

Outcomes in Community Care Practice

NUMBER FIVE

OVERVIEW: **OUTCOMES OF SOCIAL CARE FOR OLDER PEOPLE AND CARERS**

Hazel Qureshi, Charles Patmore,
Elinor Nicholas and Claire Bamford



THE UNIVERSITY *of York*

© Social Policy Research Unit

Outcomes in Community Care Practice Series

First published by the Social Policy Research Unit 1998

ISBN 1 871713 37 4

ISSN 1365-9839

This work was undertaken by the Social Policy Research Unit at the University of York which receives support from the Department of Health; the views expressed in this publication are those of the authors and not necessarily those of the Department of Health.

© Cover Photographs: John Birdsall Photography
Library photographs posed by models

Typeset by Jenny Bowes in the Social Policy Research Unit

Printed by the University of York Printing Unit

CONTENTS

Introduction	1
Background	1
Methodology	1
Structure of the Overview	2
Findings	3
Access and exclusion	3
Outcomes for older people	3
Introduction	3
Outcomes involving change rather than maintenance or prevention	4
Changes in symptoms and behaviour	4
Improvement in physical functioning	5
Improving confidence and skills	5
Improving morale	5
Outcomes for maintenance or prevention	5
Meeting of basic physical needs	6
Personal safety and security	7
Being able to live in a clean and tidy environment	7
Keeping alert and active	8
Access to social contact and company	9
Being in control of your life	9
Outcomes which relate to the way services are delivered	10
Valued and treated with respect	10
Treated as a person	11
User 'has a say' in services	11
Value for money	11
A 'good fit' with existing care giving and receiving within the family	11
A 'good fit' with cultural and religious preferences and requirements	12
Outcomes for carers	12
Introduction	12
Quality of life for carers	12
Freedom to have a life of your own	13
Maintaining health and well-being	13
Preventing social isolation	13
Peace of mind	13
Service process outcomes for carers - the way services are delivered	14
A sense of shared responsibility	14
Carer has 'a say' in services	14
Confidence in services	15
Summary and Conclusion	15
Appendix One: Development proposals	19
Appendix Two: The evidence base	27
References	31

INTRODUCTION

Background

The longer term aim of the SPRU outcomes programme is to develop and test ways in which social care agencies can collect and use information about the outcomes of services on a regular or routine basis. The brief for this initial phase of research was to explore the views of older people who used services, carers and staff at different levels in a given social services department, in order to discover what they would identify as the outcomes of social care for older people, and to investigate possible ways of collecting and using outcome information. This knowledge is then to be used as a basis for developing methods of collecting outcome information for trial use in the given department.

Fundamental to the SPRU programme is the idea that ensuring that outcome information is practical and useful is not simply a matter of developing measurement tools. Rather, the aim must be to establish a complete feedback loop in which relevant and useful information is collected, correctly interpreted and acted on. This first phase was designed to identify the right information to collect, based on evidence about the outcomes identified by older people and carers, and the views of staff about what they are trying to achieve. However, closing the feedback loop means that organisational and professional culture and practice also have to be taken into account (although not necessarily left unchanged) in thinking through what is likely to be practical and useful. Therefore staff and managers were also asked about the scope for considering outcomes in their work, and the ways in which such information might contribute to solving current departmental concerns. This overview summarises the outcomes identified in phase one and discusses consensus and conflict among different stakeholders about these outcomes and the ways in which they should be delivered.

Methodology

It was widely accepted that the language of outcomes was unfamiliar to many older people and their family carers, as well as to many staff in social care services. We therefore undertook a considerable amount of methodological preparation, including testing focus group methods such as ranking exercises, and the use of vignettes or fictional case studies (Unell and Bagshaw, 1997). We were able to build on this work, but methods varied in detail for different groups of older people, depending on: how access to the group was obtained, the wishes of individuals, practical considerations, and existing literature and expert advice and assistance on suitable methods of consultation with specific groups. Older people were consulted using group and individual interviews, with several groups meeting on more than one occasion in order to allow a fully deliberative approach with time for people to consider the issues, discuss and possibly change their opinions (Stewart, 1996). We involved people with physical impairments (high and low users of home care), people with dementia, people

with functional mental illness, users of social day care, and older people from minority ethnic groups. Two groups of carers, resident and non-resident, were also involved. Staff involved included home care, day care and care management staff and a range of managers. Details are given in Appendix Two.

Structure of the Overview

The structure of the Overview follows an important distinction made by staff and managers between:

- Outcomes which reflect the intention to achieve improvement in an older person's mental or physical condition over time, to a point where services could be reduced or withdrawn
- Outcomes which reflect situations in which only slight improvement, stability or deterioration in the person's condition was expected, where continuing maintenance of an acceptable quality of life was the aim.

Informal estimates by staff were that around 85 per cent of their work was directed towards the second kind of outcome. For the majority of people an intended outcome of home care services, for example, was to meet their physical needs in a continuing way, day after day. Similarly the intended purpose of alarm systems or check-up calls was to ensure continuing safety and reassurance where the person was considered to be at risk. This difference between services aiming to achieve change, and services aiming to continually maintain acceptable levels of outcome, has implications for the ways in which outcomes should be assessed and interpreted.

After an initial comment on access to services, this Overview will first list and describe the outcomes most often mentioned in relation to time limited change, and, second list the outcomes where the intention of services is that they should be sustained or maintained in a continuous way. Third, outcomes which relate to the impact of *the way services are delivered* on how people feel, are listed. These last service process outcomes apply whether the aim is change or maintenance. Outcomes for carers are listed separately from outcomes for older people who use services. Finally, a summary section draws together the findings and considers some of the issues involved in using the outcomes in practice. Appendix One briefly describes stakeholder views on how information about outcomes should be collected, and outlines the resulting development proposals in relation to the local organisational context. The development proposals will be taken forward during the next stage of the SPRU programme.

FINDINGS

1. Access and exclusion

For members of the Asian and Polish focus groups particularly, the issue of access to services overshadowed the question of identification of service outcomes. There was little point in discussing how to assess overall effectiveness in terms of impacts on service users if the prior problem of access had not been solved. Many people felt hampered by a lack of knowledge about what services were available and what were their entitlements, although all participants attended some form of day centre, and one or two received home care. (All were positive about the services they actually received and able to identify some outcomes.) Individual people identified a number of factors which affected access, such as the availability of information in suitable formats (a person to discuss things with face to face in an appropriate language was the preferred mode), attitudes towards services in the wider ethnic minority communities, charging for services, racism on the part of providers, the degree to which services met religious and cultural preferences.

2. Outcomes for older people

Introduction

A distinction is often drawn between intermediate outcomes, which are changes in services, and final outcomes, which are the ultimate effects on the service user. Admission to residential care is an intermediate outcome, and the intention of this report is to concentrate on final outcomes. However, avoidance of admission to residential care was seen as an important objective of community care services by staff, older people receiving high levels of home care, and by some carers. Home care staff particularly saw it as a highly valued consequence of their services. Clearly the transition from care at home marks an important shift in a range of final outcomes for older people and their families, but these final outcomes may not be made explicit. Given our focus on final outcomes, we attempted to unpick this preference in terms of individual outcomes attributed to residential care compared with home care:

- People receiving high levels of home care were particularly likely to mention the loss of assets involved in entering residential care, especially the prospect that they might have to lose their house to pay for care.
- More generally a number of older people had a negative perspective on the quality of care available in residential homes, based in some cases on their own or others' actual experiences. Negative staff attitudes and impersonal treatment were regularly cited. (We are not in a position to say how accurate these perceptions were. In contrast, older people using a day centre, who also used attached residential facilities for

breaks, were positive about the experience and happy to consider eventual permanent residence as a possibility.)

- Compared with care at home, residential care was felt to offer less freedom and control over one's own life, even if it did offer greater safety and security. These and other quality of life outcomes will be the focus of section 2.2 of this report.

2.1 Outcomes involving change rather than maintenance or prevention

In the minority of instances where rehabilitation or change was an explicit aim of services, attention might be focused on improving physical functioning, mental state or both. Although staff and managers were both convinced that these aims were relevant to a small minority of users only (15 per cent was an informed guess), they were the subject of some emphasis in staff discussion groups. Possible reasons for this include:

- It was believed that clearer identification of cases where improvement could be expected might offer the prospect of savings through enabling the withdrawal of services that were no longer necessary.
- It was easier to identify outcomes in such cases because they fitted a conventional treatment or intervention model (of the kind which applies in health).

With the exception of improvement in symptoms of mental illness, these outcomes were discussed more extensively by staff than by service users, however this may reflect the much lower prevalence of people receiving change-orientated social care inputs among home care users. It may be that such individuals were not picked up in our selection processes both because there were relatively few of them, and because they may have been more likely to refuse. In contrast, people receiving interventions for functional mental illness were specifically included because they attended centres at which discussion groups were held.

1. Changes in symptoms and behaviour

This desired outcome was mentioned by people with functional mental illness. People wanted to feel less anxious or depressed for example, to relate better to family members, to be more active and interested in life. In the relevant authority these outcomes were being aimed for by a combination of health and social care inputs, rather than social care alone. Indeed these joint health and social care facilities were specifically orientated to a treatment approach in which the aim was to intervene in a time-limited way. Here we found the only use in regular practice of measures or scales for the purpose of assessing progress of individuals. These were used and valued by both health and social care staff but the information from them was not used in an aggregated form.

Older people who had experienced mental illness emphasised strongly what they believed were the preventative effects of other social care outcomes such as social contact and engagement in meaningful activity. The question of causal relationships between outcomes will be explored further in the conclusion.

2. *Improvement in physical functioning*

This is a much measured area in the health field, and if services are explicitly aimed towards this end then it may be a legitimate outcome to consider. However if home care services are merely attempting to support people who are recovering from illness or accident for a time-limited period while they recover the capacity to meet their needs independently, then change in physical functioning is not a direct consequence of services. There is increasing evidence that intensive rehabilitation involving health and social care input can be effective in restoring functioning to the extent that people need fewer continuing services. It might be useful to monitor improvements in physical functioning in order to decide when or whether to withdraw services, but this does not make it an outcome of services. In the authority under investigation, physical functioning was measured as part of the assessment of a person's suitability for residential care but not seen as an outcome of services. An increase in services with a rehabilitative intent was being funded with the new 'Winter Pressures' money, and managers were interested in understanding the effectiveness of such a strategy. However questions about the relative effectiveness of various forms of intensive rehabilitation are research questions, which need a research design, they cannot be answered by routine monitoring alone.

3. *Improving confidence and skills*

Home care staff and managers mentioned these as aims in assisting people who were recovering from illness or accident. They were seen as essential steps on the path back to managing without services.

4. *Improving morale*

Morale as used by staff is a rather vague concept, related to happiness or psychological well-being. Care management and home care staff both identified this potential outcome. Home care users did not use this language but certainly did indicate, in discussions of fictional case scenarios, that people might be 'happier', if their needs were met and their problems dealt with. The argument here is perhaps that improved morale is an indirect effect which flows from the achievement of other outcomes. People who used day care, particularly those who used facilities for people with mental illness, described more direct effects, saying, for example 'it lifts you' or it 'keeps you going'.

2.2 Outcomes for maintenance or prevention

Perhaps inevitably, service users and carers took a more holistic perspective in assessing their needs and desired outcomes than workers operating in a particular agency are likely to do. Care managers' orientation was closest to that of users, in that they saw it as their role to assist people in gaining access to other services or resources (such as benefits or medical treatment) which would help to meet desired outcomes that social care services could not meet. Further, they emphasised the importance of enabling the service user to talk through options, make choices and have a degree of control over their life. The outcomes which follow reflect a number of areas of quality of life. Although it has been argued that these are outcomes that usually have to be maintained on a continuous basis, it is recognised that the initial involvement of social services may sometimes be designed to achieve some change by first raising these aspects of quality of life to acceptable levels. Six areas are listed, although the last - control over your life - may be best thought of as an underlying theme, rather than a separate outcome.

1. Meeting of basic physical needs

There was consensus that services were responsible for ensuring that people who were not able to carry out their own self care were personally clean and comfortable, able to be clean and presentable in appearance, and to have enough to eat. Where occasional conflict was reported between older people and formal or informal carers over levels of personal cleanliness to be achieved, this tended to involve situations where the older person had dementia or, perhaps, depression. In addition, there might be conflict over who should deliver the desired outcome, for example one disabled man reported being refused help with bathing because his wife was available to help him.

However, somewhat more differences of emphasis between stakeholders centred round the ways in which these outcomes should be delivered, with users and carers favouring times of delivery which gave a normal pattern of life, and an unhurried pace, but services being sometimes unable to deliver this because of the problematic logistics of providing intensive services with peaks of activity in early mornings and late evenings. This is a widely recognised difficulty in achieving quality (Henwood *et al.*, 1998), which has not been solved by transferring some or all demands to the private sector, because this sector is equally vulnerable to the problems involved in dealing with such uneven variations in demand (Hardy and Wistow, 1997).

Conflict and disagreement were reported, particularly with carers, in situations where health and safety regulations or employment law meant that methods which the carer experienced as unnecessarily intrusive had to be used for lifting, such as hoists, or more than one member of staff. Again this is widely recognised as a problem (Eaton, 1997).

Finally, attitudes of staff assumed a particular importance in relation to personal care, with competence, kindness and sensitivity all valued. Continuity was often important to people who did not enjoy explaining their personal care needs over and over again to different people. However there was some individual variation in the wish for continuity, and some older people enjoyed meeting a number of different members of staff.

Managers of home care services identified a need for a better understanding of service users' feelings about the process of receiving personal care. This would be useful for training, and in organising services.

Of course bathing in particular has been identified as an area of conflict about provision between health and social care services. Debates about 'medical' or 'social' baths reflect each agencies' imperatives to control or reduce expenditure, and have little relevance to service users or carers. Such disputes between agencies do not affect the legitimacy of the expectation that enabling people to enjoy personal cleanliness is an outcome to be expected from publically provided services. The development of pilot joint schemes for providing generic personal care, as is happening in one health authority in our research area, seems to be a sensible way forward in resolving conflicts about responsibility.

2. *Personal safety and security*

Care managers identified the reduction of risk as an outcome they aimed to achieve, and alarm systems and regular visits from the home care service had one function of ensuring help in an emergency, or at least prompt discovery if anything untoward happened. The feeling of being connected to sources of help 'just in case' was important to those who received these services and would have been valued by some who did not receive them. Two older people expressed the view that if older people were expected to live alone and take care of themselves, even if disabled, then such assurance of help if needed ought at least to be offered in return.

Of course different people may have different perceptions of the degree of risk involved in a particular situation, and individuals may vary in the amount of anxiety experienced in the face of a given level of risk. People with dementia expressed particular fears about crime and personal safety, although this might be attributed to anxiety generated by the experience of their condition. In one staff group, a sceptical view was expressed that the intended outcome of some referrals was to reduce anxiety on the part of other professionals rather than the older person.

This outcome is demonstrably important in affecting decisions about entering residential care, not just in the obvious sense that care managers may feel that

residential care is appropriate in situations of high risk, but also in terms of the important role played by subjective fears about safety and security in decisions made by individual older people to enter such care (NHSE/SSI, 1994).

3. *Being able to live in a clean and tidy environment*

This outcome was of considerable importance to service users although the given social services department had substantially reduced the provision of cleaning. A degree of frustration was expressed by those who felt that the outcome of this lack of a service was lower standards of cleanliness than they would wish in their own homes. Users' priorities were cleanliness of the kitchen and bathroom, although the state of the rest of the house mattered, and to some the state of the garden, particularly if it was visible to others. Discussion with older people suggested that while a clean and tidy environment was accorded importance in itself, dissatisfaction stemmed as much from the sense of no longer having control over the standards of cleanliness that prevail in one's own home, and, if it occurred, from the public evidence in the shape of a dusty home or an untidy garden, of one's incapacity to perform these everyday responsibilities.

Nationally quite a number of social services departments have withdrawn from providing cleaning either because it is considered as a less high priority or because the advent of charging means that it can be provided more cheaply by the private sector. Users in the current study sometimes expressed willingness to pay, but given their vulnerability, felt wary of using the private sector when there was no recommended supplier. There have been widespread calls for inspection and accreditation in the domiciliary care sector, and clearly, if people are expected to secure their own services, even if they do have attendance allowances or other benefits to pay for them, such regulation would be of assistance to them in making choices.

Some specific tasks that users wanted such as cleaning the inside of windows, curtains, and changing light bulbs were not performed by social services staff because of health and safety legislation. The range of specific tasks that people would have liked completing was quite wide. In general people wanted someone to assist them with those things which they would have done themselves if they had been able to do so. The specific tasks that they now required therefore depended on the nature of their impairment, and the things they would have chosen to do.

4. *Keeping alert and active*

This was seen as playing a role in preventing boredom and physical stagnation. People wanted to have something interesting to do, and somewhere to go. For most, this included opportunities to leave the house, although many of the older people's wishes about destinations were extremely moderate, for example to go window shopping, or see swans in the local park. This outcome was mentioned by care

managers and by day care staff. Many of those who attended day care saw this as one outcome, although not everyone considered this outcome as only achieved through day services, for example, it could also be achieved through enabling people to continue to pursue existing interests or hobbies.

In common with many social services departments there was some doubt at management level about the relative importance of this outcome in the context of reduced resources, and some uncertainty about the overall effectiveness of day care in producing the preventative effects which were claimed for it, although there was no doubt that service users valued the service.

5. *Access to social contact and company*

People experiencing illness and disability and hampered by lack of access to transport often had much reduced opportunities to meet people and to socialise. Company and contact was often cited as a beneficial outcome of day care, both by users and staff. It was argued by older people that this made periods spent alone more bearable, warding off loneliness and perhaps even depression. While people did often enjoy their contacts and relationships with home care staff, this was not the same kind of company and contact with equals that meeting other older people could offer. Older people using day services emphasised the mutual support which they were able to obtain from each other, although this did not mean that they did not also value opportunities for contact with younger people.

In addition, some people wanted more contact with particular individuals (usually relatives), and found themselves unable to achieve this without assistance. For some this would have been more highly valued than attendance at a day centre. Similarly, some older people wished to continue to meet with people with whom they had common interests - one older man attended a history club, for example.

Reducing isolation was widely recognised as one outcome services attempted to provide, although in general the function of social services was only to respond to this need in cases where it was a consequence of illness and disability. Day care for purely social reasons was increasingly seen as the responsibility of the voluntary sector.

6. *Being in control of your life*

This aspect of quality of life has been inferred from the discussion about ways of delivering the other outcomes and the role of services in achieving them. It might be best viewed as an underlying theme of discussion about many outcomes, and the final desired result of the provision of social care, rather than a separate outcome. The issue of control arose particularly in relation to the meeting of physical needs and cleanliness and order of the immediate environment. People wanted to be able to plan and organise their days, and enjoy a normal pattern of life. They wanted to maintain

their own standards of cleanliness and tidiness in their own homes, to feel securely connected to the world and to avoid boredom and isolation. They wanted to be able to have and deploy resources to achieve these outcomes, including having access to maximum levels of benefit to which they were entitled, having sufficient information about services and entitlements to make choices, and being able to choose whether or not, and when, to draw on family assistance, or to give care to others.

Care managers were the professionals who discussed control at most length, and who saw themselves as responsible for assisting people to understand options and choices available to them, and to deal with new and difficult circumstances which might follow illness or accident. They placed more emphasis than users on the aim of coming to terms with the onset of illness or disability, of finding ways in which to make a situation tolerable or bearable, and enabling people to come to a more positive attitude towards the future. For home care workers, enabling people to live (or die) at home if this was what they wished, was defined as in itself enhancing the control exercised by older people. Home care managers, whose role was to sort out disputes or complaints (and to keep home care services within budget limits) were the most likely group to emphasise the degree to which some users and carers had to compromise, or accept services which might be less than ideal.

For people with dementia, the desire that life should be under control was not lost, but where certain activities of daily life, such as managing finances, were becoming a struggle, people valued being able to place them in the hands of someone they knew they could trust.

2.3 Outcomes which relate to the way services are delivered

These outcomes reflect intrinsically valued aspects of the way in which services are delivered, and are relevant whether the intention is change or maintenance. Much of the available evidence indicates that user satisfaction, or lack of it, is related at least as strongly to the way in which services are delivered as to any specific impacts or changes which may result (Harding and Beresford, 1996). The effectiveness of social care services cannot be reviewed without some evaluation, either subjective or objective, of the impact of the way in which services are delivered. For a convenient shorthand these will be referred to as 'service process outcomes'. They are not attributes of services such as reliability or continuity, but rather they are the perceived impacts on users of the process of service delivery, for example, a perception that one is, or is not, 'being treated as a person'. A range of process-related objectives are of key importance in relation to social care. These are important either because of their close relationship with the achievement of quality of life outcomes already listed, or because of their impact on the feelings and satisfaction of people receiving services. These process objectives by their nature should be continuously achieved, rather

than achieved at, or by, a particular point in time. The overall impact on feelings desired is that the recipient of care should feel treated as an individual different from others, at the same time, and as a fellow human being. The process objectives are:

1. *Valued and treated with respect*

This involves conveying a belief that someone has a legitimate right to services, that they are a valued person despite their difficulties or symptoms (this was particularly emphasised by people with mental illness but applied to others too), and maintaining confidentiality and privacy. An important aspect, mentioned by older people from minority ethnic groups, was respect for cultural and religious preferences and requirements.

2. *Treated as a person*

This is seen as having two aspects, one emphasising the uniqueness of the individual, and the other resting on the quality of interpersonal interactions with staff. The first involves a recognition of, and response to, differing individual needs and preferences. In relation to the second, some personalisation of staff attitudes involving at least a degree of warmth and friendliness was valued although friendship was not expected. Again there was individual variation in what older people preferred. Some older people attached greater importance to the completion of the required tasks than to conversation or friendliness, and found that some staff spent too much time talking. There was some discussion in staff groups about the degree to which home care staff should develop relationships with older people, with some feeling this was a valuable part of their role, but others seeing it as frowned upon, and a potential source of difficulties.

3. *Having 'a say' in services*

In order to achieve desired levels of control over their lives, older people wanted to be able to influence the time and the pace at which tasks were done, the days on which services were used, and the particular work which was done when home care services arrived. Information about, and the opportunity to discuss, possible options with a knowledgeable person, were viewed as important in achieving a level of control.

Although at present older people are not able to receive direct payments, one senior manager was interested in the idea of experimenting with allowing older people to determine their own care packages more precisely and investigating the impact on the kinds of packages provided.

4. *Value for money*

This was a relatively new issue brought onto the agenda by the introduction of charging for services. The charging policy was in its early days and apparent inconsistencies emerged in group discussion. Some people had refused services

because of the cost, or because they thought value for money was poor. In the absence of services they used private commercial sources, family members or somehow managed without assistance. However, those who paid did make observations about value for money, and the fact of paying did seem to increase people's perception that they should have more say, about the tasks which were performed, for example. There was some acceptance that benefits such as attendance allowance could and should be used to pay for services (such as transport using taxis) which would make life easier, although how such benefits were used could be a contentious issue within families.

5. *A 'good fit' with existing care giving and receiving within the family*

People wanted services to be delivered in ways that would fit in well with their ideas about appropriate roles for family members. Their preference was that whether or not care was given by family members should be a matter of choice, with people receiving support in providing care if that was what they wished to do, and being enabled to access sources of help other than the family if they judged the costs of giving or receiving family help to be too high. Specific outcomes identified by carers are listed separately below. There is no intention here to suggest that older people and their families would always interpret this outcome in the same way. Indeed, negotiating an agreed path through differing ideas about who should provide assistance could be a complex undertaking. However, satisfactory interweaving of different sources of care was an objective to aim for. People did not enjoy feeling that they 'had to' rely on their families and wanted services to have appropriate or reasonable expectations of families. This issue will be discussed further when outcomes for carers are considered. In this context Asian elders had encountered a lack of understanding on the part of some service providers, of their concerns about the difficulties for unmarried sons who became involved in giving care, and of their expectation that daughters, once married, would be unable to continue to provide care for their parents.

6. *A 'good fit' with cultural and religious preferences and requirements*

This embodied a whole range of detailed issues, which varied for different groups, but which were sufficiently important for people to indicate that unsuitable services would not be acceptable. Issues included the way in which domestic tasks were performed, as well as staff characteristics, language skills and the provision of appropriate food and activities. As mentioned, an understanding and acceptance of the ways in which family obligations operate in different communities would contribute to achieving this outcome.

3. Outcomes for carers

Introduction

Carers identified a range of quality of life outcomes both for themselves and for the person for whom they were providing care. Some of the service process outcomes identified were similar to those identified by older people, but for carers an additional set of issues around support and recognition in the caring role was important. Outcomes for older people identified by carers were similar, at least in general terms, to those which older people had identified for themselves and so will not be listed again. However the importance to the carer of outcomes for the cared-for person should not be underestimated, as it was central to many of their evaluative opinions about services.

3.1 Quality of life for carers

This section lists those outcomes which relate to the carer's own quality of life, but it will be evident that many of them are identified, or defined, in relation to prevention of possible negative impacts of giving a high level of practical and emotional assistance to an older relative or friend.

1. Freedom to have a life of your own

Carers emphasised the importance of having time to themselves to pursue their own interests, or to spend time with family and friends, or otherwise maintain a life of their own. For those caring for a partner this may include the ability to spend time together, whilst being relieved of their usual caring responsibilities. For some carers being able to continue in employment was of particular importance.

Being able to set boundaries to involvement in caring, and ensure that there was time for other activities, contributed to a sense of being in control of one's life on a day to day and longer-term basis. It also meant the carer could give some attention to achieving other quality of life outcomes.

Care managers did identify enabling carers to live the life they wanted to lead as one outcome they aimed to achieve, although there was a greater emphasis across all staff groups on giving support to carers in the caring role.

2. Maintaining health and well-being

A range of aspects of caring could impact on carers' mental and physical health.

Services could reduce or prevent these negative impacts through, for example, sharing physical tasks, providing breaks or enabling the carer to sleep. Staff did identify improving carer morale as one outcome they intended to achieve, and discussed the importance of other services such as sitting services in terms of their effects in relieving stress for families.

3. *Preventing social isolation*

People could become gradually isolated as their involvement in caring continued over time or increased. Isolation could be particularly acute when communication with the cared-for person was limited by increasing cognitive impairment. In retrospect, some carers considered this outcome might best be achieved by early intervention, designed to preserve existing social contacts and relationships before they were lost, rather than by attempting to recreate or revive them after the event.

4. *Peace of mind*

Peace of mind rested on confidence about the safety and security of the older person when the carer could not be present. It was particularly significant for non-resident carers, although it was also relevant to resident carers when they were away from the cared-for person. Considerable distress and anxiety might result from a lack of confidence in alternative arrangements. In the longer term, in some instances, confidence about future care arrangements, and the availability of suitable alternatives to the carer if needed, could also contribute substantially to peace of mind. This outcome is clearly related to the degree of importance which carers attached to the welfare of the person they cared for.

3.2 *Service process outcomes for carers - the way services are delivered*

Most carers wanted to continue providing care and so a desired outcome from services was appropriate support in the caring role. Appropriate support was delivered in ways which recognised carers as having needs and rights of their own, as well as recognising the needs and rights of the older person receiving care. In addition, the responsibility of services for the welfare of the older person should be recognised and conveyed in the process of delivering services.

1. *A sense of shared responsibility*

Carers in general felt they had a unique personal knowledge and understanding of the needs and preferences of the person they cared for. However, they valued services which offered recognition and support in their caring role in a way which conveyed the sense that the responsibility was shared. Although carers expected their expertise to be recognised, this did not mean that pro-active suggestions about appropriate support or services were not welcome. Support might be practical, such as sharing the physical care, or providing information about the person's condition, prognosis or ways of dealing with problems. In addition, carers appreciated being able to turn to someone who understood their situation, for emotional support in dealing with negative feelings or talking through difficult decisions. The importance of different ways of sharing responsibility varied at different stages of the caring career. Feeling that one was initially equipped and prepared for the caring task was an important aspect which

contributed to a later sense of being in control. This included being informed about the help available. Knowing that there would be easy access to assistance in a crisis also helped to convey a sense of shared responsibility.

2. *Carer has 'a say' in services*

In order to most effectively achieve desired outcomes, both for themselves and for the person being cared for, carers found it helpful to be able to influence the timing and nature of services, and to be able to implement changes in response to changing needs or requirements. Achieving this outcome involved an expectation that staff would respect carers' choices, and their knowledge of their relative, listen to their views of services, and would deal sensitively and even-handedly with differences of opinion within the family (for example refusal by a relative to accept services).

Charging for services had introduced a new area of potential conflict within caring relationships. The cost of services was often quoted as a reason for refusal of services by an older person, and carers found this a difficult situation. Control over finances, and the expected use of Attendance Allowance to pay for services, could be a particular source of friction for those caring for people with dementia.

3. *Confidence in services*

Two aspects of confidence in services were important to carers. First, it was helpful to know that services would provide a similar quality of care or practical support that the carer themselves would provide, taking into account the older person's particular needs and preferences. Issues of matching (staff to customer), timing and pace of delivery, continuity and consistency could all be crucial to ensuring that services are accepted (not rejected or cancelled) by the older person. Secondly, and as a consequence of such trust, this reduced anxiety for carers and contributed significantly to the achievement of other outcomes such as 'peace of mind' and 'being able to live a life of one's own'.

4. Summary and conclusion

Summary

Although there are differences of emphasis, there is widespread agreement about the identification of important domains of outcome for older people and for carers, with the possible exception of the wish for a clean and tidy environment. Many staff appreciated the importance of this last outcome to older people, and regretted that it was no longer always achieved. It may be an artefact of our data collection but staff placed more emphasis than users on working through the immediate impacts of the onset of illness or impairment, coming to terms with a changed situation, and gaining the confidence to carry on. Where there was difference of emphasis, or reported conflict, in relation to identified outcomes, this was much more likely to centre on the way in which services were delivered, and the

resources or risks involved in following user or carer preferences: for example who should provide the input (should it be services or a co-resident relative who assists with personal care?), when should it be provided (will the timing help to maintain normal patterns of life and freedom to plan one's day, or fit with times when staff are available?), in what way should it be provided (health and safety for staff against unobtrusive methods of lifting, user preferences for staff of a particular race or gender against equal opportunities policies).

Much social care is concerned with maintenance or prevention, and has to be delivered on a continuing basis (although not at a constant level), but a small minority of service activity is designed to achieve changes or improvements which mean that services can be offered for a time-limited period. Changes or improvements may be sought in physical functioning, particularly the capacity for self care, or in mental state, meaning either general psychological well-being or, more specifically, symptoms of mental illness. Continuous maintenance to acceptable levels is sought in relation to: the meeting of basic physical needs; personal safety and security; cleanliness and order of the immediate environment; keeping alert and active; social contact or company. Services should be delivered in a way which preserves dignity, does not undermine worth, value and individuality of the person, fits appropriately into caring relationships within the family, respects religious and cultural preferences, and ensures as much choice and control as possible to the disabled person and those family members and friends who provide any care. Carers look for all these outcomes for their relatives, but also for support in providing care, recognition of their own expertise, shared responsibility, peace of mind, and the importance of enjoying some time and space of their own.

These are hard to argue with in principle as desirable outcomes. No one argued that older people affected by disability or illness should not be able to enjoy social contact and company, or meaningful activity, only that taking responsibility for providing these outcomes through social care agencies might not be affordable, if weighed against the meeting of basic physical needs or personal safety, which had to take priority. There was concern among staff at all levels about the possible loss of preventative effects which might flow from the neglect of other outcomes. Belief in the preventative effects of social care was true across the groups of older people from minority ethnic groups as well as the white British groups. Indeed, the Asian elders in particular outlined ways in which access to company and stimulating activity provided a valuable distraction from other worries and difficulties, and might prevent boredom, family arguments, depression and even alcohol abuse. Social care conceived in this way goes somewhat beyond the meeting of physical needs, to encompass the other kinds of outcome already listed. Perhaps the implicit model is that once symptoms of anxiety and depression reach clinical levels, then social care alone is insufficient to effect an improvement. However, early provision of social care can be preventative. Managers in the authority were themselves concerned about the possible long term effects of targeting services on people with high levels of dependency, and being forced to concentrate to an ever increasing extent on the meeting of physical needs alone. They feared the loss of

possible preventive effects for a wider range of clients but lacked research-based information that would enable them to be confident about the scope and range of possible consequences. Research, rather than routine monitoring of outcomes, would be needed to supply the information they required.

Practical use of the outcomes framework

There is research in progress on ways of measuring many of these outcomes, and this may provide useful instruments. However, to use this outcome framework usefully in practice it is not necessary to be able to measure precisely or quantitatively levels of outcome in a way that would be required in research. Parallel work in child care offers some lessons. The development of the comprehensive system for information gathering, planning, assessment and review of outcomes for children looked after by local authorities began in 1987, and the materials which have emerged, while useful for practice, differ substantially from academic research instruments (Jackson, 1995). Some important principles identified in the research and development work on outcomes for children have relevance for our programme. Parker *et al.* (1991), writing about outcomes for children, observed that outcomes are both dynamic and relative, that is, they involve both achieving change and making comparison in order to evaluate the change. In social care the first of these is not always true: the aim is not often to achieve change but more likely to hold outcomes constant, despite changes in the condition of the person or their situation. The need for some standard of comparison, however, remains as relevant in community care as in child care:

Assessment of outcomes can only occur in relation to some kind of standard and someone has to set the standard.
(Jackson, 1998, p. 49)

In the child care outcomes system, the aspirations and behaviour of 'ordinary parents' provide a framework for child development which underpins the identification of outcome domains, and together with appropriate research, gives rise to recommendations for actions if outcomes are not being achieved. The choice to use such a framework is not a technical but a moral decision, although it is a decision which, it is argued, reflects the values expressed in the relevant legislation.

In community care, quality of life, or 'a normal life', seems to be the most coherent equivalent framework, and indeed this has been used as an evaluative standard, particularly in making judgements about the impact of deinstitutionalisation. In *Caring for People* (1989), 'as normal a life as possible', 'maximum possible independence' and 'giving people a greater individual say' were said to be the intended results of the changes, although all of the subsequently listed key objectives in that White Paper were about services, procedures, market composition, funding and agency responsibilities, rather than consequences for people. Our results suggest that a clear specification, if only in global terms, of the outcomes to be aimed for by a social care agency could be possible, and might assist older people and carers who do not know what services are for, and therefore do not approach them. This

might help to improve access, and allow for more informed negotiation between users and providers. At present the outcomes that agencies aim for in community care are rarely made explicit (we know of one exception), and publically stated objectives may be phrased in an undefined aspirational way which confers no rights or entitlement, while sounding positive. Of course, to take account of individual differences, the specification of outcomes would have to set a flexible global framework which allowed considerable scope for individual variation in preferred methods and immediate purposes of assistance, as well as different priority among outcomes.

The acknowledged difficulty about using even a limited Quality of Life (QoL) framework to evaluate social care services is that social care is co-produced: that is, a whole range of possible providers, including the older person and their family, will contribute to meeting social care needs of the kind we have described. Equally, a whole range of different obstacles may prevent the achievement of QoL outcomes, some of which may not be within the powers of social services to remove. Much needed health inputs may be lacking, modifications to the physical environment may be essential, transport may be inaccessible, income may be inadequate. Given this, it may be argued, a failure to achieve these outcomes may be a consequence of factors beyond the control of social services, so it would not be fair to judge their performance on the basis of these outcomes.

On the basis of this research, we would argue that since purchasers of social care aim to take a holistic view, the framework which has been outlined best reflects the views of stakeholders about intended final outcomes of packages of care for users. This has the implication that an outcomes-based evaluation framework will have to include questions about why the desired outcomes have not been achieved, and will have to be able to identify other agencies or environmental or policy changes that would be necessary to achieve them. At the individual level, advocacy might be the resultant action, but aggregated evidence about the failure to achieve outcomes might point to necessary system level changes, perhaps within the local authority, perhaps in other agencies.

APPENDIX ONE

DEVELOPMENT PROPOSALS: STAKEHOLDER VIEWS ON INFORMATION COLLECTION, LOCAL CONTEXT AND PROPOSED DEVELOPMENTS

1. Stakeholder views on methods of collecting routine information about outcomes for users and carers

Older people, carers and staff were willing to discuss the pros and cons of methods of information collection at some length. Conducting face to face interviews with service users and carers at home was the generally preferred method of gathering information about outcomes, although people in day centres were also willing to be consulted in groups. Our own considerable difficulties in recruiting people to attend discussion groups suggested that refusals to take part would run at a high rate compared with refusals to give a personal interview and that, therefore, small group meetings would be a costly way to collect information except in congregate settings where groups already exist. Ideally, people would be offered choices about how they wanted to give their views. Some groups of staff recognised that interviews were expensive and so suggested sampling would be a useful approach, perhaps with shorter questionnaires to a wider group.

Users and carers were not completely opposed to written questionnaires as long as the questions were relevant, the overall length was short, and suitable provision was made for obtaining the views of those who could not complete written questionnaires for reasons such as visual impairment, physical impairment or language differences. On the basis of past experience, staff expected quite low response rates to written questionnaires.

Staff on balance favoured independent collection of information, although they could see some limited scope for improving statements about outcomes within existing procedures and documentation. Care managers considered that some systematically targeted reviewing might be possible, perhaps linked in with the team's own internal reviews of local issues and practice which had recently been instituted on a yearly basis. Provider review was another alternative, although this would require training.

Users favoured collection of information by senior managers in the organisation, because they would then see the situation for themselves, and be in a position to act on information gathered. With regard to information collection by staff who were in contact with them, home care users were against this on the grounds that staff were too busy already, and might feel inhibited about feeding up negative information.

2. Features of the local context which have influenced the choice of development projects

This section outlines ways in which the Department organises its activities, and current issues in the local context, which have to be considered in planning development work:

- 2.1. The primary task of care managers is assessment and care planning. The vast majority of cases are closed after six weeks, with continuing responsibility for monitoring left to providers. There is no systematic procedure for regular review. Referrals back are not routinely allocated to the same care manager who made the assessment. The department is not untypical in its greater emphasis on assessment than review in care management. Carers in particular expressed a wish for more continuous involvement, or at least better exchange of information within the department.

Some concern has been expressed in manager interviews that often objectives are not specified clearly enough for providers in care plans. Providers also make assessments and specify objectives but in home care, for example, these often do not go beyond stating the aim of keeping people at home. Record keeping by providers is inconsistent, with some good practice and some less good. This suggests that improvements in the specification of objectives in care planning might be an important prior step, before attempting to determine whether outcomes have been achieved.

- 2.2. *IT* - there is no overall computerised management information system and no client index, although community care administration keeps a database of clients for charging purposes. A computer system is in the course of being implemented throughout the department although it is anticipated this will take up to four years. This has the advantage that it presents an opportunity to link in with the development of coding systems for the care management sections of the system as they are being implemented (this planned for later this year). However it limits the extent to which any outcome information collected in the near future can be linked to other management information.
- 2.3. There is a strong expressed commitment to listen to the voices of older people and citizens in general, expressed through regular public meetings or forums for older people, and some research with a standing panel of citizens. There has been some research (external and in-house) on views of users of home care, but this has not been widely disseminated, or has sometimes been felt to be irrelevant to the local situation. Older service users do not on the whole attend public meetings, and their contact with the department is usually restricted to contact with frontline staff.
- 2.4. Budgets are largely devolved to area teams who have considerable autonomy in their activities. This can make it difficult to secure department-wide consistency if it is necessary, although this has been achieved in relation to assessment documentation,

for example. However there are quite large variations in the socio-economic characteristics of the areas, and practice and administration within the area teams. This may make it easier to run a number of experiments, but may make department-wide implementation difficult.

- 2.5. The department is to undergo an Audit Commission/SSI Joint review next year, and so is undertaking work to identify its own current strengths and weaknesses. There is some readiness for change as a consequence of this but an understandable concern to use staff time in the most productive possible way. Our proposed projects have to be relevant to Departmental concerns. The Department has recently undergone an inspection of services for carers and a number of changes are being thought through in response to feedback from the Inspection.

3. Summary of development proposals

Three development are outlined below. The three proposals cover care planning and review procedures and documentation; regular survey by senior managers of the views of older people using services; and assessment and review procedures for carers.

3.1 Proposal for a modified Care Plan, which records intended outcomes and client preferences, and a matching system of outcome-oriented client reviews

Rationale for proposal

Many staff commented that the purposes for which a client was receiving service quite easily could become overlooked - especially concerning rehabilitative goals. The Authority's current Care Plan document does not often prompt staff concerning intended outcomes. The SPRU work with service users showed widespread differences between individuals in their priorities concerning outcomes from the service and how service was delivered. Yet there was no system for recording such personal priorities and conveying them to service-givers. Thus the current Care Plan document was not effective for promoting the aims either of staff or of users. There was no systematic review system. While staff felt systematic review to be useful in principle, they stressed that it would neither be practicable nor useful to repeatedly review all clients.

Proposed additions to the Care Plan

There would be a section on outcomes sought and rehabilitation goals. There would also be an assessor's rating of the anticipated duration of the Care Package and whether there was a need for close review. The form would also record clients' most important concerns, whether these featured particular outcomes or preferences for how the service was

delivered. Another section would indicate the service's priority commitments, for instance towards particular outcomes or particular client preferences to which the service had undertaken to adhere. Additional space would record miscellaneous practical instructions to staff. It would be the Provider's responsibility to complete and update this new section of the Care Plan, drawing on a new section on the Care Managers' assessment form which would specify desired outcomes.

The proposed Review system

All new clients would get one standard review some 3 months after service began. Further Reviews would be required only for clients identified either at assessment or at their most recent Review as needing this. The Review Form would seek separate assessments by staff and by clients of the achievement of outcomes and other priority commitments named on the Care Plan form. There would be a write-in box to explain any low ratings. The client would also rate their satisfaction with the service - with, likewise, a write-in box to explain low ratings. Conclusions from the review would also be listed, plus date for any future Review deemed necessary.

Functions of Care Plan and Review documents

1. To orient face-to-face service givers to intended outcomes and clients' personal priorities - particularly important in the many situations where staff are serving clients whom they do not know particularly well.
2. To focus attention on intended outcomes and clients' major concerns at the single routine Review, which checks that service is established on a sound footing.
3. To focus managers' attention on cases where service could be reduced or withdrawn on grounds that outcomes had been achieved.
4. Once computerised (a corporate system is being developed), Care Plan and Review records would provide a database which managers could use to investigate issues like areas where achievement ratings for outcomes were low, reasons for low satisfaction ratings, or closure rates for cases intended as short-term.

Introducing the changes

After piloting, the new documents could be introduced initially for new clients and whenever a Care Plan was changed for an existing client - and subsequently extended as management saw fit. The proposals very closely reflect common views expressed in staff interviews about the types of new documentation and Review activity which could be implemented because they would be seen as genuinely useful and practicable within time-constraints.

3.2 Proposal for routine annual interviews with a 10% sample of service users by the four most senior managers in each Elderly Division Area Office

Rationale for this proposal

- At interviews with Elderly Division staff there was a very strong consensus that service users' opinions should be treated as a major index of outcome. But at present, all agreed, the service lacked any systematic method for reaching clients' views. Outside Elderly Division, this Authority places strong public emphasis on responding to the views of service users.
- Interview at home was the method for consultation which would be acceptable to a larger proportion of older service users than any other method. SPRU's interviews made plain that while other methods (like telephone interviews, questionnaires and group discussions) had some supporters, there were many service users who would not or could not use them. Interview at home was the only method which was very widely acceptable to users. Service-givers insisted on a consultation method which could reach housebound people since these utilise such an important proportion of Social Services resources. SPRU's own individual interviews in older people's homes reached service users who were appreciably older than those reached by group interview or telephone conference methods.
- A surprise finding from interviews with service users was a strong and very widespread desire to communicate their views about their services if a senior service manager would interview them at home. This idea was raised spontaneously again and again by service users both in group and in individual interviews. It stood out as an option which really strikes a chord among older people. Reasons for this preference included that it would enable users to directly inform people who had the power to make decisions and that visiting users in their homes would enable decision-makers to better understand older peoples' practical difficulties, concerns and aspirations. Symbolic value was important too in that such visits by senior staff were seen as taking trouble and hence expressing care and concern. Also, senior managers were seen as having a moral obligation to inform themselves of the results of the services for which they were responsible.

The proposal

Accordingly, since home interviews by a senior manager seem both so attractive and practicable for older people, calculations were made concerning the practicability of the method for senior managers. Around 20 interviews per year - less than one a fortnight - would be required from each of the four most senior managers in an Elderly Division Area Office in the Authority to effect annual interviews of 10% of all older social care clients. This

procedure was therefore proposed to the Authority for implementation by each Area Office, subsequent to piloting.

Issues to be resolved

If Social Services expresses interest, the proposal points out a number of issues which would need to be resolved. Extremely important would be to determine the specific purposes and content of the interviews and how their results would be used. The proposal discusses how part of the interview could comprise standard, city-wide structured questions about the outcomes of the service and interviewees' satisfaction with it. Another part could be used for questions devised separately by each Area Office about its current concerns, since there is substantial devolution of policy in this Authority. The proposal also discusses how information gained could be used to inform service development. Other issues include policy on how the sample of service-users for interview is selected.

3.3 Tools to assist definition, evaluation and recording of outcomes for individual carers

This project would aim to build on good practice and work towards establishing a consistent approach to identifying, reviewing and recording outcomes for carers. This would be achieved through:

- Sharpening the focus in practice on specifying outcomes for individual carers with the help of existing tools: Carers' Indices (CADI, CASI, CAMI) - these may assist practitioners to develop a detailed profile of a carer's unique difficulties (CADI), satisfactions (CASI) and management or coping strategies (CAMI), which could form a sound basis for identifying outcomes. The project would aim to test their usefulness in this respect and the feasibility of incorporating this approach into routine practice.
- Designing, testing and evaluating a simple system for recording outcomes for individual carers at the point of assessment and review and then aggregating the information for management/planning purposes. This would need to be integrated with any developments to standard A2 and A4 forms.
- An important aspect of this work may also be the development of a workable framework for reviewing outcomes for carers based on practical experience of the above. Features for consideration may include:
 - indicators to assist prioritising carers for reviews
 - clarification of roles, and protocols between purchasers and providers in carers' assessments/reviews
 - ways of empowering carers to gain a re-assessment when needed (i.e. where ongoing contact is not seen as a priority).

The Carers' Indices: CADI, CASI, CAMI, have been produced by M. Nolan, G. Grant and J. Keady and provide a well-researched framework for assessment, although the tools have so far been tested more thoroughly as research rather than practice tools. The authors are about to publish a practitioners guidance pack which may help to redress this balance. They are also interested in receiving feedback from practitioners experience of using the indices and the pack and would be willing to support any development work in relation to outcomes undertaken by SPRU. The indices (or extracts from them) have received a favourable response both from carers within the focus groups and practitioners on two training courses on outcomes (Dec. 1997 and March 1998). An encouraging number of social workers and home care organisers expressed an interest in being involved in further project work.

This project would involve SPRU working initially with 10-15 interested Care Managers and Home Care Organisers (and possibly day care workers?) and piloting the approach on two or three assessments/reviews done by each participant over a 6-9 month period. Staff and carers would contribute to the design, planning and evaluation of the project throughout. Through an examination of the process and outcomes of this project together with the experience of individual carers, users and practitioners, lessons would be drawn for the wider application of such a framework within the authority. This would include implications for any further training and development work.

APPENDIX TWO

SUMMARY OF DATA COLLECTION FROM STAKEHOLDERS: SERVICES FOR OLDER PEOPLE

Interviewees	Recruitment	Data collection methods
<i>Interviews with older people</i>		
1. Older home care clients (receiving <i>no more than</i> 7 hours service per week)	A random sample was obtained from the computerised charging system. This was then screened by social services staff to exclude people who either could not participate or who belonged to groups for which separate group discussions were planned. Contacts, then invitations, were subsequently made by SPRU.	Three group discussions of 90 minutes each with 8 participants Individual interviews with another 8 people
2. Intensive home care clients (receiving <i>more than</i> 7 hours service per week)	A random sample was obtained from the computerised charging system. This was then screened by social services staff to exclude people who either could not participate or who belonged to groups for which separate group discussions were planned. Invitations were then made.	Three telephone conference group discussions of around 60 minutes each with 6 participants
3. Users of a social day centre for older people	Around half those present at a single day centre on the day of interview, selected via invitations by staff	One group discussion of 90 minutes with 10 participants
4. Clients on a day programme for older people with a functional mental health problem	Around half those present at the day centre on the day of interview, selected via invitations by staff	One group discussion of 90 minutes with 8 participants (Additionally, records were obtained from a staff-led discussion with 15 participants.)
5. Polish older people	Invitations via personnel at Polish Community Centre	Two group discussions with 12 participants, conducted in Polish
6. Older Asian men	Invitations to attenders at a centre for day care	Three group discussions with 15 participants on the first occasion, 10 on the second and 9 on the third. The meetings lasted about 90 minutes and were conducted in Urdu and Punjabi.

Interviewees	Recruitment	Data collection methods
7. Older Asian women	Invitations to attenders at a centre for day care	Three group discussions with 7 participants on the first occasion, 6 at the other 2 meetings. The meetings lasted about 90 minutes and were conducted in Urdu and Punjabi.
8. Older people with dementia	Invitations via staff at a specialist service for people with dementia	A mix of formal and informal group discussions involving a total of 14 individuals. Also some individual interviews
<i>Interviews with family carers</i>		
9. Non-resident family carers for older people	Nominations by social services staff	Two group discussions lasting 2 hours each with 7 participants at the first meeting and 5 at the second
10. Resident family carers for older people	Representative sample from carers nominated by social services staff	Three group discussions lasting 2 hours each with 9 participants
11. Family carers for people with dementia	Invitations via staff at a specialist service for people with dementia	Individual interviews with 6 people
<i>Interviews with frontline social services staff</i>		
12. Home care organisers	Invitation via Home Care Managers for participants from each Social Services Area and from hospital-based teams	Two group discussions lasting 90 minutes each with 7 participants
13. Senior home care assistants	Invitation via home care managers for participants from each Social Services Area	Two group discussions lasting 90 minutes each with 9 participants
14. Social day centre staff	Open invitation via social services administration	Two group discussions lasting 90 minutes each with 9 participants on the first occasion and 8 on the second. (Seven different day centres were represented.)
15. Care managers	Invitation via principal care managers	Two group discussions lasting 90 minutes each with 7 participants
16. Health and social services staff based jointly in resource centres	Invitation to a pair of Health and Social Services staff at 2 resource centres	Individual telephone interviews with 4 staff

Interviewees	Recruitment	Data collection methods
<i>Interviews with social services managers</i>		
17. Principal care managers	Invitation to all principal care managers	One group discussion with 6 people
18. Home care manager	Invitation to all home care managers	One group discussion with five people
19. Assistant director and area managers		Individual interviews with Assistant Director and all 4 Area Managers

REFERENCES

- Cm 849 (1989) *Caring for People: Community care in the next decade and beyond*: HMSO: London.
- Eaton, L. (1997) 'Working safe', *Community Care*, 21-22, 17-23 July.
- Harding, T. and Beresford, P. (1996) *The Standards We Expect: what service users and carers want from social services workers*, National Institute for Social Work: London.
- Hardy, B. and Wistow, G. (1997) 'Quality Assured or Quality Compromised? Developing Domiciliary Care Markets in Britain', in Evers, A. Haverinen, R., Leichensening, K. and Wistow, G. (eds) *Developing Quality in Personal Social Services*, Ashgate: Aldershot.
- Henwood, M., Lewis, H. and Waddington, E. (1998) *Listening to Users of Domiciliary Care: Developing and monitoring quality standards*, Nuffield Institute for Health/UKHCA: Leeds.
- Jackson, S. (1995) 'Introduction', in Ward, H. (ed). *Looking After Children: Research into Practice*, HMSO: London.
- Jackson, S. (1998) 'Looking After Children: A New Approach or just an Exercise in Form-filling? A Response to Knight and Caveney', *British Journal of Social Work*, 28, 1, 45-56.
- NHSE/SSI (1994) *Care Management Special Study*, Department of Health: London.
- Parker, R., Ward, H., Jackson, S., Aldgate, J. and Wedge, P. (eds) (1991) *Looking After Children: Assessing Outcomes in Child Care*. Report of an Independent Working Party established by the Department of Health. London: HMSO.
- Stewart, J. (1996) 'Innovation in democratic practice in local government', *Policy & Politics*, 24, 1: 29-41.
- Unell, J. and Bagshaw, H. (1997) *Examining Outcomes in Community Care: Report on focus groups*, SPRU Working Paper. University of York: York.