IRISS
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leading for outcomes

integrated working

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introduction: an outcomes-focused approach in integrated working

what is this guide?

This guide forms part of the IRISS *Leading for Outcomes* series. The guides are designed to support team leaders, managers and trainers to lead teams in the adoption and implementation of a personal outcomes-focused approach. The initial guide, *Leading for outcomes: a guide*, www.iriss.org.uk/resources/leading-outcomes-guide, gives general evidence-based advice and support in leading this approach within the context of adult services. We have also produced a number of companion guides that complement and add to the content in the main volume. This companion guide focuses specifically on the topic of practising in an outcomes-focused way within the field of integration. Other companion guides focus on parental substance misuse, dementia and children and young people.

Following the announcement in December 2011 of the Scottish Government plan to create health and social care partnerships through associated legislation and guidance, effective integrated working within these partnerships is likely to have a high profile. It is essential however that other key players such as housing and the range of independent sector organisations are also embraced within the concept of integrated working. Moreover integrated working involving professionals across health, housing and social care is of course not new. There have always been elements of working that involve a range of different professionals, informally or through a variety of multi-professional and multi-agency teams. Areas where integrated working has been a particular focus include homelessness, intermediate care and reablement, and community mental health and learning disability. Often these services are providing support at the interface between home and hospital or are seeking to provide support to individuals with complex needs. Teams likely to operate with elements of integrated working include rapid response services, intensive support at home services, home from hospital teams, community rehabilitation teams and mental health outreach services.

an example: intermediate care

Although the definition of intermediate care can be elusive, it is generally accepted as a generic term that covers a wide range of services that support adults and help to prevent unnecessary hospital or other institutional admission, or help to facilitate early hospital discharge. Intermediate care services can be described as those services that do not require the resources of a hospital but are beyond the scope of mainstream community care services. They are generally provided on a short-term basis at home or in a care home setting for people who require some degree of rehabilitation and support. They can be provided solely by one agency, but frequently consist of multi-disciplinary teams with professionals from health and social work and sometimes third sector provision.

Intermediate care is at the frontier of integrated working, whether between hospital and community, or between health and social care agencies. Integrated working (sometimes referred to as whole systems working or partnership working) is an essential component for positive outcomes for individuals requiring support. Intermediate care cannot operate in isolation from the wider service community, and integrated working will be taking place on a daily basis whether as part of a multi-disciplinary team or as part of a network of care providers linked by care management or similar arrangements.

Intermediate care services are generally well placed to adopt an outcomes approach to their work, although they may use different terminology to describe their approach. These services usually include rehabilitation and reablement elements and will work with people who use services to identify and work towards ‘goals’, ‘targets’, or ‘independence’. They frequently provide person-centred and integrated health and social care services to support adults with community care needs.

The parent guide provides an account of the introduction of the shift from a service-led to an outcomes-focused approach to delivering health, housing and social care services in Scotland. It highlights the vital role of leadership to the success of an outcomes-focused approach. This guide will focus on issues specifically relevant to the emerging context of integrated working across health, social care, housing and beyond. Following the announcement of December 2011, the focus on integrated working will shift from the limited number of integrated arrangements in recent years to the mainstream.

An outcomes-focused approach requires a significant culture shift at both an individual and organisational level. It involves questioning embedded ways of working and staff need clear direction and support on what it means to practice in an outcomes-focused way. You may wish to consider what advice and support you can call on (for example Training Section or Organisational Development Team) to help staff and teams develop new skills and innovative approaches to practice.

> 'Culture change is, without doubt, the most difficult and least understood area of organisational life.'
>
> *(Qureshi and Nicholas, 2004)*

who is the guide for and how can it be used?

- The guide is aimed at those committed to leading an outcomes-focused approach to integrated working, including team leaders, managers and those in training roles. It should be relevant to those from a range of health, housing and social care backgrounds.
- The guide provides a framework for training and is designed to be adapted to the time and resources available and to the specific needs of your team. The guide builds on the material offered in the parent guide. We suggest you familiarise yourself with this guide before leading with this more specialist guide. Cross-references are made to the parent guide as appropriate in this document.

The guide includes a range of training materials and exercises and is divided into three parts. Part one focuses on understanding what is meant by integrated working. Part two focuses on understanding and promoting a personal outcomes approach within integrated working across health, housing and social care and beyond. Part three focuses on putting the approach into practice and on ensuring it is sustained.

general note to exercises

Depending on the particular group of staff that is involved in the training it may be helpful to change the mix of the groups between exercises. This can be particularly helpful if there is a variety of people in terms of position, knowledge and experience.

PART ONE

1

part one: defining what is meant by integrated working

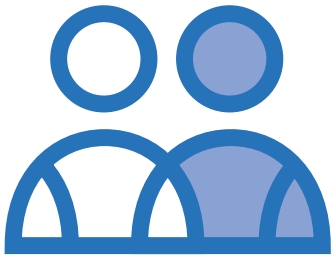
- Defining integrated working in health, housing and social care and the different forms it can take

what do we mean by integrated working

In any discussion of integrated working, a first prerequisite is that all parties define what they are talking about. Integrated working is one of those terms that has come to mean different things to different people so it is essential to ensure that everyone is talking about the same thing. A review by Hilary Robertson for the Royal College of Nursing in Scotland (Robertson, 2011) quotes a paper identifying 175 different definitions related to integration.

The word cloud below (drawing on Leathard, 2003) illustrates just some of the terms that can be associated with any discussion of integrated working.


Joint teams
Confederation
Generic
Multidisciplinary teams
Holistic
Trans disciplinary
Joint working
Merger
Forum
Liaison
Integration
Teamwork
Multidisciplinary
Partnership working
Interinstitutional
Multiprofessional
Interagency
Multi-sectoral
Joint learning
Trans-sectoral
Coordination
Trans-professional
Locality-groups
Unification
Interdisciplinary
Health and social care partnerships
Joint planning
Health alliances
Collaboration
Shared learning
Consortium
Local planning
Federation



exercise one:
what is integrated working

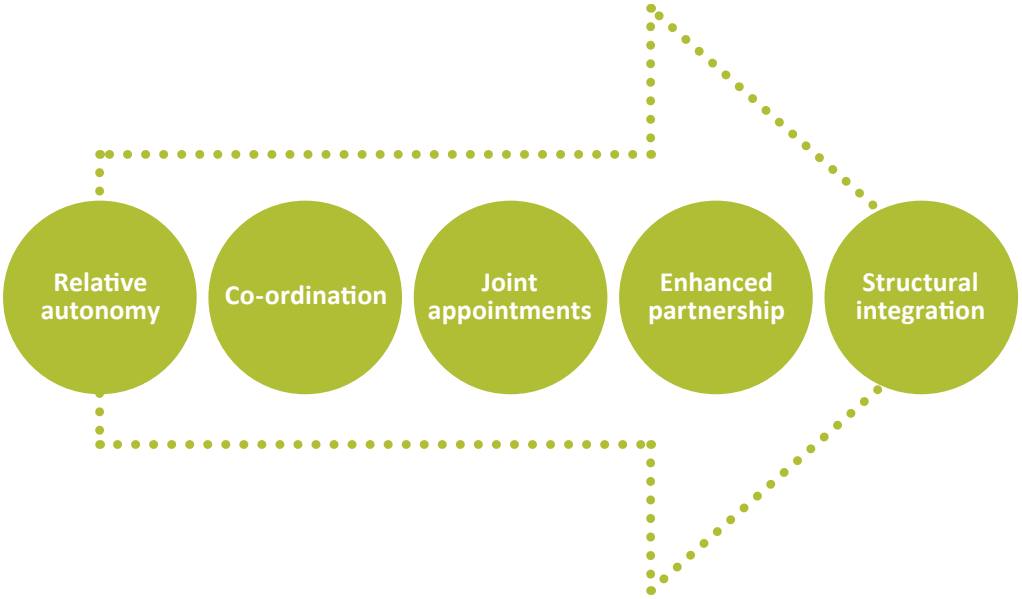
Learning outcomes
- Identifying the different definitions and interpretations that are put on integrated working

Time
- No more than 30 minutes

Materials
- Post-its (using different colours for different professional groups is useful), flip chart, copy of word cloud

Guidance
- Divide into groups of four or five.
- Each individual to write words or phrases which indicate their understanding of integrated working on post-its, one to each post-it [5-10 mins]; a leader in each group to go round the group getting a word (and post-it) from each individual in turn until all the ideas are exhausted. As the post-its are handed over group them into themes.
- Discuss similarities and differences across the definitions and identify whether there are differences or similarities across different professional groups.
- Show a copy of the word cloud above, confirming the wide range of terms that can be used – Leathard characterises it as a 'terminological quagmire'.
- Suggest that a useful way forward is to focus on the individual and to think of the delivery of integrated care and support to that individual such that the individual experiences seamless provision. Integrated working can then be seen as the route to the achievement of this integrated care and support.

A key distinction which should be drawn is between integrated structures and integrated care and support. It is useful to focus on the individual and to think of the delivery of integrated care and support to that individual. Integrated working can then be seen as the route to the achievement of this integrated care. It is also helpful to think of integrated working as taking place at different points along a continuum from autonomy through co-ordination to structural integration. This is represented diagrammatically below (NHS Confederation, 2010).



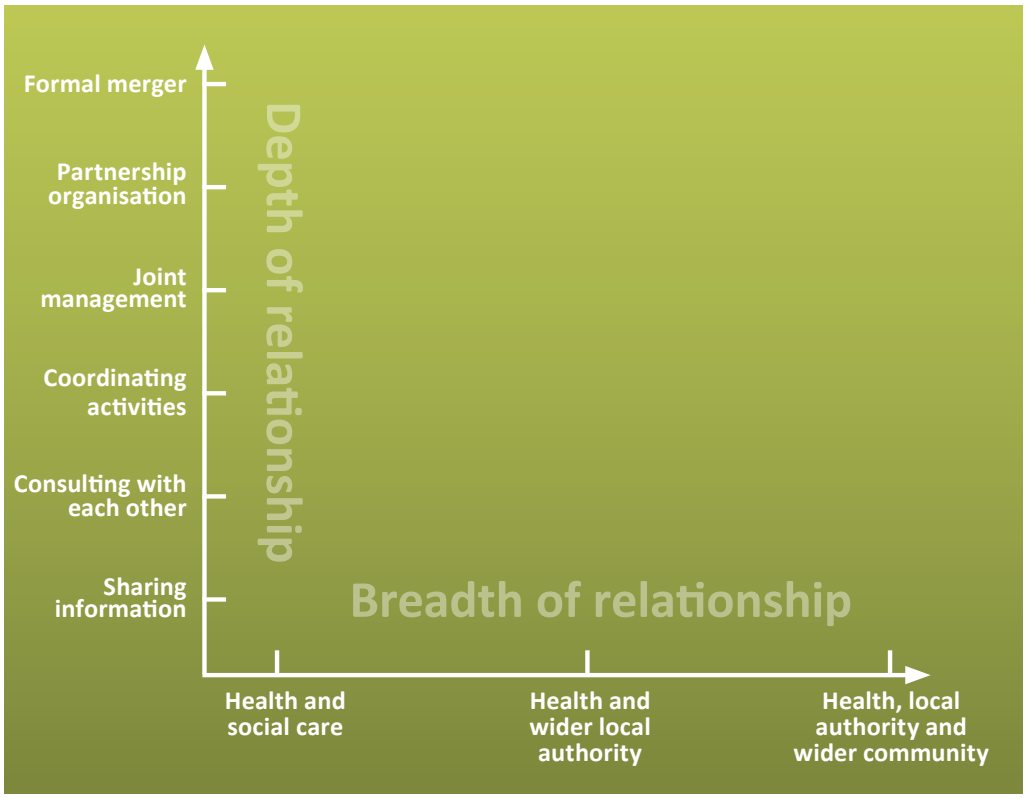
The definitions associated with this continuum relate in this context to health and social care but are relevant to other partnership arrangements also.

- Relative autonomy: the local authority and NHS meet statutory requirements for formal partnership working, but most co-ordination is largely informal
- Co-ordination: there is a reasonable level of formal commitment to joint working, with co-ordination around some areas of strategy and/or commissioning depending on circumstances
- Joint appointments: health and the local authority have some key joint appointments and the teams collaborate but are not integrated/combined

- Enhanced partnership: a system-wide commitment, shared vision and integration across most strategic and commissioning functions, senior and middle-tier joint appointments, formal high-level backing, but separate entities remain
- Structural integration: health and local authority care services have formed a single integrated legal entity or a combined service

Particularly important for the current context is to clarify the level at which integrated working is being discussed. This can be at the individual level – different professions working together; at the organisational level – different organisations seeking to deliver a seamless service; and at the structural level – strategic planning. The primary focus for this guide is the delivery of outcome-focused practice either in integrated teams or where individuals from different professions are seeking to work together to deliver integrated care and support.

Glasby et al (2011) use the idea of breadth versus depth to characterise the relationships that signify integrated working. Breadth refers to the number of agencies (or alternatively different professional groups) that are involved in the relationship; depth is similar to the continuum highlighted above and indicates the nature of the activities included within the relationship.



from Glasby et al (2011)

policy context

There is a lengthy history of moves towards partnership working and greater integration in Scotland. Successive health White Papers in 1997 *(Designed to Care)* and 2003 *(Partnership for Care)* promoted a partnership agenda. The former established Local Health Care Co-operatives (LHCCs), replaced in turn through the latter by the establishment from April 2005 of Community Health (and Care) Partnerships.

Focusing specifically on the community care field, *Modernising Community Care: An Action Plan* was published in 1998, five years after the implementation of the relevant sections of the NHS and Community Care Act 1990. The theme of partnership working permeates the Plan: 'the effectiveness of community care relies on the ability of these organisations to work together and with others to plan and deliver the services people want.' It should be noted that the then Scottish Homes was considered a key member of the triad. There was concern to make best use of the 'community care pound' and to avoid cost shunting between agencies. By the end of 1999 it was felt that the ambition of *Modernising Community Care* had not been sufficiently progressed and the Joint Future Group was established as a short-life working group by the Minister for Health and Community Care. It reported a year later in *Community Care: A Joint Future*. Key recommendations were designed to deliver a 'step-change', including local partnership agreements; sharing resources, management and information; joint planning frameworks; accelerated take-up of good practice; and all agencies accountable for performance. A number of initiatives were promoted at this time, including rapid response teams in every locality; development of intensive home support/augmented home care schemes; services designed to provide practical support with shopping, domestic and household maintenance tasks; and an annual allocation of £10m to tackle delayed discharge. The Joint Future Unit was formed at this time to progress the Joint Future Agenda; the profile of housing however had faded.

The Community Care and Health (Scotland) Act 2002 introduced legislation that enabled payments between the NHS and local authorities for certain functions of the other agency and allowed for the development of lead commissioning and for pooled (or aligned) budgets. At the same time the Joint Future Agenda was being pursued through a number of key developments, including Single Shared Assessment, Local Partnership Agreements, and the Joint Performance Information and Assessment Framework.

Over the last six or seven years there has been a shift in focus from the process of partnership working to the delivery of outcomes, embracing both individual outcomes and organisational outcomes. The Joint Improvement Team was established in 2004 and has increasingly focused on achieving better outcomes for people who access support and their carers. Members of the Joint Improvement Team have been at the forefront of progressing the implementation of the Talking Points: Personal Outcomes Approach.

In December 2011 the then Health Secretary, Nicola Sturgeon, made a statement on the future plans for integrated working across health and social care in Scotland. Following a period of engagement with key stakeholders, the proposal set out that the existing Community Health Partnerships will be replaced by Health and Social Care Partnerships. These will be the joint responsibility of the NHS and local authority in each area and will work in partnership with the third and independent sectors. NHS Boards and local authorities will be required to produce integrated budgets for adult services in order to end 'cost shunting' across organisations and a jointly accountable officer will be responsible for delivery on this budget. A set of national outcomes will be agreed that all partnerships will be required to deliver. The government had heeded the evidence base and was

> 'keen to avoid the pitfalls that can accompany centrally directed, large-scale structural reorganisation and staff transfer. Evidence from elsewhere is that changes in structures and staffing arrangements work best when designed and agreed locally, to suit the needs of local patients, service users and carers'.

The importance of a focus on personal outcomes and on the local context was emphasised:

> 'our approach has started with the key questions about what matters most to people who use these services – what are the improvements they want to see and what are the barriers in the current system that prevent staff from using their skills and resources to best effect'.

The new arrangements will require legislation and guidance and are not expected to be fully implemented before 2015. Underpinning the proposals is the core objective that a shift in the balance of care is achieved such that a smaller proportion of resources (both money and staff) is directed towards institutional care and a greater proportion in vested in community provision. At the time of writing (April 2013) the detail in the legislative proposals is awaited. However the consultation included a draft set of seven outcomes framing the legislation (see below). The focus on the achievement of these outcomes is a welcome aspect of the proposals.

health and care integration outcomes – draft at April 2013

1. **Healthier living**
   Individuals and communities are able and motivated to look after and improve their health and wellbeing, resulting in more people living in good health for longer, with reduced health inequalities.

2. **Independent living**
   People with disabilities, long term conditions or who become frail are able to live as safely and independently as possible in the community, and have control over their care and support.

3. **Positive experiences and outcomes**
   People have positive experiences of health, social care and support services, which help to maintain or improve their quality of life.

4. **Carers are supported**
   People who provide unpaid care to others are supported and able to maintain their own health and wellbeing.

5. Services are safe

People using health, social care and support services are safe- guarded from harm and have their dignity and human rights respected.

6. Engaged workforce

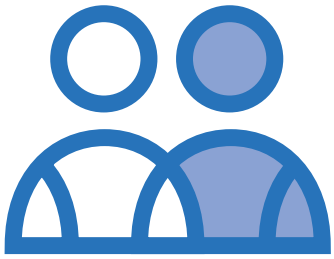
People who work in health and social care services are positive about their role and supported to improve the care and treatment they provide.

7. Effective resource use

The most effective use is made of resources across health and social care services, avoiding waste and unnecessary variation.

It is important to note that the 2010 NHS Confederation/ADASS survey cited earlier revealed that the top factors that promoted effective integrated working were locally determined; those that inhibited were at the national level. These findings are summarised in the table below.

Help	Hinder
• Friendly relationships • Good leadership • Commitment from the top • Joint strategy and vision • Co-terminosity	• Performance regimes • Financial pressures • Organisational complexity • Changing leadership • Financial complexity



exercise two:
barriers and drivers to integrated working

A individual level

Learning outcomes
- Identifying the barriers and drivers to integrated working

Time
- Around 45-60 minutes

Materials
- Post-its, flip chart, [table below]

Guidance
Each individual to draw the outlines of two people side by side, but with sufficient space to write between them. The individual is one of the outlines and the other should be a person from a different professional background that they work with. Think about the things that help you to work together and write them between the two outlines. Think about the things that get in the way of the two of you working together and write them in a different colour round the outside. As a group pool your ideas and draw up a composite diagram highlighting the barriers and drivers to working together at the individual level.

B organisational level

Repeat the exercise as above, but this time think in terms of two organisations working together eg health and housing, social care and a major provider, a housing association and a mental health team.

C problem solving

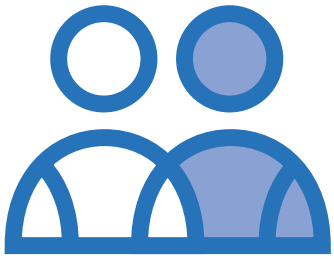
Each group to select two of the barriers to integrated working and to outline ways in which they can overcome.

The following matrix is from a study by Stewart et al (2003) of the drivers and barriers to integrated working. A more detailed version can be found at Appendix Two.

A. National policy frameworks	Joined up Strategic Realistic	Piecemeal + contradictory Promote 'projectitis' Unrealistic change agenda
B. Local planning context	Planning and decision cycles mesh Joint acceptance of unmet need Agreed, comprehensive vision, owned at all levels	Incompatible planning and decision cycles Not needs led Issues seen in isolation
C. Operational factors		
Relations between partners	Trust permits risk-taking Open, honest communication	Lack of trust prevents risk taking Defensive, limited communication
Organisational culture	Can-do culture Collective responsibility publicly demonstrated	Sees institutional and legal barriers Senior figures devalue/disown
Change management	Flexible enough to learn as goes	Common purpose Presses on regardless
Enabling staff	Agreed roles and responsibilities Staff valued	Unclear responsibilities, conflict Staff expendable
Professional behaviour	Centred on user need Willing to take risks	Tribal, protectionist Covers own back
Attitudes	'We have nothing to lose' 'We will find a way'	'We have everything to lose' 'No way'
Outcomes	User focused Visible Benefits shared	Only seen from agencies' agenda Invisible Winners and losers

An alternative formulation is presented in diagrammatic form below.

Source: Jelphs and Dickinson (2008)



exercise three:
roles in integrated working

Learning outcomes
- Identifying the roles of different professionals in integrated working
- Valuing the unique roles of different professionals
- Identifying where there are opportunities to share common roles

Time
- No more than 30 minutes

Materials
- Post-its, flip chart

Guidance
- Divide into small mixed groups. Each individual to think of their own role and identify the tasks they do that they think can only be done by their profession and what is/can be generic with other professions. Write each of these different tasks on post-its. There may be some discussion here of what has traditionally been done by one profession but may not necessarily be a requirement going forward. It may also be useful to think of the individual's journey and the various support that may be required.
- Draw overlapping circles on a flip chart sheet, one circle for each profession in the group.
- Individuals to read out their post-its and then add to the relevant part of the flip chart – in the overlapping section if shared tasks, in the section unique to their profession if seen as unique.
- Group similar features and discuss the similarities and differences that are emerging and whether there are roles agreed as distinct to each profession and roles considered more generic.

2

PART TWO

part two: understanding and promoting an outcomes-focused approach in integrated working

- Understanding what an outcomes-focused approach means
- Identifying the different kinds of outcomes
- Recognising the differences between a service-led and outcomes-focused approach
- Understanding the benefits of an outcomes-focused approach

outcomes in the context of integrated working

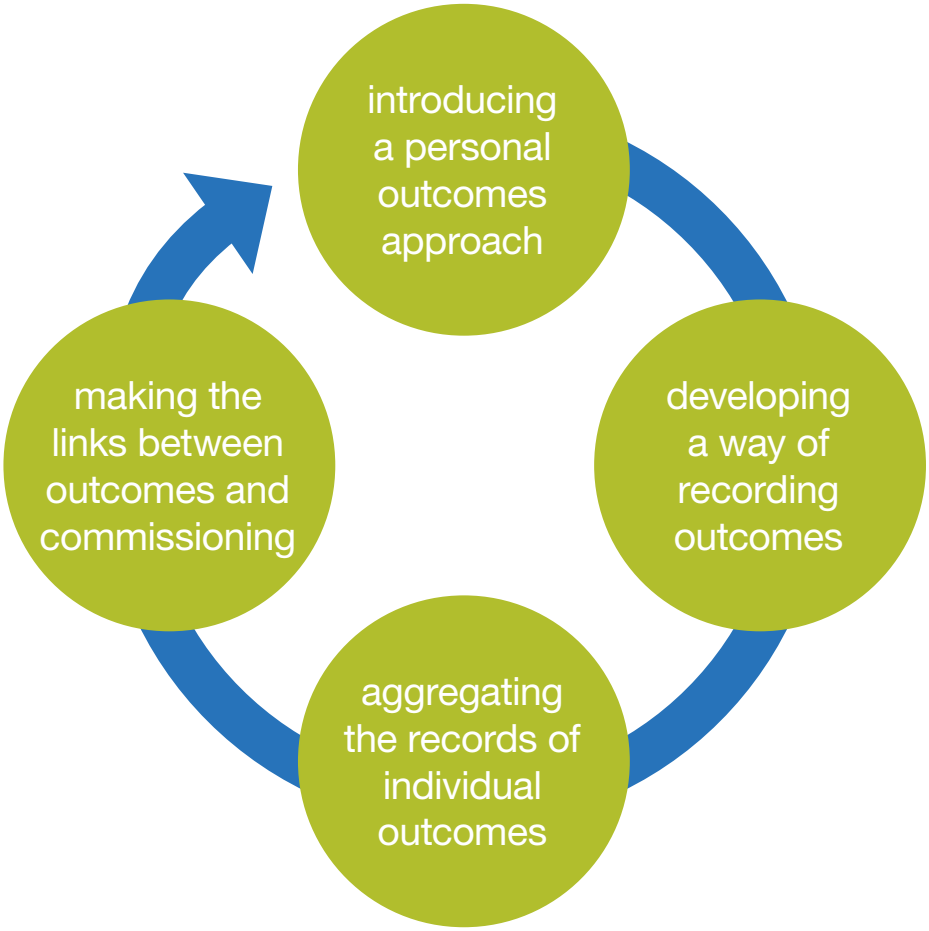
Outcomes are discussed fully in the parent guide *(Leading for outcomes: a guide)* and you may wish to refer to exercises 1 and 2 on pages 11-18 of that guide as an introduction to the outcome categories, the benefits of an outcomes-focused approach, and for an understanding of how this approach differs from a service-led approach. By **outcomes** we mean the **impact** of support on a person's life, and not the **outputs** of services. Outcomes are the answer to the question: *so what difference does it make?* They are the changes or benefits for individuals whether as service users or informal/family carers.

In their work with Talking Points, Emma Miller and Ailsa Cook have developed the 'cake analogy' which has proved very useful in assisting with the understanding of outcomes (Cook and Miller, 2012). Imagine making a birthday cake for a child. The inputs are the ingredients (eggs, flour sugar); the process is the mixing and baking; the output is the cake. The desired outcome is a happy child. However there has to be discussion with the child to see if the outcome has indeed been successful: the child may have wanted a chocolate cake while you have made a fruit cake and the impact is to make the child unhappy, not a successful outcome!

Your team may not be familiar with the term *outcomes-focused*, but may use related terms such as *goals* or *person-centred planning*. The terminology can be confusing and this needs to be acknowledged in your discussions with staff. 'Outcome' can be a vague term, susceptible to different interpretations that reflect different situational and disciplinary perspectives (Glendinning et al, 2007). Outcomes have often been interpreted as outcomes for services (such as a reduction in emergency hospital admissions or delayed discharges) and performance measures have focused on activity indicators, on inputs and processes, rather than outcomes for individuals.

The diagram below can be used to clarify the different levels at which the language of outcomes may be used. It is the personal level, the underpinning human experience, which is the concern of this guide.

However it is important to recognise that ultimately outcomes at different levels should all feed into each other. This can be represented by the outcomes cycle displayed below. Introducing a personal outcomes approach requires a focus on outcomes-based assessment and review (Bennett et al, 2009). As part of this, teams need to decide how they are going to record outcomes. Attention should then be paid as to how the records of outcomes for individuals (achieved and not achieved) are to be aggregated. Finally the knowledge generated by this aggregation – resources that contribute to the achievement of outcomes, gaps in resources, investment that is ineffective – should be fed into the commissioning process and lead to outcomes-based commissioning.



In addition to the challenge of understanding an outcomes-focused approach, those from health care, from social care and from housing tend to interpret outcomes in different ways. This in turn reflects the traditional allegiance in health to the medical model and in social care to the social model. In terms of outcomes, this translates in health to a focus on aspects of presence or absence of specific symptoms and an emphasis on clinical indicators, generally in quantitative form. In social care, outcomes tend to focus on broader criteria, indicative for example of quality of life, and are often best captured through more qualitative measures. In part this is because much of social care supports maintenance of an acceptable lifestyle rather than necessarily expecting change.

As outlined in the parent guide, and further developed in the review by Netten (2011), there is a relatively strong evidence base relating to the outcomes that people who access support and their unpaid carers are looking for. Tables One and Two are reproduced from the parent guide and highlight the outcomes that are important to many people who use services and to their families and other unpaid carers. These derive from over a decade of research originating at the Social Policy Research Unit. **Quality of life outcomes** are outcomes that relate to daily living and support an acceptable life, for example being safe and living where you want. **Process outcomes** refer to the way in which individuals experience the delivery of support, for example feeling valued and respected. **Change outcomes** are outcomes that relate to improvements in physical, mental or emotional functioning, for example increased mobility or confidence or fewer symptoms of depression.

Table one: outcomes important to people that receive support

Quality of Life	Process	Change
Feeling safe	Listened to	Improved confidence and morale
Having things to do	Having a say	Improved skills
Seeing people	Treated with respect	Improved mobility
Staying as well as you can	Responded to	Reduced symptoms
Living where you want / as you want	Reliability	

Table two: outcomes important to unpaid / informal carers

Quality of life for cared for person	Quality of life for the carers	Managing the caring role	Process
Quality of life for the cared for person	Maintaining health and well-being	Choices in caring, including the limits of caring	Valued/respected and expertise recognised
	A life of their own	Feeling informed/ skilled/equipped	Having a say in services
	Positive relationship with the person cared for	Satisfaction in caring	Flexible and responsive to changing needs
			Positive relationship with practitioners
			Accessible, available and free at the point of need

Differing health and social care perspectives on outcomes

Many of the personal outcomes relating to social care focus on the achievement and maintenance of a good quality of life, for example feeling safe, having a degree of connection to family, friends and wider community appropriate to their wishes, having things to do, and feeling a sense of control.

Discussion of health outcomes refers to the impact that healthcare activities have on people – on their symptoms and on their ability in functional terms to complete certain tasks. Health outcomes primarily focus on whether a given condition gets better or worse, the impact of the condition and the results of the treatment that is given. Patient satisfaction may also be included as a dimension in discussion of health care outcomes. There is a wide range of validated scales used to assess functional status, including a swathe of measures focusing primarily on mental rather than physical health. The Scottish Schizophrenia Outcomes Study for example used the Health of the Nation Outcomes Scale (HoNOS) and the Avon Mental Health Measures (Avon). The EQ-5D is a generic instrument embracing the five dimensions of mobility, self-care, usual activities, pain/discomfort and anxiety/depression. People are asked to record whether they have 'no problems', 'some problems' or 'extreme problems'.

In terms of physical functioning, occupational therapists often have a role in ongoing measures of long-term health status. A common measure of functional status for example is Canadian Occupational Performance Measure.

A focus on activities of daily living (ADL) often encompasses both health and social care considerations, demonstrating the advantage of the multi-disciplinary perspective available in integrated working.

Since 2009 the NHS in England has introduced patient reported outcome measures (PROMs) for four surgical procedures (hip replacement, knee replacement, hernia and varicose veins) (Devlin and Appleby, 2010). Patients are asked to record their responses to a series of structured questions about their health according to their perspective before and after surgery.

Outcomes in housing

It is essential in integrated working to recognise that a prerequisite to the achievement of any health and social care outcomes is that the individual has adequate housing. Despite being one of the three pillars of community-based care it is still the case that housing is often overlooked.

The Better Futures outcomes tool is a web-based IT tool developed by the Housing Support Enabling Unit in Scotland and designed to look at the impact of housing support (www.ccpscotland.org/hseu/information/better-futures). It enables housing support service providers working with individuals to record their support needs over a period of time. It looks at five key areas: accommodation, health, safety and security, social and economic well-being, and employment and meaningful activity. Within each of the areas 20 elements of support are addressed. It provides a means of recording a baseline when someone starts using a service, as well as plotting their aspirations using an individual scoring system. The tool also allows for outcomes to be presented in the form of an outcomes star, demonstrating progress (or otherwise) over time. The tool addresses a number of different areas, with statements scored on a number of statements related to that issue. The following is an example of a section of the tool.

extract from Better Futures Tool

Life skills

Description	Level of support required
I have never managed my own accommodation before I have minimal skills in the following; shopping, cooking, cleaning, laundry and personal care needs I need assistance to shop, cook, clean, do my laundry and with personal care needs I would benefit from learning many life skills so I could carry out simple and more complex daily living tasks myself I have lost many life skills due to illness I have chosen not to address my shopping, cooking, cleaning, laundry and personal care needs	4
I need assistance with a large number of life skills (eg shopping, cooking, cleaning, laundry and personal care tasks) I would benefit from learning to undertake some life skills for myself such as cooking.	3
I need assistance with a number of life skills to shop, cook, clean, do laundry and personal hygiene	2
Although I have some life skills, I need to be informed and learn more minor life skills (for example, shopping and laundry) I need advice and prompting to help me with life skills (eg shopping and laundry) rather than actual assistance	1
I am able to carry out my daily living tasks independently	0

Note: This part of the matrix aims to measure outcomes relating to life skills. Life skills are skills a person requires in order to live independently. These include shopping, cooking, cleaning, laundry, and personal hygiene.

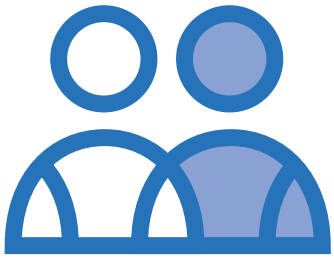
The tools mentioned above are just a few of those that seek to record outcomes and can be used as part of an outcomes-focused approach. A collection of such tools and associated resources can be found in the toolbox at http://lx.iriss.org.uk/outcomestoolbox. This includes for example a video explaining i-ROC (Individual Recovery Outcomes Counter), an outcomes tool developed by Penumbra. This is based on the four components of home, opportunity, people and empowerment (HOPE), with three elements in each of these areas (http://www.penumbra.org.uk/innovation/personalised-services/recovery-outcomes-calculator). Another resource is the outcomes star developed by Triangle (http://www.outcomesstar.org.uk). Currently there are 15 versions of this tool embracing for example long-term conditions, homelessness, domestic violence, alcohol recovery, learning disabilities, and autism and Asperger's.

For an example which illustrates the broad distinction between different types of outcomes, consider initiatives designed to support older people more effectively in the community. Health outcomes may focus on a range of clinical measures of physical and/or mental health status and functioning for the individual, together with data on for example emergency admissions. Social care outcomes would tend to highlight whether for example the older person was able to achieve the things they wanted to do, whether they felt socially isolated and whether they felt satisfied with their contact with support staff. A consideration of housing outcomes would consider whether intervention is required in this area and if so whether the initiatives that are pursued are effective in terms of their impact.

navigating the different meanings attached to outcomes in integrated working

It is essential that those involved in integrated working acknowledge the different understandings that those from different backgrounds may attach to outcomes. This can initially be challenging and in some situations where multiple agencies are involved there may be several competing or conflicting views involved in how to best achieve positive outcomes for an individual. Having an understanding of these potential differences of approach can help staff and teams (and service users and carers) to work together more productively.

The following exercise aims to develop a shared understanding about outcomes and an outcomes focus across health, housing and social services and amongst different professions.



exercise four:
understanding outcomes terminology

Learning outcome:

- Developing a shared understanding about outcomes and outcomes-focused practice across health, housing and social services and amongst different professions

Time

- No more than 60 minutes

Materials

- Post-its, flip chart

Guidance:

- Ask the individuals in the group to write on *post-its* words that they consider refer to individual personal outcomes in their field. Stress that what you are looking for is the outcomes themselves, not some definition of the term; some groups may feel more comfortable at this stage with the term 'goals'.
- Draw four columns on a sheet of flip chart paper. Head the first 'input', the second 'activity', the third 'output' and the fourth 'outcome'. Read out each term and ask the group to decide if this is indeed an outcome for individuals who use services and/or carers, or if it refers to something else such as an input, or an output. Place the post-its in the appropriate column. Some of the terms may be about organisational outcomes rather than individual outcomes and these should be grouped separately along the bottom.
- Introduce the group to the cake analogy (see page 18) and to the classification of personal outcomes adopted by Talking Points (tables one and two on page 22).
- For each of the terms identified as an outcome, identify whether they are *quality of life* outcomes, *process* outcomes or *change* outcomes.
- Ask individuals to consider whether these outcomes are commonly identified in the course of their work with both users and carers and get them to explore if different professionals in their team place greater or lesser importance on each of these outcomes.
- Lead a discussion with your group about how integrated working can achieve a complete range of outcomes.

3

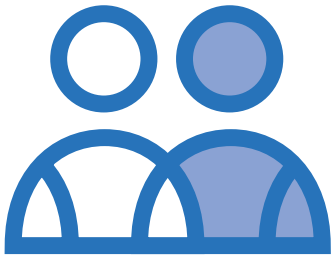
part three: practising and sustaining the outcomes-focused approach in integrated working

- Identifying different types of outcomes
- Achieving an outcomes-focused approach
- Addressing the challenges of introducing an outcomes approach
- Involving service users and carers in identifying outcomes
- Sustaining an outcomes approach
- Providing leadership for an outcomes-focused approach

the challenges of working in an outcomes-focused way in integrated working

Many people who receive support will be used to a service-led approach, with the professional in the role of expert who assesses need and then decides what services or interventions the person requires. An outcomes-focused approach requires a more conversational interaction between the practitioner and the person receiving support (and their carers) in order to understand what goals and outcomes are important to them. This requires skilled and knowledgeable staff who can engage constructively with others. Good communication is at the heart of an outcomes approach. Many practitioners will welcome the approach as they see that it builds on skills fundamental to professional practice across health, social work and housing professions. The approach is also in tune with recent developments in areas such as *self-management* in health, and personalised care through *self-directed support* in social care, with co-production as a basic underpinning principle core to the identification and provision of support. It needs to be acknowledged, however, that as with any change, some staff may initially see the approach as a threat to their professionalism, or perceive that it requires skills from them that they feel unsure about.

There is a particular opportunity when working in an integrated way to ensure that the range of health, housing and social care outcomes is addressed. This is the focus of the following exercise.



exercise five:
identifying different types of outcomes

Learning outcomes
- Identifying the importance of different types outcomes
- Understanding how different types of outcomes can be supported by the team and by others

Time
- No more than 45 minutes

Materials
- Scenarios, flip chart

Guidance
- Divide your team into small groups and ask them to choose one of the scenarios relevant to their practice (Iqbal, David, Isobel, Duncan or Rosie). Focusing on the *Quality of Life* outcome *'feeling safe'*, the process outcome of *'being treated with respect'*, and the *Change* outcome of *reduced symptoms'*, discuss what this could mean for the individual.
- Discuss what contribution the team and others could make to helping the service user achieve this outcome. Make note of the ideas that are presented.
- Lead your team through a discussion that touches on the following key ideas: a) *communication* is key to identifying outcomes, b) once outcomes are identified the outcomes-focussed approach requires that we think creatively of ways in which these might be met, c) outcomes can be reached through a *variety* of different approaches, some of which may involve services, others which may not.

Scenario one: Iqbal

Iqbal (78 years old) has her own tenancy within a very sheltered housing complex, with warden support during the day and a community alarm for summoning assistance out of hours. She was recently discharged from hospital after falling and fracturing her wrist. After an outcomes-focused conversation with the social worker from the Home from Hospital Team, it was discovered that Iqbal used to manage her own catering business before she retired. As she became more comfortable with the social worker she confided that she rarely left the housing complex after experiencing racial abuse from a neighbour's children.

Scenario two: David

David is 89 years old and has moderate dementia which has resulted in him sometimes forgetting to switch off the cooker and other appliances. In other aspects of his life he manages without much difficulty. Until recently he was supported at home by his wife but she died suddenly after a brief illness. His daughter, who lives some distance away, is anxious about the risks her father faced and contacted the social work department to ask that he be admitted to a residential care home. The duty social worker contacted the Crisis Care at Home Team and after an outcomes-focused discussion with David found that he was determined to stay at home, and that he had supportive neighbours and visitors from the local church.

Scenario three: Isobel

Isobel is 30 and spent much of her childhood in foster care. She has been treated for depression in the past, is maintained on methadone as a result of her heroin addiction, and has had a number of short-term prison sentences as a result of offences of shoplifting and assault. For the last three months since her last discharge from prison she has been staying for short periods with a number of friends and acquaintances.

Scenario four: Duncan

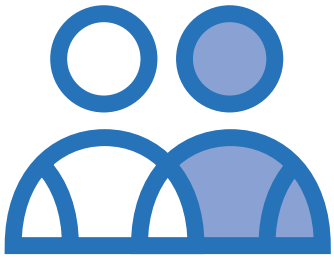
Duncan is 42 and has a diagnosis of schizophrenia. He lives in his own tenancy with floating support from a mental health project worker and is scheduled to have monthly contact with his CPN. He has missed his last two appointments and is reported as having low mood. His sister has contacted the community mental health team to express her concern that he is looking unkempt and his behaviour is increasingly bizarre.

Scenario five: Rosie

Rosie is a 24 year-old single mother of two children (six year-old male, four-year old female). She has been a housing association tenant in a four apartment house for two and a half years. Her son attends the local primary school. Her daughter attends the nearby nursery school and receives ongoing treatment from the GP for a chronic asthmatic condition.

Rosie has had a previous history of drugs misuse, but is now drug-free following a period of time spent in a drugs rehabilitation unit after which she was granted custody of her children following an 18 month-long separation. She now has £1200 rent arrears following an overpayment of housing benefit as a result of undeclared family credit and the wages received from a part-time job.

The local housing association has advised that it intends to take legal action to pursue eviction for rent arrears and has referred the case to Homelessness Services, following a series of unsuccessful meetings with Rosie in an attempt to resolve the situation. At the initial meeting with Homelessness Services, Rosie reveals a list of outstanding credit owed by her to various creditors (catalogue, storecard and hire purchase agreement from a furniture retailer) which leaves her with little or no excess disposable income after buying weekly essentials.



exercise six:
skills in working with people in an outcomes-focused way

Learning outcomes
- Recognising the skills required to be effective in outcomes-focused practice
- Identifying ways in which individuals can improve on existing skills

Time
- No more than 40 minutes

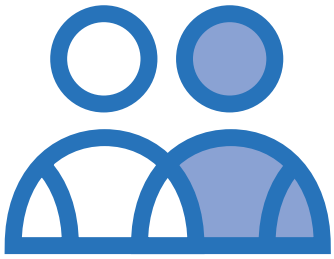
Materials
- Scenarios, flip chart

Guidance
- Provide your group with relevant scenarios from the five available (Iqbal, David, Isobel, Duncan or Rosie, see exercise five).
- Ask the group to work in pairs to identify and write down what skills they already have in working with similar individuals.
- Ask individuals to note down any areas where they may need to develop their own skills or ask others to effectively identify the outcomes that are important to those being supported through integrated working. Pay particular attention to areas where individuals feel they would need input from another profession.
- Collect feedback from the group.
- Lead a discussion with the group around these skills and explore ideas about what measures could be taken to improve communication skills for better outcomes-focused practice.

One of the papers written by Emma Miller as part of her work with the Joint Improvement Team highlights the types of questions that are useful in opening up an outcomes-focused conversation (Miller, 2011). These can include:

- What is important to you in life?
- What would you like to achieve?
- What are the things you are good at?
- What sort of things have helped you in the past?

Particular strategies can include asking about a 'good day', an 'ideal future', or a 'miracle solution'. The use of an outcomes approach accords with the adoption of an assets or strengths based approach rather than a discussion focusing on needs and deficits. See also Exercise Four in the parent guide.



exercise seven:
achieving outcomes in integrated working

Learning outcomes
- Identifying challenges in outcomes-focused practice
- Thinking creatively to overcome challenges to outcomes-focused practice

Time
- No more than 75 minutes

Materials
- Scenarios (Moira, Tariq, Gary); flip chart

Guidance
- In small groups, allocate one of the scenarios (Moira, Tariq, Gary).
- Ask each group to list the outcomes that seem important to their scenario. Encourage individuals to think about all categories of outcome.
- Ask each group to consider the challenges there may be to meeting these outcomes.
- Ask each group to choose one or more of the challenges to achieving the desired outcomes and devise a strategy for overcoming them.
- Ask each group in turn to present their scenarios and possible solutions to the wider group. The presentation should include:
    - Reasons why the particular solutions are favoured.
    - Resources that would be required. Encourage thinking beyond traditional services, to include the third sector and informal carers/networks.
    - Challenges that might be encountered in implementing the proposed solution.
    - How those challenges could be overcome.

Scenario one: Moira

Moira is 42 years old with a degenerative neurological disorder. Her mobility is poor and she experiences frequent falls. She has been referred to the Rapid Response Team due to deterioration in her condition which may result in a hospital admission if she does not receive intensive support at home. She lives alone and has personal care needs (support with toileting and washing) which necessitate a paid carer visiting four times a day. She also receives meals on wheels. Mentally she is very alert but often experiences low mood and lack of motivation. She expresses some loneliness and isolation and has been attending a day centre (the majority of those attending have learning disabilities) twice a week. She is conscious that this is not the type of social activity she would have chosen for herself. She would also like more choice in her daily life, such as what times she gets up and goes to bed, and what to eat.

Scenario two: Tariq

Tariq is 70 years old and moved to Scotland from his home in Pakistan 40 years ago. He had an emergency admission to hospital as a result of a fall, but is now fit for discharge. He has diabetes which has resulted in visual impairment and skin infections. He lives with his wife who is being treated for anxiety and depression. Unlike her husband, she does not speak English and relies on him and her children to support her in any activities that require her to communicate with non-Punjabi speakers. She receives support from a CPN. The couple have two sons and five grandchildren who live in the same town. Tariq refuses to attend a day centre or to have paid carers in his home. His family and religion are important to him and he wishes to continue to visit his sons and grandchildren weekly, and attend the local Mosque. The couple have financial difficulties and are finding it difficult to pay essential bills, such as for rent and heating.

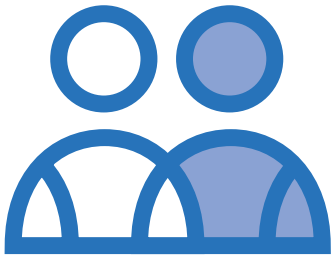
Scenario three: Gary

Gary is a 16 year old male, who was recently discharged from a residential care setting. He has a history of care placements, going back to the age of 10. The residential care setting was deemed no longer appropriate as Gary had been displaying extreme behavioural problems which were impacting on the health and safety of other children within the home. Gary is an open-case to the Children and Families Throughcare Team, has an allocated social worker and receives several hours of support per week from both a social worker and a commissioned support provider.

Gary was initially accommodated in a temporary furnished flat in the community. However over the course of two weeks, with no experience of independent living, he was unable to control his front door. This led to a succession of acquaintances coming to his flat and the ensuing anti-social behaviour and allegation of drug-taking sparked confrontation with neighbours and police involvement. The council's Anti-Social Behaviour Team insisted that Gary be moved from the flat in the interests of community safety. The flat was extensively damaged with repairs assessed at £1500.

Gary was moved to a homeless hostel but within two weeks had again displayed a pattern of unmanageable behaviour which included excessive alcohol use and aggressive/abusive behaviour towards staff and other residents. He has now been removed from the hostel and there is no alternative accommodation available.

Gary's parents are separated and have their own tenancies, but neither is willing to accommodate Gary overnight for a variety of reasons, including previous issues surrounding an alleged theft from his mother's purse, and an entrenched position on his uncontrollable behaviour, especially around younger siblings.



exercise eight:
overcoming challenges to working with personal outcomes in integrated working

Learning outcomes
- Sharing experience of different strategies to overcome challenges
- Thinking more creatively about different ways to support people to achieve the outcomes they are looking for

Time
- No more than 45 minutes

Materials
- Paper and pen

Guidance
- Each individual to identify one of the challenges to working in an outcomes focused way – these may have emerged earlier eg Exercise Seven.
- Each individual to write a story of how this challenge has been successfully overcome and personal outcomes for an individual achieved. Ideally this should be based on live experience but if the individual has a post without such experience it can be imagined. Encourage everyone to be creative: 'once upon a time…' Each story should include a pen portrait of the individual, the outcomes they had identified and how the particular outcome was met. Give people about 15 minutes to write their individual story.
- Ask people to read out their stories in turn – depending on numbers there may only be time for a selection of stories.

sustaining outcomes in integrated working

Interventions in integrated working may be short-term (typically two to six weeks for example in the case of intermediate care or reablement) or may be long-term (for example where there are major mental health issues). Even if the person has regained sufficient skills and confidence not to require ongoing services from health, housing and social care, it is important to discuss longer-term outcomes with the person and their carers prior to the end of involvement and to help them agree a plan for addressing these. It may be that some of the longer term outcomes identified by people (eg keeping alert and active and sustaining social contacts) do not on the face of it appear to be related to the core support provided by health and social services, but providing information about local community organisations may enable people to achieve and maintain these predominantly quality of life outcomes.

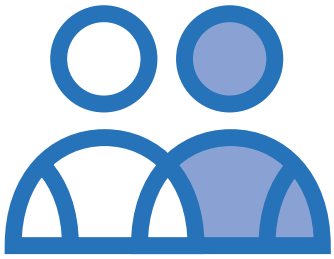
The challenge of sustaining outcomes encompasses two other challenges: a) the *limited time frame* in which support workers may operate, and b) the challenge of ensuring that *appropriate transition* is accomplished in terms of support.

There can be an initial focus on change outcomes as the person is supported following a period of illness or injury; however teams must stay mindful of how outcomes can be sustained. It is vital that the integrated care team along with the person receiving support and any unpaid carers look at how these gains in terms of change outcomes can be maintained. As well as ensuring that the person receiving care is supported to manage their own condition, this may include onwards referral to wider community based sources of support.

For example in terms of quality of life, people managed at home by intermediate care services are reported to feel safe and have improved confidence. However some people felt vulnerable at night (Petch, 2003; Regen et al, 2008). It is important that reablement or intermediate care teams consider quality of life for people following the withdrawal of the service. It is important that people continue to feel safe, stay well, have things to do, and maintain contact with other people. Intermediate care and reablement teams need to facilitate any transition to mainstream services, to the voluntary sector, or to informal supports and networks of family and friends. To sustain these outcomes clear communication with the individual, their carers and any ongoing services is essential.

In looking to sustain outcomes in the longer term, consideration of the three case studies at Appendix One (Margaret, Bob and James) will focus on a number of key issues:

- Breadth of outcomes important to individuals (quality of life, change, and process outcomes).
- Timescales: outcomes are important throughout an individual's life and do not stop being important when a particular service ends.
- Transitions are important. Individuals should be put in touch with organisations or groups that will sustain outcomes once support from integrated services ends.



exercise nine:
sustaining outcomes in integrated working

Learning outcomes
- Identifying longer term outcomes
- Understanding how longer-term outcomes can be achieved and sustained
- Developing strategies to sustain outcomes

Time
- No more than 45 minutes

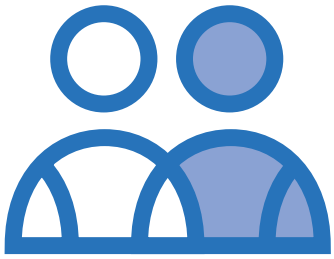
Materials
- Part one of the case studies from Appendix One; flip chart

Guidance
- According to the size of the group, use one or more of the case studies. Read part one of the case study in Appendix One.
- For each case study being used, ask one of the group to take on the persona of the individual in the case study (Margaret, Bob or James) and to have access to part two of the case study. The rest of the group to ask them questions and consider what kinds of outcomes are likely to be important to that individual and informal/family carers in the longer term after the integrated working involvement ends. If appropriate to the group this can be run as a role play.
- Discuss with the individual what supports and services may be helpful in achieving or sustaining these outcomes.
- Devise a strategy to ensure that outcomes are sustained, identifying the outcomes of particular importance.
- Following the discussion compare with the Part two examples.

leadership for outcomes in integrated working

Leaders and managers are seen as being key actors in bringing about effective integrated teams, and they can help bring about increased job satisfaction, development of a shared culture, improved communication – allowing teams to meet individuals' outcomes more readily (Maslin-Prothero and Bennion, 2010). It is recognised that managing integrated care services is challenging, and that leaders require skills around change processes, including promoting organisational learning, that encourage staff engagement and empowerment (Alban-Metcalfe and Alban-Metcalfe, 2010). As a leader or manager you may find useful the paper by Johnstone and Miller (2010) on how to provide staff support and supervision for outcomes-focused working.

There is also, however, the opportunity for work around developing an outcomes focus to provide a common sense of purpose that binds a new team or partnership together. It offers the opportunity to clarify the respective roles of different individuals in contributing to the achievement of this common purpose and, with good leadership, should provide a route to transcending traditional tribal divisions between professions or agencies.



exercise ten:
leading an outcomes-focused approach in integrated working

Learning outcome
- Strategies for leading an outcomes-focused approach in integrated working

Time
- No more than 45 minutes

Materials
- Post-its; flip chart

Guidance

- Divide the group into pairs; one of the pair to act as 'leader' the other as 'worker'.
- The worker of the pair to raise examples of actual and potential challenges in operating in an outcomes-focused way in an integrated working context.
- The leader of the pair to suggest potential strategies for overcoming these challenges.
- The group to pool their challenges and solutions and work towards a set of suggested strategies.

acknowledgements

This guide has had a long gestation period, a period during which formal proposals for integrated working in Scotland have developed momentum. We would like to thank Fraser Mitchell from Fife Council to whom we are indebted for some of the early writing and case studies; Ann Wardlaw and members of the homelessness team in Inverclyde for early piloting of the exercises; and Donellen Mackenzie, Nigel Small, senior managers in NHS Highland and health and social care staff in the emerging older people's teams in Skye, Lochalsh and Wester Ross, Caithness and Sutherland, East Ross, and Nairn for more recent trials of the exercises.

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related IRISS resources

Leading for Outcomes: a guide
http://www.iriss.org.uk/sites/default/files/iriss_leading_for_outcomes_a_guide_final-1.pdf

Leading for Outcomes: parental substance misuse
http://www.iriss.org.uk/sites/default/files/iriss_leading_for_outcomes_parental_subs.pdf

Leading for Outcomes: dementia
http://www.iriss.org.uk/sites/default/files/iriss_leading_for_outcomes_dementia.pdf

Leading for Outcomes: children and young people
http://www.iriss.org.uk/sites/default/files/iriss-leading-for-outcomes-children-and-young-people.pdf

Emma Miller (2011) Measuring personal outcomes: challenges and strategies, Insight No 12
http://www.iriss.org.uk/sites/default/files/iriss-insight-12.pdf

Related storyboard at
http://www.iriss.org.uk/resources/measuring-personal-outcomes-challenges-and-strategies-video

Emma Miller and Ellen Daly (2013) Understanding and measuring outcomes: the role of qualitative data
http://www.iriss.org.uk/sites/default/files/understanding_and_measuring_outcomes_-_the_role_of_qualitative_data_.pdf

Julie Gardner (2013) Developing a personal outcomes approach – audio recording
http://www.iriss.org.uk/resources/developing-personal-outcomes-approach-julie-gardener

IRISS/CCPS Outcomes Toolbox – a range of resources collected together at http://lx.iriss.org.uk/outcomestoolbox

appendix one: case studies

outcomes for a person receiving support and their carers

case study one: Margaret

part one

Margaret is a 61 year old woman who has moderate learning disabilities, especially in the area of communication. She lives alone but has a supportive family and neighbours. She employs a private cleaner and gardener. She stopped attending a learning disability day centre some years ago but until recently has led an active life, visiting friends and relatives and taking the bus to the shopping centre. She finds satisfaction in helping older neighbours with small tasks such as visiting those who are unwell or housebound and keeping an eye on their homes when they go on holiday, but has been unable to do these tasks in the past year.

Margaret is obese, has chronic venous leg ulcers, and high blood pressure. Her mobility has deteriorated considerably in the past year due to arthritis in the hip which caused her constant pain and largely confined her to her home. This led to increased isolation and deterioration in her mental health, with feelings of loneliness and hopelessness. Relatives and friends became concerned by her low mood. The hip replacement operation was postponed to allow her leg ulcers to be healed and for her to lose weight. She received regular visits from the district nurse and the dietician. Over the period of a year her leg ulcers improved slightly but remained a problem and after an initial slight weight loss her weight stabilised. The hip replacement only went ahead because the Consultant became so concerned by the state of her hip.

The hip replacement was a success and she was discharged home with the support of the Early Supported Discharge Team. The keyworker from the team met with Margaret and her brother to discuss her needs and her goals. Her brother helped her to understand the role of the team and helped her express her desired goals.

The key outcomes identified with Margaret were:

- Improving her mobility and confidence in walking
- Getting out of the house again to visit friends/relatives and shops
- Being free from pain
- Maintaining weight loss
- Having access to her upstairs bedroom

part two

A support plan was drawn up based around these outcomes. In discussion with the team's occupational therapist, the brother moved Margaret's bed downstairs so that she could access the bathroom and allow her to be discharged home. Once home, rehabilitation care assistants helped Margaret follow the physiotherapist's plan to help her regain skills and confidence in using the stairs, so that after two weeks the bed could be moved back to the bedroom.

Margaret learned how to use a stick to support her walking and within a few weeks she had the confidence to walk the short distance to catch the bus to the shopping centre. On the first few trips she was accompanied by a volunteer from a local charity to ensure her safety.

It was identified that one of the difficulties Margaret had with her diet was a lack of variety due to her reliance on convenience foods that could be heated in a pot or under a grill. She was reluctant to eat more fresh fruit and vegetables and did not wish to learn new skills in food preparation. However, she pointed out that one of her friends had a microwave and she thought she could learn to operate one. Her brother purchased a microwave and helped her understand the basic settings. Given her difficulties in carrying heavy shopping, he set up a weekly home delivery from a supermarket. This allowed her to have a wider selection of ready meals and the order always included grapes (the one fruit she enjoyed), and reduced the time he spent doing this task. She could continue to visit the shops for smaller food items, clothes shopping, and collect her pension at the post office.

The district nurse continued to visit to treat the leg ulcers and the GP advised on pain relief.

Within a few months she regained her ability to travel independently and once again has a good social life. Her general health has improved and this is supported by her improved diet. She is largely free from pain.

The result was that her mobility, physical and mental health are much improved and that her friends and relatives feel less anxious about her, and have regained a positive relationship with her.

case study two: Bob

part 1

Bob is a 78 year old man admitted to hospital after suffering a stroke which resulted in upper and lower limb weakness, loss of sensation, difficulty walking and reduced cognitive ability.

Prior to the stroke Bob lived with his wife Nan in a large, detached property with stairs. The bedroom and bathrooms were located in the top half of the house whilst the living areas and kitchen were situated downstairs. Bob had no previous contact with social services and lived an active and independent life with his wife. Bob and his wife have three grown up children and many grandchildren, all of whom live abroad. To stay in touch with family members Bob enjoys using the internet.

Bob underwent an extensive period of rehabilitation in hospital and after a two-month stay his discharge was planned with the help of the community rehabilitation team. The reason for referral to the team was to support Bob for a short period at home, to continue with his rehabilitation programme which included occupational therapy and physiotherapy tasks, as well as helping Bob to return to mobilising outdoors, and to his favourite hobby, bowling.

On assessment by the team the main findings were:

- Bob was independent with all aspects of his personal care
- Despite making an excellent recovery, Bob still had residual upper and lower limb weakness
- Bob tired quickly and had reduced exercise tolerance
- Reduced outdoors mobility
- Problems with cognitive functioning, which troubled Bob as he previously dealt with all of the family banking and financial affairs
- Poor concentration

At this point the team explained their role to both Bob and his wife, who were very happy to receive support from the team on discharge. The stroke support nurse also arranged to visit Bob.

part 2

A member of the team visited on the day of discharge to ensure that Bob could manage safely at home. His mobility, stair climbing ability and transfers were all re-assessed and Bob managed with ease. To allow Bob time to settle in at home the team agreed to visit in two days time to establish shared goals and desired outcomes.

The team physiotherapist and occupational therapist visited Bob and completed their assessment. The physiotherapist established an exercise programme, which included Bob walking outdoors. Both the exercise and walking programme were to be carried out by a rehabilitation assistant who worked as part of the team. The rehabilitation assistant had completed a range of competencies and was able to carry out a range of delegated, generic tasks. These tasks also included tasks delegated by the occupational therapist (OT) which involved computer based activities to help Bob improve his concentration and stay in touch with his family. Bob and the OT hoped that this would in turn help improve his ability to manage the family's financial affairs.

Bob in discussion with the team set the following goals:

- To be independent walking outdoors to the local shops
- To return to indoor bowling
- To increase the length of time spent at the computer
- To manage part of the family banking with support from his wife

Bob and the team then set about his programme. As well as regular sessions with the rehabilitation assistant, Bob had a self-management programme to complete. Bob was reviewed weekly by the occupational therapist and physiotherapist. Throughout this period he was also visited by the stroke support nurse.

Following a six-week period of rehabilitation and support at home Bob could walk to the local shops and back. He had not attempted bowling as he previously walked to the club and this was just too far for him to manage at this stage. The team contacted a local voluntary sector service that offered buddy support for older people accessing local activities. The scheme agreed to support Bob by driving him to

the bowling club and back. Bob was delighted and with the help of his friends gradually increased the amount of time he spent on the bowling club.

Bob's computer sessions were also increasing in length and he had been able to carry out some of his personal banking. Whilst this had taken a lot of concentration and was tiring for Bob, he felt a tremendous feeling of achievement, which really boosted his confidence.

The team met with Bob to review his goals. Bob agreed that he had met his initial goals and now felt that he could achieve more. However, Bob felt that he was at a stage that he could undertake this himself. In order to sustain the outcomes that had been achieved, the team established links for Bob with the voluntary sector as well as ensuring he could manage certain aspects of his long-term condition. The team explained to Bob that he could self-refer back to the team if he felt that he required their support in future.

Following his discharge from the team Bob began to attend an exercise class at his local leisure centre, and became an active member of the local stroke support group.

case study three: James

part one

James is 61 years old. When he came into contact with the homelessness service he was living alone in a private let. He was vulnerable due to his failing health and alcohol use; his finances were controlled by acquaintances that provided a few provisions in return for all his benefits. His living conditions were extremely concerning in terms of health and hygiene hazards, he had trouble walking and his flat was in the top floor of a tenement building. James was beginning to suffer from personal health care problems, isolation, neglect and financial abuse. He was not in contact with social services and received no support from either his family or the local authority.

James was discharged from hospital and was referred via the hospital discharge protocol and homelessness services took charge of the case. He therefore presented as potentially homeless due to the standard of his private let and concerns about returning there due to hazardous and below tolerable living conditions.

James was placed in temporary accommodation (furnished flat in the community) with home care support and a commissioned housing support package provided by a third sector organisation. However James was again referred to the homelessness service by the duty social worker from the health centre. Home care had been withdrawn for health and safety reasons as his electricity meter had again been tampered with and third sector organisation workers were only linking with him one day a week. He was again the victim of acquaintances 'managing' his finances.

part two

An outcomes-based assessment conversation was held with James by a member of the homelessness team. James indicated that he wanted to get away from his current flat and company but felt powerless to do so. His increasing health problems had started to affect every aspect of his day-to-day life and he was concerned that things could only get worse. However he also indicated that he was willing to move to another part of town as there was no reason for him to remain in the local area. James agreed to make an application for a flat in a sheltered housing development for older people where he would be in a more secure environment and would have an opportunity to put some of his problems behind him and to make new contacts within the development. He could also start to address other aspects of his life including a desire to start playing music again. It was established that there would be a two month period before James could be allocated a flat. In order to maintain momentum during this waiting period, James was moved to alternative temporary accommodation in the new part of town and the third sector organisation was commissioned to provide support twice weekly until the flat was available. During this period James was also put in touch with a drop-in centre in the new area and encouraged to go along.

The two months passed slowly for James and at times he became despondent. However he resisted the temptation to return to his old haunts and finally moved into his sheltered flat three months after the initial outcomes-focused discussion. A year later he has settled well and is starting to get involved in some of the activities in the development and to have more contact with others living there. His health has stabilised as a result of his improved living conditions.

appendix two:

drivers and barriers to integrated working (Stewart, Petch and Curtice, 2003)

	Drivers	Barriers
A National policy frameworks		
	comprehensive and integrated	piecemeal and contradictory
	encourage strategic approach	promote 'projectitis'
	legal, financial and guidance frameworks facilitate	legal, financial and guidance frameworks inhibit
	realistic timescales	unrealistic timescales/change agenda
	some non-negotiables	anything goes!
	establish accountability for user focused outcomes	no national pressure to demonstrate user benefit
B Local planning context		
	planning and decision cycles mesh	incompatible planning and decision cycles
	all stakeholders involved from the beginning, unions, operational staff, users and carers	partial/tokenistic involvement of stakeholders
	joint acceptance of unmet need	not needs led
	agreed, comprehensive vision, owned at all levels	issues seen in isolation, priorities not agreed, based on lowest common denominator
	user outcome driven	driven by vested interests
	provides evidence that alternative models can work	a paper strategy
	runs with 'good enough' plan, 'leap of faith'	waits for the perfect plan
	use of budgets reflects strategic priorities	'spend this money NOW!'

	Drivers	Barriers
	some stability	constant restructuring
	shared location	dispersed locations
	small can be good – knowing the people (but no alternatives!)	complexity a barrier (but can be an incentive too)
	builds on existing good working relationships, 'success breeds success'	no track record of successful collaboration, 'it has never worked here'
	restricted resources induce innovation - need to share, 'less means more', Dunkirk spirit	resources induce complacency - rest on laurels, 'more of the same'
	pressure to innovate / change to meet need, 'we can't do it alone' 'necessity is the mother of invention'	no incentives to change 'it won't work here' 'it won't work now'
	sense of momentum - 'the time is now'	baggage of the past
C Operational factors		
Relations between partners		
	partnership model	fragmentation of market
	balance of power	power imbalance, strong empires, personal sovereignty
	task complex, cannot be achieved by single agency	task simple, no perceived need for outside help
	integrated or networked eg a new community care organisation OR working as if one agency	islands
	accountability agreed/shared	accountability disputed/separate
	trust between agencies- permits risk-taking	lack of trust- prevents risk-taking
	pooled resources	different budgets/funding streams
	partners share information and skills for the bigger picture	partners have energy only for own agenda
	open, honest, transparent communication	defensive, limited communication
	shared records/systems - creative use IT	information not shared - IT an excuse

	Drivers	Barriers
	understands other's limitations	no allowances
	respects identities of other agencies	'if only they did it our way!'
	integrated working embedded in policies and structures at all levels	integrated working depends only on personal links
	informed by knowledge across settings eg through joint posts and well selected managers	imbalanced by one agency or profession's priorities
	harmonisation of practice to serve local community	policies, boundaries and catchments not co-terminous
Organisational culture		
	perceived interdependence	isolationist
	willing to share/adopt good practice	competitive
	it is everybody's agenda including accountants, administrators	the professionals' business only
	'can do' culture	sees institutional and legal barriers
	organic, flexible, more autonomy/delegated responsibility eg devolved budgets	rigid, high bureaucratic controls, 'everything has to be checked'
	cross boundary work WITHIN agencies	departmentalism, preciousness
	values difference	worships uniformity
	collective responsibility publicly demonstrated	senior figures devalue/disown common purpose
Change management		
	task focused	bogged down in resolving organisational problems
	service managed as a system to reduce confusion	complexity
	commitment and flexibility to solve ongoing problems	hides behind legal barriers
	rewards success, carrots and sticks	blames, only sticks
	willing to devolve responsibility to joint service managers	confuses accountability with direct responsibility for spending

	Drivers	Barriers
	dedicated resources for development, margin for change and innovation	resources too tight, fully committed to existing buildings/staff/ways of working
	commits development resources to engineer system change	notches up new projects, mainstream services unaffected
	promoted by management at critical stages	stifled/undermined by management
	process driven by committed leaders/managers with knowledge of different settings	no champions
	flexible enough to learn as goes, listens/evaluates, honest about what works	presses on regardless
	sustains and rolls out good practice	when champions leave, innovation dies
Enabling staff		
	supports champions who work across boundaries	supports those who maintain empires
	invests in ownership by staff and users	a management issue
	clarity of purpose transmitted to staff and users	'more paperwork! more procedures!', 'what is the purpose of all this?'
	enables innovation to come through	stifles the creativity of others
	clear co-ordination mechanism	nobody's responsibility
	clear written protocols, confidentiality concerns addressed	'no map, I will have to consult my line manager'
	clarification of remits, agreed roles and procedures eg joint protocols, team structures	unclear responsibilities, conflict
	efforts made to reduce complexity	staff left to resolve variation in everything
	time to develop and service integrated working - and have joint training, team building	rush in, staff too pressured to collaborate or prepare
	collaboration and negotiation valued and part of training	'another meeting – I suppose you were networking again!'
	training available for new skills	'I feel de-skilled by these changes'
	promises opportunities	fear of job and skill loss

	Drivers	Barriers
	creativity valued	'we've always done it this way!'
	staff valued	staff expendable
Professional behaviour		
	willing to change	burned out
	centred on user need	tribal, protectionist, different terms and conditions
	confident and flexible	threatened and restrictive
	accept challenges to mindset and learns	retreats when challenged
	willing to take risks	covers own back
Attitudes		
	'we have nothing to lose'	'we have everything to lose'
	'we have everything to gain'	'we have nothing to gain'
	'stolen with pride'	'not invented here!'
	'that's a great idea'	'not as interesting as my pet project', 'not a model we recognise', 'doesn't fit our procedures'
	'we all own this!'	'WE own this!'
	'I am confident in my skills - though I have more to learn and I respect your skills'	'I'm not sure what I know and I'm threatened by what you know', 'this is my turf!'
	'we will find a way'	hide behind legal barriers 'no way'
Outcomes		
	user focused and defined outcomes	outcomes only seen from agencies' agenda
	visible outcomes	invisible outcomes
	benefits shared	winners and losers
	some short-term gains	only long-term gains

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