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Title: Applying outcomes in community-based social care practice in England

Authors: Stacey Rand[1]∞, Grace Collins[1], Wenjing Zhang[2], Alisoun Milne[3], Barbora Silarova[1]

[1] Personal Social Services Research Unit (PSSRU), University of Kent, Canterbury, UK.
[2] Centre for Health Services Research (CHSS), University of Kent, Canterbury, UK.
[3] School of Social Policy, Sociology and Social Research (SSPSSR), University of Kent, Canterbury, UK.

∞ Corresponding author

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Data Availability. The data generated and analysed during the current study are not publicly available because participants did not consent to their data being publicly available. However, data may be available from the corresponding author, in an anonymised format, upon reasonable request.

Conflicts of Interest. The authors have no conflicts of interest to declare.

Abstract

Context. Social care outcomes (the effect of services on the quality of life of people with support needs and unpaid carers) have been proposed as a way of improving the quality and effectiveness of care. Outcomes have also been proposed as a way of re-conceptualising 'needs' that has application in needs assessment, care planning, evaluation and care practice.

Objectives. The study aimed to provide insights into social care professionals' experiences and views on the collection and application of outcomes data in practice, and what they believe are the benefits, challenges and barriers to implementation.

Methods. Interviews were conducted with 25 social care professionals in England and analysed using a framework approach.

Findings. Participants reported perceived benefits of using outcomes data, especially to focus effort on improving the wellbeing of people with support needs and carers. Perceived challenges include requirements for data collection set by funders/commissioners; the volume of data collected; difficulties in separating non-service-related influences on outcomes; and the format of collection. Participants felt a more flexible approach might facilitate more meaningful conversations, rather than a 'tick-box' exercise.

Limitations. The study sample was purposive, based on established connections. It only included professionals from London, South East and Central England.

Implications. Although outcomes are perceived as important in helping to improve people's lives, social care professionals identified a number of challenges. Further research to understand and address these challenges is needed.

Keywords

Social care; long-term care; Quality of Life; outcomes; assessment; carers

Background

In England over the last 30 years, there has been an increased focus on outcomes as a way of evaluating the quality and effectiveness of long-term care services and policy. This reflects a broad shift in public service administration and social policy, including in education and healthcare, to apply outcomes-based evaluation in decision-making and management (Bovaird, 2014). In the context of long-term care (also known as social care), outcomes have been defined as the effect of support on the wellbeing and quality of life (QoL) of people who use services (Department of Health and Social Care, 2010b, 2018, 2021; Netten *et al.*, 2012; Julien Forder *et al.*, 2018). This definition applies to outcomes for adults with support needs and their (unpaid) carers, who are understood as 'co-clients' entitled to needs assessment in their own right under the Care Act (2014), even if there remain significant barriers to identification and support of carers in practice (Rand and Malley, 2014; Mitchell, Brooks and Glendinning, 2015; Marczak *et al.*, 2021).

This conceptualisation of social care 'outcomes' (also known as *individual* or *personal outcomes*) as the effect of services on QoL or wellbeing has been informed by household economics, especially the social production of welfare model combined with the capability approach (Forder and Caiels, 2011; Ann Netten *et al.*, 2012; Forder *et al.*, 2018; van Loon *et al.*, 2018). It has also been shaped by the personalisation agenda (Netten *et al.*, 2012). Personalisation is a contested concept, especially in how it may be implemented in practice (see for example (Beresford, 2011; Slasberg, Beresford and Schofield, 2013)). However, it has been presented as a way of shifting away from service delivery for its own sake with an emphasis on measuring only outputs and/or costs, towards a view that considers its effect on people's QoL or wellbeing (Department of Health and Social Care, 2010, 2018, 2021).

The original impetus for the measurement and application of outcomes was their use in public sector performance management, including their *purposeful* use by managers to drive improvement through feedback and subsequent action to improve quality and effectiveness (McAdam, Hazlett and Casey, 2005; Moynihan and Pandley, 2010; Kroll, 2015). An example is the *Maryland Ask me!* study, which applied self-report QoL collected from adults with intellectual disabilities to identify areas for targeted service improvement (Bonham *et al.*, 2004). However, there are various other understandings of outcomes (Kroll, 2015), including as a mechanism of control over locally-delivered services by central government or commissioners (e.g., in resource allocation or outcomes-based commissioning in extra-care housing (Smith *et al.*, 2017)) or to provide accountability and transparency (e.g. the English Adult Social Care Outcomes Framework (ASCOF) (Department of Health and Social Care, 2010)).

The concept of outcomes has also been incorporated into the English Care Act (2014). Instead of defining 'need' in terms of the (in)ability to complete activities of daily living (e.g. washing, dressing), the Act, and its related guidance, define 'need' in terms of QoL/wellbeing, and outcomes as the potential of social care support to improve QoL/wellbeing. The outcomes specified in the guidance include the ability to maintain family and personal relationships, work or education, and being able to access local facilities. Although statutory needs assessments must consider outcomes, the guidance does not specify the use of a standardised format for assessing or recording them (Department of Health and Social Care, 2015). Individual or personal outcome-based approaches are also found in Welsh and Scottish social care policy and legislation, especially with regard to the assessment of need, reviews and care planning, although there are differences of approach, e.g. specified reporting format (Welsh Government, 2016; Scottish Social Services Council, 2018).

Shaped by the policy and legislative context, community-based social care services collect and apply outcomes data on clients (i.e. adults with support needs and/or carers) as an integral part of service delivery and care practice. Outcomes data (whether qualitative or quantitative) may be collected for different purposes, including: (i) outcomes-based needs assessment, reviews and care planning; (ii) commissioning or applying for grants and/or contract monitoring; (iii) in-house service quality monitoring and service planning; and, (iv) regional or national level monitoring or planning. Each of these applications has different objectives and involves different stakeholders; however, they share a common goal of understanding how services affect people's QoL and wellbeing.

Some of these applications have been explored in research, for example, applying the Adult Social Care Outcomes Toolkit (ASCOT) measure of social care outcomes (Netten *et al.*, 2012) for local or national level monitoring or planning (van Leeuwen *et al.*, 2014; Heath *et al.*, 2015; Rand, Forder and Malley, 2017; Yang, Forder and Nizalova, 2017). There have also been studies on the use of outcomes in needs assessment and care planning (for example, Johnstone and Page, 2013, Guberman *et al.*, 2003). For other uses, however, especially applying for grants or funding, local monitoring or contract compliance, there is limited evidence on how outcomes are understood, applied and embedded in social care organisations.

Given the enhanced emphasis on outcomes in social care and the shift in their definition and meaning, it is important to explore whether, and how, social care professionals collect and/or apply outcomes in their practice with adults and/or older carers, and their views on benefits, challenges and barriers to applying outcomes in practice. These are the aims of this study. The professionals worked for community-based social care organisations (care providers, carers organisations and local authorities) that support adults and/or carers, aged 65 or over. The study considered the collection and application of outcomes, broadly, to consider their use in statutory or informal needs assessment, review and care planning; oversight or review of funding, commissioning and contract management; and internal monitoring for performance management, service planning, design and improvement (i.e. uses (i), (ii) and (iii) above).

Methods

Study design

This qualitative study was part of a project that aimed to gain insights into the impact of social care on the QoL of older carers and the people they support, both individually and dyadically.

The wider project consisted of a scoping literature review (Zhang *et al.*, 2022), qualitative interviews with carers and care recipients (to be reported elsewhere) and interviews with social care professionals. The latter focused on professionals' views on the needs and outcomes of older carers, as well as their views on applying a dyadic QoL outcomes approach in practice, as reported elsewhere (Rand *et al.*, 2022). They also captured data on professionals' views and experiences of their application of outcomes in practice, which are considered in the analysis presented here.

Selection and recruitment of participants

A purposive sampling approach was applied to recruit social care professionals in England from a range of organisations and backgrounds, including, but not limited to: social workers or support workers, commissioners, and service delivery or strategic-level managers. Through the research team's connections within the field, and support from the study advisory group, help was sought from local authorities, care providers and carers' organisations to identify potential participants. Participant information sheets were shared with these contacts for them to pass on to colleagues. This resulted in 33 participants being identified to the research team as potential participants. Four of these potential participants put us in touch with another colleague, who they felt would be more suitable, due to expertise. Eight declined to participate due to other commitments.

Twenty-five social care professionals consented to take part in the study; 19 of these participants were interviewed one-to-one, and six participants chose to be interviewed as three pairs, where each pair was two colleagues from the same organisation. Participants' roles are shown in Table 1. Participants represented carers organisations (n=7), community-based support and/or care providers (n=4) and local authorities (n=3) in central or South Eastern England and London.

Table 1. Study participant roles

Professional role	Number of participants
Senior management	10
Service manager or team lead	7
Social worker	5
Apprentice social worker or support worker	2
Commissioner	1

Data collection

Semi-structured interviews were conducted via MS Teams, between January and July 2021. Interviews were conducted by an experienced qualitative researcher (Author 1). No prior relationship was formed with the majority of participants (except where four participants were known to the researcher, through support of one or more previous studies, since 2012, e.g. by sharing study information in newsletters or via networks), other than the initial contact to participate in the study. Where the researcher and participant knew each other, there were no identified conflicts of interest that would affect participation in this study. Consent was written or verbal, and interviews were recorded with permission. All interviews were transcribed verbatim by a professional transcriber, except for personal identifiable data (i.e. personal, place or organisational names), which were replaced with pseudonymised codes. Data were only accessible to the research team. Interviews lasted 34 minutes, on average (range: 22 to 48 minutes).

The semi-structured interview guide was developed by Authors 1, 2 & 4. Topics included: (1) participants' professional background, current role and description of their employing organisation; (2) the types of support for carers and/or care-recipients that their organisation provides; (3) how outcomes were used in their practice, including the benefits and challenges; (4) views on using a dyadic QoL outcomes approach to support older carers and care-recipients. In this paper, we focus on the data collected in response to topic (3), using outcomes in practice.

Participants were asked to briefly describe the outcomes data they collected from the people they supported (adults with support needs and/or carers) and how they were used. The study considered all outcomes data related to people's QoL or wellbeing that was systematically collected and recorded. This included qualitative and quantitative data, collected in structured (e.g. self-completion or interview questionnaires) and unstructured or semi-structured formats (e.g. one-to-one conversation or interview, free text boxes, focus groups, narrative case studies). To contextualise the findings, quotes include a brief description of the outcome(s) collected and their use(s) by the professional and their organisation.

Data Analysis

The framework approach was applied to the data analysis (Ritchie and Spencer, 1994; Gale *et al.*, 2013). An initial framework was developed after familiarisation and coding of the first three interview transcripts by Author 1. This was then reviewed and discussed by the research team. The remaining interviews were then coded using this initial framework by Author 1, with the addition of new codes or sub-codes to reflect the data. Ten of the 22 interviews were independently coded by another researcher (Author 3), using the same process. Authors 2 and 5 reviewed the remaining 12 interviews. Any discrepancies were discussed and resolved within the team. NVivo was used to generate framework matrices to facilitate charting. Interpretation was conducted throughout the analysis process.

Ethics and Research Governance. Ethical approval for the study was given by the North West Liverpool Central Research Ethics Committee (Reference: 20/NW/0473/281639), with approval also from the Association of Directors of Adult Social Services (ADASS) and local research governance approvals from participating LAs.

Patient and public involvement in research

Three public members were involved in the project; Helen Ramsbottom throughout the project, Christina Reading from proposal development through to end of fieldwork and Della Ogunleye from end of fieldwork to project end. The public members all have experience of being carers and engaging with community-based care organisations. They were invited to attend and contribute to the study advisory group, which met three times throughout the study to provide input into the study design, set-up, oversight, preliminary results and approach to dissemination. They also attended project team meetings and provided advice and feedback on the study documents (information sheets, consent forms and interview schedule), interim findings and how best to engage with professionals, service users and carers in our dissemination plans. The latter included advice on the design and development of resources, including a summary of findings and recommendations that could be used by social care professionals and a plain English summary.

Results

All participants reported that their practice included routine outcomes data collection from carers and/or the people they support. This included in the context of needs assessment and care planning (*n*=9), commissioning of services or applying for grants or contracts (*n*=10), in-house monitoring for service planning and delivery (*n*=10) and/or providing feedback to clients or service users as part of local accountability (*n*=2).

Outcomes data were collected in a variety of formats from structured questionnaires to open-ended text-based, diagrammatic or conversational approaches. Some participants reported the use of validated outcome measures of QoL, wellbeing or associated constructs: specifically, the WHO-5 (*n*=2) and WEMWBS (*n*=2) measures of mental wellbeing (Tennant *et al.*, 2007; Topp *et al.*, 2015) and the CORE-10 measure of psychological distress (*n*=1) (Barkham *et al.*, 2013). Systematic frameworks or approaches to assess personal outcomes were also used; specifically, the Carers Outcomes STAR (*n*=6) (Triangle Consulting, 2016). Meanwhile, over half of respondents reported the use of in-house tools or frameworks to assess or collect outcomes data (*n*=14), of which three were explicitly reported to align with Care Act outcomes. These tools/frameworks included outcomes relating to physical or mental health (*n*=5); overall wellbeing or life satisfaction (*n*=4); independence, choice and control (*n*=4); maintaining social relationships and/or social isolation, loneliness (*n*=4); feeling supported and able to continue caring (*n*=4, *carers only*); and ability to maintain interests, leisure activities or employment (n=3).

Themes related to the benefits (**Theme 1**) and challenges/barriers of using outcomes data in practice (**Theme 2**), specifically for funding, commissioning and contract management (use of outcomes, ii) and internal monitoring and service planning or improvement (use of outcomes, iii). Themes 1 and 2 related to the data collected by the 18 participants, excluding the social work and related roles (*n*=7, see Table 1). Social workers also routinely collected and applied outcomes data in needs assessments and care planning (use of outcomes, i), but were less aware of the terminology of 'personal outcomes', even if they were integrated in their practice. Therefore, we consider findings from social workers (*n*=5) and social-work related practitioners (*n*=2), alongside data collected from practitioners within carers' organisations who conducted assessments (*n*=2), separately, under **Theme 3**, applying outcomes in care assessments and planning.

Theme 1. Benefits of using outcomes data in adult social care practice

The most commonly-cited perceived benefit was that outcomes may guide service commissioning, planning and delivery to focus on people's wellbeing and experience, rather than the needs and priorities of service providers, practitioners or commissioners.

> *"They [carers] have got something visual and it's easier to see the improvement in outcomes. And see what areas that you [service provider] need to improve if you can… they [carers] actually feel part of the process."*
>
> PS12, Service Manager/Team Lead, care provider (older adults and carers)
> Outcomes: in-house format, Carers Outcomes STAR

Application: (i), (ii), (iii)[1]

> *"If commissioners would commission on an outcomes based process that'd be quite innovative really of them, would it not? It would win back some pre-tendering and widget based commissioning, as we call it - you know, payment by your thirty minutes or whatever… then actually you could deliver a holistic service. That's what we try to do."*

PS2, Senior Manager, carers organisation (carers only)
Outcomes: in-house format
Application: (i), (ii), (iii)

Another perceived benefit was the way in which outcomes may demonstrate the beneficial impact of services, especially to influence or guide external decision-makers, in a way that keeps people's voices, needs and concerns at the centre:

> *"[A] focus on outcomes really brings to life the impact the services are having on people's lives, and helps to… bring that story of why there's an ongoing need for services, particularly in the time we still live in, in a time of austerity."*

PS24, commissioner for adult social care (older adults and carers)
Outcomes: WHO-5, in-house framework
Application: (ii)

> *"When I'm advocating to someone, like a politician, for example, it's really crucial that I can have that evidence [outcomes]. It would be easy for volunteers to say it sounds like a marvellous service, I'm sure that's very useful. But if I can then say, and as a result of this support group sixty-five percent of these carers felt less lonely as a result of it or forty-five percent of carers felt empowered to seek employment. See what I mean? Those kind of stats are much more useful."*

PS13, Senior Manager, carers organisation (carers only)
Outcomes: various depending on context/funder
Application: (ii), (iii)

Outcomes data were also seen as a way of demonstrating the significance, meaning or value of an organisation's work and its collective effort, in the way that focuses on the positive impact on people's lives, as 'what matters'.

> *"It justifies why we're doing something, not only to the carer, or the grant recipient, who is the carer centre or scheme, but also to ourselves as well, and our organisation."*

PS4, Senior Manager, carers organisation (carers only)
Outcomes: various depending on context/funder
Application: (ii), (iii)

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[1] Application of outcomes by the respondent in their direct professional role and/or by their organization, if in a senior management role: (i) outcomes-based needs assessment, reviews and care planning; (ii) commissioning or applying for grants and/or contract monitoring; (iii) in-house service quality monitoring and service planning.

These perceived benefits were couched within the caveat of challenges or limitations for two participants. First, for the senior manager of a small care service for people with dementia and their carers, outcomes offered a way of collecting information on people's wellbeing and the effect of the service, but "*standard scales aren't particularly accessible to people living with dementia*", so there were challenges in collecting meaningful and usable data (PS6 care provider). Second, a service-level manager employed by a local authority spoke of outcomes data collection in *"lengthy and detailed forms*", which sought to "*improve their QoL"; however*, the language of the description was highly caveated *("at the end of it you hope – well, the idea is you come up with …"*), which indicated a mismatch between the experience of the process and its goal or aim, of supporting people (PS20, LA adult social care manager). In addition to these two cases, where challenges and barriers were linked to the description of benefits (i.e. benefits with caveats), the other participants also identified challenges and barriers, as outlined in the next section.

Theme 2. Challenges/barriers to using outcomes data in adult social care practice

2.1. The purpose of data collection

A key perceived challenge related to the use of outcomes for funding, commissioning and contract management (use of outcomes, ii). Some participants reflected on tensions between what they were required to collect by funders and commissioners (mostly, local authorities, but also other funding bodies) and the outcomes that would best capture the provider organisation's vision, strategy and view of what matters most to the people they work with.

> *"And the questions are so silly. They're not relevant sometimes. It doesn't capture the work that we're doing with that person."*
>
> PS11, Service Manager/Team Lead, care provider (older adults and carers)
> Outcomes: in-house format, Carers Outcomes STAR
> Application: (i), (ii), (iii)

> *"They've [the questions] got to have that value. They've got to be meaningful, especially for the carers that we work with."*
>
> PS16, Support Worker, carers organisation (carers only)
> Outcomes: in-house format/framework
> Application: (ii), (iii)

Concerns were also raised over using outcomes for performance or contract management, including its potential to limit innovation, especially if there is pressure to deliver exactly what was promised to the funder rather than respond flexibly: *"it could stifle something different"* (PS4, carers organisation). In addition, it was recognised that supporting carers and people with care and support needs are not typically a linear, short-term journey to 'improvement', as would be typical in a medical model of ‘treatment’ interventions. The aim of social care is to maintain people’s QoL in light of long-term, fluctuating and/or deteriorating care-related needs. Outcomes-based approaches, as commonly applied in contract monitoring and evaluation, may be set to expect ‘improvement’ over a limited or short-term timeframe. This does not accurately or realistically reflect the complex trajectory of care and caring:

> *“The carers’ journey doesn’t necessarily have a clearly defined start and end; whereas with some interventions, it’s much easier to say okay we’re going to work with you for twelve weeks or whatever, and we’ll measure this at the start and we’ll measure this at the end.”*

PS14, Senior Manager, carers organisation (carers only)
Outcomes: WEMWBS, in-house framework, various depending on context/funder
Application: (i), (ii), (iii)

Finally, one participant’s perspective was that the aim of improving person-centred outcomes is simply unrealistic in a sector struggling with chronic underfunding and delivery models that include limit costs by, e.g. 15-minute home care calls:

> *“You probably wouldn’t be getting somebody up in the fifteen minute call but there’s a whole range of things that you’ve got to do when you get in there. So, as much as everybody talks about there being quality of life, dignity, outcomes of domiciliary care – it’s impossible, in reality, to deliver those things.”*

PS9, Senior Manager, carers organisation (carers only)
Outcomes: In-house framework
Application: (i), (ii), (iii)

2.2. Volume of data collection

Another commonly-reported perceived challenge was the large amount of data that was routinely collected, especially as ‘performance indicators’ for funders or commissioners:

> *“The majority of our funding is council contract. We have probably about ninety key performance indicators that we have to report on, every six months.”*

PS3, Senior Manager, care provider (older adults and carers)
Outcomes: In-house format, various depending on context/funder
Application: (i), (ii), (iii)

Some participants reported that this may limit the ability to use the data in local decision-making, due to lack of capacity and/or limitations in how data are shared between organisations:

> *“… the outcomes are collected for performance monitoring, the delivery of a contract… we haven’t really yet got to grips with how we [organisation] want to use that information yet.”*

PS14, Senior Manager, carers organisation (carers only)
Outcomes: WEMWBS, in-house framework
Application: (i), (ii), (iii)

> *“[The sector has]… evolved to have all these outcome data coming in, but actually I don’t think there’s enough investment in the sector around really intelligently using that data, or using that in a more collaborative or collective way to achieve change..”*

PS7, Senior Manager, carers organisation (carers only)
Outcomes: Carers Outcomes Star, Core 10, in-house framework
Application: (i), (ii), (iii)

From the perspective of staff, such data collection and reporting may direct effort away from client-focussed work, increase workloads and affect staff wellbeing *(‘we get so overwhelmed with paperwork’* (PS12, care provider)).

2.3. Format of data collection

Outcomes data collection in a standardised format, as often requested by funders or commissioners, was perceived to interfere with service delivery and access, or be burdensome or even distressing for some clients. They may also provide benefits in guiding and deepening conversations.

> “*It can be sometimes seen as quite invasive for people, especially if someone’s been referred to us and doesn’t necessarily want to engage at first. It might take a while for us to be able to ask those questions… but having some structured questions give the care navigators a much better idea of what’s going on in someone’s life.”*

PS3, Senior Manager, care provider (older adults and carers)
Outcomes: In-house format, various depending on context/funder
Application: (i), (ii), (iii)

Some respondents reflected on the benefits of adopting a flexible and responsive approach, rather than using standardised outcomes formats:

> *“It can be sometimes seen as quite invasive for people… sometimes people just want more of a focused conversation. The ‘outcomes’ [in a standardised format] can be seen as a barrier.”*

PS1, Senior Manager, care provider (older adults and carers)
Outcomes: In-house format
Application: (i), (ii), (iii)

However, outcomes data collection through one-to-one interviews or conversations, qualitatively, requires skill, knowledge and experience, especially when working with people in difficult circumstances and experiencing emotional distress. Skill, experience and judgement are especially important in avoiding harm in the collection of data, as well as to ensure data quality and value.

> *“There’s something around the skill of the person using those outcome tools… it’s knowing the appropriate time to approach these conversations.”*

PS1, Senior Manager, care provider (older adults and carers)
Outcomes: In-house format
Application: (i), (ii), (iii)

2.4. Capturing contextual influences on outcomes

Routinely-collected cross-sectional standardised outcomes data, as required by funders or commissioners, do not capture the broader context and impact of other (unrelated) factors, like age, deterioration in a health condition or mobility, and access to other sources of formal or informal support outside of the service. This was recognised by some participants, who voiced concerns over the use of outcomes data by funders or decision-makers:

> *"What they're not seeing [with quantitative outcomes data], is that, when you're working with carers, their scores might go down because their caring role's changed… You can put in all the support you like for a carer, eventually that caring role is going to become too great and things are going to need drastic action, like the cared for having to go into a care home."*

PS11, Service Manager/Team Lead, care provider (older adults and carers)
Outcomes: in-house format, Carers Outcomes STAR
Uses: (i), (ii), (iii)

Case studies, or other approaches to present and frame outcomes, qualitatively and contextually, were proposed as a way to support understanding the impact of services on people's lives:

> "*I would much prefer, if instead of 'outcomes', as such, we did more case studies. So that the funders could see from start to finish the difference that was made to that person's life."*

PS12, Service Manager/Team Lead, care provider (older adults and carers)
Outcomes: in-house format, Carers Outcomes STAR
Uses: (i), (ii), (iii)

Theme 3. Applying outcomes for needs assessments and care planning

A range of approaches to assessment were used by different organisations, each with their own format, content and approach, even if there were some commonalities: for example, in applying broad approaches ('the strengths based approach' or 'the whole family approach') or in a focus on the eligibility outcomes specified in the Care Act guidance. Some participants expressed the view that a flexible approach is most appropriate in practice. The reliance on tightly-structured questions inhibits practitioners' ability to use their experience, knowledge and skills, flexibly and effectively, including observation skills, to understand people's needs and address them.

> *"Social workers are qualified to use their observation skills. That needs to be recorded as well [but often is not]…I feel that is gone, like people are like robots. They [Social Workers] just keep on asking the same questions, how it is impacting [the person]. They [Social Workers] are not using observation skills, as [this] is not being recorded. So they're not seeing things."*

PS21, Social Worker, local authority
Outcomes: Statutory outcomes, 'holistic' approach
Uses: (i)

Another social worker spoke about the importance of working both relationally and reflectively, to ensure that practice remains centred on the person, within their wider social network, and their outcomes (‘what matters’). This was contrasted with an approach that was more instrumental and routinised, and less relationally focussed:

> *“We’ve moved to kind of what they call a “What Matters Approach”. It’s putting the person at the centre and thinking about the networks around them… there was a period of where it was more care management. People were going out and being quite robotic doing assessments, coming back, getting the package, going out reviewing. We’re now trying to move to being more working with people…”*
>
> PS22, Social Worker, local authority
> Outcomes: Statutory outcomes, ‘what matters’ approach
> Uses: (i)

Some practitioners spoke of the effective use of tools, which allowed flexibility, yet also provided a guide for the conversation and a way of recording key information. In particular, tools that enabled an open and meaningful conversation between carer/client and practitioner, as part of an ongoing relationship, were viewed favourably:

> *“That was a very good tool to use because the carer was left with a copy of it and that would form their journey. When you score, you do the first initial score…, then you go back over it with the second one, and they can see their points growing. They can see it taking shape.”*
>
> PS12, Service Manager/Team Lead, care provider (older adults and carers)
> Outcomes: in-house format, Carers Outcomes STAR
> Uses: (i), (ii), (iii)

Discussion

This study aimed to understand social care professionals’ experience and views of the benefits, challenges and barriers to applying outcomes in their day-to-day practice; specifically, in needs assessment, review and care planning, funding, commissioning and contract management, and internal monitoring, service planning and improvement. Outcomes were perceived as beneficial, as they place the person and their wellbeing at the centre of service delivery, and they reframe the meaning, value and significance of service delivery around improving people’s lives. The use of outcomes was viewed as beneficial in enabling organisations to demonstrate their impact on people’s lives, whether for internal purposes (e.g. service planning, staff motivation) or to gather external support or funding. Perceived challenges included: the purpose of data collection, including tensions that arise due to competing concepts or priorities; the volume of routine data collection, which inhibited the application of the data locally and placed a burden on organisations and service users/carers; format of data collection, which could add burden to staff and service users/carers; and the question of how to capture contextual influences on outcomes, so that the impact of services (to the exclusion of non-service-related factors) may be better understood.

These findings also align with other studies, which have focussed on outcomes data collection and application by the English social care sector, especially at a national level or by care homes (both of which were not considered in this study). Outcomes data collection at a national level, for example, via the Adult Social Care Survey in England, offers a rich resource for analysts, researchers and policy-makers but is not used to its full potential, due to lack of resources (Heath *et al.*, 2015). There are also issues around linking or sharing of data, partly informed by data protection concerns, but also driven by logistical or practical issues (e.g. incompatible data systems) or lack of commitment to collaboration and data sharing due to competing organisational or commercial interests, which limit the usefulness of data. This finding is mirrored here at the local level, where outcomes data are required by funders or commissioners to evidence impact, quality or for contract monitoring. The focus on data collection has an impact on organisations, staff and service users/carers, who are all invested in the activity. However, it does not allow them to make full use of the collected data, due to limited capacity and lack of access to linked or pooled data.

Despite the policy focus on outcomes, which is proposed as a way of placing people at the centre of care and ensuring that care delivery adaptably and flexibly meets individuals' needs (Department of Health and Social Care, 2021), an 'outcomes focus' by care organisations and providers does not *necessarily* lead to person-centred care delivery and organisational focus. Implementation issues related to the use of outcomes in commissioning of social care have been identified in other research, especially as it relates to the personalisation agenda; not least, how to effectively implement a focus on outcomes in light of inadequate funding and investment in the sector (Paley and Slasberg, 2007; Smith *et al.*, 2017). The findings of this study add to the evidence base, by illustrating the perceived tensions between an emphasis on outcomes data collection and their use by social care professionals in their practice.

Specifically, the findings suggest that the requirement to collect outcomes data set by commissioners and funders may drive data collection and reporting, even where this activity has limited perceived value, meaning or usefulness to the professionals who collect or apply the data. At times, they may be used primarily to demonstrate impact for the purpose of securing more funding. In this way, collecting outcomes data becomes an end-in-itself. Care providers and organisations may then find themselves serving a system of data generation that has limited value to them, at best, or may even have detrimental effects (e.g. requiring providers to ask people questions that cause distress or burden). A more collaborative approach to outcomes, whereby stakeholders co-produce what should be collected, how and for what purpose, may alleviate some of these concerns; it may also facilitate the development of innovative local solutions regarding the better use of data, to not only inform strategic oversight, but also embed outcomes in service planning, delivery and practice. Further research in this area to explore whether, and how, this approach could be beneficial, is warranted.

Related to this, are the ways in which a focus on outcomes may not deliver what it aspires to (i.e. placing people's lives at the centre), if there is not adequate recognition that the effect that services have on people's QoL and wellbeing (i.e. outcome) is affected by people's experience of services, which relate to the *process* by which they are delivered. This association between process indicators (e.g. timeliness, satisfaction) and outcomes has been demonstrated in a number of studies, especially the interpersonal aspects of care delivery (van Leeuwen *et al.*, 2014; Malley, D'Amico and Fernandez, 2019). This corresponds to qualitative studies of older adults' transitions between health and social care settings, which found that process (e.g. consistent interpersonal relationships that offered continuity and allowed the development of trust) were valued by people and linked to improved outcomes (Tanner, Glasby and McIver, 2015). The adoption of an outcomes approach does not preclude an appreciation of the important role of process, but it may allow this to emerge if it is implemented in a way that abstracts 'the outcome' from 'the person', as well as the relational and interpersonal journey by which outcomes are achieved.

In needs assessment and care planning, the application of outcomes, embedded in assessment processes and recording, underpinned by the Care Act (2014) definition of outcomes, was also perceived to offer a framework for person-centred focus. However, the degree to which that was achieved in practice was viewed as dependent on the combination of process, format and professional skill. The ability of practitioners to build trust and develop rapport was identified as crucial, as well as flexibility, empathy and attentiveness to the person, in context. These skills have been highlighted in other studies of assessment practice in nursing and social work with older people (Carradice, Shankland and Beail, 2002; Ray *et al.*, 2015; Tanner, 2021; Willis *et al.*, 2022). Certain formats and approaches were viewed as encouraging an unhelpful routinization of the assessment process, in a way that inhibited the development of trust and open conversation; whereas other formats, which allowed or promoted greater flexibility, whilst still offering a structure to the conversation, were perceived more favourably. This is consistent with previous studies of assessments, which have highlighted that formats may be too task-focussed or overlook relational needs or issues (Seddon and Robinson, 2015), even if outcomes-based tools may facilitate focus on the individual and person-centred assessment (Guberman *et al.*, 2003). In the English post-Care Act landscape, however, whilst there is guidance on the eligibility criteria for adults with support needs and carers based on an outcomes approach (Department of Health and Social Care, 2015), there is no specified approach or tool for their application. Each LA may adopt its own approach, process and use of tools, which are often designed in-house and may not be developed to consider these issues.

The study has a number of limitations. The sample also only included social care professionals in London, South East and Central England. However, participants were recruited from a range of organisational types (LA, third sector, care provider and carers organisation) and, in different roles within the social care sector, had experience of applying outcomes across the three uses (i to iii) considered in this study. Therefore, the study provides an insight into professionals' experiences and views of applying outcomes in areas of practice, especially in local or in-house ways that have not previously been widely considered in the literature. Further research would usefully focus in-depth on different roles and contexts.

Conclusion

This study provides insight into social care professionals' perspectives and experience of collecting and applying outcomes data, particularly their perceptions of the benefits, challenges and barriers. Most participants expressed a positive view towards the collection and application of outcomes, as it places the primary focus on people's QoL. This aligns with the policy direction of the last 30 years, which has shaped both organisational and care practices in England. However, the study findings also suggest that there are challenges and barriers: for example, funder or commissioner requirements for data collection and reporting do not always align with an organisations' purpose, aims or values, and/or may be perceived to be inappropriate, burdensome or even intrusive. Concerns were also expressed over the volume of routinely-collected data and whether these data are currently used to their full potential. Additionally, standardised outcomes data collection and reporting, typically as one-off or cross-sectional data, do not always adequately consider the influences of the wider context or other impacting factors. Within practice, applying outcomes for needs assessments and care planning are sometimes viewed positively, especially where tools or formats allow conversations to take place in a way that is structured, whilst also allowing for flexibility. Overall, it is clear that there are still challenges and barriers to overcome, if collecting and utilising outcomes data is to improve the lives of people with care and support needs and their carers.

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