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East Dunbartonshire Council

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OUTCOME-FOCUSED

PRACTICE

GUIDANCE AND TOOLKIT

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INTRODUCTION

East Dunbartonshire is committed to embedding an outcomes-focused approach throughout its processes for assessment and support management with adult customers.

This guide is not intended to be a comprehensive manual on how to practice with an outcomes focus. There are a wide range of publications – most of them available online – which each practitioner will be expected to be familiar with as apart of professional development.

The main aims of this guide are therefore to:

- outline how the new tools introduced into assessment and support management can be used to promote outcome-based work
- discuss the challenges involved in changing practice and how these can be addressed
- describe what an outcomes-focused approach should include
- acknowledge the organisational requirements for this Council in fully supporting the new approach
- provide a virtual toolkit pointing practitioners to some of the materials available to inform practice

SECTION 1 - WHAT IS OUTCOME-FOCUSED PRACTICE?

The following are two standard definitions of what we mean by an 'outcome'.

Outcomes = Impact of support on a person's life.

' The definition of outcomes is the impact or end results of services on a person's life. Outcome-focused services and support therefore aim to achieve the aspirations, goals and priorities identified by service users (and carers) – in contrast to services whose content and/or form of delivery are standardised or determined solely by those who deliver them.'

(Glendinning et al, 2008)

Outcomes can be categorised into the following three areas:

Quality of Life Outcomes = outcomes that support an acceptable quality of life (e.g. being safe and living where you want)

Process Outcomes = the way in which support is delivered (e.g. feeling valued and respected or having a say over how and when support is provided)

Change Outcomes = outcomes that relate to improvements in physical, mental or emotional functioning (e.g. increased confidence or fewer symptoms of depression)

Quality of Life Outcomes

These are also referred to as 'maintenance' or 'preventative' outcomes and are less to do with making significant and more related to ensuring that an adult has an safe, acceptable and stimulating experience of life in whichever setting they may reside.

'Quality of life outcomes centre on having access to normal activities and patterns of life in ways that maximize feelings of choice and control and encompass social, physical and emotional needs'.

- access to social contact and company
- having a sense of social integration
- access to meaningful activity and stimulation
- maximising a sense of autonomy
- maintaining a sense of personal identity
- feeling safe and secure
- feeling financially secure
- being personally clean and comfortable
- living in a clean and comfortable environment

(Bamford and Bruce 2001)

This illustrates that outcome-setting should be offered and applied to people from all groups and ages to achieve small, realistic but meaningful changes to someone's life however structured that might be.

Process Outcomes

Process outcomes are concerned with the desired impacts of services being provided to individuals.

- having a say in services and being listened to
- feeling valued and respected
- being treated as an individual
- being able to relate to other service users
- reliability of response

(Bamford and Bruce 2001)

This includes the quality of the contact customers and carers have of social work staff as well as staff from other agencies.

For example is the experience they have of going through our processes for taking referrals, being allocated a worker, undergoing assessment, support planning and service delivery a positive or a negative one – supportive and informative or deeply frustrating and alienating?

The Scottish Government's Outcomes Framework for Community Care (2009) identified the following desired national outcomes for change:

- improved health
- improved social inclusion
- improved well-being
- improved independence and responsibility

This framework uses the following performance measures:

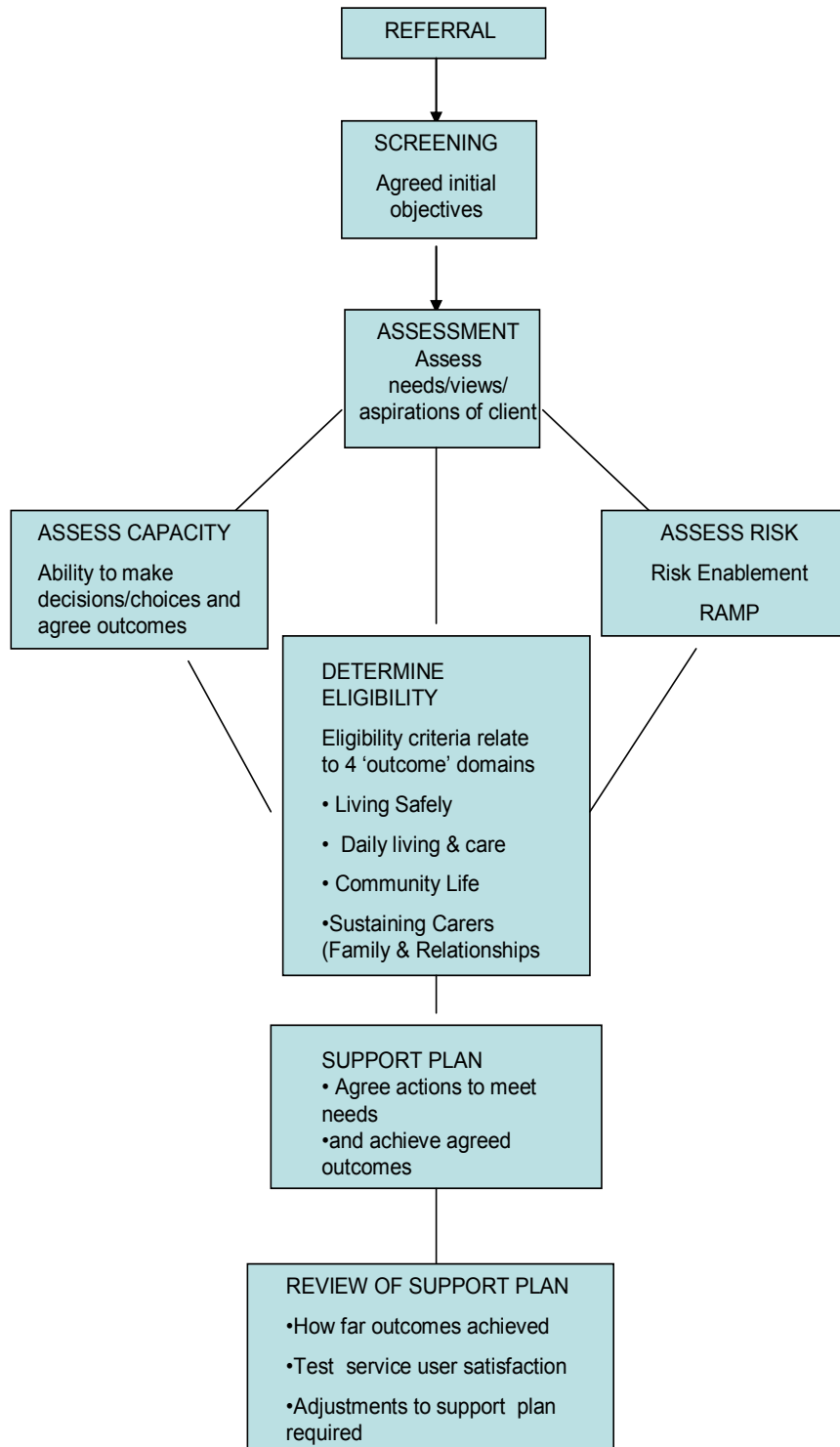
- user and carer satisfaction
 - feeling safe
 - satisfied with their involvement in the design of their care package
 - satisfied with opportunities for social interaction
- faster access to services
- support for carers
- quality of assessment and care planning
- identifying those at risk
- moving services closer to users

Change Outcomes

This would involve significant changes to someone's life which are both positive and (if possible) measurable in promoting an enhanced life situation which might include improvements in

- confidence/morale
- skills
- health/mobility
- social interaction
- relationships
- financial management

PROMOTING OUTCOMES THROUGH THE ASSESSMENT AND SUPPORT MANAGEMENT PROCESS



i) SCREENING

The process of identifying and agreeing outcomes with the service user, carer or referring agency should commence at the point of referral and form part of the screening process.

East Dunbartonshire's Assessment & Care Management Procedures (page 5) illustrate this as follows:

Contact/Referral



Stage 1 Identifying individual outcomes and agreeing them with the person, including risks to independence, health and well-being



Stage 2 Deciding whether needs call for the provision of services and whether a full assessment is required. Agree outcome with the referrer/individual

This is avoid moving immediately to discussing the provision of services with the referrer without first identifying either what the person is wishing to achieve or deciding if an assessment of need is required which will inform a needs-led rather than a service-led approach.

The new Screening Tool to be used within Adult Intake prompts the identifying and agreeing of initial objectives and desired outcomes.

It may not be possible to do more than agree broad initial objectives but this is important. It may be that a more appropriate route can be agreed with the referrer rather than moving directly to the assessment stage including:

- advice and information (see page 8 of Assessment & Care Management Standards on 'Access and Information')
- referral to another service
- no further action

We need to consider if these initial outcomes can be partially or wholly achieved at this point via a more preventative or early intervention approach.

Current examples of this would include:

- the community assets approach for people with mental health problems being developed with East Dunbartonshire in partnership with IRISS
- the dementia advisory clinic being run with KHCC
- the groupwork approach for new referrals being implemented within the Community Addiction Team
- the role of our Local Area Co-ordinators in providing an alternative to formal social work intervention whose work centres around agreed goals

The expectations of the referrer will be a factor in all this. The skill in screening effectively and sensitively will be to respond appropriately to those who contact us with a clear (or in some cases fixed) idea of what they want for themselves or the person they are referring by moving the conversation onto objectives. The provision of an interim or emergency service may be required on occasions but this still needs to form part of a longer-term strategy.

However ensuring that this becomes more than just tokenism and ticking a box will be dependent on all staff involved in taking referrals consciously adjusting their approach and the time they devote to an 'outcomes conversation' with the referrer.

ii) **ASSESSMENT**

Single Shareable Assessment

Within the Assessment & Care Management Procedures the following performance criteria relate to Standard 3 on 'Assessments' :

The opportunities for the customer to fully participate in the assessment process will be maximised, including evidence of their views and expectations

The outcome of the assessment emphasises the strengths, abilities and aspirations of the customer as well as needs and difficulties

You should be clear about the difference between 'assessing need' and 'setting outcomes'. These are complementary but distinct processes.

Our social work assessments via Single Shareable Assessment formats will continue to be primarily a professional assessment of need in order to fulfil

our legal duty in this area. Whilst striving to fully involve the person assessed and significant others in the process the conclusion of the assessment must be a reflection of the assessor's view of the person's needs.

'Need' has been defined as

'the requirements of individuals to enable them to achieve, maintain or restore an acceptable level of social independence or quality of life as defined by the particular care agency or authority' (Department of Health 1991)

In other words meeting assessed needs provides the building blocks for working towards agreed outcomes and needs still should be clearly specified.

The formal agreement with the customer around outcomes comes later at the Support Plan stage. However it is vital that the assessment provides the 'raw material' and evidence for setting outcomes by its emphasis on the following:

- strengths and competence of person
- emotional/psychological needs as well as physical needs
- relationships with others and social networks
- views and aspirations of the person (and/or carer, advocacy worker or significant others)
- ways of sustaining and promoting independence and (if it is the case) breaking a relationship of dependency with services and/or professional support

Risk Assessment

'Risk is often seen as a negative thing with negative consequences. However, in taking an outcomes-focused approach, people's desired outcomes may well involve them undertaking a certain amount of 'risky' behaviour, which needs to be given consideration and supported by the practitioner. Additionally, practitioners themselves may find applying an outcomes approach 'risky'. With an outcomes focused approach it is important to move away from more traditional attitudes to risk that centre around avoiding all risks to people that receive support and towards the concept of taking risks in a positive and mindful way to allow them to achieve their desired outcomes'.

IRISS Leading for Outcomes: A Guide

‘Working to achieve outcomes that promote independent living will inevitably involve risk. Risk averse practice can lead to over protection and can unnecessarily inhibit ambitions and aspirations. Risk aversive practice can also significantly inhibit the choices and empowerment of individuals and families who are denied the opportunity for self-directed support, particularly for reasons relating to perceived legal barriers to uptake. It is important to identify and manage risk in a way that is shared among the person, family and friends, the Council and the provider(s).

The shift to co-production, outcomes monitoring and risk enablement will require training for staff across the social care and health sectors, and leadership from all levels of management. It will be all the more important that individuals and families understand risk and the responsibility for accepting levels of risk, if a culture that focuses on the failure of social work to intervene is to give way to enabling people to have control’.

Scottish Government: Self Directed Support: A Strategy for Scotland 2010

Agreeing outcomes involves the practitioner identifying and evaluating risk within the following areas:

- risks to the person
- risks to informal carers
- risks to support provider(s) - as an organisation or to individual staff
- risks to the practitioner – accountability if things go wrong, uncertainty around innovation

Outcome-focused work does not sit outwith the Council’s normal statutory obligations and a proportionate response is required where the actions of the client may lead to harm or exploitation.

All assessment formats should incorporate at least a baseline assessment of risk and a summary of risks alongside assessed needs.

Where identified risks are more significant and complex the RAMP (Risk Assessment and Management Procedures) process should be triggered to assess risks and draw up a risk management plan. However the customer’s potential for enablement and autonomy should be built in at all stages of risk planning.

Assessment of capacity

All assessment should also incorporate at least a baseline assessment of the person's mental capacity. This will determine the extent to which the customer can be involved in identifying outcomes.

Where the person is unable to fully participate the involvement of an proxy, carer/relative or advocacy worker will help inform the outcomes process.

'Dementia can pose challenges to the outcomes conversation especially if there are communication impairments where the person with dementia has difficulty using or understanding language. When this happens, the interpretation of nonverbal communication and observation skills become even more important. It is important to remember that all behaviour in dementia is communication, so staff will need to try harder to work out what is being 'said'. The outcomes conversation relies heavily on staff's capability to ask the right questions and to be an active listener.....using an alternative communication tool such as Talking Mats can help for those with communication impairments'.

IRISS Leading for Outcomes – Dementia

iii) ELIGIBILITY

Although an initial determination of eligibility takes place at referral following screening the substantive categorisation in line with the Council's eligibility policy occurs at the point between the completion of the assessment and the decision to proceed to constructing a support plan.

The 'priority/risk matrix' contained within the Assessment & Care Management Procedures (pages 11-15) is structured around four outcome 'domains' namely

- living safely
- being enabled to maintain personal care and domestic routines
- participating in community life
- sustaining the carer(s) in their caring role

This will involve the practitioner not only evidencing the need for a service to be provided and the risks inherent in its not being provided but also gearing this to the achievement of outcomes within one or more domains.

The revised CC4 format (now entitled Access to Resources) deliberately starts from agreed outcomes recorded in the first column before moving on to specifying the services recommended to contribute to those outcomes backed by the eligibility domains and risk categories.

iv) SUPPORT PLANNING

Good support planning lies at the heart of an outcome-focused approach.

Setting and working to objectives is what social workers have always done.

The Support Plan tool (see Appendix 2) provides a structured format for identifying and agreeing desired outcomes with clients (or carers) across a range of life 'domains':

1. Community Life
2. Family and Relationships
3. Managing Money
4. Health and Wellbeing
5. Home and Domestic Environment
6. Daily Living and Care
7. Living Safely

The key processes within the tool are:

- converting assessed needs to outcomes
- building a bridge between assessment and support planning
- agreeing actions to work towards outcomes identifying by whom and by when
- where required converting agreed actions into one or more proposed services (subject to eligibility and authorisation of expenditure)
- populating a support timetable to illustrate how these services will be delivered
- detailing the cost of the proposed services including if applicable the charge which would be made to the client if the service is provided

- identifying the proposed finance stream to meet all or part of the proposed services i.e.
 - funded via a direct payment
 - funded via a personal budget
 - provided directly by the local authority
- outlining a contingency plan to cover any emergencies

Practice notes

1. This is a support plan and services proposed within it can only commence once an Access to Resources proforma has been authorised by the relevant manager.
2. It is intended to be a 'living document' recognising that in some cases a support plan will need to be developed and amended over time as the process of assessment is ongoing and as the relationship with the customer and/or carer builds.
3. This means that it is only necessary to complete the 'domains' which are judged to be relevant at any point i.e. you should not attempt to complete all the domains for the sake of completeness - gaps are acceptable if they can be justified. You may decide with the customer to focus on only one or two outcomes which can then be reviewed at a later date.
4. However each Support Plan signed off by the worker and customer should stand alone as a record of the agreement at that particular date. You should not attempt to amend a Support Plan once it has been signed off and should prepare a fresh Plan should the outcomes being worked on change significantly.
5. The Support Plan does not require to be signed off ahead of an urgent service commencing as long as the latter has been authorised via an Access to Resources proforma. It is preferable that a Plan as far as possible reflects the 'package' of support going in to meet outcomes.
6. Emergency situations aside a Support Plan should accompany all requests for funding of services whether to the fund holding manager or as part of an Additional Expenditure Request (AER).
7. Support planning should not however be a routinised matching of assessed needs to the nearest outcome - it is an opportunity to 'think outwith the box' with the client or carer.

8. Support Plans form part of the Single Shareable Assessment framework and should therefore be shared internally (e.g. homecare, occupational therapy, joint teams) as well as with other relevant professionals/agencies with the consent of the customers or proxy.

9. Ensure that the Support Plan distinguishes clearly between
 - Needs - what is required to achieve an outcome?

 - Actions - how/when will we go about achieving an outcome and who has responsibility?

 - Outcomes - what is the end result or impact we are aiming for?

Link to standards

Standard 6 around 'care planning' within the Assessment and Care Management Procedures (page 17) includes the following performance criteria to be adhered to:

- the care plan will be completed within four weeks of the completion of the assessment

- the customer has been fully involved in drawing up the care plan and agreeing objectives/outcomes

- the customer or carer will be provided with a user-friendly version of the care plan within four weeks of the completion of the assessment which will include a meeting with the customer

This requires that at least an interim Support Plan is agreed with the client within this timescale even if the fully-formed Plan justifiably takes longer than this.

Standard 7 on implementing the care plan (page 18) states that

'The care manager will adopt a personalised and outcomes-based approach to meeting needs wherever possible with matching to existing services being only one of a range of option'.

The Support Plan tool should provide a comprehensive and collated picture of the overall direction of travel between the practitioner and customer.

However it is not intended to replace existing planning tools or more specialised tools or processes addressing work in specific areas, including:

- Person-Centred Planning – used with people with a learning disability and other groups
- Risk Enablement - used primarily with older and physically disabled people and based around an outcomes framework (see Appendix 3)
- Recovery Model - no specific tools but an approach used within both Addiction and Mental Health emphasising the need for customers to move on from 'treatment' and for work on aspects of recovery to commence if possible in tandem with treatment (as part of a support plan) rather than waiting for treatment to be concluded. Areas for recovery-based work would tie in with the outcome domains within the Support Plan including Community Life and Health & Wellbeing relating to access to education , employment and leisure activities.
- Care Programme Approach - used within Mental Health to agree objectives and review progress.

v) **REVIEWING INTERVENTION**

The Review of Support Plan tool provides a format for the following:

- reviewing progress in achieving agreed outcomes
- identifying 'what is working' and 'what is not working' in progressing outcomes
- agreeing what (if anything) needs to change in order to facilitate outcome achievement
- recording a judgement as to whether each outcome has been
 - fully met
 - partially met
 - not met at all
- gauging the views of significant others, including family members and support agencies
- reviewing support costs and identifying if the need for changes in the support 'package' are indicated
- including a standardised brief questionnaire for the client to record his or her level of satisfaction with the service(s) provided including
 - how far customer involved in designing and reviewing the support package

- the quality of the support/care provided
- opportunities for social interaction
- inclusion of a question within the above questionnaire for one or more carers (if there is one) as to whether they feel supported in and capable of continuing the caring role
- a summary of the review detailing
 - agreed outcomes (either continuing, new or amended)
 - agreed actions and by whom and by when

Practice notes

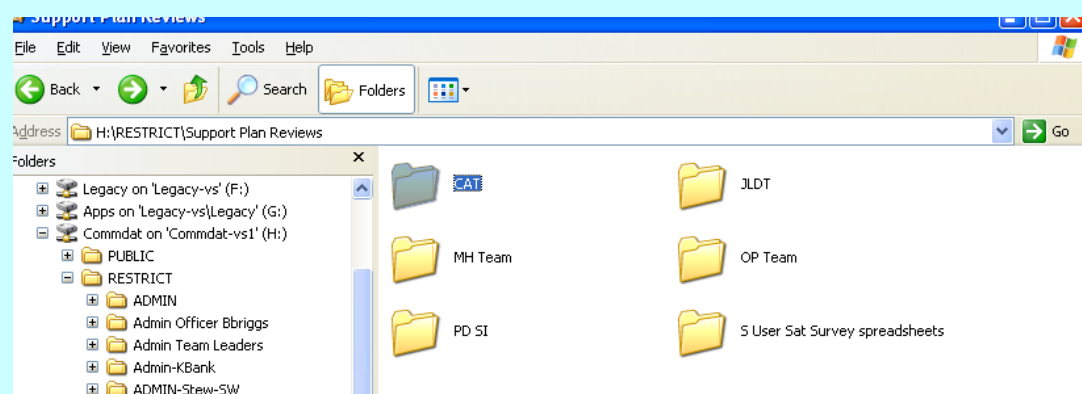
- outcomes reviewed should link to those agreed within the Support Plan
- where the requirement to alter the support package entails additional expenditure this can only be confirmed to the client and/or carer once authorised by the relevant manager
- all completed Review of Support Plan documents should be saved into a single folder to be used across all teams in order to collate all reviews for purposes of data collection - see procedure for doing this in the box below

Saving Review of Support Plan documents

A new folder has been created on the network called H:\Restrict\Support Plan Reviews, to which all relevant staff should now have access. With effect from 1 April, 2012 all Support Plan Reviews should be saved within this new folder as directed below.

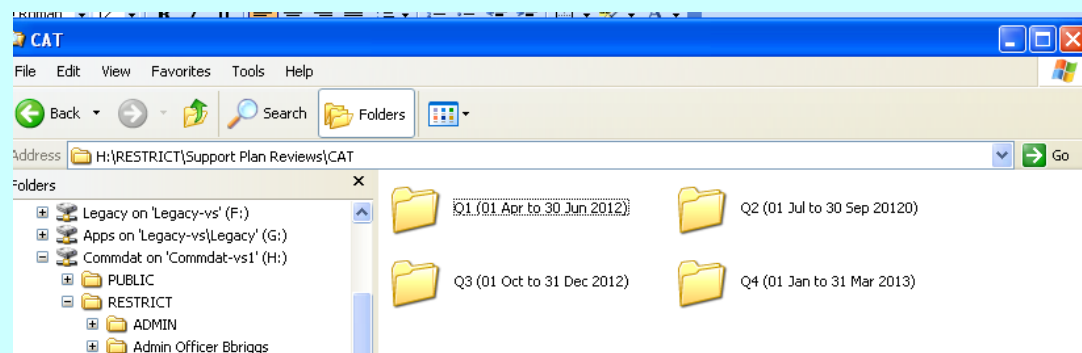
Within the new folder there are 6 sub folders, namely:-

- CAT
- JLDT
- MH Team
- OP Team
- PD SI
- S User Sat Survey spreadsheets – For Admin Team Use Only



Within each of the team sub folders there are a further set of sub folders denoting the 4 quarters of the year:-

- Q1 (01 Apr to 30 Jun 2012)
- Q2 (01 Jul to 30 Sep 2012)
- Q3 (01 Oct to 31 Dec 2012)
- Q4 (01 Jan to 31 Mar 2013)



The Support Plan Reviews should be saved into the Team's folder and then the relevant quarter folder relating to the date the review took place, and named as follows:-

Date of review (format is Year.Month.Day) Surname comma First Initial (Worker's Initials) ie 12.04.01 Smith, J (DH)

Link to standards

Standard 10 headed 'Monitoring and Reviewing' includes the following performance criteria:

- the review format will focus on outcomes for the customer and/or carer both in evaluating progress towards previously agreed objectives and in setting new objectives
- the customer will as far as possible be involved in the planning and conduct of the review

Standard 13 on 'Evaluation' states that

- use of standard leaflets or questionnaires to obtain feedback around satisfaction/experience from all or a proportion of customers who have received a service
- piloting of more formal tools to provide a wider and more in-depth picture of the views of and outcomes for a customer or carer following interventions

SECTION 3 - BARRIERS/CHALLENGES TO OUTCOME-FOCUSED PRACTICE

In order to deliver an outcomes-focused approach we need to be aware of and tackle potential barriers both externally and with in ourselves as practitioners.

This will involve action in the following five areas:

1. Changing your practice

- being aware of how your own values and beliefs may influence the 'outcomes conversation' and skew the setting of objectives towards what you think is desirable and achievable rather than the customer's preferred goals.
- practising anti-oppressively so that our assumptions or views around age, disability, gender and sexuality do not inappropriately restrict goal-setting - taking religious and cultural preferences into account
- ensuring that the Support Plan starts from agreed outcomes rather than identifying available services to meet assessed needs
- placing an emphasis on the practitioner as a 'resource' - building a relationship with the customer or carer to uncover aspirations, build confidence and assertiveness and resolve dilemmas

2. Taking clients (and carers) with you

- recognising that customers and carers can also be bound by a service-driven approach and can understandably opt for the known and the reliable rather than the challenging and not-yet-existing
- customers/carers may regard an outcomes approach as a cost-saving exercise or a way of restricting access to particular known resources
- balancing the autonomy and decision-taking of the client whilst acknowledging the views of carers and others who may have concerns/anxieties around altering the model of support - involving proxies and advocacy workers where someone assessed as lacking capacity

3. Competing objectives - whose outcomes?

- resolving any conflicts around desired outcomes between clients and family members (or significant others) e.g. impact on carer of setting new objectives
- balancing 'risk management' and 'risk enablement' approaches and being explicit where this impacts of goal-setting
- reconciling any conflict between meeting the needs/aspirations of the customer and others e.g. safeguarding child affected by parental substance misuse where the welfare of the child is paramount - if statutory planning requires to override client objectives this needs to be transparent and recorded

4. Involving other agencies

- many outcomes will only be achieved with the active co-operation of other professional/agencies
- social work support planning needs to be integrated with other goals e.g. clinical priorities to improve health and wellbeing, pathway to securing accommodation set by housing agency, routes to employment
- requires Social Work to be clear to referring agency where latter has an expectation that a 'service' will be routinely delivered
- work with internal and external support providers where model of support requires to be innovative and flexible in order to facilitate outcomes e.g. maximising benefit from homecare and day services around areas of focus and choice of times/activities, promoting independent living, work on daily living skills, widening community activity - involving commissioning staff where necessary

5. Maximising the use of limited resources

- an outcomes approach is not about diverting people from existing services in order to reduce costs - nor is it only aimed at people wishing 'personalised' support via direct payments - it is applicable to all clients

- however in an era of shrinking budgets and increasing demand this approach should prompt a 'lateral thinking' and a more creative approach focusing on preventative measures where possible and maximising the use of community networks and resources

SECTION 4 - DEVELOPING AN OUTCOMES APPROACH

i) BUILDING RELATIONSHIPS

An emphasis on forming good constructive relationships with customers in order to build confidence and trust and work therapeutically has always been at the heart of social work.

Practitioners have reported that outcomes based working has re-asserted their role as a significant resource in working with individuals. Until recently there has been a reduced emphasis on the importance of relationship building with people using services. An outcomes based approach is based on more direct involvement with people, and the role of the professional as agent of change. This can require quite a different emphasis for staff who have become used to very prescriptive ways of working, and staff need to know they have permission to do things differently

Outcomes focused work is based on the concept of a conversation, based around the outcomes that we know are important to people. Practitioners are therefore establishing rapport and listening to the person's 'story'. Where practitioners have become used to pre-determined question and answer formats, it can be a challenge to move towards less structured formats. There is significant skill involved in being able to work flexibly around a framework of outcomes, allowing the person to determine the order in which they want to talk about their lives, while ensuring that core areas are covered.

Smale et al (1993) describe three models of assessment;

The **questioning model** – where the *assessor* is the expert and asks all the questions in order to determine what the person needs

The **procedural model** – where the *forms and procedures* are the expert and the assessor just follows their instructions which will determine what services should be provided

The **exchange model** – where *everyone* is an expert, including the assessor, service user (by experience) and carer, assessments and planning including review are therefore co-produced.

An outcomes approach would support the "exchange model" where the strengths, capacity and aspirations of the services users are central to the assessment.

Johnstone/Miller 2010

Practice notes

- it may take more time
- it places even more of an emphasis on eliciting the client's views and aspirations including where the person has difficulty in communicating
- think why it might be hard for someone to identify specific objectives
- customers may be distrustful, uncomfortable and find it difficult to be open and honest if there is current or previous statutory intervention, for example in relation to child or adult protection. You need to spend time trying to uncover the reasons for any presentation of fear, distrust or resistance
- customers who lack self-esteem will find it difficult to acknowledge positive aspects within their lives or strive towards changing their behaviour or life situation towards what they might dismiss as an 'ideal' and unattainable.

Using a 'strengths and values' approach may assist with this - see the resource from Hamer (2005) using 'strengths' and 'values' cards which can be downloaded in the Toolkit section.

'Dementia can pose challenges to the outcomes conversation especially if there are communication impairments where the person with dementia has difficulty using or understanding language. When this happens, the interpretation of nonverbal communication and observation skills become even more important. It is important to remember that all behaviour in dementia is communication, so staff will need to try harder to work out what is being 'said'. The outcomes conversation relies heavily on staff's capability to ask the right questions and to be an active listener. An insight into the person with dementia's personal background can help to understand them and what they are trying to communicate. Using an alternative communication tool such as Talking Mats can help those with communication impairments'.

IRISS Leading for Outcomes: Dementia

ii) **SETTING OUTCOMES**

Agreeing the right outcomes is important if he or she is to see them as achievable and be motivated to work towards them.

Practice notes

- use the domain framework within the Support Plan as a guide but do not be constrained by this or use more domains than are relevant and achievable at any one point
- think in all three outcome categories i.e. quality of life, process and change
- think in **SMART** terms
 - Specific**
 - Measurable**
 - Attainable**
 - Relevant**
 - Time-bound (or Trackable)**
- if possible start with **small and achievable** goals initially
- however bear in mind that some clients may find it difficult to identify small or 'quick win' objectives rather than focusing on one large goal such as - in the case of a parent with substance misuse - 'I want to get my children back'
- you may need a mixture of 'hard' (SMART) and 'soft' (non-SMART) outcomes
- wherever possible and appropriate involve partners, carers, other family members or other professionals in the outcome setting process
- you may need to negotiate - if there is a conflict of outcomes between practitioner and client or between customer and carer/family be explicit about this (see Section 3)
- you can also work with carers towards outcomes (see example below) as long as these are compatible or negotiated with the customer's outcomes

- consider setting 'core intervention' areas for your own team (see example below) - not to standardise or constrain work with any individual but to agree a framework for intervention

Core intervention and risk areas - Aberlour Scotland (from IRISS Leading for Outcomes: Parental Substance Misuse)

Risk Reduction	Resilience	Parenting	Dependency	Life Skills
Child Health	Secure Base:	Basic Care	Legal Issues	Education/ Training
Safety at Home and in the Community	- Attachment - Friendships - Self-Esteem	Attachment/ Emotional Warmth	Physical Health	Employment
Safe Relationships and Keeping Safe	Self-Efficacy	Stimulation	Psychological Health	Home Making/ Finance Management
Housing/ Safe Environment	- Social Competencies - Education	Guidance and Boundaries	Current Substance Use (and medication)	Emotional Literacy
Pregnancy		Family Background/ Experience of being parented	Substance Use History	Social Competencies
		Significant Relationships	Self-Efficacy and Motivation	

The IRISS Leading for Outcomes guide on dementia provides some examples of outcomes relating to this group.

Outcomes important to people with dementia

Quality of life outcomes centre on having access to normal activities and patterns of life in ways that maximize feelings of choice and control and encompass social, physical and emotional needs

Access to social contact and company
Having a sense of social integration
Access to meaningful activity and stimulation
Maximising a sense of autonomy
Maintaining a sense of personal identity
Feeling safe and secure
Feeling financially secure
Being personally clean and comfortable
Living in a clean and comfortable environment.

Service-process outcomes are concerned with the desired impacts of service delivery'.

Having a say in services
Feeling valued and respected
Being treated as an individual
Being able to relate to other service users.

(Bamford and Bruce, 2001)

SECTION 5 - SUPPORT AND EVALUATION

i) SUPERVISION

Outcome-focused practice also involves a shift by both line manager and the practitioner around how supervision sessions are structured both in terms of examining the overall approach by the practitioner and a focus on objective-setting when discussing cases.

This may well already form the basis for your supervision and an explicit move to a dialogue around outcomes will not be significant.

The template used in supervision should record agreement on the outcomes for each case discussed embedded within the Support Plan.

There are strong parallels between the role of the practitioner working with the individual to identify and work towards the outcomes important to them, and the role of the supervisor working with the practitioner to identify their strengths and skills, and to be outcomes focused in the work that they do.

Outcomes focused supervision requires a future focus, developing clear descriptions of the desired outcomes and goals, and envisaging the endpoint at the beginning. Just as a focus of work with people using services is to formulate a plan with a clear sense of direction, a key outcome for the professional leaving supervision or support session is that they will have a sense of clarity about the direction of the work and steps they are going to take [.....]

It is also an opportunity to explore the concept of risk enablement and support reasonable risk taking, such as those taken by most of us in our everyday lives, which can create learning opportunities. [.....]

Reflective practice is necessary to support an outcomes focus and it is helpful to think of outcomes for staff being as important for outcomes for users and carers e.g. feeling valued and respected. Just as the professional needs to actively listen to the person they are supporting, the supervisor needs to listen to staff with a constructive ear, listening for positive aspects of practice and identifying things that are going well. Although it is tempting for the busy supervisor to provide quick answers to the practitioner under pressure, supporting staff to be reflective in their practice enables them to think more independently in the longer term.

Johnstone & Miller 2010

Progress in evidencing an outcome-focused approach in practice should be included in objectives set within professional development sessions, including post-qualification programmes and PDR.

ii) REFLECTIVE PRACTICE

Each practitioner should take responsibility for encouraging and facilitating reflective practice both within your own team and across teams.

The positive feedback from the 'action learning sets' run within the Outcome-Focused Practice training would underline the potential benefits of taking time out to share experiences, voice uncertainties and offer advice and suggestions within a safely constituted group with clear parameters. Support from managers will be available to assist in establishing such groups.

As with any new approach to working, motivation is key to sustaining and embedding an outcomes approach. Letting staff know that their feedback is important and valued is one way to motivate them. Other methods could include:

Staff development days where staff have a chance to share their success stories of using an outcomes approach and positive feedback from people who use services. These days can also be a good opportunity to develop stronger links between managers and frontline staff.

Action learning sets could be built into development events. An 'action learning set' refers to a small group of individuals that work together to reflect on practice, discuss challenges and possible solutions with a view to improving performance. These group discussions harness peer support and the sharing of practice wisdom, experience and creative problem solving.

Smaller scale events such as lunchtime seminars could be organised to bring staff together regularly in an informal way. Staff could suggest themes and agendas for these seminars, promoting a sense of ownership.

A network of champions and enthusiasts for the approach could prove a valuable source of inspiration and support to keep staff motivated.

Communities of Practice that meet face to face and / or online can also provide a means for continuing the dialogue about outcomes, exchanging experiences and sharing ideas. The Supporting Better Outcomes Community of Practice is one example that staff can become part of

(<http://www.idea.gov.uk/idk/core/page.do?pageld=8934336>)

(IRISS Leading for Outcomes)

iii) EVALUATING PERFORMANCE

Measuring outcomes is notoriously difficult and a recent paper from IRISS outlines some of the challenges (Miller 2011) including:

- the purpose of measuring outcomes - improving practice or evaluating practitioner performance?
- how easy is it to measure 'softer' outcomes around 'quality of life' or the client's experience ('process')?
- how far can practitioners be either credited for positive change or held responsible for negative effects from 'unintended consequences'?
- how do we avoid outcome tools (such as the Support Plan) becoming just another form and being mechanically completed?
- variations between service users or customer groups around age, health, expectations, future focus etc.

However we need to demonstrate what methods the Council has in place to evaluate our effectiveness partly because we would want to do this as professionals but also we will otherwise be evaluated by other organisations.

It is an ongoing process but to date we have:

- included a basic measure for agreed outcomes within the Review of Support tool allowing practitioners and customers/carers to judge at each review whether a particular outcome has been fully or partially achieved or not at all
- incorporated a brief questionnaire for customers within the Review of Support Plan to prompt regular feedback on satisfaction levels
- set performance criteria attached to each standard within the Assessment & Care Management Procedures
- included questions on outcomes within the tool used for the annual Community Care case audit - including a judgement by the auditor as to how far changes in the customer's situation (positive and negative) can be attributed to the practitioner
- included a question on evidence of outcomes work within the tool used by team managers for case sampling
- linked with our Information Development and Performance Team in designing the tools to facilitate some measuring of our effectiveness

You can avoid the completion of the support planning tools becoming routine or tokenistic referring to the section on Setting Outcomes by

- setting simple achievable objectives as well as longer-term outcomes
- ensuring agreed outcomes are SMART
- not trying to complete all the outcome domains only the ones that are meaningful and relevant
- 'making the shift' in your whole approach to work with customers and initiating shared opportunities with colleagues to sustain and motivate

SECTION 6 - TOOLKIT

East Dunbartonshire Outcomes Tools

**Support Plan
Review of Support Plan
Risk Enablement Planning
Assessment and Care Management Procedures**

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

Leading for Outcomes

<http://www.iriss.org.uk/category/resource-categories/leading-outcomes>

Leading for Outcomes - Dementia

<http://www.iriss.org.uk/resources/leading-outcomes-dementia>

Leading for Outcomes - Parental Substance Misuse

<http://www.iriss.org.uk/resources/leading-outcomes-parental-substance-misuse>

Reshaping Care and Support Planning of Outcomes

<http://content.iriss.org.uk/careandsupport/>

Joint Improvement Team

The outcomes conversation

<http://arcuk.org.uk/scotland/files/2011/08/JIT-Good-conversations.pdf>

Talking Points ; an outcomes approach

<http://www.jitscotland.org.uk/action-areas/talking-points-user-and-carer-involvement/>

Other resources

Talking Mats

<http://www.jrf.org.uk/publications/using-talking-mats-help-people-with-dementia-communicate>

Outcomes Star

<http://www.outcomesstar.org.uk/>

http://www.careknowledge.com/uploadedFiles/CareKnowledge_CMS/Public/Journals/Housing_Care_and_Support/HCS2011/The_development.pdf

Strengths and Values Cards

<http://www.option-2.moonfruit.com/#/tools-resources/4549822903>

http://www.another-way.co.uk/downloads_page.htm

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Hamer, M (2005) Preventing breakdown: A manual for those working with families and the individuals within them, Dorset: Russell House Publishing

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Institute for Research and Innovation in Social Services (IRISS) Leading for Outcomes - A Guide

Institute for Research and Innovation in Social Services (IRISS) Leading for Outcomes - Dementia

Institute for Research and Innovation in Social Services (IRISS) Leading for Outcomes - Parental Substance Misuse

Smale G et al (1993) Empowerment, assessment, care management and the skilled worker London HMSO