Unified Assessment in Wales: older people with complex needs and their families

Final Report to the Wales Office of Research and Development for Health and Social Care

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Diane Seddon[1], Anne Krayer[1], Catherine Robinson[1], Bob Woods[2] and Yvonne Tommis[1]

[1]School of Social Sciences
[2]Institute of Medical and Social Care Research
Bangor University

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Executive Summary

Introduction

This report presents key findings from a recent study looking at the implementation of Unified Assessment (UA) from key stakeholder perspectives, including, older people, their carers and staff working in health and social care organizations. The work was funded by the Wales Office of Research and Development for Health and Social Care.

Method

This research was undertaken in seven study sites across Wales and was informed by a multi-sectoral Project Reference Group. Adopting a qualitative approach, it involved face-to-face interviews with older people and their carers as well as telephone interviews with a broad range of staff that had practice-based experience of UA.

Findings

There is a considerable gap between UA policy and UA practice in a number of key areas, including, the implementation of person-centred and outcome-focused approaches, care coordination for older people with complex health and social care needs and the sharing of information between health and social care practitioners.

Key challenges to the implementation of **person-centred approaches**, that involve practitioners establishing and maintaining relationships with older people and their carers, include:
- Rigid adherence to highly structured assessment documentation that precludes the use of core assessment skills which focus on the interaction between practitioner and older person.
- Variability in practitioner recording styles, particularly the use of service users and carers own words.
- Capacity issues that relate to time constraints, high caseloads and high levels of staff turnover.
- Practitioner concerns about raising service user and carer expectations.

Despite successive policy and practice Guidance emphasizing the importance of **outcome-focused practice** that distinguishes between needs, outcomes and service provision, we found:

- Health and social care practitioners remain service-driven and task-focused; they continue to equate outcomes with the provision of practical services to older people and their carers.
- Only limited evidence of practitioners identifying and exploring outcomes with older people and their carers that relate to social inclusion and the emotional aspects of ageing and caregiving.
- Traditional services are ineffective in achieving basic outcomes for older people and their carers, such as maintaining social contacts.
- Whilst UA has helped to facilitate some improvements to care planning processes, and outcomes to be achieved are now more explicit, organizational barriers to creativity remain, in particular service commissioning arrangements.

The policy ideal of **seamless and coordinated care** to support older people with complex needs is not realized in practice:
- Ambiguity and controversy surrounds the role of the care coordinator, which is seen as synonymous with care management.
- Whilst the UA Guidance of 2002 outlines key care coordination tasks and specifies that both health and social care practitioners might appropriately take on the role of care coordinator, UA continues to be viewed as a social care responsibility.
- Health practitioners are reluctant to engage in care coordination activities, citing the perceived additional demands on their workload.
- Older people and their carers are critical of the lack of a consistent point of contact in health and social care services; they themselves continue to chase progress and coordinate. From their perspective, UA has not succeeded in reducing duplication of effort as they continue to repeat information to various practitioners.

The successful implementation of UA requires effective and timely **information exchange** between health and social care:

Whilst eight years have now elapsed since the publication of the UA Guidance, difficulties remain in terms of reaching agreement on the type, content and format of assessment documentation. This detracts from the realization of key UA objectives; in particular it hinders the sharing of information and the development of more consistent approaches to assessment and care management.
- Practitioners find UA documentation lengthy and protracted and have concerns about the proportionality of some assessments to presenting needs. Older people and their carers confirmed this.
- Agreeing and implementing shared systems is problematic; information sharing is not routinely embedded in practice. The

situation is compounded by the different terminology used by various professional groups.

- The electronic exchange of information is especially problematic; basic practical issues, such as practitioner access to networked computers were highlighted alongside incompatible IT systems across health and social care.

Implications for policy and practice

- Whilst there are a number of unresolved issues relating to assessment documentation, in seeking to find solutions it is important not to loose sight of core assessment skills relating to competent interviewing, observation, counseling and relationship building.

- There needs to be greater consistency in relation to recording information in the service users and carers own words especially when completing domains one and two.

- Having confidence in and trusting the professional judgments of others is essential if duplication is to be minimized; it must be addressed in joint training, ongoing staff supervision and monitoring.

- Shared understanding of key values and principles underpinning the UA process, such as person-centred and outcome-focused, is essential. For example, the development of timely and creative responses to individuals in need requires all practitioners to make the fundamental distinction between needs, outcomes and service provision.

- Change and development is needed at the service provider level to create opportunities that will make a positive difference. Commissioning organizations must work more closely with communities to develop flexible local providers that can support individuals to achieve a variety of personalized outcomes. This includes social and emotional outcomes that are important in shaping wellbeing and qualify of life in older age.

- Opportunities that have been created for traditional health and social services organizations to adopt more flexible and potentially effective arrangements for developing provision, through pooling budgets and lead commissioning, must be capitalized upon. It is also important to embrace the potential of direct payments and individual budgets.

- Strategic and more coordinated direction from within the health and social care divisions of the Welsh Assembly Government is necessary to facilitate a whole systems approach to assessment and care management in which health practitioners fully engage with UA processes.

- An evidence-based care coordination intervention may help to guide care coordination activity and the delivery of more seamless support to individuals with complex health and social care needs and their carers.

- Investment in the IT infrastructure to underpin the UA process is long overdue; in particular, there is an urgent need to address access to IT facilities for health care practitioners if they are to be supported in contributing effectively to the UA process.

- Sharing information in paper format is not sustainable; UA was not intended to operate as a paper-based system. Shared IT systems that facilitate the timely exchange of information across organizational boundaries, thereby reducing duplication of effort for older people, carers and practitioners alike, are required.

- Steps must be taken at strategic level to try to address some of the longstanding capacity issues raised by practitioners and identified as adversely affecting their ability to undertake assessments and reviews; this includes high caseloads and staff turnover.

Chapter One Overview

Introduction

This report presents findings from a qualitative study looking at the implementation of Unified Assessment (UA) in Wales from key stakeholder perspectives, namely, older people (aged 60 and over) and their carers, as well as health and social care practitioners. Chapter One outlines the aims and objectives of the research, sets the policy context and considers the existing research evidence. Chapter Two describes the methods of data collection and analysis, whilst chapters Three to Six explore the main findings. The concluding chapter considers the implications for health and social care policy and practice and also explores areas for future research development.

Study aims and objectives

Drawing on the first-hand experiences of older people and their carers, as well as the practice-based experiences of health and social care staff, this study aimed to:

1. Meet an identified gap in the existing knowledge base by exploring service user and carer experiences of UA, for example, the sensitivity of the UA process in identifying and exploring needs, and its effectiveness in helping service users and their carers achieve a set of agreed outcomes.
2. Identify and explore person-centred and outcome-focused approaches to assessment and care planning and the extent to which these feature in current practice.
3. Consider ways in which organizations can work collaboratively to plan and deliver support to older people with complex needs and their families.
4. Synthesize data from key sources in order to make recommendations that will facilitate the translation of UA policy into practice.

The work was completed in seven study sites across Wales.

A Project Reference Group, comprising older people, carers, academics and representatives from statutory and independent sector organizations, informed the research process.

Policy context

Fulfilled Lives (Welsh Assembly Government, 2007a) outlines a ten-year vision for modernised social care services that are outcome-

led, focused on prevention and early intervention and responsive to individual need. Assessment is a crucial first step in realising this vision and a key driver underpinning the planning, commissioning and delivery of outcome-focused support.

In April 2002 the Welsh Assembly Government published Guidance *Creating a Unified and Fair System for Assessing and Managing Care.* The Guidance, commonly referred to as Unified Assessment, applies to all adult service-user groups and provides a co-ordinated, overarching system of assessment and care management. As with the Single Assessment Process (SAP) in England (Department of Health, 2002) and the Single Shared Assessment Tool in Scotland (Scottish Executive, 2001), UA aims to:

- Ensure effective joint working.
- Reduce duplication of assessments, including the need for service users and their carers to repeat the same information.
- Secure better outcomes for service users and their families.

These aims reflect the Welsh Assembly Government's strategic direction for health and social care, as described in *Designed for Life* (Welsh Assembly Government, 2005) and *Fulfilled Lives* (Welsh Assembly Government, 2007a), namely, to deliver:

- Seamless and timely support to individuals in need, which encourages independence and choice.
- A common assessment framework for Wales that is person-centred and proportionate to need.
- An outcome-focused approach to care planning that puts service users and carers at the centre.

In Wales, the term *unified* replaced *single* and *single shared* to emphasize the coordinated approach to assessment and care management that is required. Protocols and systems for how organizations interact with each other and share information should be agreed. Subject to certain constraints, basic personal and assessment information should be stored in a UA Summary Record that is accessible across health and social care. The *Framework of Services for Older People,* which is currently being developed by the Welsh Assembly Government and seeks to promote accessible and responsive support that is delivered flexibly and consistently across organizational boundaries, reinforces the importance of the unified approach described in the 2002 Guidance.

UA emphasizes the importance of engaging with service users as partners in the assessment and care planning processes, taking into account their strengths and abilities and ensuring their views and

wishes shape the assessment process. Consistent with other health and social care policy initiatives which underscore the importance of partnerships, such as the *Strategy for Older People in Wales* (Welsh Assembly Government, 2003a; 2008a), the *National Service Framework for Older People in Wales* (Welsh Assembly Government, 2006) and *Improving Health and the Management of Chronic Conditions in Wales (*Welsh Assembly Government, 2007b), assessments should be completed in a way that enables individuals to:

- Gain a better understanding of their situation.
- Identify the options that are available for managing their own lives.
- Identify the outcomes required from any help that is provided.
- Understand the basis on which decisions are reached.

It is essential to achieve and maintain a balance between promoting independence on the one hand and safeguarding vulnerable adults on the other; the UA Guidance outlines a risk assessment framework as key to achieving this balance. Health and social care organizations are required to work together to assess the extent to which identified needs present a risk to an individual's independence and to consider: the past, including family history where appropriate; the present and longer term intensity of particular needs, including physical pain or distress; the instability/predictability of needs; and, the complexity of needs, including how needs interact and the ways in which individuals respond to the challenges facing them.

There are twelve domains to guide the assessment of need in Wales, whilst in England there are eight domains of assessment and, in Scotland, there are twelve components of need. Using the service-user's and carer's own words to build a rounded picture of the challenges they face, assessments should be proportionate to the individual's needs, as well as responsive to changing circumstances and levels of independence. The UA Guidance outlines four types of assessment, namely, contact, overview, specialist and comprehensive:

> **Contact assessment** - this level of assessment refers to a contact, following referral, between an older person and health and social care services where significant needs are first described or suspected. Basic personal information is collected and the nature of the presenting problem is established.

Overview assessment - this is completed if in a professional's judgement an individual's needs are such that a more rounded assessment should be undertaken or if older people themselves request more intensive help.

Specialist assessment - a more in-depth assessment confirms the presence, extent, cause and likely development of a problem or health condition and establishes links to other conditions and needs.

Comprehensive assessment – this involves specialist assessments of all or most of the domains of the UA. Comprehensive assessments must be completed where the level of support likely to be offered is intensive or prolonged, including permanent admission to a care home, intermediate care services, or substantial packages of care at home.

The Welsh Assembly Government cautions against implementing these types of assessment in an ordered sequence, as practice is usually more complex than that. It believes that local implementation of UA by health and social care organizations promotes better care services, improved outcomes for older people and more effective use of professional resources. Consequently, it did not prescribe specific UA tools; each Local Authority in Wales was required to develop their own documentation in response to the UA Guidance. This stands in contrast to the SAP in England that requires Local Authorities to select from a list of accredited assessment tools. The Care Programme Approach (CPA) to support people with serious mental health problems is a specialist assessment within the UA framework; this also contrasts with England and Scotland, as CPA is not integrated into the Single or Single Shared assessment processes.

The UA Guidance specifies that care planning is concerned with identifying outcomes and creative responses and should not be service-led; Personal Plans of Care should reflect the minimum intervention possible to achieve a set of agreed outcomes. Outcomes should include preventative and rehabilitative measures to optimise independence, reflecting what people can do and their ability to self-care. Objectives must be specified in terms which demonstrate the contribution that each service or intervention makes in realising the desired outcome.

Where needs are complex and require the input of several professionals, one professional should be nominated as the care co-ordinator and act as the focus for communication, care planning and the ongoing management of care. Whilst the term *complex need* is

not defined, the UA Guidance notes that *complex* implies the requirement for specialist assessments of all or most of the twelve domains. Key care coordination tasks are listed as:

- Acting as a consistent point of contact.
- Progress chasing.
- Advising on the sharing of information.
- Coordinating case conferences.
- Instigating reviews and adaptations to Personal Plans of Care.
- Determining whether services meet eligible needs and help to achieve outcomes.

The use of care coordination is well established in the CPA, used in mental health services, as well as other initiatives focusing on integrated care. For example, similar Care Tracker functions were developed as part of the Integrated Cancer Care Programme to explore how cancer services could be delivered more effectively in the community. Health and social care organizations are required to agree local protocols to guide care coordination activities, covering basic information such as who should act as the care coordinator and the tasks involved. Guidance is explicit in specifying that UA applies to *both* health and social care organizations and indeed recommends that where an individual's main needs are health-related a nurse or other health care professional should assume the care coordinator role. It suggests that care managers and community-based nurses are best placed to act as care coordinators as they usually have long-term involvement with service users and their families, whereas specialists may only be involved for a limited time. The importance of acting flexibly and in the best interests of service users and their families is emphasized.

The UA Guidance does not formally extend to housing authorities or other statutory organizations, despite their important contribution to maintaining independence and wellbeing and a body of research evidence which suggests that assessors, planners and commissioners should think more broadly across professional fields (Harrison and Heywood, 2000). However, health and social care organizations must take account of their duties under the NHS and Community Care Act (1990) and invite housing authorities to contribute to assessment and care planning where housing need is identified; organizations may establish care coordination arrangements between relevant staff in different disciplines through *virtual teams.* Arrangements for care coordination must be recorded in Personal Plans of Care.

The UA Guidance highlights the importance of developing a fairer approach to the setting of eligibility criteria and more equitable

access to social care services; the Fair Access to Care (FAC) Guidelines are intended to help organizations consider the way in which they set their eligibility criteria. The FAC Guidelines are integrated within the UA Guidance, rather than separate, as is the case in England and Scotland. The UA Guidance prescribes a framework for all adult social care services; there is only one eligibility decision, drawing upon an evaluation of the four factors of independence (autonomy, health and safety, managing daily routines and involvement) and subsequently determining if assessed needs pose a critical, substantial, moderate or low risk to an individual's independence. The most recent *Strategy for Older People* (Welsh Assembly Government, 2008a) reinforces the need to achieve consistency in the availability of social care services across Wales.

The importance of actively managing and regularly reviewing cases is recognized. UA Guidance describes the purpose of review as establishing the extent to which services provided have achieved the outcomes recorded in the Personal Plan of Care and support an individual's potential for improving their level of independence. It specifies that as a minimum there should be an initial review within three months of services first being provided and, thereafter, reviews should be scheduled at least annually or more often if individuals' circumstances appear to warrant it.

Research evidence

To date there has been only limited research and evaluation of UA in Wales, which has focused chiefly on staff accounts of strategic and operational issues relating to implementation (Seddon *et al.,* 2010). Very little is known about how service users and their carers experience this fundamental change in approach to assessment and care management. Work by the National Leadership and Innovation Agency for Healthcare highlights the need to formalize systems and develop tools which capture service user experiences of and satisfaction with UA (NLIAH, 2007).

Research conducted in England (Christiansen and Roberts, 2005; Mackenzie *et al*., 2005) suggests that the SAP is helpful in reducing duplication of assessments and is encouraging more timely responses to individuals in need. Challis *et al*., (2007) suggest that following the implementation of the SAP, needs are more effectively identified, especially those relating to cognitive functioning and mobility. However, a number of common difficulties have been reported across England, Wales and Scotland. These include: engaging general practitioners and specialist clinicians (Dickinson, 2006; Ridout and Mayers, 2006); sharing information between

health and social care organizations (Glasby, 2004; Seddon *et al.,* 2010); and, addressing concerns about the erosion of professional roles and identities, particularly amongst Occupational Therapists (Cornes and Clough, 2004; Huxley *et al.,* 2007).

Whilst assessment and care planning processes are meant to be the cornerstone of community care, research suggests that they are neither consistently effective nor efficient. The lack of a common understanding of key principles amongst professionals and how these relate to service provision, in particular, needs and outcomes, is especially problematic and hinders shared practice (Challis *et al*., 2007). A considerable amount of work is required to embed an outcome-focused approach into practice; indeed, what constitutes an outcome remains a conceptual challenge for health and social care practitioners alike. Nicholas (2003) suggests that an outcome-focused approach requires a cultural shift, as some practitioners find it difficult to distinguish outcomes from needs and services, and lack time to define and monitor such outcomes. This cultural shift, alongside UA protocols that encourage practitioners to think innovatively about ways to respond to individual needs, should in future help to improve both symmetry and synchronicity, which are key factors in determining the effectiveness of support (Nolan *et al.,* 2003; Hanson *et al*., 2006; 2008). Symmetry refers to the intended goals and outcomes of a service and the degree of consensus between individuals and service providers, whilst synchronicity relates to the timely delivery of services. Research suggests that the lack of validated assessment tools to enable service users, carers and practitioners to think about outcomes and innovative ways of meeting these is problematic; consequently, support is often inconsistent with service user and/or carer-defined outcomes (Hanson *et al.,* 2008) and is less than satisfactory (Boyle, 2004; Commission for Social Care Inspection, 2006, 2008; Scourfield, 2006, 2007; Themessl-Huber and Hubbard, 2006). Home care and intermediate care services are identified as especially problematic (Townsend, 2006; Burholt and Windle, 2007; Scourfield, 2007). In addition, research suggests that there is scope to adopt more flexible approaches to service organization and delivery (Audit Commission, 2004; Commission for Social Care Inspection, 2008; Clarke and Riley, 2006) and strengthen relationships between health and social care and wider community organizations to deliver more personalized, outcome-focused support (Department of Health, 2007).

Translating the policy of care coordination into practice is problematic, not least because of ambiguities associated with the term; amongst health care professionals, care coordination is seen as synonymous with care management and is also confused with

advocacy and brokerage roles (Seddon *et al.,* 2010). This complicates the process of agreeing local care coordination protocols. Additionally, health care practitioners appear reluctant to assume this role and report being hindered by the lack of a robust administrative infrastructure required to facilitate care coordination activities. Difficulties with electronic sharing of information (Mouratidis *et al*., 2003; Challis *et al*., 2007), the complexities associated with commissioning services across health and social care organizations and the lack of cross-boundary agreements to support the care coordination role compound the situation (Seddon *et al.,* 2010). The lack of effective care coordination procedures has detrimental consequences both for the alignment and integration of assessments undertaken by health and social care practitioners and the delivery of seamless support.

Research in the field of mental health (Huxley *et al*., 2007) suggests that the implementation of the FAC Guidelines, which seek to increase consistency and transparency, has proved problematic because of limited inter-agency and intra-agency communication and insufficient staff training relating to the purpose and operation of the Guidelines. There remain differences in the way eligibility criteria for social care services are applied and difficulties in reconciling FACS and CPA in England (Hudson and Henwood, 2008).

Variation in access to services across England and Wales, and indeed across Europe, is well documented (Hudson and Henwood, 2008; Lamura *et al.,* 2008). Also, Local Authority discretion to determine social care budgets has led to differences in the availability and types of services to support older people and their carers (Care and Social Services Inspectorate Wales, 2008; Hudson and Henwood, 2008).

Inter-organizational information sharing is one of the cornerstones of assessment and effective, joined-up service delivery; despite the importance of information technology to single, single shared and unified assessment procedures, there is little evidence of documents being made available electronically (Challis *et al*., 2007). Most communication is paper-based, as health and social care computer systems do not provide the functionality that is required to implement this approach to the assessment and management of care (Mouratidis *et al*., 2003). In particular in health, there are issues around hardware availability and appropriate training (Ward *et al*., 2008). Differences in governance requirements in health and social care influence the ease of information flow and require careful negotiations with respect to information sharing protocols (Richardson and Asthana, 2006).

Whilst technological issues such as hardware, software programmes that are *fit for purpose* and training are important, the main challenge lies in implementing change in practices and attitudes both at organizational and individual levels (Pirnejad, Bal and Berg, 2008; Sicotte and Paré, 2010). For example, there is evidence in the literature that information technology can be seen as undermining professional expertise, which can lead to resistance to integrating information sharing processes into work routines (Nettleton and Burrows, 2003; Stam *et al.*, 2004). Buy-in and resistance to information sharing is related to organizational cultures and perceptions. There are differences in how the patient/client is perceived in health and social care and joined-up service-delivery brings these differences into sharp focus (Baines *et al.*, 2010). Professional accountability also has been shown to play a role in the resistance to information sharing (Hudson, 2001). Thus effective information exchange is fraught with difficulties not only in terms of the available technology but also in terms of organizational frameworks and professional cultures. Information technology needs to be efficient and *fit-for purpose*, but there is a fundamental need to move beyond merely technological issues.

Chapter Two Method

Introduction

This study adopted a qualitative approach to exploring the implementation of UA from key stakeholder perspectives. Here we describe the methods of data collection and analysis used.

Study sites

Seven Local Authorities in Wales were purposively selected as study sites; our sites reflected differences in geography (urban, rural), size of Local Authority, strategic and organizational features underpinning UA and expenditure on services for older people.

In-depth interviews with older people and their carers

We completed in-depth face-to-face interviews with older people (aged 60 years and over) and their carers.

Interview sample

Following ethical approval from the Wales Multi-Centre Research Ethics Committee and the Association of Directors of Social Services, bilingual study packs, comprising letters of invitation, information sheets, consent forms and freepost reply envelopes were forwarded to potential study participants by health and social care practitioners in our seven study sites when completing either a specialist or comprehensive assessment. Individuals wishing to take part completed the consent form and returned this directly to the research lead in a freepost envelope. Individuals consented to their contact details being stored on a confidential database and for a member of the research team to make contact with them to talk about the study and to schedule a suitable time and date for interview.

Older people and their carers were given the option to be interviewed either separately or jointly. In those cases where we managed to achieve pairs (n=9), all interviews were completed jointly at the participants' request. A further 4 interviews were completed with an older person and 2 were with carers looking after an elderly relative. Altogether we spoke to 24 people (13 older people and 11 carers). Further sample characteristics are presented in Tables One and Two.

Table One Characteristics of interviewees – older person

	Male (n = 5)	Female (n = 8)
Mean Age (SD)	80.20 (4.55)	72.62 (10.61)
Carer		
Spouse	5	6
Niece/nephew	-	1
Friend/neighbour	-	1
*Condition**		
Diseases of the circulatory system	1	3
Diabetes and related complications	3	
Diseases of the muscular-skeletal system and connective tissue	-	4
Diseases of the nervous system	4	3
Diseases of the digestive system	1	4
Diseases of the genitourinary system	3	2
Diseases of the eye	1	2
Diseases of the ear	-	1
Cancer	-	1
Orthopedic joint implants	-	3
Falls	-	2

*Note. 12 participants had multiple conditions

Table Two Characteristics of interviewees – carers

	Male (n = 3)	Female (n = 8)
Mean age (SD)	79.00 (2.65)	60.00 (23.63)
Cared-for		
Spouse	3	4
Sister-in-law	-	1
Aunt	-	1
Employment status		
Full-time	-	2
Retired	3	4
Mean years of caring (SD)	5.67 (5.51)	17.39 (23.48)
*Hours per week spent caring**		
1-19	1	1
20-49	-	3
50+	2	1

*Note: Only 5 females answered this question. Information relating to employment status was not available for all female carers.

Of the two female carers whose cared-for declined to be interviewed, one looked after her mother (68 years old) with multiple sclerosis, whilst the other looked after her husband (88 years old) who had emphysema.

Interview approach

Interviews were framed by a topic guide (see Appendix One); in developing the topic guide we drew on the most recent research, policy and practice literature and discussed the content with members of the Project Reference Group (see below).

Older people and their carers were encouraged to speak openly about their first-hand experiences of UA, including:
- Expectations of assessment.
- Focus of assessment.
- Involvement in decision-making.
- Exploring circumstances and defining needs via the domain approach.
- Arriving at a set of agreed outcomes and determining whether these have been met.
- Relationships with practitioners, including care coordinators and their potential to deliver change.
- Outcomes of assessment, including support received and its perceived effectiveness.
- Aspects of the unified assessment process that work well.
- Aspects of the unified assessment process that are problematic and how these might be addressed.
- Reviewing needs, expectations and priorities.

In addition to the areas of interest listed above, we also asked carers about:
- Rights to assessment.
- Sensitivity of assessment, particularly in relation to discussions about ability and willingness to care.
- Exploring needs *in* and *beyond* the caring role.
- Carer defined outcomes and support needed to achieve these.

The use of topic guides to explore expectations, experiences and support needs is highly effective, especially when discussing *potentially* sensitive issues; they help to keep discussions focused whilst at the same time allowing individual perspectives and experiences to surface (Birch and Miller, 2000; Johnson, 2002; Goodrum, 2007). We ensured that participants had sufficient privacy and time to become comfortable talking about themselves and their families. Interviews were paced so that themes emerged

gradually and rest breaks were offered; all interviews were completed in peoples' own homes. On average, interviews took between 1.5 to 2 hours to complete.

Telephone interviews with staff

We conducted in-depth semi-structured interviews, over the telephone, with 43 staff across our seven study sites. We have found telephone interviews to be a practical way of eliciting data on a regional and national basis (Seddon *et al.,* 2009, 2010).

Interview sample

Staff were nominated for interview by the Director or Chief Executive of their organization because of either their practice-based experience of working with older people and their carers or their managerial experience of supervising practitioners. A breakdown of the staff sample is presented in Table Three overleaf.

Table Three Staff interviewees by employing organization and designation

	LHB	LA	NHS Trust
Designation			
Nurse Director/Assistant Director	1		2
Clinical Development Director	1		
Discharge Liaison Nurse			4
Community Nurse	1		
Nurse Reviewer	1		
Head of Occupational Therapy	1	1	3
Occupational Therapist		2	
Care Manager	3	9	
Hospital Social Worker		3	
Community Team Social Worker		3	
Review Officer		1	
Long-term Conditions Case Manager	1		
Domiciliary Care Manager		1	
Commissioning Team Manager		1	
Local Authority Team Manager		2	
UA Project Manager	1*	1	
Total	10	24	9

Note. *This interviewee also works with the LA

Interview approach

The interviews were framed by a topic guide, which was developed in consultation with the Project Reference Group (see Appendix Two). Staff were prompted to describe their first-hand experiences of implementing UA, including:

- Ensuring assessment is proportionate to need.
- Translating person-centred and outcome-focused approaches into practice.
- Using the domains and seven key issues of assessment in practice.
- Evidencing needs and unmet needs.
- Using the matrix approach to explore risks to independence.
- Translating identified needs into outcomes.
- Care planning.
- Care coordination.
- Sharing information.
- Adopting an outcome-focused approach to review and re-assessment.

- Key changes to practice and their effects on service users and carers.
- Using assessment information to advocate for/develop new services.
- Local arrangements for monitoring and evaluating UA from service user and carer perspectives.
- Staff training needs.
- Examples of good practice which are transferable across service settings.

On average, interviews took 1.25 hours to complete.

Management of all interview data

Detailed interview notes were taken and where permission was given interviews were taped, using MP3 recording equipment, and fully transcribed with the exception of identifying information. All data (hard copy and electronic) was anonymised and held securely.

Data analysis

Detailed readings of the interview transcripts helped establish a familiarity with the data and encapsulate the emerging themes. An outline coding scheme to highlight what Patton (2002) refers to as *units of meaning* was devised. A series of codes (free nodes) assigned a conceptual label to sections of transcript. The codes were generated *a priori* based on our understanding of the literature and from preliminary readings of the transcripts. The range and variation of themes was mapped using data displays (Richards, 2005). Further refinement of some key themes was undertaken in discussion with the Project Reference Group during the second PRG meeting. More detailed analysis allowed the identification of commonalities and contrasts and resulted in a more complex coding framework represented as hierarchical code groups. Team discussion about node definitions and patterns in the thematic analysis facilitated the interpretation of the data.

Data was entered on to QSR Nvivo 8, which enables researchers to electronically organize qualitative data into themes so that it can be effectively searched and analyzed by category. Nvivo 8 facilitates the development of inductive and deductive approaches to data and supports the sensitive exploration of themes.

Our *initial* and *continuing* analysis considered each data set separately. *Final* analysis synthesized the datasets generated from the interviews with older people, carers and staff, enabling contrasts and comparisons to be made and the exploration of

salient themes. For example, where staff perceive the deficits in practice and where older people and carers perceive these to be. Data displays facilitated this process, as recommended by Thomas *et al.,* (2004) and Creswell and Plano-Clarke (2007).

Project Reference Group

A multi-sectoral Project Reference Group, comprising older people, carers and representatives from statutory and independent sector organizations, was established with the aim of involving key stakeholders in the research process. The PRG met on two occasions and members were invited to comment on:

- The development of interview topic guides.
- The analysis of research data, for example, the interpretation of emerging findings.
- Policy and practice implications.

Members of the group were encouraged to share their own personal experiences and to also contribute a wider consumer perspective, as recommended in the literature on consumer involvement (Buckland and Gorin 2001). In line with the principles of good practice set out by Involving Consumers in NHS Research (2002), members travel expenses were paid. At the outset, members were given a short information booklet that explained why their involvement was important, detailed their likely contribution and clarified the resources available to facilitate their involvement.

Chapter Three Person-centred approaches to the assessment and management of care – key findings

Introduction

This study has generated rich qualitative datasets from key stakeholders involved in the UA process. The findings presented in this report do not reflect the full scope of the data but encapsulate a number of important areas of interest arising from our analyses. Further findings will be reported in papers for peer review and professional journals. We have used quotes from older people, carers and staff to illustrate the findings. The notation below each quote indicates the unique identification number given to the interviewee.

This chapter considers key findings relating to person-centred approaches to the assessment and management of care. A person-centred approach, which places the service user and their carer at the centre of the assessment process, is *the* core principle underpinning UA. Older people, carers and staff reflected on the meaning of person-centredness, as well as its translation into practice. In doing so, they highlighted a series of challenges to the implementation of person-centred approaches across health and social care, as well as some modest successes, and identified a number of training needs. These training needs correspond closely with the deficits in assessment practice reported by older people and their carers.

Characteristics of person-centred approaches

Person-centred approaches are described by older people, carers and staff through a range of defining features, including:

- Recognition of what individual older people prioritize as important for them.
- Commitment to promoting independence and choice by focusing on individuals' strengths and abilities.
- Engagement with older people and their carers as experts and as partners in the care process.
- Commitment to delivering individualized packages of care that are shaped by older people and their carers.

Implementing person-centred approaches in practice

Experiences related by all study participants highlight challenges in achieving the ideals listed above. A key challenge relates to using the assessment documentation devised in response to the UA

Guidance. Whilst the Guidance did not prescribe lengthy or overly complex documentation, many practitioners believe the highly structured documentation they use detracts from the implementation of a person-centred approach, particularly, the building of relationships with older people and their carers:

> *I think that going out and possibly not taking the UA with you is more person-centred rather than trying to hit all of the domains that are there [….] I think they find the UA very repetitive and it takes a lot more time to complete, which would detract time away from spending it with the service user, which then doesn't become a person-centred way to approach a situation [….] people also feel like they're pigeonholing people and trying to put them into boxes and make things fit, which is also less person-centred.*
> *UA27.6, Care Manager*

> *[….] putting it all in boxes is daft really because you, when you're having a conversation with someone, it doesn't necessarily come in the boxes like that does it [….] you're not focusing on the person then you know, you are focusing on trying to get your writing done and making sure that you've got enough information for your document.*
> *UA42.6, Care Manager*

Older people and their carers agree; they too criticized the structured nature of assessment documentation, which they perceived as overly complex and repetitive. They shared their personal experiences of its implementation in practice:

> *She just wanted facts [….] I wasn't particularly impressed. My recollections of it, it felt like a questionnaire as opposed to any other sort of interaction. You know the sort of, I don't know, no frills thing, I mean she, I mean she was a very nice lady but she sort of [….] she got down to it immediately.*
> *UA328.0, Interview with older person*

> *[….] you find yourself repeating because you'd answered something for this section and then the next one seemed to be, well aren't they asking the same thing there or have we got it wrong there?*
> *UA376.0&1, Interview with older person and their carer*

Because you, you felt the district nurse, who's got a limited amount of time, she was spending far, far too long in filling the form in [….] she might spend 10 minutes with me as a patient then she'd have 2 hours of writing to do.
UA376.0&1, Interview with older person and their carer

Across our seven study sites strict adherence to the UA documentation, in particular to the twelve domains of assessment and their associated sub-domains, distracts from practitioners exercising core, person-centred assessment skills that include: getting to know people; learning about peoples' past experiences and the things that shape them as individuals; understanding the things that matter most to people; exploring family circumstances and the home environment; and, identifying potential ways to support people in their daily lives. The emphasis practitioners place on documentation rather than the interaction between themselves and service users and/or carers is by no means unique to the UA process. Indeed, previous studies completed by members of the research team during the 1990s (Seddon and Robinson, 2001) and prior to the publication of the UA Guidance highlighted this as a fundamental weakness in the assessment of carer need. Our subsequent work in this area following legislative changes relating to carer assessment confirms the entrenched nature of this problem (Seddon *et al.,* 2007). Some of the older people and carers that we interviewed wondered about the type and content of professional pre-qualifying training for practitioners and suggested that its coverage of basic assessment skills, in particular communication, interpersonal and social skills, might be improved upon. These skills were highlighted by older people and their carers as important in establishing and maintaining successful relationships; some practitioners were perceived as insensitive and found to be lacking the most basic skills:

[….] he was short and sharp.
UA1.0&1, Interview with older person and their carer

"It's time …" in front of my husband "… it's time you faced up to the fact your husband's never going to get better whatever bed or whatever he has".
UA88.1, Interview with carer

I didn't find her particularly sociable really, she asked the questions and that was it [….] she conducted the meeting in a sort of business like manner, maybe perhaps too heavy on the, on the business side.
UA328.0, Interview with older person

Longstanding capacity issues in health and social care relating to high case loads and subsequent time constraints were also identified as challenges to the implementation of person-centred approaches to the assessment and management of care in both acute and community settings:

> *It's about the time factor, if you've got the time to sit down with people, the person-centred care then becomes much more, well person-centred care really [….] Well in a hospital it's "let's put a plaster on, let's get you … let's mend you and get you out" really.*
> *UA11.6, Head of Community Nursing*

> *If you've only got an hour to dash in and dash out, to make sure that all their risks are avoided, it actually feels like quite a luxury to be able to spend time to do the user's perspective and then have time to write up all the evidence that you've gathered and the risks you've identified.*
> *UA18.6, UA Project Manager*

> *I think it's something that gets forgotten very easily when you've got cases, assessments, new assessments piling up on top of you and all of this work to deal with, I think you can very easily forget about the person and their involvement with the assessment and just get bogged down with your ability to record it and get it signed off and get a service in for them really.*
> *UA27.6, Care Manager*

Practitioner commitment to person-centred care is tempered in practice by their prior knowledge of services that are available locally. Despite the plethora of policy and practice Guidance that has been issued since the community care reforms of the early 1990s urging practitioners to disregard resource and service availability considerations when working with individuals to determine what might best support them, in practice assessments remain predominantly service-led and practitioners remain cautious of raising service user and carer expectations. In this respect, UA appears to have had a very limited effect on practice:

> *I mean one of my concerns is that we are still very very service-led [….] the person-centred approach has got to be well what are the solutions that the person wants, rather than what have we got and what can we offer you, there's still a tendency I think to look at well what services have we got and which ones do you need […] they won't ask them what they*

would have liked to have done, they will just say oh well we can arrange you to go to some day care, where you'll have some company and your daughter will have a break, is that okay with you?
UA18.6, UA Project Manager

Very often we'll start off our meetings by saying there isn't 24-hour care available out there, this is what we can offer you. Sometimes then I often think we are shifting the goal post for that person-centred approach. We're sort of saying we can do it but within the realms of, this is what we've got to play with, how can we now move those goal posts to meet your needs. It's not wonderful, not what we really want to be doing but what we have to. So person-centred, it's how it should be ideally, it's an ideal image, the reality is unfortunately very different.

UA20.6, Discharge Liaison Nurse

Older people and their carers recognized the pressured and resource scarce environment in which health and social care practitioners work; however, they highlighted some very basic requirements such as continuity and the building and maintaining of relationships over time with *individual* practitioners:

Keep getting new ones and keep getting letters saying "I'm your new social worker!" and then they leave!
UA349.0, Interview with older person

Experiences related by older people, carers and practitioners suggest that staffing and capacity issues in health and social care services, which effect both the *initial* and *ongoing* assessment, management and review of care, can militate against the implementation of person-centred approaches. Allied to this, older people and their carers were frustrated at having to repeat the same information, over time, to newly designated practitioners:

He took everything on board but he didn't have any of the previous social workers notes so I had to explain to him again mum's care package and as I said to you, it's a very detailed [….] It's a bit tedious to have to keep repeating it! So to actually go through that with somebody and, again, for them to get their heads around it, it takes time, you know!
UA88.1, Interview with carer

Their experiences suggest that to date UA has not succeeded in reducing duplication of effort in the assessment and care planning

processes. Further examples of duplication are highlighted in Chapter Six, which considers the sharing of information.

Capturing information in the service users and carers own words

The Guidance places considerable emphasis on recording information in the service users' and carers' own words to build a rounded picture of the challenges they face; however, this fundamental requirement is not always achieved in practice. Indeed, we found considerable variation in recording styles used by practitioners *across* our study sites and amongst practitioners *within* particular health and social care teams:

> *No, we've gone down the route of tick the boxes because we're very aware of complaints, litigation and everything like that [….] we've taken away the holistic view of looking at patients.*
> *UA11.6, Head of Community Nursing*
>
> *Social Services did an audit of assessments for all the teams and asked me to be a part of it and one of the things that we were actually looking at was had the Social Workers completed the user's perspective in their own words and it's incredible to see how many hadn't [….] So some people had actually put the – not in their own words, but had actually said Mrs Jones said, so you know you got the sense that at least this was what Mrs Jones had said. Others, it was just their opinion of what a carer or Mrs Jones, they thought Mrs Jones was wanting.*
> *UA18.6, UA Project Manager*
>
> *I know the social worker, the UAP assessment here does use the carer's own words a lot, we don't, we do quote some things, we do [….] but it's generally my assessment with some of their quotations added.*
> *UA26.6, Occupational Therapist*

Whilst UA aims to promote greater consistency in assessment style across Wales this is not being achieved in practice; our findings highlight the importance of staff supervision, team management and training to try to achieve greater consistency in recording style. Practitioners agree that information recorded in the first person can usually generate powerful evidence to inform the assessment, care planning and service delivery planning processes, as well as Statements of Purpose, and can also help in meeting increasingly strict Local Authority eligibility criteria; however, this very basic principle often fails to translate into practice. Practitioners also

agree that older people with dementia and/or communication difficulties present particular challenges in terms of recording information in ways that capture their individuality, personal priorities and support needs:

> *The only difficulty we have found with our elderly clients is that for those patients who are not able to converse really, for example, a lot of our patients have cognitive deficits. It's obvious we're having to presume, estimate or try and gauge an idea of what exactly their thoughts and feelings would be.*
> *UA20.6, Discharge Liaison Nurse*

> *[….] they fail to see the person behind the illness and I think that that is evidenced sometimes and that is, it's really unfortunate that that does happen […] a lot of the patients that we see have got an advanced dementia and you know we wouldn't be able to really work with the person themselves.*
> *UA51.6, Community Nurse*

Problems relating to the electronic recording of information were also highlighted during discussions with practitioners about person-centred practice; present IT systems that comprise a critical part of the UA infrastructure allow for data entry in the English language only. In one of our study sites, a predominantly Welsh speaking area, concerns were raised that nuances and subtleties in the Welsh language are not always translatable. Key findings relating to the recording and sharing of information are presented in Chapter Six.

Person-centred approaches – aspects of assessment practice that are judged to be working well

Notwithstanding their concerns about the UA documentation practitioners welcomed the introduction of the seven key issues of assessment, used in the initial contact assessment, as well as domains one and two in the comprehensive assessment that relate to the service user and carer perspectives. Staff suggested that domains one and two encourage older people and their carers to talk about the things that matter most to them, as well as highlight their existing strengths and abilities, prioritize goals and their perceived support needs. Some practitioners cited this as evidence of UA having led to positive changes in practice, whilst others maintained that the emphasis on service user and carer perspectives has served to formalize previous assessment practice:

> *We had a file audit last year, the tail end of last year, and there'd been a file audit the year before and the improvements are actually you know, the comments are that*

the client centred approach is certainly coming through in a lot of the assessments, and I think people are, you know, quite happy to write how they feel, which is what we used to do, but then I think we lost it somewhere along the line years ago.
UA7.6, Care Manager

So it's about the service user's perspective and how that impacts, so that's how I feel, I feel that UA has actually opened it up to us being a bit more creative if – creative if you like with regards to meeting what the person's perceived level of care is, level of need, d'you see what I mean? [….] we're almost making the person the expert which is what we should be doing anyway.
UA46.6, Care Manager, Reablement Team

Right, okay, heaves a big sigh when they say the word "person centred" - simply because my old fashioned view is what the hell do you think we're doing anyway 'cause we're going out to see the person, deal with the person and it's about social work skills as to how you do that.
UA47.6, Local Authority Team Manager

Reflecting positively on the domains that capture the service user and carer perspectives, both team managers and practitioners suggested that their inclusion in the assessment is empowering for older people and their carers and heightens their sense of involvement in the process:

[….] the user's perspective of the assessment is excellent because it actually gives that person the opportunity to say exactly what they feel they need and want.
UA46.6, Care Manager, Reablement Team

[….] the user's perspective is a good way of actually making them feel listened to.
UA47.6, Local Authority Team Manager

Evidence in support of this assertion is mainly anecdotal given the very limited UA monitoring and evaluation activity reported across our study sites.

Staff training needs
Our findings highlight a number of staff training needs in relation to the translation of person-centred approaches into practice, which include: using the UA documentation as a framework in support of

professional judgment; developing more consistent styles for recording information from service users and carers; engaging in person-centred practice with older people with dementia and those with limited capacity as defined under the mental health legislation; and, managing service user and carer expectations. Clearly, staff training alone is unlikely to facilitate the implementation of key UA objectives into practice and must be reinforced by work-place monitoring and encouragement of good practice.

Chapter Four Outcome-focused approaches to the assessment and management of care – key findings

Introduction

Practitioners welcomed the outcome-focused approach to assessment, care planning and service delivery planning outlined in the UA Guidance and fully supported the principles underpinning this approach. Reflecting on their practice-based experiences to date, they identified challenges to the implementation of outcome-focused approaches, as well as a number of basic training needs, and in doing so highlighted both strengths and deficits in current health and social care practice. Concerns related by older people and their carers suggest that outcomes which they consider to be important are not always prioritized during assessment and care planning or subsequently achieved; through their first-hand accounts they highlighted a considerable and enduring gap between policy and practice.

Defining outcomes

Our analysis of the practitioner data highlights a good deal of confusion over what constitutes an outcome; this presents a fundamental challenge to the implementation of outcome-focused approaches:

> *I'm not absolutely sure what's meant by an outcome-focused approach in all honesty, I don't know if that means that you sort of evaluate the outcome or if you set an outcome that you're aiming for.*
> *UA28.6, Discharge Liaison Nurse*
>
> *[….] ward staff struggle to see that there's almost an outcome [….] it's almost like their services are put in just to maintain that person.*
> *UA46.6, Care Manager, Reablement Team*

Successive health and social care Guidance, including the 2002 UA Guidance, emphasizes the importance of distinguishing between needs, outcomes and service provision and specifies that practitioners should consider preventative, rehabilitative and or re-ablement outcomes with a view to optimizing independence. In the main social care practitioners across our study sites *continue* to equate outcomes with the provision of services and or equipment to assist with practical activities of daily living, whilst health care practitioners *continue* to describe outcomes in terms of discharge

from hospital, specific clinical interventions and care pathways. Service-driven and task-based, these ways of defining outcomes are widely recognized as weaknesses in current practice:

> *I'm not sure that on the whole people have thoroughly grasped the difference between an outcome and a service on occasions. Because we did an exercise on our training, around outcomes and we, there was an exercise that [location] devised around calls where you had to decide is this an outcome or a service? And the number of people when we had the initial discussions who said 'Well what's the outcome for that? [….] and it was like well home care and re-housing and you know they're not outcomes, they're services, so there was a you know real education [….] I think there's a real fear sometimes that – I mean if we didn't provide them with anything, isn't that a waste of time? [….] people seem to equate success as providing services.*
> *UA18.6, UA Project Manager*

Practitioners suggested that older people and carers *themselves* conceive of outcomes chiefly in terms of service provision, for example, receipt of home care and day care:

> *[….] when you go out and do assessments and kind of say "What do you want? How can we help you?" they kind of tend to think, okay, home care that'll help me [….] they still think of the traditional services.*
> *UA27.6, Care Manager*

However, analysis of the older person and carer data does not support this, which suggests a lack of shared understanding amongst assessing practitioners, service users and carers about the everyday situations and experiences older people encounter. Outcomes identified by older people and their carers, as well as potential ways of meeting these, include: enabling the older person and their carer to go out *together*, facilitated by the provision of a motorized wheelchair; allaying fear of the future through one-to-one support from emergency planning schemes; reducing the need for regular community nursing visits, facilitated by the delivery of basic training on catheter care; and, opportunities to meet other people, facilitated by support to attend social events organized through local carer support organizations:

> *[….] but it would be lovely just to be able to take him out with an electric wheelchair, without having to push it [….] I would like sometimes just to be able to go out without having to rely on my family or friends even. Just even to go and*

really to go in [to town] and have a coffee and for the Crossroads and my name's been down on Crossroads for oh about a year, two years and that's what I wish could improve, but then again that is a voluntary funded thing.
UA204.1, Interview with carer

Our findings suggest that despite the emphasis in the UA Guidance on service user and carer defined outcomes, there remains limited scope for older people and their carers to prioritize outcomes that matter most to them:

> *[….] we were interested in a walk-in bathroom but she dismissed that and said I wasn't allowed to answer.*
> *UA648.0&1, Interview with older person and their carer*

We found only limited evidence of practitioners identifying and exploring outcomes with older people and their carers that relate to social inclusion, the emotional aspects of ageing and caregiving, as well as lifestyle and behavioural issues, yet these are all key factors that policy initiatives such as *Fulfilled Lives* (Welsh Assembly Government, 2007a) and the *Strategy for Older People in Wales* (Welsh Assembly Government, 2008a) consistently identify as important in shaping older peoples' quality of life and wellbeing.

Harnessing service user and carer expertise

Whilst the policy rhetoric emphasizes the importance of engaging with service users and carers as experts and as partners in the care process, this is not always achieved in practice as professional perspectives continue to shape the assessment and care planning processes. Striking a balance between the various stakeholder perspectives can be especially difficult when making decisions about risk and risk management:

> *[….] the occupational therapist might say they need help four times a day when in fact the client themselves are saying, "No, I don't want somebody coming into my house four times a day, I might accept somebody two times, twice a day", we have to be sensitive to their wishes. It is a balancing act, yeah, yeah definitely, I mean, sometimes you know that that person does need four times a day, but you really have to be sensitive to the fact that well they're saying they only need two calls a day although you might try to, how can I say, explain to them the risks involved, you have to be prepared for that person to take their risk.*
> *UA4.6, Hospital Social Worker*

> *Yeah and are they your outcomes or are they the patient's outcomes? [….] I think paternalism is still very rife in the health service and often the outcomes that we want are certainly not those of the patients and again it comes back to having things done to you.*
> *UA13.6, Discharge Liaison Nurse*
>
> *[….] there's not a great deal of negotiation because you obviously, if somebody has a chronic condition this is the, it's a kind of set plan of care, this is what we're going to kind of do, we need to go through inhaler technique [….] it's not like social services where they can look at day care or luncheon clubs, you know, it's not like that, it's kind of you know, it's a bit more structured around, it's like a pathway really.*
> *UA17.6, LHB Case Manager, Long-term Conditions*

Experiences related by older people and their carers confirm this, particularly in relation to adaptations to the home, where individuals felt that their expertise was not acknowledged:

> *V1: I don't always agree with them because there was one lady who came here and she was talking about having a different bathroom. We are very particular people and we spent a lifetime doing our own DIY! [….] We've become very proficient at it, you see. We know the form and then when people start talking about knocking this down, knocking that down without realizing they are support walls, the structure of the house and everything else.*
> *V2: Yes, I rather surprised that young girl didn't I! She said 'this will have to come down and this' and I said 'yes, and then the roof will follow it!'*
> *V2: I said don't you know anything about support walls and she said 'I am a clinician, not a builder'. I said 'we are builders!'*
> *UA648.0&1, Interview with older person and their carer*

Outcome-focused planning

Successive policy and practice Guidance has challenged traditional, service-led approaches to decision-making and care planning. Whilst the need to think more flexibly about outcomes and engage in more creative care planning is recognized in principle by most social care practitioners and indeed is reinforced at strategic level by their team managers, the shift from a service-led to an outcome-led culture has yet to be fully translated into practice:

[….] while people still believe we've only got a handful of services, all they're doing is matching up people to what they've got [….] people have got locked into this is how we do things now and perhaps some of the time to listen and then have the confidence to actually act in a way that is different to commissioning care management services is perhaps a shift that hasn't happened yet, because you know social work equals care.
UA18.6, UA Project Manager

But I think it is about changing the culture because people again still think that the traditional way of meeting somebody's needs is to provide a service to that person or to move them from home into a care setting whereas we're trying to get people to say that you can meet needs in lots of different ways, and we want people to be quite innovative in the way that they think about that and work with the patient and our client and their family to do that.
UA2.6, Nurse Director

Further challenges relating to the development of more creative, outcome-focused approaches to supporting individuals in need were identified. For example, commissioning arrangements, which are able to respond to a range of individual needs for support, as well as the perceived need to manage service user and carer expectations of achievable outcomes:

[….] sometimes people can identify outcomes that we may not be able to meet and perhaps it's giving service users unreal expectations of the assessment process by kind of saying "What would you like today?" when there may be things that we … due to financial constraints and things like that, we're not able to meet for them, I think that's a danger.
UA27.6, Care Manager

Given the finite amount of resources I think having an outcome-focused approach I think it does need to be tempered with a degree of realism; realistic expectations.
UA41.6, Care Manager

As previously noted in Chapter Three, our analysis of the older person and carer data suggests that study participants aspire to relatively modest outcomes and do not have unduly high expectations of services. Indeed at interview older people and their carers recognized the financial constraints facing service organizations, in particular voluntary sector organizations, as well as the increasing demand on services given the ageing population.

Descriptions of their circumstances, desired outcomes and support needs were often framed comparatively against those of their peers, especially those who were perceived to be less fortunate than them.

Outcome-focused approaches - aspects of assessment and care planning practice that are judged to be working well

Despite widely reported problems associated with the UA documentation, social care practitioners suggested that the inclusion of the service user and carer domains, which reinforce the importance of harnessing peoples' strengths and abilities, as well as problem-solving and maintaining independence, is beginning to facilitate changes in care planning practice and encourage more outcome-focused approaches:

> […] now it's about saying "Well, no, the way you write an assessment, a care plan, it's got to be about what you're trying to achieve and it's not about Mr Jones needs homecare four times a day, it's about, what does that person actually need and how are you going to meet those needs".
> *UA46.6, Care Manager, Reablement Team*

Social care practitioners suggested that outcomes to be achieved are now documented more explicitly in care plans, statements of purpose and service delivery plans, though as previously noted, the practice of recording information in the service users and carers' own words is variable. Practitioners believed that social care providers now have a clearer idea of the difference that a service needs to make to an individuals' life and its contribution to realizing outcomes:

> So the agencies and the people that we actually use these days for domiciliary care are much more aware of providing what the client wants and not what they can provide, so you know, fitting in with people […] I think by us being clear in what we're asking of them then we're better serviced to provide that service.
> *UA7.6, Care Manager*

> I'd say it's more outcome-focused and it's more sort of like, it's – it's cross-referenced more, so it's more clearer and explicit on what that person needs, why I think they need what they're – what they're having, and – and the outcomes really.
> *UA46.6, Care Manager, Reablement Team*

Whilst this is viewed as a positive change to practice, and is consistent with our earlier work which noted improvements in the content of care plans following UA (Seddon *et al.,* 2010), progress in achieving this longstanding policy objective remains slow. Social care practitioners do not underestimate the implications for provider organizations, in particular, the need for more flexible and responsive ways of working to meet individual outcomes:

> *[….] it's a challenge for whoever's providing the domiciliary care because not everybody wants to get up at 8 o'clock in the morning and have their breakfast at half 8 [….] we have to compromise a little bit I think sometimes because we can only have one worker going round and fitting into rotas doesn't always happen as we would want them [….] it's really quite difficult to get somebody working up till say 10 o'clock at night sometimes [….] those are challenges that are outcome-focused and they are big challenges really to try and get the workers to see it in a different way, because they just think, they want to get home and finish their job as well don't they?*
> *UA7.6, Care Manager*

They also recognize that it is not a cost neutral undertaking.

Supporting older people and their carers to achieve outcomes

Experiences related by older people and their carers highlight the importance of flexible, creative and responsive support; traditional types of service provision, for example, day care often proved ineffective in realizing basic outcomes, such as the desire for increased social contact or engagement in meaningful activity:

> *V1:   There's only the one thing that sort of fell by the wayside … was the day centre, they linked me up with the day centre, didn't they? [Name]. And I went there and I found that I was playing bingo most of the time. Well it didn't really appeal to me, I'm not a bingo…*
> *V2:   He's not a bingo … he isn't.*
> *V1:   So I decided to give it a miss, that …*
> *V2:   And he can't play snooker and he don't like sitting and just watching the television so … not unless there's something interesting.*
> *UA395.0&1, Interview with older person and carer*

> *I'd said to [Name] look, I don't want to go and play bingo, Whist and all that. I don't want to do that.*
> *UA325.0&1, Interview with older person and carer*

Flexibility in relation to the timing of services is particularly important for older people and their carers, whose first-hand experiences suggest that there remains considerable scope for improvement:

> *You know you don't want to be standing round in your dressing gown half the day.*
> *UA328.0, Interview with older person*

The potential for direct payments is highlighted by practitioners in relation to helping older people achieve outcomes relating to the establishment and maintenance of social contacts, as is the use of community resources and facilities, in particular local churches and libraries. However, practitioners across our seven study sites reported a low uptake of direct payments amongst this particular client group. This was confirmed by older people and carers themselves; whilst one older person was in receipt of direct payments and used these to successfully secure the support of three part-time staff of her choice, others were wary of the administrative and legal implications of direct payments and chose not to use them.

Monitoring and reviewing outcomes

A major deficit in current practice, identified by older people, carers and staff alike relates to the ongoing management and review of care, which successive policy and practice Guidance recognizes as essential in determining whether outcomes agreed at the time of assessment and documented in individual care plans have been achieved:

> *So it's getting to the outcome-focused approach and then measuring it [….] because well you are building on somebody's strengths and abilities [….] you know to give them their skills back [….] rather than thinking about well this person's got this problem, we've got some services that usually solve that problem and that's the end of it.*
> *UA18.6, UA Project Manager*

> *[….] with staffing levels the way they are it's very difficult to be able to go back and measure how effective things were and I do think it's quite important because it does go with*

> *justification of the service and it does also show you how good the service, or how bad the service, I guess is.*
> *UA26.6, Occupational Therapist*

Practitioners maintained that they lack time and capacity to monitor outcomes. This finding is consistent with our earlier work (Seddon *et al.,* 2010), which identified a considerable and enduring gap between policy and practice; it reflects long-term infrastructural issues in health and social care that serve as a barrier to implementation of UA as well as other health and social care policies.

The limited review activity reported across all of our study sites has far-reaching implications for older people and carers alike, as it is difficult to: re-consider or re-define outcomes where appropriate, for example, in the light of changing circumstances; determine whether support provided helps to build on individuals' strengths and abilities to achieve outcomes, for example, maintaining or improving independence; establish individuals' continued eligibility for support; and, prevent older people and their carers from becoming over reliant on services and thus using resources unnecessarily. The potential of the care coordinator role was raised in this context and is explored in Chapter Five.

Staff training needs

Our synthesis of the older person, carer and staff data highlights a number of very basic training needs that relate to the translation of outcome-focused approaches into health and social care practice. These include: defining outcomes and distinguishing them from services; recognizing the importance of social and emotional outcomes to older people and their families, as well as practical outcomes; negotiating outcomes with older people and their families and successfully managing expectations; amalgamating service user, carer and practitioner expertise in the care planning process, particularly in relation to perceived risks in the home; building practitioner confidence to think more innovatively about ways to meet service user and carer outcomes; challenging traditional service-led cultures; and, monitoring and reviewing outcomes.

Chapter Five Care coordination – key findings

Introduction

UA Guidance outlines the important role of the care coordinator in supporting individuals with complex health and social care needs. However, determining responsibility for care coordination activities across health and social care organizations has proved extremely contentious. Experiences related by older people and their carers suggest that the support they receive is far removed from the policy ideal of seamless, coordinated provision.

Care coordination – whose role, whose responsibility?

Health and social care staff reported that translating the principles of care coordination into practice is problematic and that ambiguity and controversy surrounds the role of the care coordinator:

> *[….] it's a bit like a hot potato.*
> *UA20.6, Discharge Liaison Nurse*

There is considerable variation in the terminology used to describe the care coordinator role both at strategic and operational levels. For example, the terms care coordinator, care manager and case manager are used interchangeably, which is confusing for practitioners across the spectrum of health and social care services:

> *[….] I think we need clarity of terminology and consistent terminology because that confuses staff in health and social care, because different people use different terminology and with regards to training, then operational staff, clinical staff are saying they would need to know what the roles and functions of that is and they would need training.*
> *UA1.6, Care Manager, Intermediate and Continuing Care*

> *Care coordination it – it's never been properly defined who that's supposed to be [….] I think as well there's always anomalies in the – in the language [….] because you – you have care managers and case managers and social work [.…] and that's quite a clearly defined role [.…] but that's not familiar language to nursing, you know, I mean the other – the other one that comes up is they call it the healthcare coordinator. So again, does that mean that that's only for healthcare and not the social care needs?*
> *UA28.6, Discharge Liaison Nurse*

This is somewhat surprising, as the UA Guidance is explicit in outlining key tasks associated with the care coordinator role and specifying the professions who might act in this capacity. Confusion amongst practitioners is reportedly compounded by the failure to refer to or define care coordination in other policy documents, such as *Designed to Improve Health and the Management of Chronic Conditions in Wales* (Welsh Assembly Government, 2007b) and the recent *Community Nursing Strategy for Wales* (Welsh Assembly Government, 2009).

We found no evidence of local, jointly agreed protocols to guide care coordination activity in our seven study sites and make explicit who should assume the care coordinator role and under what circumstances:

> *[….] there's no agreement then over who is going to be the care coordinator [….] So if for instance a patient was referred to me and needed an awful lot of my input, but having a fairly standard package of care that was quite stable, then I would be, I would feel that I would be the care coordinator, but at no stage has anybody ever said, "Well, are you the care coordinator?" [….] what you're finding is that people don't, you know, people do their own documentation but never get back and update the care coordination because it's still not recognized that process, still isn't in place.*
> *UA17.6, Case Manager, Long-term Conditions*

Also, we found no evidence of cross-boundary agreements specifically to support care coordination. This proves especially problematic when arranging and managing discharge from hospital for older people with complex care needs and highlights the potential utility of a national protocol to guide care coordination activity across Wales.

Practitioners with first-hand experience of undertaking the care coordination role reported that confusion is compounded by ineffective channels of communication as service users progress along their care pathway and their designated care coordinator changes accordingly:

> *[….] when we have the caseload meeting on the Monday morning, I mean that is a time where the care coordinator just changes, I mean, basically it's rubbing out one person's name and putting another name there, it's as simple as that on a piece of paper really, but you need to make sure that other people in the team are aware of it as well.*
> *UA6.6, Care Manager, Intermediate Care Team*

[….] sometimes there's a breakdown then on discharge from hospital, you know, and the person is left without a care coordinator that's happened in the past.
UA51.6, Community Nurse

Older people and their carers confirmed this:

I think the only thing is the communication when these situations do change [….] I would say that is probably something in the last year that has been a little poor, even when the social worker changed. Because the one prior to the one last year, mum and dad really liked him but he actually left the country, I think he went to work for [Name] but they weren't told that until they needed to contact him about something and they said 'oh, he's left' [….] I guess that part of it, the communication of that is poor. I guess then it can be tricky to know who to go to for advice [….] Different people have taken over at different times and nobody really knows, I guess somebody new takes on a case and they don't really know what's happened previously.
UA88.1, Interview with carer

Whilst the Guidance specifies that arrangements for care coordination must be recorded in Personal Plans of Care, and up-dated as necessary, practitioners conceded that a named care coordinator does not always appear in the documentation. Consequently, staff reported that older people and their carers may not know who their designated care coordinator is. This is confirmed by some of the older people and carers that we interviewed. The situation is considered to be less ambiguous when an older person is assessed as having continuing health care needs; he or she is allocated to a Nurse Reviewer who becomes their care coordinator.

The confusion at practice level, as reported by staff, is reflected in the first-hand accounts of some older people and their carers, who raised very basic concerns about the limited availability of both health and social care practitioners to provide ongoing support, information and advice; they were especially critical of the lack of a consistent point of contact:

V1:   No, I think we've got a phone number we can ring haven't we [Name] if we wanted to?
V2:   Yes, if there was any problem with anything, but sometimes it's quite difficult to get through to them.
Interviewer: Is that like a named person or …

> V2:   Just a department.
> *UA154.0&1, Interview with older person and carer*

Issues relating to staff sickness and high levels of staff turnover were highlighted in this context as problematic for individuals seeking help:

> *Yeah and I mean obviously you try and contact somebody, oh they're off sick all this sort of carry on and oh dear it's… you get quite despondent with it all actually.*
> *UA325.0&1, Interview with older person and carer*

Some older people said that their GP is usually the first point of contact if they need information or their circumstances change, rather than their care coordinator, whilst others reported more positive experiences:

> *And they left a telephone number if ever we need anything, you know, but they're at the end of a telephone and when we have needed help they've been here, haven't they? [….] Because like I say, if we want anything we just ring the number she's given me, if she's not there she'll ring back and she says if we need any help or we need anything that would help, you know, [Name] at all, give her a ring and she'll come out and see us. And fair enough she has done that.*
> *UA395.0&1, Interview with older person and carer*

Embracing care coordination across health and social care

Although the Guidance is explicit in specifying that UA applies to both health and social care organizations and indeed recommends that where an individual's main needs are health related a nurse or other healthcare professional should assume the care coordinator role, care coordination is seen predominantly as a social care responsibility and as synonymous with care management:

> *I think there's always been that expectation that it has been the social worker.*
> *UA22.6, Assistant Director of Nursing*

> *So you know it's us, we are the care coordinators by default. As my manager says, 'the buck does stop with us'!*
> *UA9.6, Care Manager, Community Team*

This partly reflects the limited impetus to take forward UA from within the health division of the Welsh Assembly Government following the publication of the Guidance in April 2002:

[….] everybody goes "Ooh" particularly in health [.…] it was very much at the beginning seen as social services.
UA2.6, Nurse Director

Both health and social care staff conceded that remains limited ownership of the unified assessment process amongst healthcare practitioners; difficulties in engaging key professional groups, such as General Practitioners, Occupational Therapists and District Nurses, were highlighted in this context as having a detrimental effect on care coordination and the implementation of a joint approach to the assessment and ongoing management of care:

Patchy and I would say that there is no real sense of ownership or responsibility from the staff.

UA21.6, Lead Occupational Therapist

Traditional views relating to the roles, responsibilities and associated skills of social care practitioners are reported to persist amongst healthcare professionals and act as a barrier to operationalizing care coordination practice in a unified way:

Well I think it's not their traditional role basically of providing care and I think overseeing care, care packages they see that as the role of social services, I think we might, you know, in the future, I think we've got a way to go on that really and unfortunately I do know that the care coordinator stands with the workers, social worker or assessing and reviewing officer really, because they don't want to, they don't feel it's their place to plan meetings or do anything in particular and keep the records, because it's also record keeping isn't it?
UA6.6, Care Manager, Intermediate Care

Whilst all staff recognized the potential of the care coordinator role in supporting individuals with complex needs, for example, acting as a channel for communication, ensuring that care plans are completed, progress chasing and triggering a review or reassessment, they suggested that healthcare practitioners are reluctant to take on this role because of the perceived additional demands on their workload:

I think it would just clog up our … and not allow us to do our specialist assessment, so while the care coordinator, you know, is basically that, co-ordinates care, co-ordinates, make sure that everything's running right for that client, I think it's better placed with the social worker at the moment in [Area]

and I don't believe it's a role that I would like to be doing to be honest, I don't believe it's a role that I would like to be undertaking [….] I've become an OT because I wanted to do occupational therapy, not be a care coordinator, but that's just my opinion.
UA26.6, Occupational Therapist

Yeah, I think the reality is when I talk to colleagues, CPNs and nurses, they don't want to touch it with a bargepole [….] because of course it's the responsibility of coordinating all the services, if there's a problem you have to deal with the problem and they know full well the paperwork that's involved and the knock-on effect of all the demands that are put upon them [….] you know, they're more than happy that social workers exist 'cause that's the last thing they want.
UA47.6, Local Authority Team Manager, Older People

Nursing and OT staff expressed concern that engagement in care coordination activity compromises time spent with patients and the delivery of practical care:

[….] it's a really difficult one because as I say the nurses do feel that you know we are here for the patients and yet they're giving me all this extra paperwork, they're giving me all this, I've got to do this, this and this, and I seem to be moving further away from the patient's bedside.
UA28.6, Discharge Liaison Nurse

Whilst the Guidance emphasizes the importance of acting in the best interests of the service user by being flexible in relation to who assumes the care coordination role, and indeed this is recognized in principle by staff, this is not achieved in practice. The potential to negatively affect joint working relationships is acknowledged, as well as the detrimental consequences for the integration of assessments undertaken by health and social care practitioners and the delivery of seamless support to older people with complex needs and their families.

Highlighting some of the fundamental tensions associated with translating policy into practice, for example, infrastructural and time constraints that impinge on but also extend beyond UA, all staff agreed that individuals working in the health service are hindered by a lack of administrative support necessary to conduct and manage care coordination activities:

It's just getting everybody together that is time consuming. Trying to gather… trying to get an MDT meeting is extremely

time consuming, because everybody, obviously we don't have admin and everybody is busy and trying to fit everybody in at the same time you know, so that is difficult.
UA15.6, Discharge Liaison Nurse

Consistent with our earlier work on UA (Seddon *et al.,* 2010), problems relating to IT systems and reaching very basic agreements on the sharing of information were also highlighted both by staff and older people themselves:

But this unified assessment is not available to anybody else other than the clinic. I mean my notes go, they, they play bat and ball between [Place] and the, the [Place]. If I have a scan in [Place] that I go to see the oncologist in [Place] he can't bring up the scan on the screen in, in [Place].
UA376.0and1, Interview with older person and carer

But also because we can't actually access their computer system and they can't access ours, then we've got in effect two systems going on one person in lots of places you know, it does make it difficult.
UA6.6, Care Manager, Intermediate Care

In particular, current operational systems preclude the timely transfer of information about service users and the sharing of the most up-to-date records, assessment documentation and Personal Plans of Care. Access to Summary Records is highlighted by health and social care practitioners as especially problematic, leading to duplication of effort for practitioners, older people and carers alike. Our findings relating to IT and information sharing are described in more detail in the next chapter. Suffice it to say, practitioners recognized the detrimental consequences for mobilizing support to individuals in a timely way and coordinating and reviewing cases to determine whether support is effective in meeting identified needs. This is confirmed by older people and their carers, most of whom reported waiting for considerable periods for time for practical help, such as equipment and adaptations to the home:

V2:   It's co-operation really between people.
V1:   Yes co-operation.
V2:   Yep and making things happen.
V1:   I know if it took as long as we were…
V2:   It's better if somebody is saying I passed that on to such and such. Even though they passed it on to such and such, they should be responsible for seeing that such and such does it.

> *V1:* *Because so much time has gone in between it that we've been sort of saying well what is going on all the time? That's our thing because when we start in November and here we are, we still haven't got a stair lift and we still haven't got a wet room. It's now August and…*
>
> *V2:* *And we're still I think two or three months from it at least.*
>
> *V1:* *The buck gets passed round obviously doesn't it?*
>
> *UA325.0&1, Interview with older person and carer*

Staff training needs

Our analysis of the staff, older person and carer interview data identified a number of very basic training needs to support professional practice in the area of care coordination. Future joint training should build upon the Strategy for Joint Staff Training outlined in the Guidance by focusing on: defining key terms used by practitioners across health and social care to help achieve clarity of role, responsibility and function, in particular, the distinction between care coordination and care management; encouraging joint ownership of the care coordination role; and, making explicit the important contribution care coordinators make to supporting people with complex health and social care needs, in particular, the capacity of the care coordinator to deliver change.

Chapter Six Documentation, sharing information and information technology – key findings

Introduction

The aim of developing UA procedures is to ensure more consistent assessments across Wales that are supported by an agreed evidence base; areas can opt for different tools or approaches to assessment, however they must produce a UA Summary Record comprising standard care management information and share this information with relevant organizations. Our findings suggest that the effective and timely exchange of information, which is critical to the realization of a more consistent approach to assessment, is not achieved in practice; there are many unresolved challenges in terms of devising assessment documentation that is fit for purpose and agreeing and implementing shared systems. Issues around documentation have become closely intertwined with issues around professional roles and responsibilities and IT. Experiences related by older people and their carers suggest that they repeatedly provide the same information to different practitioners they come into contact with; there remains a considerable gap between the policy ideal of reducing duplication and current practice.

UA documentation

Whilst eight years have elapsed since the publication of the UA Guidance in April 2002, it remains a challenge to agree on the type, content and format of assessment documentation:

> *What's happened is the information required is quite extensive, how people use it is variable and then we get people saying yes you can have a discharge document, as long as it's only two pages. What the data contains in it doesn't necessarily in some of the areas meet the data set that UA, the Assembly had for UA, so therefore you get, there are constraints about what information is provided […] So they kind of, UA support it in principal, but the practicality brings out sort of pragmatic adaptations which maybe don't meet the principals and objectives of UA.*
> *UA22.6, Nurse Director*

It is hard to deviate from the view that timescales for agreement on fundamental implementation issues are extremely protracted.

Consistent with our earlier work (Seddon *et al.,* 2010) which reported that the Guidance is helpful in terms of specifying the

types of information to be collected but weak in terms of advising how organizations might set about *collecting* this information in a consistent way, we found that assessment documentation is far from unified *across* or indeed sometimes *within* our study sites:

> *In practice, assessment isn't unified here at all and we haven't got the same documentation that's being used by Social Services, Health and Housing, each have their own.[…] And also I think it's more complicated than that insofar as it's not even, I think, totally the case that – that Health use the same documentation everywhere.*
> *UA38.6, UA Project Manager*

We identified considerable variability in the nature and volume of information collected by practitioners across our seven study sites. Some practitioners suggested that a common assessment template for Wales would help to overcome this and facilitate a more unified approach to assessment whilst others were more cautious. The potential utility of a common assessment template is explored in the discussion section. There is a broad consensus that, to date, a disproportionate amount of time and effort has been spent devising and indeed wrangling over assessment documentation and protocols; this has detracted from implementing key UA objectives in practice. A lack of involvement in the development of UA documentation and subsequent ownership of this documentation was mentioned by health care practitioners.

The completion of the UA documentation is sometimes perceived as a hurdle instead of a useful tool to help inform the assessment, care planning and service delivery planning processes:

> *I really think that actually things that have changed are limited. I think it could be so much … it's a great idea, UA, but it's just not happening. It's, you know, there's so much more information that could be shared that would reduce duplication and I think it would provide a better service for the client, but it's not, it's not being shared, it's not happening, there's not enough people on board, there's not enough people sharing information.*
> *UA26.6, Occupational Therapist*

Barriers to using the documentation in practice include: the different reporting mandates for health and social care organizations; the different terminology used by various professional groups, for example, referring to individuals as patients, clients and service users; lengthy and unwieldy

assessment protocols; and, confusion over the four types of assessment and their distinguishing features:

> *We like to do the reviews together, but what we found was that I was doing my UA documents and social services were doing their UA documents, which sort of, you know, it's not swapped. It's meant to be about really, it's meant to reduce duplication but, you know, we need our documentation 'cause we're commissioners and social services need their documentation.*
> *UA19.6, Nurse Reviewer*

We found several instances where locally agreed documentation is adapted or changed to suit professional requirements:

> *We adapted our documentation because we felt it wasn't particularly nursy-fied, the way that the questions were phrased didn't fit in with nurse thinking, and as a consequence we found that we were having great difficulty in actually getting nurses to fill them because the questions.*
> *UA13.6, Discharge Liaison Nurse*

Ensuring assessment is proportionate to need

Practitioners raised concerns about the proportionality of some assessments to the presenting need and, consistent with our earlier work, the collection of large data sets that are not utilized during decision-making and care planning processes. Allied to this, practitioners, older people and carers alike raised concerns about the protracted, time consuming nature of assessments; as noted, this can detract from the building of relationships between practitioners, older people and their families and, consequently, the realization of key UA objectives:

> *So it's a long-winded document that puts a lot of people off and when you actually go to fill it in you sort of lose the will to live by about domain seven so it's had major knock-on effects to – to working practice really.*
> *UA47.6, Team Manager*

> *V1: They take a very long time to complete and I think they over egg the pudding, they could be simpler, they should be simpler.*
> *V2: I'm not stupid and some of these questions I just don't understand!*
> *UA648.0&1, Interview with older person and their carer*

The Guidance recommends that assessments should be proportionate to need. However, feedback from social care practitioners in particular suggests that this is not always the case. This was seen to have negative implications for assessment practice and service provision in health and social care:

> *I've think we've been feeding back ever since we've been doing this form. It can be very time consuming. […] I'm not saying the waiting list is solely around the UA but I mean I'm sure it has an impact on the waiting time. Because we're bogged down with the paperwork we can't get out and do new assessments because we're forever trying to catch up with the paperwork.*
> *UA43.6, Social Worker*

This is coupled with extreme frustration when other organizations do not use the documentation as intended:

> *We have to send it out to care agencies and I've been out on initial visits with care agencies and they've asked questions that have been on the form and I, you know, at the end of the thing, not in front of the client, at the end of the thing I've said, "Look, you know, a lot of what you've asked was on the form" and they've said, "Well, I haven't read it, it's too big" and you just think I've spent four hours completing that, you haven't read it.*
> *UA24.6, Social Worker*

Professional roles and responsibilities

The challenges around agreeing and using documentation are linked to un-resolved issues about professional roles and responsibilities; as noted in the previous chapter, UA is still very much perceived as a social care led initiative by health professionals. Health and social care practitioners mentioned that the schedule for implementing UA in health care lags some way behind social care; this creates a sense of frustration, particularly for social care practitioners:

> *[….] the UA document is still very much in its infancy as far as the health care trust is concerned. They're still going through their document control process to review a potentially suitable document that they can use within healthcare.*
> *UA39.6, Intermediate and Continuing Care Manager*

Despite the Guidance making explicit professional roles and responsibilities, we found only limited understanding amongst health care practitioners of the contribution of key stakeholders to

the UA process. This highlights the importance of strategic level support to promote shared goals, expectations and objectives, clarify the roles of the various professionals involved and help to promote a change in culture:

> *I think it's more than training now. I think it's to do with unique management; endorsing a document is really important, to give it some weight, some priority really. You need a changing culture that actually it isn't just something social services need.*
> *UA21.6, Head of Occupational Therapy*

Different professional interpretations of key terms used in UA documentation, for example, activities of daily living, compound the situation. Whilst nurses and other health care practitioners describe activities of daily living in terms of breathing, swallowing, and the like, social care practitioners describe them in terms of getting washed and dressed:

> *I think there were a lot of problems initially, because the terminology used by Social services and used by Health are quite different. So that for instance the activities of daily living as an example, nurses are trained to see it as something different.*
> *UA15.6, Discharge Liaison Nurse*

There are issues around trust and professionalism. For UA to work successfully, practitioners from different backgrounds need to be able to trust each others professional judgments:

> *[….] we've got to learn to trust other professionals really and trust their view you know, but we still like to go and do it ourselves don't we and I know that that does still certainly happen in this area.*
> *UA51.6, Community Nurse*

This seems to be linked to issues around professional status and accountability:

> *I feel confident then that I've done a thorough assessment on what that person needs and it makes me more confident in my decision to actually advise people on what I feel they need, 'cause that is a … you know that's a, it's a big thing to actually tell somebody what you feel they need in their life.*
> *UA46.6, Social Worker*

Consistent with our previous work, Occupational Therapists raised concerns about the erosion of professional roles and identities; they are sometimes reluctant to present evidence in support of their professional judgment in ways that comply with locally developed UA protocols. This can create problems in terms of integrating specialist and comprehensive assessments.

A related issue, and previously described in Chapter Three, is the commonly reported perception that rigid adherence and completion of the assessment documentation detracts from spending time with older people and their carers and building a sufficiently detailed picture upon which to base professional judgments:

> *It's just a writing exercise or a computer exercise now and our skills are being with the client and offering social work support and counseling and stuff like that many of us don't have time to do anymore!*
> *UA9.6, Community Team Social Worker*

Sharing information

UA Guidance highlights the importance of robust and reliable systems for sharing information across health and social care organizations. However, our analysis of the staff, older person and carer data highlights deficits in both the collection and sharing of information. Information sharing is not routinely embedded in practice, which contributes to duplication of effort for practitioners, older people and their families alike:

> *The social workers are doing them and district nurses and hospital staff, that sort of thing and we are sharing assessments to produce comprehensive assessments from time-to-time, I don't think that's working as completely as it should be, as fully as it should be so that we have not got a great system working between ourselves and the district nurses.*
> *UA48.6, Team Manager Adult Social Care*

> *Yeah, and the thing about that is, that not only do we do it, the nursing staff do and fill in on their admission document, the social worker will come and ask these same questions, quite often these poor people have been asked something about five or six times and the same question [...]; it must be terribly repetitive to repeat information.*
> *UA21.6, Head of Occupational Therapy*

From an older person's point of view, the repetition can be very wearing:

> *I mean even from sort of the … initially going for a biopsy and things, you know because they take down all your information but then as an inpatient they take it all down again, you know and you think, oh for goodness sake this is ridiculous I've told you all this once, you know they should be able to retrieve, retrieve it.*
> *UA376.0&1, Interview with Older Person and Carer*

> *For example, when that social worker took over last year, I suppose really somewhere it should have been written down already what her, mum's care package was! And she would have already known that…or had a basic idea.*
> *UA88.1 Interview with Carer*

Although the Welsh Assembly Government is clear that older people and their carers have ownership of the information that is held about them and that health and social care organizations are responsible for managing this information, difficulties in reaching agreement on information sharing protocols act as a barrier to the implementation of UA; a number of practitioners were unaware of any locally agreed information sharing protocols in their area and only *one* mentioned the Wales Accord on the Sharing of Personal Information (WASPI), published in January 2007. Differences between the information sharing practices of health and social care can create difficulties; practitioners reported that health service procedures for sharing personal information are very strict:

> *Well, I think for some reason the health authority they go down the line of confidentiality which I agree is very, very important, but when there's a need to know I think it helps the client, you know, we're both there for, well we'll all there for the client's best interest and the ability to share information would just help so much, but it doesn't at the moment.*
> *UA1.6, Intermediate and Continuing Care Manager*

Whilst these difficulties are by no means confined to UA they nevertheless have a deleterious effect on the translation of UA policy into practice.

Unified assessment and information technology (IT)

Everyone agreed that IT is the best way forward to sharing information between and within organizations; indeed, IT is

perceived to be a crucial part of the infrastructure required to deliver UA. The expectations are that this should reduce duplication, speed up service delivery and provide a smooth interface between health and social care. However, all staff mentioned that the practicalities of electronic information sharing had not been resolved and this impeded progress:

> *UA process was established with a view to electronic systems being able to function. Now six years down the line there is no real commitment to that and therefore we're, I would be honest, I think it would be fair to say that we flounder under a paper based system that should be moving towards an electronic based system, to enable transferring of information and not duplication of information, version control and keep asking recipient of care or prospective care a thousand times the same question.*
> *UA22.6, Nurse Director*

In particular the use of different IT systems in health and social care was mentioned as one of the main barriers to information exchange. IT systems varied not only *between* but also *within* health and social care:

> *There are issues there with – we are very shortly joining the [Area] Local Health Board, which I'm sure you're probably aware, but it's the joining of our NHS trust organisation, [Area] healthcare NHS trust with its five surrounding Local Health Boards [Areas]. […] Now those five, two use one system and three use another. So even though we would have or could have one health UA IT software package available, which we haven't, but even if we did it would still need to be compatible with those two different social care databases.*
> *UA39.6, Intermediate and Continuing Care Manager*

Consistent with our earlier work, we found issues relating to access to networked computers, practitioner IT skills and the reliability of the hardware; these are especially problematic for health practitioners:

> *Generally on a ward you only see usually one to two computers on a ward, so that could be a problem.*
> *UA46.6, Social Worker*

> *[....] so in terms of, you know, the competence to access that information isn't always there, neither is the expertise, and neither is the actual access to the machines as well.*
> *UA28.7, Discharge Nurse*

As health and social care organizations do not have joint or even compatible electronic systems information is mainly shared via fax, email and post. This is perceived as very cumbersome and wasteful of professional time and resources:

> *Ah well, you know, it's so tiresome having to fax reams and reams of UA documentation, both for nurses and for ourselves and that's probably one of the things that holds us back on sharing more information.*
> *UA48.6, Team Manager Adult Social Care*

The failure to routinely share information in electronic format is identified as one of the key reasons why GPs do not engage with the UA process, as GP records now operate on a paperlite or paper free basis. The implications for older people and their carers are far reaching. GPs are well-placed to complete a contact assessment in order to establish the nature of presenting problems and to refer people on to potential sources of support. Also they hold information that is fundamental to the UA process, such as information relating to the domains on clinical background, disease prevention, personal care and physical wellbeing and mental health. Failure to share this information leads to duplication of practitioner, service user and carer effort:

> *I think you know GPs are able to do that, they all have that tool, but I think they're just quite protective over their information if you like. We write to them, you know, and they deal with declarations and they do answer our letters, but they charge for that, you know, we pay them for that.*
> *26.6 UA Occupational Therapist*

Importantly, all the difficulties associated with sharing information in a timely way mean that different versions of assessments and care plans might be in circulation at any given point in time and that information could be out-of date:

> *I mean the thing is it depends on how quickly you can orchestrate that, that document can be the documents coming across by post. This is it again, you know, or being faxed through 'cause you're reliant on, you know, admin staff doing that.*
> *UA17.6, Long-term Conditions Case Manager*

The importance of a timely information flow to and from assessing practitioners and those on the frontline responsible for delivering services is highlighted:

> *Other social workers who are involved would have access to the care plan, managers would, but the carers whether they're employed by social services or externally they can't access Paris to look at care plans, so it would need to be printed out and passed to them, but it's not. And then what happens then is they actually devise their own care plan.*
> *UA5.6, Hospital Social Worker*

However, some interviewees recognized that these difficulties would not necessarily be resolved through compatible IT systems as version control is an issue that needs to be addressed independently of electronic or paper documentation:

> *But it's looking at the professions then and how they can update that in a timely fashion, to make sure you've got the current action plan, to come out to the next service, yeah? And the difficulty you have is different people will be seeing that client at different points in time, so it's what ifs and how do you maintain these updates, to make sure from a clinical governance point that that is the up to date version and how do they update it. Is it a hard copy, is it an electronic copy? You know, so again it's back to operational systems, but also IT systems.*
> *UA1.6, Intermediate and Continuing Care Manager*

One interviewee pointed out that access to a timely version was not only relevant for health and social care professionals but also for clients:

> *Yeah, and if you are looking at an electronic UA system that can be shared between health and social services that's fab. Then what about the user, the person, they're not going to have access to an electronic database where their latest UA is, are they? So they're always going to have a paper copy and that does run a risk of pages getting missed and it being out of date and perhaps been a newer one that's been done but not circulated out to the person.*
> *UA21.6, Head of Occupational Therapy*

In essence it seems that issues around documentation have become very much intertwined with issues around professional roles and responsibilities and IT. *Informing Health Care* emphasized:

[….] the introduction of technology without changed working practices will have little impact. Changed work practices without new technology will be harder to sustain in the long-term.
(Welsh Assembly Government, 2003b)

More effective information systems and better information sharing between professionals should only be seen as a means to provide better care services and outcomes.

Two interviewees pointed to the importance of understanding that IT is not a panacea; it is only a tool:

But now we're going over to a totally new system which again is being built from scratch even though it's a company […] And then we're right back to this situation of you know, is – is, you know, what – what is coming first, is it the computer design or is it the document and … and all that kind of stuff - which on top of UA is not particularly helpful.
UA47.6, Team Manager Learning Disability

And if they [nurses] don't start looking at data sets and what information did they want, I think the transition to eventually to an electronic record will be really difficult. So if we start thinking like that, they wont get caught in the double pang of but we only wanted four pages and that documents a better document, actually it's not the documents, it's what's in it. That's what I'm trying to do.
UA22.6, Nurse Director

Examples of good practice

We found evidence of work underway which tries to accommodate different professional requirements and working practices:

So work then developed to pull together using the information from complex care teams across health and social care, community to actually say, well, what do we need. […] Now what they've come up with and it's still going through its draft format at the moment, is a generic UA document that has a supplement to complex care assessment attached to it, but then also have a transfer documentation that can be used for when social services/social care need to know the health part with that individual.
UA39.6, Intermediate and Continuing Care Manager

Work on a web-based system was mentioned in one study area. It is anticipated that this will allow sharing information between health and social care and control levels of access to information. Practitioners envisaged that the care manager will be the gate keeper to the information:

> *The way that we'd envisaged it was it would be all based around the care co-ordinator, so what it would be is a UA system with all the UA information in it, but the only people who could see it would be the people who are part of that service user's team. So what you would create is a virtual team. […] The idea was that instead of having to service two IT systems, the information would move from the Social Services system, into the web based system.*
> *UA18.6, UA Project Manager*

Looking at the wider context, the recent re-structuring of Local Health Boards across Wales was mentioned as an area of great concern as this meant that information sharing protocols had to be re-negotiated and resource availability discussed:

> *Yes we've got information sharing protocols, but the protocol for sharing information obviously needs to be signed off again by the new organization.*
> *UA22.6, Nurse Director*

Further guidance and a commitment of resources from the Welsh Assembly Government are seen as essential:

> *But IT always comes up. IT compatibility always comes up as an issue that needs to I believe be led from the centre. We need some more guidance from the Welsh Assembly. We might need a massive cash investment to actually say, well, we recognize that this is a problem but we also need to make sure that our information is shared efficiently. All the problems going on now with patient identifiable information, patient personal identifiable information, where information is lost, left, we can't afford to have this happening.*
> *UA39.6, Intermediate and Continuing Care Manager*

Summary

Our findings suggest that there is a danger that health and social care professionals expect IT to resolve all difficulties instead of seeing IT as a tool. The assessment process needs to be integrated in daily work practices and be compatible with professional requirements. Agencies and organizations need to develop a shared

culture and common understanding of the aims and purposes of the UA.

Chapter Seven Summary and Discussion

Summary of key findings

UA aims to provide an overarching system of assessment and care management and heralds opportunities to implement an outcome-focused approach to supporting older people and their carers. However, eight years following the publication of the UA Guidance there remains a considerable gap between policy and practice. Experiences related by older people, carers and practitioners highlight a number of enduring challenges and missed opportunities, as well as a lack of sharing understanding of key UA principles. Implementation appears constrained by restrictive thinking and practices, as well as longstanding capacity problems and difficulties with whole systems working. Consequently, UA is not realizing core objectives that relate to ensuring effective joint working, reducing duplication and securing better outcomes for service users and their carers.

Our analysis to date has focused on key issues relating to the implementation of person-centred and outcome-focused approaches, care coordination for older people with complex health and social care needs and the sharing of information between health and social care practitioners. In practice, assessment and care planning remains service-driven and task-focused; rigid adherence to highly structured assessment documentation detracts from the use of core assessment skills and the building of relationships between practitioners, older people and carers. Agreeing and implementing shared systems is problematic and in the main UA is viewed primarily as a social care responsibility.

Ongoing analyses will focus in detail on the implementation of the Fair Access to Care Guidelines, the domain approach to assessment and the ways in which risks to independence are explored and evidenced within the UA framework. Specific challenges relating to the implementation of person-centred approaches with people who have a cognitive or sensory impairment will also be considered. Findings will be reported in peer review and practitioner journals.

Implications for policy and practice

We now move on to consider the issues that policymakers, practitioners and service providers might find helpful in focusing their efforts on bridging the gap between policy and practice and promoting future good practice. These are presented under three headings that mirror the objectives of UA. Whilst the discussion is

based on our work with older people and their carers, the recommendations for policy and practice also have direct relevance for other service user groups, such as learning disability, mental health and physical and sensory impairment.

Ensuring effective joint working

As issues affecting older people and their carers transcend the boundaries between health and social care, joint ownership of the UA process amongst both health and social care practitioners is essential. Strategic and more coordinated direction from within the health and social care divisions of the Welsh Assembly Government is necessary to facilitate a whole systems approach to assessment and care management in which health practitioners fully engage with UA processes, effective local partnership arrangements are developed and the links between UA and other key policy initiatives, for example, the *Community Nursing Strategy for Wales* (Welsh Assembly Government, 2009), are made explicit. This is a critical first step in effecting positive change and reinforcing the shared nature of responsibility.

Shared understanding of key values and principles underpinning the UA process, such as person-centred and outcome-focused, is essential, as is the development of joint systems to enable the timely exchange of information. These are explored below.

Our findings highlight the challenges associated with ensuring the effective coordination of care and support for older people with complex needs and their families, as well as the potential usefulness of an evidence-based care coordination intervention to guide care coordination activity. In particular, a care coordination intervention that encompasses the broad spectrum of organizations and professions involved in UA might: assist with the development of local care coordination policies that reflect the substance of the UA Guidance; make explicit the distinguishing characteristics of care coordination, case management and care management; and, encourage ownership of the care coordinator role amongst health care practitioners. The use of different terminology by the various professional groups should not obscure the importance of care coordination activities. Our future research plans include work to develop, pilot and evaluate a care coordination intervention.

The administrative infrastructures within health care organizations, which were identified by both health and social care practitioners as critical to enabling care coordination activities, should be reviewed and where necessary strengthened; they must not continue to act as a barrier to care coordination and the delivery of more seamless

support. The perceived additional demands on workload, associated with the care coordinator role and highlighted by health care practitioners, must be offset against the duplication of professional resources and crisis management activity that lack of coordination often leads to.

Despite recent guidance, older people with complex health and social care needs are still unsure who their designated care coordinator is. Clearly there is an urgent need to look at ways of ensuring this information is routinely recorded on Personal Plans of Care and that people are informed and up-dated on any changes. Team managers should ensure that this happens in practice.

Reduce duplication of assessments, including the need for service users and their carers to repeat the same information

Our findings highlight variability in the nature and volume of information collected by health and social care practitioners across our study sites, as well as considerable duplication of effort. Having confidence in and learning to trust the professional judgments of others is critically important if duplication is to be minimized; it must be addressed in joint training, ongoing staff supervision and monitoring. Joint training is critical to achieving change, supporting high levels of competence and realizing the Welsh Assembly Government's strategic goal of supporting partnerships which promote the health and wellbeing of vulnerable individuals and their families.

Organizations must carefully consider how the information collected during assessment informs the care planning and service delivery planning processes. Whilst the UA Guidance provides a framework to underpin the development of local assessment documentation, this has proved particularly challenging. There is some support from study participants for a common assessment document for Wales that reflects the principles of person-centred care. Whilst this might help to promote greater consistency, in practice the development and adoption of a common assessment document may prove problematic, not least because of the reported difficulties associated with reaching agreements amongst the various professional groups who each have their established methods of working and presenting information. Indeed, there is a danger of compromising joint working relationships and loosing sight of the need for some flexibility in the way data sets are presented. For example, the presentation of information by occupational therapists and the integration of their specialist assessments. Given the variability in assessment documentation and local processes adopted *across* and indeed *within* our study sites, as well as the considerable time

investment that has already been made, reaching a consensus and reconciling established local and professional processes is likely to be charged with difficulties and meet with some resistance.

Whilst there are a number of unresolved issues relating to assessment documentation, in seeking to find solutions there is a real danger of obscuring the importance of core assessment skills and professional judgment. Skills relating to competent interviewing, observation, counseling and relationship building are fundamental to the assessment of need. To effect positive changes in practice, it is these skills that should guide the assessment and care planning processes rather than the bureaucratic business of completing documentation that generates large data sets that are not proportionate to need and ultimately have little bearing upon decision-making. Primarily, practitioners must be enabled to exercise core social work and health care skills that lie at the heart of the *caring professions;* administration should be a secondary component of their role.

Our findings suggest that investment in the IT infrastructure to underpin the UA process is long overdue. Addressing fundamental problems of access to IT facilities for health care practitioners, in particular access to networked computers, is a priority if practitioners are to be supported in contributing effectively to the UA process and the key objectives of *Informing Health Care* (Welsh Assembly Government, 2003b) and *Informing Social Care* (Welsh Assembly Government, 2003c) are to be met. This includes promoting new ways of working through investment in information technologies to deliver pan-Wales information and infrastructure services. Some very basic steps need to be taken, not least making available the full range of local assessment documentation in electronic formats to all staff groups involved in the UA process and ensuring accurate version control; current, protracted timescales are unacceptable. Sharing information in paper format is not sustainable in the medium-term to long-term; UA was not intended to operate as a paper-based system. The care coordinator has an important role in terms of ensuring that the most up-to-date version of the assessment and care plan is available to all relevant health and social care practitioners, as well as to the service user and their carer.

A consistent message from both health and social care practitioners is the need for shared IT systems that facilitate the timely exchange of information across organizational boundaries, thereby reducing duplication of effort for older people, carers and practitioners alike, encouraging effective care coordination and enabling the delivery of more seamless support. It is beyond the scope of this study and

indeed the expertise of the research team to make detailed technical recommendations relating to systems design, however, familiarization and joint training on national guidelines relating to the sharing of information (including WASPI and Data Protection), may help to ameliorate some of the concerns raised by professional groups in relation to implementing shared systems in practice. Clearly, integrated health and social care records would transform the assessment and management of care across the broad spectrum of service user and carer groups. Whilst we do not underestimate the considerable challenges this entails, in particular, agreeing a system design and funding the necessary infra-structure and systems development, it is a priority area for action that in future would helpfully underpin the UA process.

Secure better outcomes for service users and their families

UA provides a sound platform for innovative thinking around care planning, service design and service delivery that seeks to secure better outcomes for older people and their carers. However if the vision of person-centred, outcome-focused support is to be fully realized, health and social care organizations need to address key deficits in current assessment practice, as well as in the commissioning and delivery of services.

The development of timely and creative responses to individuals in need requires practitioners to make the fundamental distinction between needs, outcomes and service provision, as outlined by the plethora of policy and practice guidance that has been published since the community care reforms of the early 1990s. Our analysis compared the ways in which older people and their carers perceive outcomes with those of staff and confirmed that there is a lack of shared understanding. Involving older people and their carers in delivering joint staff training and drawing on their expertise may help to address the gulf. This would not only facilitate staff gaining a clearer view of outcomes, but also provide an opportunity for fundamental values change with older people and carers being seen as partners and having something to contribute to the process. Along with training, workplace monitoring and encouragement of good practice are essential. This might usefully focus on defining, measuring and monitoring outcomes, thinking flexibly about outcomes and allaying practitioner fears of raising service user and carer expectations. At present the implementation of person-centred, outcome-focused assessment practice is hindered by restrictive, task-based thinking and financially driven priorities; these temper expectations of what can be achieved and prevent potentially innovative solutions even being tried. Thus, training and the encouragement of good practice should also incorporate

discussions about organizational, policy or practice barriers to creativity. This recommendation is consistent with the aims of the Social Care Workforce Strategy which recognizes the workforce as central to the transformation of social care services and aims to support workers in promoting person-centred care (Care Council for Wales, 2008).

Engaging with older people and their carers as partners in the care process, recognizing and affirming their expertise, strengths and abilities and prioritizing the outcomes that matter most to them are fundamental to the implementation of person-centred, outcome-focused approaches. Models that describe this approach were developed during the 1990s, see for example, Nolan *et al.,* (1996), and provide a basis for staff training and ongoing professional development. The service user and carer domains, if completed appropriately, provide a sound evidence base to underpin future care and service delivery planning, especially when combined with a practitioner remit that prioritizes innovation and creativity over gate keeping and administration. Our findings highlight the need for greater consistency in relation to recording information in the service users and carers own words when completing these domains, particularly when supporting people with a cognitive or sensory impairment. It is important not to underestimate the shift this requires and to recognize the progress that has been made to date.

There is no blue print for effective, outcome-focused provision given the diversity of situations and circumstances that older people and their carers face. However, key policy initiatives such as the *Strategy for Older People in Wales* (Welsh Assembly Government, 2008a), the *National Service Framework for Older People in Wales* (Welsh Assembly Government, 2006) *Designed for Life* (Welsh Assembly Government, 2005) *Fulfilled Lives* (Welsh Assembly Government, 2007a) and *Designed to Add Value* (Welsh Assembly Government, 2008b) reflect the need for partnerships across the statutory and independent sectors, underscore the importance of shaping provision around service users and their carers and acknowledge the need to rebalance services towards the community, including local provider development. Similarly, the *Framework of Services for Older People,* currently being devised by the Welsh Assembly Government, aims to promote accessible and responsive provision that is delivered flexibly and consistently across organizational boundaries. Opportunities that have been created for traditional health and social services organizations to adopt more flexible and potentially effective arrangements for developing integrated services, through pooling budgets and lead commissioning, must be capitalized upon. Also, embracing the

potential of direct payments, individual budgets and wider community resources is essential, along with developing capacity to effect change and investment in local organizations. This includes voluntary sector organizations, such as Crossroads, which our ongoing programme of work has identified as particularly helpful in supporting older people and carers via the delivery of flexible, individualized support in familiar settings (Seddon *et al.,* 2009). The extension of social activities in sheltered housing schemes to include older people living in the local area provides an example of how community resources might be effectively mobilized to help older people establish and maintain social relationships, as an alternative to traditional day care services, and ultimately support more valued experiences. It fits with the vision of inclusive communities, as described the literature (see, for example, O'Brien 1990), that create networks of opportunities for support by sharing ordinary places and activities.

If the principles of outcome-focused provision as outlined in the UA Guidance are to be realized, more inclusive approaches to the commissioning of services need to be fostered, that actively involve older people and their carers in shaping their communities and developing innovative solutions to the challenges they face. Recent work by Bennett (2008) highlights the potential of such approaches and outlines a framework for Local Authority commissioners. Our findings confirm that change and development is needed at the provider level to create opportunities that will make a positive difference. Commissioning organizations must work more closely with communities to develop flexible local providers that are capable of supporting individuals to achieve a variety of personalized outcomes, including social and emotional outcomes that are important in shaping wellbeing and qualify of life in older age. They must also have the capacity to support people as their circumstances change. Whilst ideas about developing networks of local providers are not new, they sit comfortably with the substantial evidence base about effective ways for supporting older people in their own homes and communities. Clearly, any programme that seeks to develop networks of local providers would need to take into account a broad a range of issues, including the intensity of demand in localities, the requirements for competent performance and delivery, as well as monitoring arrangements, staff training and channels of communication between stakeholder organizations.

Successive policy and practice guidance highlights the importance of monitoring and review to the implementation of outcome-focused approaches and also to the development of preventive work with older people and their carers. Our findings suggest that there

remains an enduring gap between policy ideals and current assessment and care management practice. In seeking to address this gap, it is important that older people and their carers have the opportunity to: re-consider and if necessary re-define outcomes in light of changing circumstances; discuss with practitioners the extent to which an agreed set of outcomes have been achieved; and, feed back whether support provided is consistent with the goals, priorities and intended outcomes identified during assessment and corresponds with expectations. Steps must be taken at strategic level to try to address some of the longstanding capacity issues raised by practitioners and identified as adversely affecting their ability to undertake reviews; this includes high caseloads and staff turnover.

Endnote

In summary, this research has considered the implementation of UA policy into practice in seven sites across Wales. Whilst health and social care staff are committed to the principles underpinning UA, a range of practical, professional and organizational factors can make it difficult to translate these principles into practice. Our analysis of the older person, carer and staff data highlight areas of consensus and areas where perspectives contrast, in particular, around the definition of outcomes and perceived expectations of services. The recommendations and discussion highlight potential ways to bridge the gap between policy intentions and achieving outcomes in practice.

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Appendix One Interview Schedule for Older People and their Carers

Unified Assessment in Wales: older people with complex needs and their families

Introduction

Thank you for kindly agreeing to talk to us about your experiences of assessment and the services that you receive. In particular we are keen to find out about any changes that have happened since you completed the questionnaire.

Please take as much time as you need to answer the questions. If there's anything that you don't understand, please ask me to explain it. There are no right or wrong answers.

Please say if you would like to take a break. Remember you can stop the interview at any time if you wish to.

What you tell me will remain strictly confidential. Your name will not appear on the interview notes that I am making today or in any reports.

It would be helpful if we could record this interview so that the information we collect is as accurate and complete as possible. If you are agreeable to this, please sign the form giving us your permission. Thank you.

Instructions to interviewer

Interview notes should contain the following information:

- Participant ID number
- Interviewer
- Date of interview
- Time interview commenced
- Time interview ended
- Joint or separate interview

Prior to commencing the interview:

- Obtain signature on consent form to record interview form.
- **PRESS RECORD on MP3 recording device.**

- Record information in **PARTICIPANT'S OWN WORDS.**

General prompts

- "Tell me more about that" / "Anything you can add to that" / "Perhaps you can give me an example"

Background information

You recently completed our postal questionnaire in which you told us about your experiences of assessment and services – I'd like you to tell me a bit about yourself and the main things that affect you on a day to day basis.
Prompts: health; family life; social life; leisure; emotions; finances.

Tell me about any recent changes in your life. These might be changes in your health (improvement or deterioration), changes in your family circumstances, or changes in any services or support you receive.

Your assessment

Thinking back to when you met with someone from social services or the NHS to talk about yourself and your circumstances……..

Establish who was there – cared for, carer, family members?

Purpose of assessment

Tell me how you were first put in touch with ……

Tell me what you thought the meeting was for.
Prompts: to find out about your needs; to talk about services that might be helpful to you.

Tell me what you were you expecting the meeting to be like.
Prompts: process; arrangements; practitioners involved; types of questions asked.

Focus of assessment

Tell me what you talked about when you met.
Prompts: your strengths and abilities; recent changes in your life; medical conditions; hospital stays; physical health; mental health and wellbeing; medicines you use; keeping healthy; everyday

activities, such as washing, dressing, shopping; everyday things that you might find difficult; your safety; getting out of the house; accommodation and the place where you live; services that might be helpful; help you receive from family and friends; money; the future.

Tell me about any needs that you talked about when you met.
Prompts: practical needs; personal care needs; emotional needs; social needs; financial needs; information needs.

Tell me about any needs, issues or concerns that you wanted to talk about but didn't have the opportunity to. Explore why these were not discussed.

Decision-making and care planning

Tell me about any decisions that were made during or shortly after your meeting.
Prompts: extra support/services

Tell me about your involvement in the decisions that were made.
Prompts: nature of; how; barriers to involvement and facilitators; feeling listened to.

Tell me about any compromises that were made.

Tell me how your views were taken into account during and after your meeting.
Prompts: written down by practitioner; recorded in own words; used to inform decisions.

Tell me about any disagreements that occurred during your meeting – perhaps with the practitioner/carer/cared-for/other family members.
Prompts: nature; how resolved?

Tell me what you were expecting to change.
Prompts: services received, more appropriate support provided.

Copy of care plan.

Relationships with practitioners, including care coordinator

Tell me how you got on with the person(s) you met with.

Prompts: interactions with; approachable; sensitive; level of contact; pick up phone for more help?

Do you have a named person to contact if you have a problem or if your circumstances change? Have you contacted them - how did you contact them, how helpful were they?
Prompts: helpful in what ways; communicating; coordinating input from different agencies; managing conflict; arranging and conducting reviews.

Relationships with other practitioners, for example, GP, staff in voluntary sector agencies.

Overall impressions of assessment

How important it was to them.

Tell me about the things that worked well.
Prompts: things they liked about it; duration; privacy; preparation time; member of family/someone present to provide support; questions easy to understand; relevant questions/probing of issues to enable clear perspective on circumstances; listened to; informative, e.g. about help available; planning for the future.

Tell me about the things that didn't work well.
Prompts: duration; privacy; timing; lack of preparation time; questions difficult to understand; person(s) conducting the assessment; limited involvement;

Let's think about things that might have improved your experience……...
Prompts: Practical arrangements; timing; easier to understand

Following your assessment

Tell me about what happened after your meeting, including any help that you received.
Prompts: services received/not received but identified as needing; timescales; what participant expected? what participant had asked for?

Tell me about the things that have changed for the better.
Prompts: health and wellbeing; lifestyle; independence; support network; relationships; help received.

Tell me about the things that have stayed the same.

Tell me about the things that have got worse.

Tell me about your experiences of using services.
Prompts: ways in which services make life easier; ways in which services make life more difficult; accessibility; reliability; flexibility; sensitivity; responsiveness, meet needs/not meeting needs. Statutory and independent sector.

Do you pay for services?

Let's think about the things that might improve your experience of using services.
Prompts: better organization; being able to rely on it; listen to my needs; financial assistance; more regular services.

Tell me about any help that you receive from friends and family.
Prompts: nature and extent of help, how often they help.

Tell me about any needs for help that are not being met.
Prompts: nature of; ways in which needs could be met.

Tell me about any meetings with people from social services or the NHS that have taken place since your initial meeting.
Prompts: triggers; decisions taken; practitioners involved; outcomes, including services.

Additional discussion points for carers only:
During the assessment of the person you care for, did anyone ask any questions about you?
Were you offered a carer assessment?
Did you have a carer assessment – how long ago? If refused, reasons why.
Tell me what you talked about – focus and how differ from the carer domain in the UA.
Did you find the carer assessment helpful – in what ways?
Let's think about the ways it might have been improved – timing; location; privacy; questions asked.
Outcomes of assessment.
If refused any services explore reasons why.

Is there anyone else who relies on your help and support? Please tell me about them and the ways that you help.

Close

Thank you very much for talking to me and sharing your experiences. All this information will remain strictly confidential and you will not be identified in any reports. If you wish, we will send you a summary of our key findings and recommendations.

Interviewer, please:

- Note if the participant would like to receive a summary of findings.
- Record the **time the interview ended** on the front cover sheet.
- **PRESS STOP** on MP3 recording device.

Appendix Two Staff Interview Schedule

**Unified Assessment in Wales: older people with complex
needs and their families
Staff Interview Schedule**

Introduction:
There is only limited understanding of how older people and their
carers experience UA and its effects on practice.   This study:
1. Explores, over time, service user and carer experiences of UA
   and subsequent outcomes.
2. Identifies person-centred and outcome-focused approaches to
   assessment and care planning and the extent to which these
   feature in current practice.
3. Identifies ways in which organizations can work
   collaboratively to support older people and their families.
4. Makes recommendations to inform policy and practice
   development.

This study is being completed in seven study sites across Wales
using a multi-method approach. We are interested in your views on
the implementation of UA policy into practice and, in particular, its
effects on older people and their carers.

Consent:
- It would be helpful if we could record this interview so that
  the information we collect is as accurate and complete as
  possible. Please confirm that you are agreeable to this.

- **Press record:** *"The interview is now being recorded...."*

Assessment:
Tell me about........
- Key agencies and how they are involved in the UA process –
  engagement of key stakeholders in practice; challenges of
  engagement.
- Guidance outlines 4 types of assessment [contact, overview,
  specialist & comprehensive] – tell me about how these work
  practice - ensuring assessment is proportionate to need.
- Tell me about the domains and sub-domains & how these
  work in practice – things that work well; problematic; changes
  that might improve practice.
- Tell me about the 7 key issues of assessment & how these
  work in practice.
- UA should identify the presence of a carer & their
  requirements for assessment – tell me about how carer need
  is assessed within the UA framework.

- Fair Access to Care Guidelines and how these work in practice.

Person-centred approaches:
Tell me about......
- Characteristics of person-centred approaches and how these work in practice – including challenges.
- Some of the ways practitioners try to ensure older people and their carers are at the centre of the assessment process.
- Guidance underscores the importance of describing needs using older peoples' and carers' own words – tell me about how this works in practice.
- Thinking about person-centred approaches – tell me about any changes to practice, brought about by UA, and their effects on older people and carers.
- Are you able to describe any examples of good practice and areas where practice could be improved.
- Any staff training needs in relation to person-centred approaches.

Managing risk:
Tell me about......
- The ways practitioners explore risks to independence with older people and carers – tool used; things that work well; things that are problematic; key changes to practice brought about by UA; effects on older people and carers.
- Reconciling different approaches to risk.
- Are you able to describe any examples of good practice and areas where practice could be improved.
- Any staff training needs in relation to managing risk.

Outcome-focused care planning:
Tell me about.......
- Challenges presented by adopting an outcome-focused approach – e.g. defining outcomes in practice.
- Describe the ways in which practitioners set about working with older people and carers to define outcomes.
- Sharing information, joint planning, decision-making and implementation.
- Key changes to care planning practice, brought about by UA, and their effects on older people and carers.
- Examples of good practice and areas where practice could be improved.
- Any staff training needs in relation to outcome-focused planning.

Care coordination:
Tell me about.....
- Role of the care coordinator and how this works in practice – who assumes role; potential to deliver change.
- Locally agreed protocols for care coordination.
- Aspects of care coordination that work well and why.
- Aspects of care coordination not working so well and why.
- Examples of good practice and areas where practice could be improved.
- Any staff training needs in relation to care coordination.

Service delivery planning:
Tell me about......
- Ensuring service provision is outcome driven and responsive to needs.
- Using assessment information to advocate for/develop new services.
- Pathways for the flow of information.
- Key changes to service delivery planning, brought about by UA, and their effects on older people and carers.
- Examples of good practice and areas where practice could be improved.

Review:
Tell me about......
- The review process and how it works in practice – triggers; barriers; facilitators.
- Adopting an outcome-focused approach to review - identifying and taking account of unmet need in practice.
- Involving older people and carers in the review process.
- Key changes to review practice, brought about by UA, and their effects on older people and carers.
- Examples of good practice and areas where practice could be improved.

Local arrangements for monitoring and evaluating UA from the perspectives of older people and carers:
Tell me about......
- Any local arrangements and how these work in practice.
- Using monitoring and evaluation data to inform future practice.
- Examples of good practice.
- Awareness of work being undertaken in other areas of Wales.

In closing:
- We are almost at the end of the interview – is there anything else that you think is important for us to note.....OK....

- Sentence to summarize your experiences of implementing UA.