work in A Risk Society* (2006), Webb uses the term, ‘technologies of care’ to refer to technical methods such as care

management, risk assessment and evidence based practice. His contention is that within social work practice authentic and efficient knowledge creation are deeply embedded in an inter-personal context but that the application of such technologies assumes that knowledge can be made mobile and lifted out of these contexts. This process may consequently inhibit collaboration and trust (p142).

The NHSCCA also launched a new emphasis on quality assurance. Local authority and independent sector social work as well as private social care providers are all now subject to closer regulation. Through Single Outcome Agreements with the Scottish Government, many Community Care Partnerships opted to report on performance through the National Community Care Outcomes Framework (2007). This is seen as a central driver to improve outcomes for service users (Stewart, 2008). The framework identifies four high level outcomes, which also relate to wider agendas of Public Service Reform, Delivering for Health (2005), Changing Lives (2006) and Supporting People (2003). These are:

- improved health,
- improved wellbeing,
- improved social inclusion and
- improved independence and responsibility.

Beneath these are sixteen performance measures; six of which relate directly to the experience of service users or their carers. Similarly the National Minimum Information Standards (NMIS), which sets out the minimum information which professional groups within social care, health and housing would expect to discuss and record, also views service user feedback as integral to the processes of assessment, care planning and review (Stewart, 2008).

The advent of the NHSCCA and subsequent policy developments heralded a new emphasis on the empowerment of users and carers of social care

services. The political context of the 1990s relocated service users as consumers within a market place. Good practice now dictates that individuals should be closely involved in the process of designing their own support packages and, where possible, should have a choice of services (Scottish Executive, 2006). The Community Care (Direct Payments) Act (1996) and Self Directed Support policy (Scottish Government 2010) now enable individuals to assume much more control than in the past. Representatives of service user and carers' groups are routinely consulted about the way in which health and social care provision is delivered and there is recognition of the need to involve service users and carers in the training of professionals who will be working in the fields of social work, health and social care. (Brown and Young, 2008, Branfield, F, 2007)

It is apparent, however, that the extent of meaningful service user and carer involvement is variable. The Changing Lives Report (Scottish Executive, 2006) found that people who used services had little say over how they were delivered and often had to accept what was available rather than what was needed.

A further significant policy development, which adds to the picture, is the Scottish Government's strategic requirement to work in partnership across organisational and professional boundaries, primarily Health and Social Work, to deliver better outcomes for service users and carers (Scottish Government, 2007b, 2009a & b, NHS Scotland, 2009). Midlothian Community Care Partnership is an example of such developments alongside the Single Shared Assessment process (Scottish Executive, 2001). This is intended to promote a more holistic approach to assessment with the lead role being taken by whichever professional is best placed to do so in consultation with others involved.

1.2 Research into Outcomes

It is within this context that a new movement to consider actual outcomes for service users began to emerge. There appears to have been a growing realisation that the way services were being delivered did not give service users the choices and meaningful participation in the provision of their care that the rhetoric suggested. In 1995 the Social Policy Research Unit at York University (SPRU) commenced a Department of Health funded research programme to investigate the outcomes desired by users of social care services (Glendinning et al, 2006) A significant body of research into outcomes for service users and carers has developed (Qureshi et al, 1998; Nicholas, 2003; Petch et al, 2005; Petch et al, 2007; Harris et al, 2005; Glendinning et al, 2006; Glendinning et al, 2008). The concept of outcomes is not universally understood but research has helped to clarify meaning;

“....outcomes are defined as the impact, effect or consequence of a service or policy. Outcomes-focused services are, therefore, those that meet the goals, aspirations or priorities of individual service users. They can be contrasted with services whose goals, content or mode of delivery are standardised, regardless of the circumstances of those who use them; or are determined primarily by commissioners or providers rather than users.” (Glendinning et al, 2008, p6)

Glendinning et al (2008) found that outcomes-focussed assessments can be helpful in enabling individual older people to identify what they would like to achieve through services rather than assessments focussing on deficits or eligibility for particular services. In practice a focus on outcomes might involve a frail older man and life long football fan who is experiencing the early stages of dementia and being cared for at home by his wife. Desirable outcomes might be for social contact, something to do and for his wife to have regular time to herself. Instead of providing day care at a residential home for older people, an outcomes focussed response might involve supplying funding to

buy a football season ticket so that a neighbour can take him every week. The outcome being that he is doing something he enjoys and his wife gets a break from her caring role.

1.3 Talking Points: Personal Outcomes Approach (formerly UDSET)

The User Defined Service Evaluation Toolkit (UDSET) was developed by Petch et al (2007) through a two year Department of Health funded project at Glasgow University. In collaboration with user research organisations, the project aimed to identify the outcomes that were most important to users of services delivered in partnership between health and social care (Petch et al, 2007). Building on extensive work undertaken at SPRU, they identified service user defined outcomes under three key headings: 'Quality of life' (how this is supported), 'Process' (how services are delivered by staff) and 'Change' (making things better).

In 2006 two of the researchers; Emma Miller and Ailsa Cook were commissioned by the Joint Improvement Team (J.I.T.) to investigate how research findings and tools from the project could be put into practice in Scotland. Through scoping work with Community Care partnerships in Orkney, Fife and East Lothian, the outcomes were refined and the UDSET was found to have potential as a generic information gathering framework as the basis for a number of different consultation, review and evaluation tools. The key aim was to shift engagement with people who use services away from service-led approaches in order to achieve the best possible impact on their lives (Stewart, 2008). The Service User Defined Outcomes can be found in Table 1 on page 13.

The next phase, led by J.I.T. was for the UDSET to be piloted across Scotland; one of the sites being Midlothian Community Care Partnership (CCP).

Quality of life	Process	Change
Feeling safe	Listened to	Improved confidence
Having things to do	Having a say	Improved skills
Seeing people	Respect	
As well as can be	Responded to	Improved mobility
Life as want (including where you live)	Reliability	Reduced symptoms

Table 1: Service User Defined Outcomes (Petch et al, 2007) ¹.

A further framework, the Carer Defined Service Evaluation Toolkit (CDSET), was developed through a separate research project. (Cook et al, 2007)

The Talking Points approach is intended to be used by practitioners within the core tasks of assessment, intervention planning and review to maintain a focus on outcomes that are important to the individual in order to provide more relevant interventions and improve outcomes for service users and carers. A further function of the approach is the production of data about user and carer outcomes which can contribute to service planning, improvements and performance management (Miller and Cook, 2007).

1.4 Theorising Outcomes

We know that service users value the caring relationship of social work. Interpersonal dispositions of warmth, acceptance, honesty and trust are frequently cited as being paramount (Webb, 2006, Scottish Executive, 2006).

¹. Various refinements have been made to the outcomes grid. One version also includes, "Dealing with Stigma/Discrimination" in the Quality of Life domain. Staff may have been aware of these due to different recording formats being used. The above grid was used in the evaluation project.

Inherent within Talking Points is a focus on a conversational approach, taking time to explore in depth, the aspirations and experiences of service users in a holistic way. This could be seen as running counter to prevailing procedural and deficit approaches and clearly fits with the Exchange Model of assessment (Smale et al, 1993). In contrast with the Questioning and Procedural Models, which view the practitioner as the expert in identifying and addressing need, the Exchange model values the individual's perspective on their circumstances and recognises their expertise in relation to the problem they face. The Talking Points approach, therefore, encompasses a person centred, strengths oriented approach, which is intended to support a move away from service led, procedural approaches (J.I.T. 2009b).

1.4 Conclusion

It is apparent that the impact of the NHSCCA and subsequent policy and societal as well as practice developments within the Community Care field have resulted in a landscape in which social work, across the UK, has become more routinised and procedural with a reduction in practitioners' confidence to make professional judgements and decisions. Scope for therapeutic relationships and in depth work with service users has been reduced as care managers undertake a role which some authors have seen as primarily administrative (Jones, 2001; Postle, 2002; Webb, 2006). There has also been a growing emphasis on measuring and reporting on performance (Scottish Executive, 2006).

It is against this backdrop that *UDSET*, later to become *Talking Points: Personal Outcomes Approach* has been piloted across Scotland. Is it reasonable, then, to expect practitioners to readily embrace Talking Points and engage with it on a level which promotes an outcomes-focus? A key objective of this project, therefore, was to explore how practitioners engaged with the approach; whether it supported them to work in an outcomes-focussed way or whether, in fact, *Talking Points* might fit with Webb's (2006) notion of *technologies of care*.

Chapter 2: Research Design and Methods

The pilot within Midlothian Community Care Partnership had set out to test the application of the service user defined outcomes (UDSET) so practitioners were not generally familiar with using the carer defined outcomes (CDSET). The research project, therefore, is restricted to consideration of the Talking Points approach as used with service users.

2.1 Research Questions

The project set out to explore the following questions:

- How do practitioners engage with the Talking Points approach and what is its impact on them?
- How does professional background influence use of Talking Points?
- Does the use of Talking Points change practice?
- How does practice setting influence use of Talking Points?
- To what extent does use of Talking Points improve outcomes for service users and carers?
- How do service users and carers experience Talking Points?

2.2 Methodology

A qualitative research strategy was undertaken involving semi structured interviews with staff and a focus group with care home residents. The objective of this research project was the evaluation of the Talking Points approach from several perspectives. Firstly, as experienced by care home residents who have taken part in a consumer involvement exercise using a Talking Points approach. Secondly as applied by practitioners in the Community Care Partnership and thirdly as perceived by their managers and those with strategic roles within the organisations.

The methodology was guided by Pawson and Tilley's (1997) concept of Realistic Evaluation in that it was interested in the question; what is it about Talking Points that works for whom? As opposed to asking the question,

“does Talking Points work?” The research was also guided by ‘Utilisation-Focussed Evaluation’. (Quinn Patton, 1997) and will be used to inform the roll out of the Talking Points approach within Midlothian.

2.3 Methods

2.3.1 Preparation

A semi structured interview approach was chosen. This meant that two versions of the interview question guide were devised; one which focussed on practitioners and aimed to explore their experiences of using the approach. A second one focussed on managers’ perspectives on practice, strategic plans and developments relating to Talking Points.

2.3.2 Data Collection

Through the consent and information forms I was able to gather basic information such as age, gender, role and professional qualification (staff). The interviews and focus group were recorded with participants’ consent. Interviews, which lasted approximately one hour, were fully transcribed enabling me to listen to the recordings alongside reading the transcriptions.

2.3.3 Participants

The sampling technique used in the evaluation was purposive in that my intention was to interview as many people as possible who had been involved in the pilot (Bryman, 2004). I interviewed seventeen participants comprising 85% of those staff targeted. This involved seven practitioners, two front line managers (one of whom also had direct experience of using the approach), the Performance & Information Systems (PIMS) Manager and seven managers with a strategic role (including the director of social work). Eleven participants were women and six, men. Further details relating to participants are summarised in Table 2. The approach was piloted in 2 further sites which came on stream later and were consequently not included in the evaluation.

Table 2: Staff Participants

Participant	Role	Professional Qualifications	Employer	Gender
1	Practitioner	Vocational	Social Work	F
2	Practitioner	Social Work	Social Work	F
3	Practitioner	Social Work	Social Work	M
4	Practitioner	Vocational	Health	F
5	Practitioner/ Manager	Vocational	Voluntary Organisation	F
6	Practitioner	Vocational	Voluntary Organisation	F
7	Frontline Manager	Social Work	Social Work	F
8	Practitioner	Social Work	Social Work	M
9	PIMS Manager	Vocational	Social Work	M
10	Strategic Manager	Social Work	Social Work	F
11	Practitioner	Social Work	Social Work	F
12	Strategic Manager	Community Work	Voluntary Organisation	F
13	Strategic Manager	Social Work	Social Work	M
14	Strategic Manager	Nursing	Health	M
15	Strategic Manager	Social Work	Social Work	M
16	Strategic Manager	Nursing	Health	F
17	Frontline Manager	Nursing	Social Work	F

NB Vocational qualifications included management and SVQ level 4 social care qualifications as well as non accredited in-house training.

The age range of staff participants is shown in Figure 1.

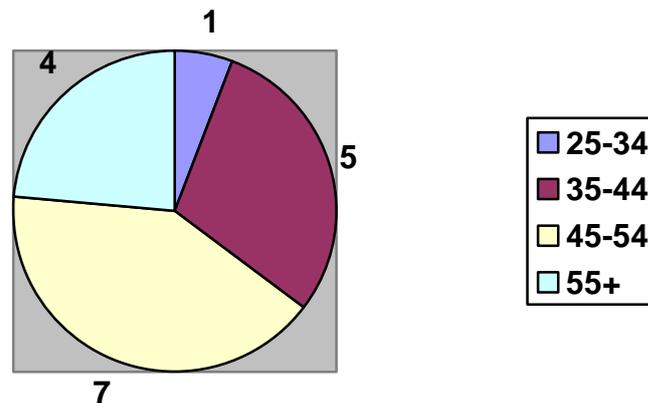


Figure 1: Age range of staff participants in years

Of the seventeen people interviewed, eight had direct experience of using the approach (although ten were directly involved at an operational level) and the number of times that they had used the Talking Points approach ranged from five to 25. This is shown in Figure 2.

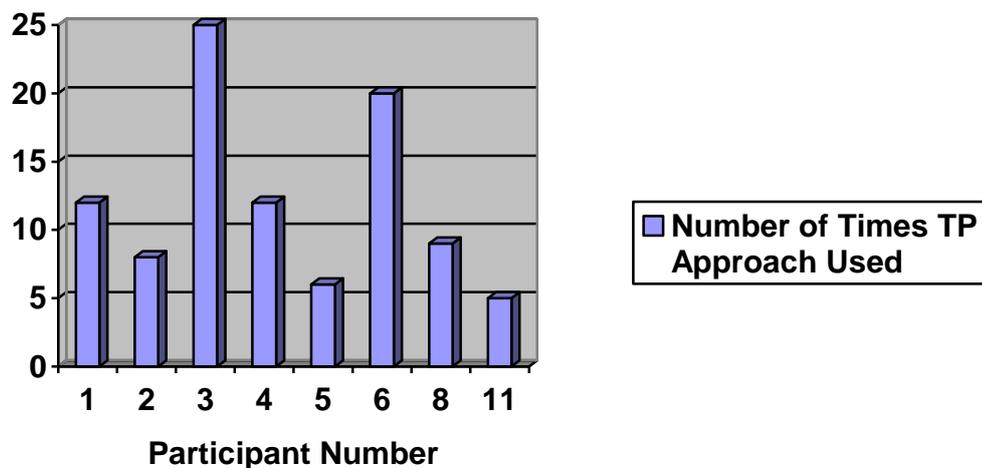


Figure 2: Number of times the Talking Points approach has been used by each practitioner.

The service user focus group was smaller than had been hoped for. It involved three older men who were living in a local authority care home (Table 3).

Table 3: Focus Group Participants

Care Home Resident	Age	Gender
1	79	M
2	86	M
3	89	M

2.3.4 Analysis

An initial coding framework was devised based on the research questions. The transcripts were turned into fragments relating to these and to thematic categories which emerged from the data. When I had worked through the transcripts of both the interviews and focus group, I made initial comparisons in terms of how frequently themes were occurring. In the latter stages of interpreting the findings, I considered their significance for practitioners, managers and service users in the light of the literature which had provided a basis for the project (Bryman, 2004)

2.4 Reflections on the Methods and Methodology

Across the seven pilot sites included in this evaluation, six different recording formats were used, for this reason it has been apparent that, in some respects, the project cannot compare like with like. The Outcomes Focussed Review Form (Appendix 1), for example, incorporated Process and Quality of Life Outcomes but Change Outcomes were not explicitly mentioned. In the

User Defined Service Evaluation Questionnaire-Telecare (Appendix 2), on the other hand, the three Outcomes areas were embedded within a series of questions and only explicitly mentioned in the summary section.

In recognition that most of the pilot Talking Points interviews had taken place some time before, I decided to undertake a focus group with service users who were already coming together. Two practitioners were planning to meet with a group of residents of an older people's residential home in order to give them feedback on a Talking Points exercise they had participated in. This project had involved interviewing residents of two homes prior to their move to the new home and again six months later. This allowed me to meet with people who had participated in Talking Points interviews and, although these had happened some time before, would be reminded of it through contact with the two practitioners and feedback about their findings.

I attempted to set up a focus group of carers who had links with the care home where the service user participants were living. In the event, no volunteers came forward and it was necessary to complete the evaluation without their input. This is clearly a limitation of the research.

Chapter 3: Findings

As anticipated, the semi structured interviews provided a rich source of data regarding participants' perceptions of Talking Points and its use in practice. It was apparent that the approach was used in widely different ways across pilot sites. There were no discernable patterns relating to factors such as age, gender, professional background or role. The variable of age was difficult to separate from position within the organisations as the older participants tended to be in more senior, strategic positions. Perhaps not surprisingly, it was apparent that participants working in the same team shared similar perspectives. In these cases, however, team mates also shared similar professional backgrounds so it was difficult to separate potential influences.

The following section summarises and explores key themes emerging from the data.

3.1 Receptiveness to Talking Points

All seventeen staff participants reported seeing Talking Points as a positive way forward. Practitioners generally reported feeling positive about the approach itself;

"....that's why I am strongly in favour of talking points because it re-orientates us as social workers, I feel, on the ground with the people who are receiving the services..."

(Participant no. 3)

There are a number of factors potentially influencing this judgement which relate to the meaning people ascribe to the approach. The fact that the Scottish Government has adopted Talking Points through the J.I.T. and the Council has taken the decision to roll it out across its adult services is likely to have influenced some participants' views alongside their own understanding of the approach and how it works in practice.

Alongside people's recognition of Talking Points as a positive way forward, there was some initial resistance amongst participants in the pilot.

For four practitioners and two frontline managers the UDSET pilot was experienced as extra work while others were undertaking specific projects using the approach. For some, it meant undertaking an additional process and separate recording format to be added to review meetings and this was experienced in some respects, as a burden;

"There were times when it just felt like quite a bit of pressure was added to us" (Participant no.2)

Six practitioners highlighted significant difficulties in using Talking Points but it was apparent that often these difficulties related to the fact that it was a pilot so the approach had not been integrated into agency recording formats. For some service users this made the process too lengthy and demanding of their concentration as well as adding to the administrative demands on staff. These findings are in line with those of Nocon and Qureshi (1996b cited in Nicholas, 2003 p34) who highlighted that measurement of outcomes can be seen as yet another bureaucratic process which adds to the burden of administration unless it becomes an integral part of the practitioner's involvement with service users. Further to this, Glendinning et al (2006) found outcomes-focused approaches to be incompatible with the standard tools used within the Single Assessment Process (English equivalent of the Single Shared Assessment in Scotland). The need for integration into assessment, planning and review processes has been acknowledged by the Community Care Partnership and by the Joint Improvement Team (Stewart, 2008, J.I.T. 2009c).

One participant acknowledged that she had been reluctant to embrace UDSET as she saw it as *"teaching granny to suck eggs"*. She felt that she was already working in an outcomes-focussed way with significant emphasis on consumer involvement;

“ I was concerned that this might come in and change the way I work, but having overcome that I think it is a good tool and it means that we are all doing it in a similar way...”

(Participant no. 1)

3.2 Taking More Time

For practitioners who were using Talking Points within the core processes of assessment, planning and review, it was clear that the approach took more time than their usual practices and that this was not simply a feature of the approach being an *add-on*. Four participants commented that using Talking Points takes more time.

“.... practitioners value the kind of attitude that lies behind the UDSET, which would be saying you’ve got to take the time to get to know your client. It is not an administrative job putting a care package together; this person is unique, how you deliver outcomes for that particular individual will vary from person to person. I think they would also say that that takes more time than we currently have and that social work will have to grapple with that dilemma.”

(Participant no. 13)

In a survey evaluation of the use of UDSET in pilot sites across Scotland, Stewart (2008) found that the promotion of engagement with users and carers was viewed as a key strength while the involvement of more staff time was seen as a weakness.

One participant commented that despite the additional time it gave her more job satisfaction;

“...it certainly does take a lot more time with people with dementia. It can actually be really fun and its good for interaction, it really is, and I like that.”

(Participant no. 5)

These findings are in line with those of several authors; (Nicholas, 2003, Shaping Our Lives, 2003) who reported that an Outcomes approach requires additional time to implement effectively. Pilots of the Talking Points approach across Scotland have confirmed this although staff have reported the extra time reducing as people become familiar with the approach. They have also seen the additional time as a positive investment in ensuring the inclusion of people’s views (Stewart, 2008, J.I.T. 2009c). This theme is echoed by a senior manager;

I would think, and this is a hypothesis if you like, that we need to look at as this begins to bed in, that investment at the beginning of the process should actually yield benefits at the end of the process because what you should be putting in are services that are more sustainable, more relevant, more targeted, more effective...”

(Participant no. 15)

3.3 Understanding of Talking Points/UDSET

Central to this project is the significance of participants’ understanding of Talking Points. The meaning they attribute to it will largely determine how they engage with it in practice which will, in turn, affect outcomes for service users. Participants were, therefore, asked to describe its key principles.

It was apparent that some participants had a more in depth understanding than others and this was reflected in the range of responses; from one sentence to involved discussions of how a focus on outcomes required a shift

in thinking about service provision and putting service users at the centre of the planning process.

A range of features were mentioned although most participants emphasised particular principles over others. Six participants emphasised service user feedback as its main principle, three talked about achieving outcomes important to service users, four made a connection between obtaining service user feedback to adapt service provision, three focussed on the conversational elements of the approach; enabling people to talk about what is important to them and one participant stressed its connection to social work values.

Whilst each of these perspectives accurately reflects an element of Talking Points, the diverse range of emphasis suggests that neither a complete understanding of Talking Points nor the concept of outcomes were thoroughly embedded within the cultures of some the teams in which participants worked. This might be expected within a pilot but does indicate an area for development. Glendinning et al (2008) found that both a good understanding of outcomes and investment in change management are important factors in facilitating an outcomes approach. This finding is significant in that the emphasis on certain principles is likely to be reflected in how participants talked about their experiences of using Talking Points or how they thought it should be used.

Subsequent to the Midlothian pilot, the Joint Improvement Team has issued two papers which aim to encapsulate the value base of an outcomes approach as well as key messages from practice. Both the Key Messages and Philosophy and Principles papers (JIT, 2009c and JIT 2009d) offer a helpful resource which could be used to support practitioner understanding and organisational development within Midlothian.

3.4 Working with the Service User Defined Outcomes

Although participants were using a variety of versions of the Talking Points approach, the Service User Defined Outcomes were central to each. Most participants were familiar with all three outcome domains of *Quality of Life*; *Process* and *Change* although some recording formats did not incorporate *Change* outcomes. Interestingly, one participant commented that using the Service User Defined Outcome grid itself to guide her would have probably been easier than using the form.

Through discussion about the outcomes, participants highlighted a number of issues relating to the interpretation of some of the outcomes as well as issues arising when using them in practice.

3.4.1 Outcome Domain 1: Quality of Life

Nine participants identified some difficulty exploring the outcome: **'Feeling Safe'** particularly in relation to people who were living in a residential care setting.

"...its difficult for people to understand...yes I am in here I'm not out in the community...so it was difficult for people to understand what you mean by feeling safe'...."

(Participant no. 1)

One residential service user stated however;

"If you feel safe you are happy within yourself"

(Care Home Resident no.1)

Another participant commented;

“...feeling safe, some people thought that was a really odd thing to ask, you know... well of course, I think that’s something you don’t really think about unless you don’t feel safe...”

(Participant no. 2)

It was possible to see how this might relate to feelings of confidence that staff would be there if they fell etc. One participant commented on people feeling safer immediately after admission to a care home from the community. Another participant described ‘feeling safe’ as a “moving target” (participant no. 8) on the basis that someone’s sense of this might keep changing. He also highlighted the difficulties which can arise when a practitioner views a situation as unsafe while the individual is unconcerned. This might be particularly difficult when there are issues of capacity; if the individual concerned has a learning disability or a condition such as dementia, for example.

The practitioner involved in the Telecare pilot found, in contrast, that ‘feeling safe’ was the most straight forward outcome to explore as people immediately related to equipment in the house which was designed to make them feel safer such as the bogus caller alarm, key safe or falls monitor. This raises some interesting issues in that the focus of this practitioner’s work seems to have been on the Telecare service rather than taking a holistic view of the service user’s circumstances, as Talking Points intends. This appears to be a feature of the design of this particular pilot project.

The different perspectives on whether ‘**feeling safe**’ is an easy or difficult outcome to work with is also interesting in that it highlights differences according to setting in which the practitioner is working as well as the service user’s circumstances.

Three participants identified ‘**Having things to do**’ as a difficult outcome to gauge partly because, although there might be activities available in a residential setting they might not be the sorts of things that the individual

would have chosen to do when living in the community. For those in the community, practitioners would be likely to have less insight into this and whether someone feels they have sufficient things to do will be very subjective so could vary enormously from one person to the next. Again, this highlights the importance of gaining the individual's perspective.

One participant thought having things to do was an easier outcome to measure;

"...because you can say; well what did you do before the care package went in? and what did you do before the day service? that's easier to measure."

(Participant no. 7)

Focus group participants talked about various activities being organised within the care home. They talked enthusiastically about playing indoor bowls and skittles as well as social events involving an opportunity to have a drink at the bar. One commented upon these evenings not being long enough but also stated that residents didn't always want to participate so staff were 'wasting their time' bringing people along to activities then having to take them back to their rooms as they were not settling.

One participant commented on timing in relation to having things to do;

"...hospital discharge...its more about people being able to function safely within the home environment first and maybe that will take 3 months, 6 months, 9 months before they eventually wish to step out of the front door..."

(Participant no. 3)

Another participant highlighted that some service users who have dementia believe that they do have things to do, such as going out to work, when in fact this is not an accurate picture.

One participant commented on, '**seeing people**' as a potentially difficult outcome to gauge with people who have dementia;

“you actually know for a fact the family visit loads, there is a good social network of friends and people say, I've not seen anybody, I've not seen anybody for months so you are having to take the information that you are getting but actually know that it isn't correct, so you are documenting something you know isn't right and then you are reminding the person; you had your son in this morning.... oh yes he might have been, so...”

(Participant no. 5)

Another participant saw '**seeing people**' as difficult to gauge as for some the relationship with a paid carer could be crucial in terms of social as well as practical support and this might depend upon their social networks and varying levels of importance placed on this by individuals.

Four participants identified, '**Living life as you want (including where you live)**' as a complex outcome to explore with service users. As Participant 1 put it;

“...people are saying well I'm not living life as I want, I actually don't particularly want to be here, its lovely, but I'd rather be at home. So then what you did was you explored with them right, you're here what sort of things do you get? ...and talked about living life as they wanted but in the context of the residential home so you just had to change it slightly”

(Participant no. 1)

Similarly, one participant highlighted people's health or disability issues getting in the way of living life as they want. It could be difficult to get people to focus on living life as they want within the limitations of their circumstances.

“...it was very rare for people not to contrast what they would choose to do if they had the ability and what things are now...”

(Participant no. 2)

One service user stated that he had been “*virtually forced*” to move into residential care following a lengthy period in hospital;

“I have to take what’s in front of me now and just accept it.”

(Care Home Resident no.1)

Participant no. 7 related ‘**living life as you want**’ to Maslow’s (1954) hierarchy of needs; highlighting the importance of feeling, safe, secure and warm before thinking about where you want to live. She also commented on the difficulty of ensuring that people have an opportunity to make choices when delayed hospital discharge scenarios may result in people having to move to a care home which was not their first choice.

3.4.2. Outcome Domain 2: Process

Participant no.5 commented that she particularly liked this section although she expressed some concern that people may tell you what they think you want to hear for fear of losing a service. Another participant commented on the value of involving family members in gathering feedback on process outcomes such as whether staff are reliable, partly because individuals may be reluctant to make critical comments.

The Care Home residents who took part in the focus group agreed that Process Outcomes were important. Resident no.1 commented that staff are often busy and they might have to wait for a response. They also commented that they recognised staff had lots of people beside themselves to care for. This was nonetheless frustrating for them at times. One resident commented in relation to support to improve his mobility;

“I get walking if they’ve got time, to me that shouldn’t come into it...”

(Care Home resident no. 3)

All three residents reported generally good relationships with staff, one commented upon his ability to talk to his key worker if things were bothering him;

“I call her my second Mammy!”

(Care Home Resident no. 1)

3.4.3. Outcome Domain 3: Change

Some participants were not familiar with the change outcomes as not all the recording formats included them.

One participant commented on the lower likelihood of improved skills once an older person has moved into a residential care setting as opposed to discharge home from hospital. Another commented on residents’ lack of expectation that they would make any improvements in any respects;

“It was almost as though they felt that... you know there wasn’t any improvement to be made because if you talked about improving skills and improving their ability it was a kind of a blank... people didn’t really understand what you meant; they were just sort of, oh we are just doing away you know it’s just where we live and there wasn’t any sort of impetus or expectation that they would improve skills and ability things like that...” (Participant no. 4)

This may relate to cultural expectations about older age (Beckett and Maynard, 2005). Most of the service users involved in the pilot were older people and it would be interesting to see how *Change Outcomes*

are viewed by younger service users and the practitioners working with them.

Another participant commented on the difficulty of exploring '**reduced symptoms**' with people who have dementia as many people do not appreciate that they have the condition.

The difficulty of being able to gauge the change outcomes was highlighted by one participant as their involvement in the pilot had been at the review stage without a baseline measurement against which to judge.

Participant number 8 highlighted the difficulty of measuring improvement in some circumstances;

“...if the situation previously was placing them at risk then is the value placed on the change [a move to a care home] an improved one or is it simply you take their loss of independence which might mitigate against a sense of feeling they are in a better place than they were. Things like, you know confidence, some people might say they have more confidence, others might feel that they have lost independence and that is working against that sense of feeling confident...”

A participant from the Rapid Response Team highlighted how closely the change outcomes related to the purpose of the team's work in that they would see each change outcome as a core aim of their work with individuals and would, therefore, be keen to use Talking Points to evaluate the service.

In terms of general comments on the process of incorporating the outcomes into a structured conversation, five participants talked about people sometimes not understanding the questions. This related to review forms which incorporated questions based on Talking Points user defined outcomes.

“if there were things that people didn’t understand I tried to simplify the question... it was really hard actually because you didn’t want to use examples too much because you didn’t want to kind of lead them down the path of being overly prescriptive and kind of moving away from the outcome and just asking them a yes/no question about an aspect of care that, yes may have fitted as an example you end up kind of steering them too much....” (Participant no. 4)

In order to be person centred, a flexible approach is needed (JIT, 2009c, JIT 2009d). Having a prescribed set of questions might make this more difficult, while using the Service User Defined Outcome grid itself to support a semi structured conversation could help. This flexible approach, alongside a sound understanding of outcomes principles, gives practitioners scope to exercise professional judgement in achieving a focus on outcomes that are important to the individual.

One participant commented on the value of involving carers in the process because service users may not give an accurate picture;

“...we should be listening to what people are saying but we should be checking it and not just taking it as read...” (Participant no. 3)

Another participant commented on the potential conflict of interests between service users and their carers and the need to ensure that service users were supported to express their views.

The care home residents who took part in the focus group indicated that they saw both Quality of Life and Process Outcomes as relevant to them and agreed with the outcomes identified under these headings. They appeared to see the Change Outcomes as less important although one service user was able to identify the role of physiotherapy in relation to improvement in his mobility. As Glendinning et al (2008) found; the importance attached to each

of the three outcome domains is likely to vary according to individual circumstances.

Other than the difficulties reported with some of the outcomes as discussed, all seventeen staff participants and all three care home residents indicated that the service user defined outcomes represented what was important to people.

Feedback from practitioners on their use of the outcomes in practice highlighted a number of important points; firstly the complexity of people's circumstances and the interplay of issues such as cognitive impairment and the involvement of carers. Secondly; the wide variety of meanings attributed to outcomes within the grid. This was identified by some practitioners as a problem yet it would appear to highlight the way in which these outcomes can be used as triggers to explore more individualised outcomes for service users. The fact that some practitioners saw this as a problem could be indicative of a tendency to use the tool in a procedural way with a dependence upon the form itself rather than an ability to use it as a prompt. This would be consistent with the views of Postle (2002) and Webb (2006) in relation to the impact of community care reforms on the way in which practitioners now tend to operate. Not all of those involved, however, had worked within a setting where care management prevailed and it is difficult to know how much the culture had impacted upon their services. Practitioners also had different professional and vocational backgrounds but there were no identifiable patterns in terms of how different groups related to the approach. This might be expected as the number of practitioners who had used the approach was small (8) and they also had limited experience of using it. Alternatively, the issue could relate to a limited understanding of how to use the approach as a result of having limited training. This issue will be explored in the following section.

3.5 Training and Preparation for using Talking Points

Training to use the Talking Points approach was highlighted as important amongst participants, particularly those who had experience of using it. As this was a pilot exercise there was no training programme in place. In order to familiarise themselves with the UDSET approach, as it was then, fourteen participants reported attending information sessions both within and out with the CCP or team sessions with the project manager. Ten reported making use of materials on the Joint Improvement Team Website and two reported preparation through individual meetings with the project manager. All six practitioners who were using UDSET as members of a team described the benefits of discussing the approach with colleagues;

“We met with each other, we looked at the questions; we tried to work out how to say these questions so that people understood what we were talking about...” (Participant no. 1)

Nicholas (2003) highlighted the importance of continuing discussion and reflection for practitioners during implementation.

Of the eight practitioners who had a direct involvement in using the approach, seven reported feeling under prepared;

“...it came as a bit of a surprise and it was almost like we had to figure out a way to make it work, I felt that we were kind of on our own to a certain extent [.....] I think we were under prepared and possibly if we had had a bit of training it wouldn't have been so difficult to implement it...” (Participant no. 2)

Four people related their feelings of being under prepared to the newness of their team or their own inexperience in practice. They were trying to familiarise themselves with UDSET alongside learning other aspects of their work and this presented some challenges. While some people strongly expressed the

view that they would have liked more training in the approach, others felt more confident;

“ I think I felt fairly confident and supported in that knowing it was a pilot and that everybody was really just trying it out and attempting to use it in a way that suited them and met their needs then I sort of felt quite confident in doing that myself really...” (Participant no. 4)

Of the eight people who had direct experience of undertaking UDSET interviews, three described how they had drawn upon their experience as practitioners in implementing the approach and four talked about how they became more skilled at using the approach with experience of using it.

Three participants identified the need for staff to have the right training and support to encourage them to engage with Talking Points fully. One practitioner stated;

“I think it needs to go back to the start of training, if you get that bit right, because I think that is the biggest fear of practitionersI’m not sure if I am even asking this right, am I doing this right? The lack of confidence innot in the actual tool but in how to do it....”
(Participant no. 5)

Three participants identified changing the organisational culture to become more outcomes- focussed as a key aspect of the way forward.

One highlighted the potential benefits of training in terms of a culture shift as opposed to rolling it out with limited support to staff;

“.... if you do that you are just not going to get buy in you are not going to get people understanding the kind of shift in thinking from this assessing for a deficit model and assessing for an abilities, capabilities model so there is a lot of work to be done.”
(Participant no. 7)

Nicholas (2003) concluded that training and support for practitioners, which encouraged reflective practice and opportunities for dialogue are crucial in overcoming difficulties and integrating an outcomes approach into practice.

3.6 Adapting Forms

Several participants talked about adapting the Talking Points recording format to suit their needs. Others designed their own questionnaires or evaluation projects drawing on the principles of UDSET. One participant expressed the view that some of the terminology in the version she had used needed to be simplified. This was echoed by others;

“The sort of version 1; we tried it once and we adapted it straight off because the language was wrong for us so we tried to adapt into an easier way it was us trying to think well what does that question actually mean, how would you translate that?” (Participant no. 5)

Some of the changes made related to how questions were worded but others were more fundamental;

“...we’ve not got as many questions, but we find that these are relevant, you have to ask questions that are relevant to the people that you are working with, there is no point in asking a question that’s going to upset the person even if you think it’s very simple and clear for them to answer....” (Participant no. 6)

She also indicated that in terms of the outcome domains, questions relating to **Process** were the same, those relating to **Quality of Life** were different and the **Change** Outcomes had not been incorporated.

One participant saw Talking Points as offering an approach which was suited to being tailored to different circumstances;

“I think when people do come back to looking at those outcomes they say; well of course that’s exactly what we want to find out about; that’s what UDSET is all about, is focusing on these issues and giving them back the power to sort of use that and develop it in a way that suits them so depending on their client group you know they will need to take different approaches how they actually go about finding out information and getting feedback. There can’t be one uniform sort of way of doing it across all client groups I don’t think.”

(Participant no. 4)

Participant no. 14, in fact, described how service users and carers were involved, from the outset of a consultation exercise, in selecting the Talking Points outcomes as a framework and building the process from its principles.

The flexibility of the approach is seen as positive yet as participant no. 13 highlighted, this can result in a difficulty in relation to performance measurement;

“... organisations becoming more user driven, having the user at the centre then changing the methodology of it probably doesn’t matter but at the level of wanting to measure performance of services then it does.”

He added;

“I think there are real dangers of people just amending the tool as they see fit I don’t think that will be sustainable longer term but within the context of piloting and learning what works and what doesn’t work [.....] I think it’s a legitimate thing to do. Actually if we change these questions round to this then it makes it easier for somebody with dementia to understand and I think it’s good to try that but as we move to mainstreaming then it would be important to put some controls on it.” (Participant no. 13)

It would appear that making changes to the wording of the form used along with the fact that six different formats were used within the pilot, is not necessarily a problem in terms of focussing on outcomes that are important to the individual, as long as people remain true to outcomes principles. When more fundamental changes occur such as missing out outcomes or, indeed, an entire outcome domain then the integrity of the Talking Points approach is being undermined.

Such changes have been made with good intentions and as participants 5 and 6 reported, they were believed to be true to the outcomes as originally defined. We have already established, however, that understanding of Talking Points principles varied. It seems likely then that some adaptations made may have inadvertently undermined Talking Points, potentially resulting in outcomes of importance to the individual being ignored in the assessment, planning or review process.

3.7 Using Talking Points with People Who Have Dementia

It is already widely acknowledged that using the Talking Points approach with people who have cognitive impairments such as dementia and learning disability or communication problems is not straight forward (Stewart, 2008). It should be noted, however, that this is not a difficulty which relates exclusively to Talking Points. The complexity of communication with some service users is also an issue in assessment and intervention planning in general (Phillips et al, 2006). These concerns have been echoed by the findings of the evaluation as eight participants commented on the challenges of attempting to use the Talking Points approach with people who had dementia;

“There were some people who seemed to have a form of dementia and it’s quite difficult to communicate for a long period of time; they

were sort of drifting in and out of the present time and one minute they'd be elsewhere again and it felt like it was quite difficult".

(Participant no. 4)

Difficulties identified included obtaining accurate responses when people thought they were living in a hotel rather than a care home, for example, people struggling to follow the conversation due to short term memory deficit and people becoming anxious as they didn't understand the questions. One participant highlighted the importance of context;

"You learn through your mistakes I have to say, I tried to complete it with a guy and it was quite obvious he was really not understanding what I was trying to do because I was asking him about day care service when I was talking to him at home and he couldn't relate, that was my fault; that was my stupidity." (Participant no. 5)

Sometimes people with cognitive difficulties were excluded from the process. Two participants, who had been involved in using the UDSET approach with care home residents before and after their move to a new home, found that several people's dementia had progressed to the point that it was not possible to undertake the second interview with them. As a result change outcomes could not be measured. When the Talking Points interview was added onto the end of review meetings, some service users were struggling to participate in the process as a result of cognitive difficulties so practitioners felt unable to proceed with the Talking Points part of the interview.

Perhaps not surprisingly, five participants mentioned drawing on professional skills in order to engage in a conversation about outcomes with people who had dementia. They referred to the value of relationships and conversation, observing non verbal communication and involving carers in discussions. Three participants mentioned involving carers in the interviews but for each of them there was an awareness that this could result in eliciting the carer's perspective rather than that of the service user. Six Participants identified

Talking Mats (Murphy et al, 2007) as a possible way of overcoming communication difficulties with service users who have dementia.

Staff concerns about using Talking Points with people who have cognitive impairment have been acknowledged by the J.I.T., interim guidance produced and further research and development of support materials is underway. (J.I.T. 2009b),

3.8 Potential Impact on Service Users

Five participants commented that it was too early to know whether using Talking Points was having an impact on service users or carers in terms of their feedback being used to shape service delivery. Another participant commented that using Talking Points had not made any difference in terms of responding to people's needs as they felt that they were doing this any way. One participant commented that asking people their opinions was not new but that the approach encouraged a more holistic way of looking at the outcomes that people might want to achieve.

Five participants commented on people's appreciation of having been asked about their experience of services;

"...they felt like they were being asked these things because someone was actually interested and they would have the opportunity to talk about something that people don't usually bring up." (Participant no. 2)

"I just think what it has taught me is that we need to do more of it actually, we do need to do more of it because there are lots of positives out there and people come back and say I felt really consulted thank you for asking."

(Participant no. 7)

Two participants commented on the process of using UDSET at the review stage in helping people to realise that the services were actually improving their quality of life. Both expressed the view that through discussion, some people had taken the opportunity to reflect on how far they had come. One gave an example;

“...for them to think oh yes crikey, I used to feel really anxious at home and now I feel so much better now that someone is coming in.” (Participant no. 7)

Four participants made reference to potential benefits of the approach in terms of being able to measure what is working for people in order for organisations to plan and deliver appropriate services.

“It should assist us within planning because if this is being used and used appropriately and effectively it will help us ... move services, you know, in the way that they need to be going.....” (Participant no.10)

An example from the pilot was cited by two practitioners who had been involved in a consumer involvement exercise using Talking Points. Their findings had been fed back to senior management who were now in the process of implementing changes to service delivery.

Four practitioners expressed concerns, however, that people may not feel able to give honest feedback;

“I did think that there was an element of pleasing the professional rather than telling you what they really wanted.... they were frightened to say the wrong thing you know it's difficult to get over to some people there is not rights and wrongs here; it's your experience it doesn't matter to me what you are telling me you

know it doesn't make any difference we are not going to take the equipment away and I think you had to be very aware of the power imbalance that was there" (Participant no. 11)

Similarly, two participants highlighted the importance of talking to people without staff being present;

"...we either went to the individual's room or there is a quiet room....people were concerned about saying something in case somebody was listening..."

(Participant no. 1)

"You just meet people and then they start asking you if you feel respected by the care staff here... I think at times people were a little you know, will this get back to the carers?"

(Participant no. 2)

Two participants talked about the Talking Points approach supporting individualised assessments based on outcomes and having a care plan that is genuinely personalised moving away from outputs to outcomes.

"I think in terms of the impact on service users it will allow them clearly to articulate what it is they want; what impact they expect services to make for them..." (Participant no. 15)

One participant commented on the adjustments to service delivery that can be made which can really improve someone's life, as a result of people being given an opportunity to talk about their experiences of the service and encouraged to speak about aspects that they are less happy with.

"I think the difference if we are able to do what we are planning, which is around building in outcomes from the very start of the process and then I think that does.... that will lead to more creative,

more diverse responses to people's needs I think at the moment there is a relatively restricted menu of services.....It's become a bit of a conveyor belt... the volume that comes through doesn't lend itself to people taking really creative and individualised approaches its around eligibility criteria for the services that are already commissioned....." (Participant no. 13)

Several participants took up this point and commented on their hope that Talking Points would lead the way to more flexible services;

"I just find it so frustrating when you know a client maybe wants... just something... different times, or..... maybe a basic time when they normally get up in the morning that's when they want their package of care and we can't give it to them." (Participant 17),

"An example is around respite; sometimes a carer only wants a couple of hours out on a Saturday afternoon, to go for a coffee with friends or to go and get their hair done but actually what they have had to take is a weekend's respite because there is nothing else, and they don't want that." (Participant no.1)

In the same vein, another participant expressed the hope that outcomes would be recognised and used within the resource panel when looking at commissioning services. Outcomes focussed services can only be delivered if there is a flexible approach to service provision which can deliver services in ways that are consistent with the person's aspirations (Glendinning et al, 2008). In order for this to happen effectively, there need to be multiple communication channels between service users, commissioners, contracts managers, team managers, care managers and front line staff in provider agencies (Glendinning et al, 2008, p16). Here the impact of managerialism is apparent; it is questionable whether such tailored services can be delivered if decisions about which provider to commission are taken by a panel rather than an individual practitioner. Glendinning et al (2008) highlight that what is

required is a shift of power from commissioners to service providers & users, this being dependent upon good relationships and trust. These findings point to the need for organisational change, which the J.I.T. recognises as being necessary in order to take forward an outcomes approach in Scotland (J.I.T. 2009d)

From the study it is apparent that practitioners see potential for Talking Points to have a positive impact on service users firstly, through experiencing a sense that their views are important, secondly through their views being taken into consideration in planning services both for individuals and in terms of influencing wider service provision and thirdly, through opportunities to reflect on the progress they have made towards achieving desired outcomes. Challenges in terms of how to enable service users to give honest feedback were identified as was the need for organisational change to support outcomes focussed practice.

3.9 Performance Management

Talking Points' dual aims of promoting outcomes focussed practice alongside a way of measuring performance has emerged from the research as an interesting area for exploration. One participant highlighted Talking Points as a way of measuring outcomes that people aspire to rather than simply focussing on outputs. This was echoed by participant number 16;

“They [the management board] need to start understanding that this is important and how we measure these things [outcomes]... it's not about the number of people we see or, you know, the number of people we keep out of hospital....”

These comments concur with Gregory and Holloway (2003) who suggest that a social constructionist approach to social work which re-values language can

deconstruct the language of performance indicators and quality outcomes to promote a dialogue in which the service user's interpretation of their circumstances is understood and valued. Similarly this approach could be related to NHS HEAT targets (2009).

"...rather than turning a conversation with a service user about how they think and feel about their situation into easily measurable service inputs, the social worker strives to reflect that conversation in the framing of objectives which are driven by the service user's own internalised understanding of 'quality'." (p50)

One participant identified the potential for Talking Points to evolve to consider more individualised outcomes;

"I suppose if you take it to its logical conclusion you would be developing outcomes for each individual person but the problem with that is that you have then a really complicated job measuring your performance".

(Participant no. 13)

One participant described the difficulty of using outcomes such as 'feeling safe' to evaluate social work services;

"...when thinking about how safe you feel you will not just be thinking about social work services you're thinking about life as a whole, the house you live in, the neighbourhood, whether the streets are well lit, how many police are around etc.[.....] We need to find a way of factoring in other very Important influences and I don't think it is a flaw in the methodology I just think around life it's complicated and one service makes a difference but it doesn't make all the difference."

(Participant no. 13)

This is an important point in terms of performance management as a focus on outcomes will not necessarily provide a measure of service delivery. Positive or negative outcomes for people may be dependent upon a number of factors which are unrelated to the services they receive from the organisation. As Shaping Our Lives National User Network (2003) found; other services such as housing and information are very important to people.

The Performance and Information Systems (PIMS) Manager discussed the ways in which data generated through Talking Points will be used for performance management. He identified the data as being useful in planning as well as reporting to inspection services.

Data could be used both to measure the experience of individuals and any changes over time as well as looking at specific services;

“...you could do it for the care home; you could map it across for everybody in the care home and you would be able to see whether or not there were problems with having things to do or social contact, so that if there's not enough things to do then there is obviously a problem that has to be addressed...” (Participant no. 9)

Glendinning et al (2008) highlight the importance of ensuring that outcomes are identified, measured, audited and recorded so that desired outcomes and progress towards achieving them can be monitored.

Burnham (2006, cited in Clarkson, p182) found that enabling practitioners, who are generally not keen to undertake measurement and routine evaluation, to view their practice as part of the care planning process, offered them a greater incentive to use performance information so that desired outcomes for service users could be recorded and analysed.

The PIMS Manager described how difficult it had been to interpret the qualitative information recorded on initial UDSET forms which led to the

adoption of a 'negative, neutral, positive' or; 'red, amber, green' traffic lights system.

"...later stuff that had the comment plus the score for it made it so much easier and you could tie them together and say yes you can understand what has been said and what they were meaning from that." (Participant no. 9)

He also recognised the difficulties of translating qualitative data into quantitative measures;

"I've always said it's a very simplistic approach that I've taken.... you could do all sorts of analysis and looking at different aspects of it but I just wanted to have something that was readily visible and quite indicative of the service we were giving the service user, the effect and to demonstrate it that way and I thought well.. using positive, negative, neutral it's simple and it was easy and every time I tell people what we did I always put in that caveat it could be seen as a very simplistic approach but in all the presentations I've done for this everybody has agreed that it works...." (Participant no. 9)

Four participants expressed reservations about using the scoring system;

"It did feel uncomfortable, I have to say, because sometimes it was clear cut you know people were very, very positive about a certain aspect whereas at times it was nuances and just to kind of reduce it to well that's a 1 then you know, it felt really slap dash you were sort of going through going 2, 1, 0, you know things that can dramatically change it if that's going to be taken seriously then that could change the whole way that the service operates"
(Participant no. 4)

Four participants reported viewing the red, amber, green measurement system as a positive development. One participant described its value in terms of a visual representation of progress;

“...this is a continuous process and it has to be measured against something, whenever; last month, six months ago, a year ago [.....] people move from areas of concern out of the red into the amber or green and you can actually see the progress and if there is a way of endorsing that progress then you know that should be satisfactory from all points of view.”

(Participant no. 8)

He expanded on this idea;

“It could operate as almost like an annual planning chart you know so that you can actually see whenever there was any discussion or review or meeting or whatever... case conference you can identify whether things have gone forwards or backwards like the traffic light system. I mean is it just obvious? I don't know, is seeing your traffic light system in operation some kind of over simplification? I don't know.... I think if someone opened a file and saw a lot of green... an inspector... then they could take that at face value say wonderful or you know they can poke about and go back a bit you know and any file should have the evidence that led to the explanation that it was all green.” (Participant no.8)

Participant number 15 picked up this theme;

“It's like you need to have the information that sits below it if you want to interrogate it...”

Guidance from the J.I.T. (2009c) recognises the value of using quantitative data in outcomes focused approaches but prioritises qualitative data in terms

of ensuring that the person's views are central, what is working and what is not can be explained and in order to avoid returning to a tick box approach to assessment and care management. Findings from the evaluation suggest that rather than translating qualitative data into quantitative measures, there is a strong case for reporting on both in order to obtain the true value of the information gathered and really understanding what is happening at a local level.

There was variation in opinion about whether service users' explicitly expressed views on outcomes as they related to them, an interpretation of what they were saying or the practitioner's assessment should be recorded.

"...it's not the care managers' perception of how things have changed it's the service user or carer's perception of how things have changed so I wouldn't like to think that a care manager would be trying to influence or put down their thoughts as to whether or not there had been a difference".

(Participant no. 9)

It was clear, however, that not all participants viewed it in this way;

"I would obviously start with them to see if I can arrive at their view of where they would be in that type of scale- between strongly agree or not applicable but at the end if I had to choose it I would be trying my best to err in the right direction" (Participant no.8).

One participant talked about how she and her co-worker had interpreted service user responses;

"On most of them we readily agreed there was the odd one we sort of talked round and said well is there enough there to give it a 2 or but I would say almost all of them it was obvious where they should sit" (Participant no. 1).

One participant highlighted that alongside the service user's own evaluation of, for example, how safe they were, there would be a need for other measures;

"I'm a firm believer in the process but I would be very nervous of seeing it as the panacea, I don't think it is being viewed that way but it's just to have it within that broader context of measuring the impact of service delivery."

(Participant no. 13)

The Shaping Our Lives National User Network (2003) expressed the view that the subjective perspectives of individual users should be incorporated. The J.I.T. Key Messages bulletin (September, 2009) indicated that differences of opinion should be recorded as part of the process.

The dual purpose of Talking Points in terms of embedding user and carer outcomes in practice and its performance management role has been identified as key area of tension (Stewart, 2008). The findings of this study reflect this in that participants have highlighted the loss of important detail in translating people's experiences of outcomes into a simple three level measure. It is also apparent, however, that participants can see benefits to the traffic light system in terms of a visual representation of progress or deterioration and being able to report on service user experience in national reporting systems. The possibility of using detailed qualitative information alongside quantitative measures seems to offer a potential way forward although the issue of how to record differing perspectives needs further investigation.

Chapter 4: Conclusion and Recommendations

As with many pilots, a number of teething problems were encountered. The fact that in several of the sites it was necessary to use the approach as an 'add on' to existing systems was problematic. Similarly the fact that outcomes focussed staff development opportunities had not yet been established also left participants feeling that they would have liked more preparation and support with implementing UDSET/Talking Points. It is important to acknowledge these areas in terms of valuable learning but it is also important to recognise that many of the difficulties encountered relate to the fact that people were trying out the approach within the context of a pilot rather than the difficulties being inherent within the approach itself.

The study demonstrates that participants engaged with Talking Points in different ways according to their understanding of its purpose. There was variation in people's perception of its core principles, which meant that flexible use of the approach and adaptation to recording formats could result in inadvertent undermining of its integrity and potential failure to focus on outcomes important to service users. In such circumstances, Talking Points could be in danger of becoming what Webb (2006) would identify as a *Technology of Care* thereby failing to achieve its intended impact.

The evaluation suggests that flexible use of the Talking Points approach was not in itself problematic as long as its principles were understood. This underlines the importance of opportunities for staff development in order to effectively implement Talking Points. Since most of the pilots in Midlothian were undertaken, a variety of materials have been developed by the Joint Improvement Team and partnerships to support consistent understanding and application of the approach.

A further area of learning relates to the recognition that changes in how practitioners undertake assessment, intervention and review processes form only part of the picture. As has been documented elsewhere, changes to the

systems for planning and commissioning of services are also necessary to enable greater flexibility and more outcomes-focussed delivery of services. Commissioning has been identified as a priority area for development by the Joint Improvement Team in 2010.

The study has highlighted both potential and some difficulties in the use of Talking Points for performance measurement. It is apparent that there are significant challenges in both translating the qualitative content of a conversation into easily measurable quantitative data and in developing ways of using qualitative data for reporting purposes. As a summarised account alongside in depth recording, however, a scoring system, such as the traffic light system piloted, could offer a valuable way of ensuring that the service user's voice is heard in planning and national reporting.

Talking Points incorporates key features of contemporary Community Care aspirations in that it promotes service user and carer involvement in decisions about their own care and wider service planning, it encourages a focus on creative practice in addressing desirable outcomes rather than service led provision and it attempts to incorporate performance measurement in order to inform planning. It also supports the agendas of recovery, re-ablement and self-management where relevant, in involving the person in identifying the role that they will play in achieving their outcomes. It is my perception that evaluation participants have demonstrated commitment to the people of Midlothian and a desire to find ways of overcoming difficulties with the pilot in order to effectively implement Talking Points and achieve better outcomes for service users and their families.

Appendix 1

Midlothian Community Care Partnership

OUTCOMES FOCUSED REVIEW FORM

Client's Name:		Date of review:			
Current Address:		Tel No:		CHI: Not applicable	
Post Code:		Mobile No:		Client Index:	
Worker Responsible for Review:		Services Used: Not Applicable			
Reason for review:		Date of any previous reviews in last 2 years:			
Changes in circumstances since last assessment / review: Recorded in main Review Form					
Are there any concerns that the client has or may shortly have difficulties in managing their own financial affairs or making decisions due to incapacity under the Adults with Incapacity (Scotland) Act 2000? Give an indication of which other agencies have been asked to contribute to their view. Recorded in Main Review Form					
What is the view of the client and his/her family carer(s) relating to the above? Recorded in Main Review Form					
PERSONS CONTRIBUTING TO THE REVIEW			DATE & METHOD OF CONTRIBUTION		
Name:	Designation / Relationship	Phone	Letter/ report	Individual meeting	Attend review
Service User's Signature:			Date:		
Workers Signature:			Date:		
SENIOR WORKERS RECOMMENDATION: Recorded in Main Review Form					
Signed:			Date:		
PERSON RESPONSIBLE FOR NEXT REVIEW:					
Date of Next Review:			See Client Index		

Details input to Database: YES/NO		Date of input:
PROCESS OUTCOMES:		
To what extent does the client feel that staff within the service / services:		
Listen to them	Give them a choice over the nature and timing of support	
Respect them as an individual (including addressing issues of discrimination and stigma, if appropriate)	Do what they say they will	
Are responsive to their needs and wishes		
QUALITY OF LIFE OUTCOMES:		
What difference does the service make to the client's life in respect of:		
Taking part in activities of their choice (including employment and training if appropriate)		
Social contact	Staying as well as they can be (Including general health and wellbeing)	
Living where they want	Feeling safe (Physical- neighbourhood, home, services. Emotional- feeling at ease, knowing someone will be there for you)	
Daily living skills, confidence and mobility		

OVERALL

To what extent is the service / package of support delivering the outcomes that the client wants?

What changes would the client / carer / other most like to see?

What can be changed to deliver these outcomes?

What must be changed to meet the needs of the client?

Is the review of outcomes derived from the clients own reports? If not, what information has been provided and by whom?

OUTCOMES SUMMARY

Based on the client's own response where possible, please highlight answers to the following questions:

Is the client supported by their package of care to feel physically and emotionally safe in their own home and environments where community care services are provided?

Strongly agree Agree Disagree Strongly disagree Not applicable

Is the client satisfied with their involvement in their package of care thinking particularly about whether they have choice, have been supported to make their own decisions and have the information needed to do so?

Strongly agree Agree Disagree Strongly disagree Not applicable

Is the client satisfied with the opportunities available to them to:
Engage in leisure and social activities of their choice?

Strongly agree Agree Disagree Strongly disagree Not applicable

Is the client satisfied with the opportunities available to them to:
Take part in activities of their choice (including employment and training if appropriate)?

Strongly agree Agree Disagree Strongly disagree Not applicable

Is the client satisfied with the opportunities available to them to:
Have social contact with others?

Strongly agree Agree Disagree Strongly disagree Not applicable

Appendix 2

User Defined Service Evaluation Questionnaire

Section 1. The nature and extent of support provided.

This section should be kept as brief as possible.

1. Can you tell me about the kind of help that you get from the Telecare Service?
Look for the 'facts': Tasks get help with, how often, by whom/
2. Where else, if at all, do you get support from?

Section 2. Impact on you and your life

There are several things that people have said that are particularly important in life. These are: feeling safe, seeing other people, having things to do, living life as you want as well as where you want and staying as well as possible, avoiding discrimination. Can you tell me if Telecare and the support that they give you makes a difference to you and your lifein respect of:

- Feeling safe
- Seeing other people
- Having things to do
- Living life the way you want
- Living where you want e.g. remaining in your own home
- Staying as well as you can be
- Social Inclusion (Avoiding discrimination / stigma)

3. Is there anything else that you think that the service could or should do?
4. What difference has using this service made to your life?

In this question probe for change outcomes: reduced symptoms; increased confidence and skills; increased mobility.

Section 3. What happens when you use the service

For each question probe for what people in the service do and don't do, and ask for specific examples where possible.

5. What is your experience of people in the service? Do you feel listen to and are your own needs, wishes and circumstances take into account?
6. Do you find that people in the service value you and treat you with respect?
7. If someone has offered you a service is this normally carried out?

8. What choice, if any, do you have over the kind of help you get and when you get that help?
9. Can you tell me if people are responsive to your needs and wishes?
10. Can you tell me if, there anything that you would like people in the service to do differently?

Section 4. Your thoughts on the service overall

11. How, if at all could the service be improved for you?
12. How easy did you find it to get the service?
13. Can you tell me if there been any delays in getting help or support from this service?
14. What do you remember about the equipment being installed?
15. Which piece of equipment is most/least useful?
16. Is there anything else you can think of that would be helpful to you?
17. Is there anything else you would like to tell me about Telecare?
18. Do you have any questions about this interview?

Close

Outcomes Recording Sheet: Review

Name of Service User	Date
Name of Worker	
Other relevant information and reflections	

Outcome	Experience of service user / carer	Score	Learning
Quality of life outcomes: big difference/ small difference/ no difference/ worse			
Safety			
Having things to do			
Social Contact			
Staying as well as you can be			
Living life as you want / where you want			
Change outcomes: big difference / small difference / no difference / worse			
Improved skills			
Improved confidence and morale			
Improved mobility			
Reduced symptoms			
Process outcomes: always / sometimes / never			
Being listened to			
Treated with respect			
Choice			
Reliability			
Responded to			

Appendix 3 Details of Pilot Sites

Pilot site	Activity	Services	Number of staff interviewed
1) Midlothian Council Community Care Review Team	Outcomes-focussed interview using Outcomes Focussed Review form as an additional element of review.	Residential care provided to older people.	2 practitioners 1 Team Leader
2) Residential Care Homes for older people	Consumer involvement exercise involving Outcomes focussed interviews with residents prior to the move to a new home and again several months after the move. (adapted questionnaire)	Residential care provided to older people living in two residential homes preparing for a move to a new purpose built home.	2 practitioners
3) Rapid Response Team	Trial of Outcomes based assessment recording format (Outcomes Recording Sheet: Assessment/Review). (Did not proceed to full pilot)	Provision of care and support packages to enable people to be discharged from hospital after emergency admission or to avoid admission to hospital.	1 Team Leader 1 Manager
4) Adult Protection Case Conferences	Outcomes-focussed interviews with individuals who had been subject to Adult Protection Case	Support services provided to both older people and adults who have a learning disability	1 practitioner (employed specifically for this project).

	Conferences (User Defined Service Evaluation Questionnaire- A.S.P.)	living either in residential care homes or in their own home in the community	
5) Voluntary Organisation Day Care and Home Support Services	Outcomes-focussed interviews with carers using the Outcomes Focussed Review Form and an internally adapted service review form to incorporate Carer defined outcomes.	Day care and home support services provided to older people who have dementia and their carers.	2 practitioners 1 senior manager
6) NHS Mental Health Services	Review of Mental Health services using a questionnaire adapted from UDSET/CDSET Interviews & focus groups undertaken by an independent interviewer.	Range of services provided to people who experience mental ill health and to their carers.	1 manager
7) Telecare	Outcomes-focussed interviews with participants in the Telecare pilot. (User Defined Service Evaluation Questionnaire- Telecare)	Technology within the person's own home designed to support independent living. (Primarily older people and some people who have physical disabilities)	1 practitioner (Undertaken as student project whilst on placement with X Council).

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