

An Outcome-Based Approach to Domiciliary Care

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Abstract

The article presents an approach to commissioning and providing domiciliary care on the basis of outcomes, in the context of current policy. It is suggested that this approach may provide a solution to the over-rigid prescription of time and tasks which has militated against flexibility and responsiveness. It is also a means of ensuring the centrality of service users to the process. The concepts of outcome based working are explained and key steps to implementing an outcome approach are discussed. Early feedback from authorities in the vanguard of this movement are reported.

KEY WORDS: DOMICILIARY CARE, CARE OUTCOMES, CARE PARTNERSHIPS

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Introduction

Increasingly national policy objectives are expressed in terms of the outcomes they are intended to deliver for service users. For example, the National Service Framework for Older People, Intermediate care, Modernising Social Services and Valuing People all refer to working towards specific outcomes, rather than the input oriented approach delivered through conventional provider accreditation, commissioning and service specification developed over the last twelve years. The recent Green Paper states:

We propose clear outcomes for social care derived from what people tell us they want. The outcomes will be used to test and challenge how far social care is moving towards delivering the vision (DoH 2005).

An outcome-based approach is relevant to much of what social services do but the use of outcomes as a basis for working in domiciliary care has particular potential. A joint paper (Lewis J, Sawyer L, 2001) looked in detail at some models of care managed services and their success in supporting frail older people in their own homes with enhanced quality of life and also considered some of the barriers inherent in the system to the delivery of flexible, person-centred home care services. This paper drew attention to:

- the highly prescriptive, short, task oriented visits increasingly commissioned which militate against care providers' ability to respond flexibly to the changing needs of service users
- the inability to promote or maximize independence which was also a consequence of this type of service provision
- the need for greater autonomy for providers so that the relationship between providers and service users became paramount rather than the, often adversarial, relationship between providers and purchasers which tended to marginalize service users
- suggestions that the system is so demotivating and dissatisfying for staff that it could well be contributing to the current crisis in staff recruitment and retention.

From various studies we know what service users, particularly older service users, regard as good quality services. Some of the most recent studies reflect their concerns with the sorts of issues identified in the paper discussed above. Older people set out their views and priorities for health and social care in *Our Future Health* (Help the Aged, 2000), emphasising the importance of the relationship between the individual and their care worker, the need for choice and flexibility over tasks undertaken, the need for the service to be individual and person-centred and for the user to have greater control. Older people also pointed to the need for continuity and flexibility in a recent JRF report. Two other studies (Henwood, 2001; Sinclair *et al*, 2000) reported older people's dislike of care workers' lack of autonomy and flexibility to deliver the type of service which users want and their lack of control over the tasks the care worker could undertake.

What are outcomes and how can this approach be implemented?

If an outcome-based approach is to overcome these barriers to person-centred domiciliary services it is critical that there is better understanding about what this really means in practice. Increasingly authorities are exhorted to move in this direction but are not necessarily clear about the implications and often lack information about, and access to, the available resources.

The Social Policy Research Unit (SPRU) at the University of York has been the main resource for those seeking to implement outcome focused work. A programme of research and development in partnership with a number of local authorities was designed to address at least some of the barriers. Concepts have been thought through and a number of well researched development projects got to grips with many of the practical problems of applying the ideas in practice. There are various useful outputs from this work, one of which is an excellent resource pack (Nicholas *et al*, 2004).

A conceptual framework

Essentially the conceptual framework developed at the University of York offers clarity about outcomes in the context of the often complex and varied situation of individuals needing social care support. The framework distinguishes between maintenance and change but also recognises the importance of the way in which services are delivered.

- A service user might, for example, state that she wanted her home care service to assist her in feeling fresh and clean. This would be regarded as a 'maintenance' outcome and in order to achieve it the service provider would be expected to negotiate with the user and agree what help was needed, within an agreed budget. Rather than specifying a bath or shower on a certain day each week, the service could respond more flexibly to the user's needs and preferences.
- Another service user might say that he hoped to be able to get about better in his own home as a result of the service. This 'change' outcome might well be time limited and although domiciliary care might have a role in helping to achieve the outcome, it is likely that there would be a multi-disciplinary approach which might involve adaptations, equipment, physiotherapy or mobility training etc. The key point is that all members of the team would be focused on achieving the agreed outcome.
- The experience of service 'process' will matter to most service users, for example, feeling that they are valued and treated with respect by staff. This third type of outcome is not so clear in terms of its ability to be monitored and measured because often these outcomes will mean different things to different people. For example 'being valued and treated with respect' might, for some people, mean that the service is culturally sensitive, whilst for others what is important is that they are treated with warmth and friendliness, or that the service is reliable. Setting service process outcomes may only be possible once the user has already received some service. Both the staff (attitudes, competence etc) and the logistics of the service provider organisation will affect the ability to achieve these outcomes.

Another possible category of outcome might be the process of accessing the service. Service users themselves, from a variety of user groups, have suggested this (Joseph Rowntree Foundation, 2003).

Commissioners are likely to have a range of corporate outputs that they want to see delivered as a result of the service, for example a decrease in the numbers admitted long term to care homes or a decrease in the size of care packages over time. Being clear about what is an output and what is an outcome is important – and often difficult. Outputs are likely to be of great interest to audit

and are much more likely to be easily measurable. It will take time and understanding before those whose main preoccupation is accountability for budgets accept outcomes as of equal value and importance in measuring the effectiveness of money spent. What is also important is that corporate outputs are not allowed to conflict with the individual outcomes upon which each care plan should be based.

Implementing an outcomes approach

As suggested above, key to the success of this approach in contributing to more person-centred services is that the outcomes must be the service user's own expression, in everyday language with which he is comfortable, of his aspirations for the service(s). So long as outcomes are used in this way, in which they are meaningful for service users, this is likely to be a very effective means of involving people in thinking and planning for their own services. It is also an effective way of moving from over-rigid prescription of tasks and times to a service which is able to respond to users' changing needs and preferences.

Outcomes are likely to be monitored and reviewed regularly. Once the outcome and an appropriate budget have been agreed, the aim should then be for the service provider to negotiate the day to day details with the service user and to have sufficient autonomy to respond flexibly to the user's needs and preferences. Thus the key relationship should be between provider and service user, rather than between provider and purchaser.

As the interface between care manager and service provider becomes far less 'busy' the care manager will be released to undertake both timely assessments and routine monitoring of the service user's perceptions of the service and its achievements in the form of outcomes. Ideally this data can then be used to develop management information which helps us to understand 'what works' and supports evidence based planning for continual improvement.

Discussions with some of those involved in implementing outcomes suggest that it may be helpful to think in terms of a hierarchy of outcomes. For example, whilst the over-arching outcome might be for an individual to regain independence and control over his own life, progress may be better monitored if there are a series of bite-sized outcomes such as being able to:

- make a simple meal
- dress and undress without help
- wash or shower on his own
- organise his own shopping needs

and so on for the whole range of other activities of daily living (and, of course, determined by the service user). Not only is this likely to give the individual a more rapid sense of achievement but also it will enable staff to focus more clearly on specific areas. If complete independence is not achievable it will provide

clarity about the areas with which there may need to be continued help and it may also enable a more sensitive and appropriate reduction in service provision.

The outcomes experience

We do not yet have a clear picture of which authorities are moving towards implementing an outcomes approach to service provision, however research newly commissioned by SCIE and to be undertaken by SPRU at the University of York will provide us with a better database over the next few months. In the meantime we are aware that the following authorities are among those working towards this goal. Both local authorities and Primary Care Trusts in these areas may be involved:

- Medway
- Thurrock
- Blackpool
- Cheshire
- Nottingham
- Cumbria
- Tameside
- North Lincolnshire
- Torfaen
- Hartlepool

Although not in a position to have undertaken any systematic analysis of these developments, we are aware of some aspects of the experience of the various stakeholders involved in this work.

It is clear that the different areas have chosen to move towards outcome working in very different ways. Thurrock, for example, are piloting the approach in one area with one service provider, whilst Medway – on the other side of the Thames estuary – have introduced an outcome focus on the back of new service contracts throughout their domiciliary care provision.

Authorities' interpretation of approach also varies. Hartlepool, which has made considerable progress and reports significantly improved relationships with service providers, nevertheless consigns all service users with predominantly maintenance outcomes to independent providers and reserves the achieving of change outcomes to the in-house team. Whether or not they will take the further step of involving all providers in the full range of outcomes work is not yet fully resolved, although it is probably an important step in enabling all providers to build stable, successful workforces. No doubt other models are being developed. Building our knowledge of these models and ensuring that there is evaluation of the different approaches is going to be very important over the next two to five years.

Some early feedback is very encouraging. Not only do service users receive a more individual personalised service which is more responsive to their changing needs and preferences (Hartlepool) but also, where outcome-based services have been implemented, we are beginning to get reports of improved staff retention (Blackpool, Hartlepool, Medway, Torfaen). It seems that clarity about the results they are trying to achieve, together with the autonomy to respond more flexibly to service users, is making the provision of home care services much more fulfilling and satisfying to staff.

Barriers and solutions

Whilst an outcome based approach may sound relatively simple there remain significant barriers:

Culture change

One of the greatest challenges lies in achieving the culture change required for effective implementation. Everyone concerned needs to understand the concepts, what the aim is and how it is to be achieved – and this will include finance staff. All those who are directly involved will need to understand the new way of working and how their own role will change.

Experience with key provider stakeholders so far is as follows:

- Care staff often take to the new approach very naturally although there is some un-learning from the over-rigid approach in which they have previously been trained and were expected to operate
- Care providers, particularly those who have experience of providing home care services for privately funded clients, do not find the change difficult, although those whose businesses have been mainly or wholly concerned with services contracted from local or health authorities, may initially miss the security of rigid prescription
- The greatest difficulty appears to be experienced by care managers who find it very difficult to give up the day to day control they have previously enjoyed. Changing from assessing on the basis of needs to assisting service users to state their own chosen outcomes is also a real challenge. In addition there is anxiety at what is perceived as loss of role although in fact, they will retain a pivotal role.

Trust

Anxiety about inadequate levels of trust in independent home care providers is often cited as a barrier to implementing the necessary changes in working. However, some authorities that have gone down this road are reporting growing trust and real partnership working. Hartlepool is one of them. Through establishing a real dialogue and shared ownership of the objective in changing the way of working and through discussion of providers' needs they have been able to reduce the number of providers, reach agreement about contracts and

price, and introduce the changes in a positive and helpful way. In another area, where there was less involvement of providers at an early stage, and where providers had little influence on the content of the contract, there are still some difficulties in developing real trust. Resources for training and/or bringing the various stakeholders together for real and meaningful dialogue, are crucial, as are the other aspects of true partnership:

- open communication
- shared values and goals
- sharing risk
- sharing and working together on problems
- a no-blame culture

Need for champions

Systems, too, such as financial and IT, need to reflect and support the new ways of working, not impede it. In one area (and there may well be others) the whole process of change to a more flexible way of working is being hi-jacked by financial and IT systems which still require detailed pre-planned schedules to which payments are linked. Unless this problem is tackled effectively people both within the authority and those providing services independently are simply going to become increasingly frustrated.

Concerns about finance and audit may act to deter some authorities from moving towards outcome-based service provision. The purchasing of home care has been rigidly based on paying only for contact hours, usually on the basis of visits programmed by care managers and timesheets authorised by service users. The idea that providers may be reducing or increasing the length of visits without authorisation, or using a time budget flexibly over a week or longer, tends to spark off acute anxiety, not to mention all the other possible complexities. Additional issues related to charging service users will also need to be sorted out. Nevertheless these potential difficulties are being addressed successfully in some areas and we need to learn from that experience.

One of the elements of success which has become clear to us is the need for the change to an outcomes approach to be owned and championed at a very high level within the organisation. Often intervention at this level is the only way of ensuring that other departments, such as Finance, are willing to find a way of adapting their requirements to the new way of working.

Service users

The barriers mentioned so far are all on the service provider side. What of the service users? Whilst most reports are encouraging, suggesting that service users are enthusiastic about the change and appreciate the flexibility of the new approach, there has been some feedback which must at least make us think hard about how we introduce a change such as this. In one area, for example, comments reflected a less than enthusiastic response to the proposal that

service users would be helped to regain their independence, of the 'My Mum's worked hard all her life, now its her turn to be looked after' variety. In another area service users were anxious that they were being 'handed over' to independent agencies which would provide services to suit themselves, rather than the service users.

Both these responses indicate the importance of involving service users, introducing the proposed changes very carefully and providing very clear information about how things will work. Having said that, one of the objectives may well be to reduce the level of provision over time as independence is regained, justifying the concerns of users who fear the loss of their home care service. The answer to this may lie in using time gained through greater independence, for an additional agreed period, to support the individual to re-integrate with his or her community. Such a solution would fit well with the proposals in the recent Green Paper.

Contracts

Commonly an outcome approach is introduced on the back of new service contracts. Changing contracts can mean considerable disruption for both staff and service users, and often also for service providers. The focus can all too easily slip from the new way of working to the setting up and management of a new service commitment. We are aware of at least one area where the focus on new contracts predominated, to the detriment of the new way of working, at least for several months. We need to learn more from the whole range of authorities involved about how change has been introduced and what has proved successful in supporting it.

The key elements for success

The check list in *Box 1*, below, may prove helpful:

Box 1: A CHECKLIST FOR SUCCESS

- Clear vision
- Scope the project
- Endure there is a project leader
- Support from a 'champion'
- Secure the environment
 - consultation with users, providers and other stakeholders, and amend plan if appropriate
 - develop relationships – purchaser/provider
 - tender – evaluate and select providers
 - plan and provide training for care managers, provider managers and care workers
- Develop appropriate documentation
- Ensure outcomes express service user experience and expectations
- Evaluation

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