

All Together Now

A collaborative and relationship-centred approach to improving assessment and care management with older people in Swansea

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ABSTRACT

The need for more holistic and inclusive approaches to assessment and care management for older people is widely promoted but difficult to achieve. This paper describes the All Together Now initiative in Swansea, South Wales, which seeks to promote better practice in assessment and care management by actively involving all stakeholders, older people and family carers, and practitioners and service providers from across the statutory and third sectors. The project is underpinned by a relationship-centred approach based on the belief that an enriched environment of care will only be created when the needs of all stakeholders are acknowledged and given attention. How such a model was used to establish the goals for the project is described, together with the proposed model of evaluation.

KEY WORDS

Assessment care management relationship-centred care
enriched environment evaluation older people

INTRODUCTION AND POLICY CONTEXT

City and County of Swansea incorporates both Wales's second largest urban area and Gower, Britain's first designated Area of Outstanding Natural Beauty. The total population currently numbers around 220,000, of which 18.4% are aged over 65 and 2.2% are aged over 85. Over the coming years, both the absolute numbers and relative proportion of older people are set to increase, particularly in the 85+ age range. Like other local authorities in Wales, City and County of Swansea is exploring how it can best meet the needs of a growing older population, within the context of expected budgetary pressures.

This paper explores the background to, and progress to date, of one particular project, entitled 'All Together Now', which explores how the local authority can rise to the challenge of '*delivering more for (probably) less*' over the coming years.

Whatever the financial circumstances of local authorities, the Welsh Assembly Government is committed to the development of what it terms 'citizen-centred' public services (Welsh Assembly Government, 2006). This is reflected in *Fulfilled Lives, Supportive Communities* (Welsh Assembly Government, 2007), a ten-year strategy for social services in Wales, which states that it should become:

'...a strong distinct coherent and accountable function of the Local Authority, in tune with citizens' and communities' needs, promoting social inclusion and the rights of individuals, concerned with outcomes and high quality support services that are provided in a joined up, flexible and efficient way in partnership with service users and carers, and where and when they are needed'. (Welsh Assembly Government, 2007)

Keen to embrace this vision, City and County of Swansea signed up to working with the Social Services Improvement

Agency (SSIA) as a 'pioneer' local authority on their outcomes-focused assessment and care management project, one of a number of short-term service improvement projects that the agency currently funds across Wales.

The SSIA was set up to support local authorities in Wales to increase the pace of improvement and promote excellence within social services. Hosted by the Welsh Local Government Association, the SSIA is a partnership enterprise between the Association, the Association of Directors of Social Services Cymru and the Welsh Assembly Government.

OUTCOMES-FOCUSED ASSESSMENT AND CARE MANAGEMENT

In a review conducted for the Social Care Institute for Excellence (SCIE), Glendinning *et al* (2006, p2) defined outcomes as:

'The impacts or end results of services on a person's life. Outcomes-focused services therefore aim to achieve the aspirations, goals and priorities identified by service users.'

An outcomes-focused approach to assessment and care management is central to UK-wide government policy, and is seen to have clear benefits, as highlighted in a detailed study by researchers at York University (Nicholas *et al*, 2003), which suggests that an outcome-focused model supports:

- a person-centred approach
- effective partnership working
- best value.

There are seen to be three broad sets of outcomes (Nicholas *et al*, 2003):

- **maintenance** - with a focus on *maintaining* health and well-being
- **change** - with a focus on *improving* health and well-being
- **process** - with a focus on the *way that services are delivered*, in terms of what constitutes 'quality service' for the person concerned.

Whilst the concept of outcomes-focused assessment and care management appears quite simple, making it a reality is far more complex (Glendinning *et al*, 2008a), with several issues needing to be addressed, including:

- the need to take a 'whole system' approach
- further debate about the discourse of 'outcomes' and how they are prioritised
- the need to think 'outside the box' rather than work within traditional service boundaries.

Glendinning *et al* (2006) also express concern that, whilst the York University model identified three sets of outcomes, there has been a relative over-emphasis on *change* outcomes with older people, linked to the promotion of the independence and autonomy agenda. Whilst there is certainly an important role for reablement services (Kaambwa *et al*, 2008; Ryburn *et al*, 2009), many older people are as, if not more, concerned about *maintenance* or quality of life outcomes, than they are about *change* (Glendinning *et al* 2006).

This is consistent with the suggestion of Nolan *et al* (2006), who argue the application of an individualistic model of services based on notions of independence for older people, is often less appropriate than an approach that recognises the importance of interdependence within the context of relationships, especially for those with long-term chronic conditions that are unlikely to benefit from reablement.

Nolan *et al* (2006) present the 'Senses Framework' as a model to promote the well-being, not only of older people, but also of their carers and the staff who work with them, all of whom should experience a sense of:

- security - to feel safe within relationships
- belonging - to feel part of things
- continuity - to experience links and consistency
- purpose - to have a personally valuable goal or goals
- achievement - to make progress towards a desired goal or goals
- significance - to feel that you matter.

The importance of relationships and the 'senses' to older people, carers and staff is widely evidenced in the literature (Beresford *et al*, 2008; Hanson *et al*, 2006a; Jones & Wright, 2008; Manthorpe *et al*, 2008; McGarry, 2009; Seddon *et al*, 2006; Sheard, 2007), as is the general failure to address them (Borthwick *et al*, 2009; Flemming & Taylor, 2006; Kydd, 2008; Swinkels & Mitchell, 2009).

At a time when staff morale is low in social work teams (Evans & Huxley, 2009; McDonald *et al*, 2008), it is interesting to note that in a recent survey of more than a thousand social workers, *Community Care* magazine noted that, '*The single thing most likely to persuade them to change their mind (from leaving) is less paperwork and more client contact.*' (*Community Care*, April 2007).

This suggests the need to reappraise the value base that informs services if an outcome-based model is to be successful.

THE VALUE BASE MODEL SELECTED BY CITY AND COUNTY OF SWANSEA FOR MANAGING THE PROJECT

Nolan *et al* (2006) refer to the development of '*enriched environments of care*' in which the 'senses' are achieved for older people, carers and staff. Whilst this approach was originally developed for use in care homes and similar settings, City and County of Swansea were particularly interested to see if they could develop 'enriched environments of care' across the wider community care sector, where there is increasing local concern that bureaucratic processes might be undermining best practice and demoralising everyone as a result. Such 'system induced' problems are well documented (Hart, 2001).

For example, whilst social workers may be criticised for not thinking creatively, Seddon (2008) suggests that it is often the 'system' that is at fault, with staff not being given time to reflect on and shape practice, develop good working relationships with others and explore the communities in which they work:

'Like the police service, adult social care is designed as a bureaucracy to feed the regime, not a service to meet older people's needs. The regime constrains method. It is a bureaucracy of call centres, functional specialisation, activity targets, budget management, form filling and counting, designed according to the requirements of the regime. And the bureaucracy is cemented with information technology, all of which has been designed from the point of view of electronic data management and reporting, not solving people's problems.' (Seddon, 2008, p137)

Seddon (2008) suggests that the most important learning occurs at the front line where staff and service users interact. He suggests that the role of management is to *value* and support frontline staff by listening and responding to what they say needs to change, rather than burden and undermine them by over-reliance on targets and bureaucratic performance management systems built on a relationship of mistrust. Such an approach is entirely consistent with a relationship-centred model of care.

As Parker & Glasby (2008, p50) note in a critique of the benefits of reorganisation within the NHS in England:

'Investment on reorganisation may be better spent on supporting the workforce to move from being policy victims to policy entrepreneurs and able to deliver real and sustainable transformation.'

From the outset of the project, City and County of Swansea were therefore determined not to take a 'command and control' bureaucratic approach

to improving assessment and care management, but to make a commitment to collaborative working, valuing and involving all key stakeholders in a 'whole system' approach to reform.

THE PLANNING AND EVALUATION MODEL SELECTED BY CITY AND COUNTY OF SWANSEA FOR MANAGING THE PROJECT

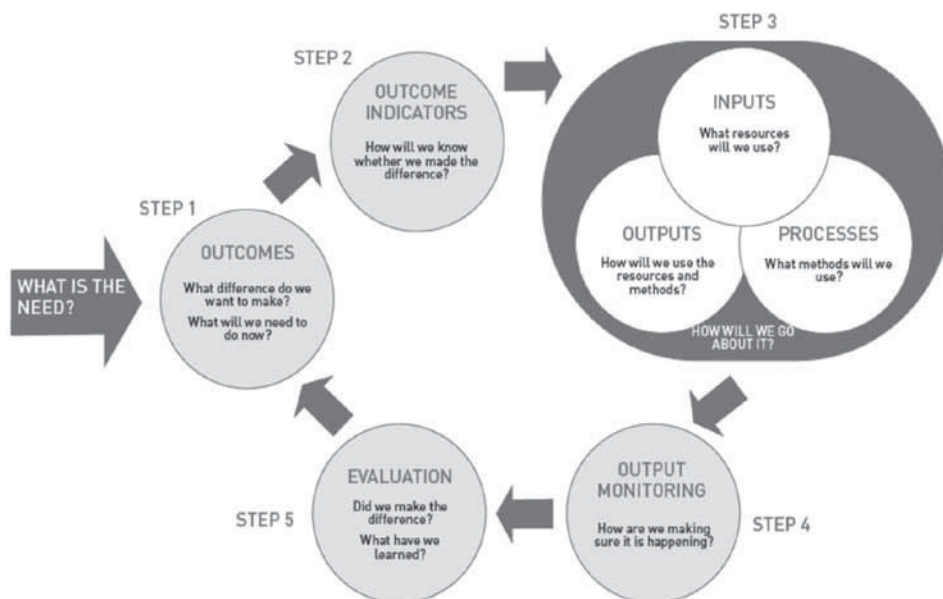
Taking the Senses Framework as an underpinning value base model for the project, City and County of Swansea also adopted the use of a collaborative outcomes-focused project planning and evaluation model used in community development known as LEAP, an acronym for Learning, Evaluation and Planning (see *Figure 1*), not only because of its commitment to *outcomes*-focused planning and evaluation, but also because of its focus on collaborative *learning*.

In a review of the efficacy of the NHS and Community Care Act (1990) a decade after its implementation in Wales, Parry-Jones & Soulsby (2001) found that, although the aim of 'needs-led' assessment was to support creative and individualised assessment and care planning, social workers were, in general, still rationing out a limited range of standard services.

The authors suggest that the strong 'service-led' culture of public services is not an easy one to shift, especially within the context of increased bureaucracy and emphasis on ever-tightening eligibility criteria.

As pointed out by Glendinning *et al* (2006), if we are to develop a truly citizen-centred approach, then outcomes should be defined by service users and carers. However, under the NHS and Community Care Act (1990), it is '*the assessing*

Figure 1: The LEAP Cycle (Barr & Dailly, 2008)



practitioner (who) is responsible for *defining the user's needs*' (Social Services Inspectorate, 1991 p53). The 'exchange' model of assessment and care management (Smale *et al*, 1993) might suggest something in between.

The obvious tension between agency-defined 'eligible' needs and needs defined by older people themselves was noted by the Joseph Rowntree Foundation (2005) in a summary report on their Older People's Programme. It has also been evidenced in initial outcomes workshops with assessment and care management staff in Swansea, many of whom were worried about 'raising people's expectations'. As a result of this, many staff appeared to be focusing on addressing needs that were eligible for a social services funded response, rather than recognising the importance of the 'little things' that can often be so important to older people in terms of achieving good outcomes (Commission for Social Care Inspection, 2008).

The following equation was used for discussion with staff in Swansea, to explore the possible tension between a person-centred approach and the fair allocation of limited public resources:

$$\text{good outcomes} = \text{addressing 'eligible' and 'ineligible' needs.}$$

A strength of the LEAP model is that it supports making the best use of limited resources, by bringing together all key stakeholders, including older people themselves, to see what can be done to improve communities (Barr & Dailly, 2008). Within Swansea, it was felt that although there are a large number of agencies and groups working to support older people and carers, awareness of each other's activities can often be poor. Indeed, particular concern was expressed by assessment and care management staff that an increased emphasis on office-based data inputting and administration over the past few years had actually undermined their knowledge of community resources and ability to support creative and cost-effective care planning.

A further benefit of the LEAP model is that it places a strong focus on 'visioning' in developmental planning, before considering activities and the use of resources. Unlike the private sector, where there is an imperative to deliver what the customer will buy, the public sector is in danger of 'doing its own thing', irrespective of whether the public like it or not. Consequently, it has been suggested that one reason some users of social care services have chosen Direct Payments is not because they wanted control over purchasing, but rather because existing services were not 'up to scratch' (Seddon, 2005; Slasberg, 2009).

The LEAP approach suggests the following approach to planning (Barr & Dailly, 2008).

In addition to this basic principle, the model suggests the need to:

- clarify exactly what you are trying to achieve
- be clear about whose needs are being addressed
- recognise that there is more than one way of thinking about what a need is
- consider all the dimensions of what the need is about ('whole system').

Taking this approach, City and County of Swansea chose to name the SSIA project 'All Together Now', because of its emphasis on pulling together a wide range of stakeholders from the health and social care community, along with older people and carers, to begin to explore what older people's services should be about, and how they can be improved by making the best use of everyone's time and resources. This is consistent with an approach to service improvement termed 'co-production'. Whilst currently lauded as a model for service development (Gannon & Lawson, 2008), it is worth noting that co-production is not a new concept and that it was promoted during the 1970s '*at a time when movements to challenge professional power and increase citizen participation in community affairs coincided with efforts to reduce public spending*' (Needham & Carr, 2009, p1).

Whatever the context, the benefits of a collaborative and relationship-centred approach to winning hearts and minds was captured in a Thought for Today feature on BBC Radio 4 (UK) regarding the public services reform agenda, in which Gyles Fraser suggested that:

*'The most important crucible of transformation is the **human heart**. Without this, all the new initiatives that come from government are bound to fail. Deep change only ever takes place when people decide to do things differently, when they experience some sort of conversion.'*

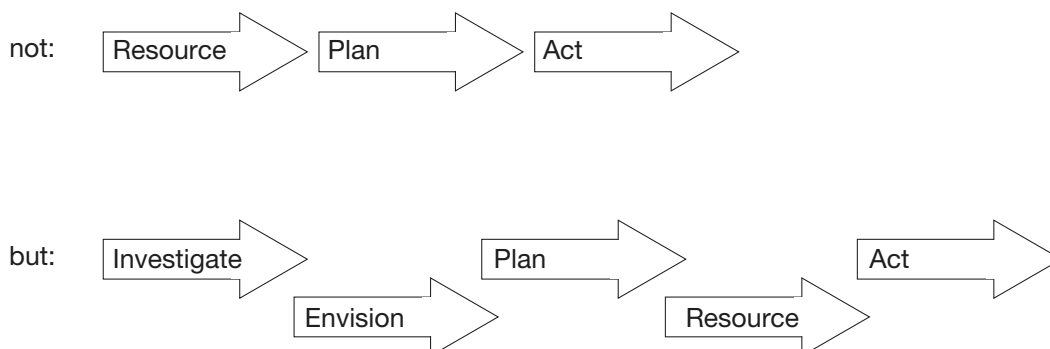
(Today Programme, BBC Radio 4, 29 June 2007)

It was such a conversion that we hoped to achieve.

GETTING STARTED AND BEGINNING TO ADDRESS THE GREAT 'DIVIDE'

A range of needs and issues in older people services in Swansea had already been identified in the local health, social care and

The LEAP approach suggests the following approach to planning (Barr & Dailly, 2008)



well-being strategy, prior to commencing the All Together Now project. Many of these had been identified nationally, including:

- changing culture and practice in long term care homes – moving away from treating residents as passive recipients of care, towards treating them as active participants within a community (Brown-Wilson, 2009; Help the Aged, 2007)
- transforming long-term domiciliary care services, to make them more flexible, reliable and responsive to changing needs (Patmore & McNulty, 2005)
- promoting the social inclusion of older people, and expanding day opportunities beyond traditional day centre provision (Godfrey *et al*, 2004)
- strengthening support for carers (Seddon *et al*, 2006)
- tackling the issue of low staff morale, recruitment and retention in older people's services (Equal Opportunities Commission, 2004)
- listening and responding to *what matters most* to older people in 'assessment', including issues and needs that may not be eligible for local authority funding (Commission for Social Care Inspection, 2008)
- more person-centred support for people with dementia, which builds on their strengths (Brooker, 2007; Kitwood, 1997)
- better supporting older people through transitions (eg. hospital admission and discharge) to maintain their independence and well-being (Borthwick *et al*, 2009; Swinkels & Mitchell, 2008)
- more effective partnership working across the whole system, including a renewed focus on the importance of working with frontline staff (Innes *et al*, 2006).

Underpinning all of these areas for development is the need for a robust, 'joined-up' approach to assessment and care management. Whilst unified assessment guidance in Wales was intended to deliver this (Welsh Assembly Government, 2002), it would appear that progress has been slower than expected for a number of

reasons (Seddon *et al*, 2008). Some of the reasons cited by these authors are related to the health/social care interface, including the incompatibility of IT systems. However, little mention is made of the other important interface, that of the purchaser/provider.

Whilst partnership working with health services is undoubtedly a priority for social services, the reality in Swansea is that approximately 75% of the budget for older people's services is spent on long-term care homes and domiciliary care. Following implementation of the Care Standards Act (2000), both of these services became subject to national minimum standards (NMS), under which a more robust approach to service provider assessment and service delivery planning has developed. However, awareness of the NMS amongst assessment and care management staff in Swansea is often poor.

Whilst the NMS guidance suggests that service delivery planning should build upon information provided within unified assessment documentation for people who are funded by health and/or local authorities, the evidence in Swansea is that it often does not. Indeed, there is local evidence to suggest that these two *separate* assessment and care management systems are in danger of 'divergent evolution'. The implications of this are profound, not only in terms of unnecessary duplication, but more importantly in terms of being able to promote a consistent outcomes-focused approach from initial assessment through to service delivery.

Further exacerbating this situation in Swansea, was an apparent lack of trust between many frontline assessment and care management staff and some provider agencies, and an honest admission by many provider agencies that the information being shared with them from unified assessments often did not provide what they required to support outcomes-focused service delivery planning. In addition to this, flexibility and responsiveness, which are key features of outcome-focused service provision (Glendinning *et al*, 2008a; Patmore & McNulty, 2005) were often stifled by the need for provider agency staff to refer back to assessment and care management staff before making any changes to care plans.

It is for the above reasons that the particular focus of the SSIA All Together Now project in Swansea has been on the promotion of outcomes across the purchaser-provider 'divide'.

DEVELOPING WORK STREAMS AND NEXT STEPS

Starting from the premise that good outcomes for older people and the people who care for them is *everyone's* business, a number of work streams were identified, where a collaborative and relationship-centred approach to outcome-focused assessment and care management could be explored across a number of purchaser/provider 'divides' (*Table 1*).

Working to the LEAP model, all four work streams spent the first three months of the project exploring project outcomes and potential project outcome indicators, before focusing on activities. The findings from these workshops were collated into a series of nine outcome statements, which were subsequently used as the basis for action planning (*Table 2*).

Having identified a number of project outcomes and possible outcomes indicators, the four work streams developed their own action plans, which at the time of writing are in the process of being implemented. Over the next six months, the project will be subject to evaluation based upon a constructivist model of participatory research (Hanson *et al*, 2006b). Whilst this is still in the early phase of implementation, there is anecdotal evidence to suggest that there is widespread enthusiasm for the approach being taken, and a sense of optimism that taking a collaborative and relationship-centred approach to assessment and care management might indeed be a '*better way*' (Seddon, 2008).

CONCLUSION

The approach being taken on the All Together Now project in Swansea is attempting to address the concerns raised by Glendinning *et al* (2008a) in their analysis of why the relatively simple concept of delivering outcomes-focused support may be more complex than might first be thought.

If, as these authors state, a 'whole system' approach to reform is needed, then

Table 1: Work streams where a collaborative and relationship-centred approach to outcome-focused assessment and care management could be explored

Work stream 1:	A locality-based co-production (Needham & Carr, 2009) pilot in West Swansea, seeking to improve outcomes for older people and carers, involving a wide range of stakeholders from across the statutory, independent and voluntary sectors, including links with Age Concern Cymru and Help the Aged in Wales's 'My Home Life Wales' pilot.
Work stream 2:	A pilot to explore the interface between the social services assessment and care management in north Swansea and the recently established in-house extended assessment/reablement domiciliary care service.
Work stream 3:	A pilot to explore flexible and outcomes-focused partnership working between the social services assessment and care management team in central Swansea and a housing association 'extra care' provider.
Work stream 4:	A pilot to explore person-centred approaches to working with people who have dementia, involving the social services older people's mental health team in partnership with a number of care home and day service provider agencies.

Table 2: Findings from project workshops

<p>1. What matters to older people and their carers is at the heart of everything we do.</p>	<ul style="list-style-type: none"> • We have an evidence-based foundation to our work, based on the <i>views of older people and their carers</i> as researched across the UK and beyond. • Older people and carers participate fully in development work on the ground in Swansea.
<p>2. Stakeholders have a shared vision and common language for supporting older people.</p>	<ul style="list-style-type: none"> • We have a concise and inspiring vision statement that is owned by all. • Stakeholders spend time together and share views/issues. • Training and development work are completed in partnership. • No jargon – policy and procedures are short and to the point, and can be read by all.
<p>3. There is a relationship of trust and mutual support between all stakeholders.</p>	<ul style="list-style-type: none"> • There are clear ground rules for mutual respect. • Stakeholders spend time together and share views/issues. • Stakeholders do not make empty promises for other stakeholders. • Stakeholders are aware of each other's boundaries/constraints. • Stakeholders value each other's roles (see below). • There is a shared approach to positive risk taking and a no blame culture. • Multi-agency meetings are used for key decision-making.
<p>4. Stakeholders have a clear understanding of each other's roles.</p>	<ul style="list-style-type: none"> • The key roles and responsibilities of each stakeholder are set out in concise format and shared. • Stakeholders spend time together and share views/issues. • Stakeholders have shadowed each other at some point in time.
<p>5. Staff time is used to best effect in supporting older people.</p>	<ul style="list-style-type: none"> • Time spent with older people and carers is prioritised, as this is what older people want. • Staff carry out activities that make the best use of their individual knowledge, skills and values. • Staff activity is complementary and diverse, not competing and repetitive. • Relationship-centred communication and networking are prioritised.
<p>6. Individualised outcomes for older people are identified and tracked for achievement across the purchaser-provider 'divide'.</p>	<ul style="list-style-type: none"> • An outcomes framework guide is shared between stakeholders (eg. in care planning and service specification). • Individualised outcomes statements are recorded in care plans, and become the primary focus of review. • Failure to meet outcomes is used as a learning opportunity for service improvement and development.
<p>7. Creative, individualised, holistic and cost-effective support/ care plans are designed and implemented.</p>	<ul style="list-style-type: none"> • Staff feel they are supported to be creative and flexible. • Eligibility for funding is separated out from person-centred support planning. • Staff are aware of the cost of services and the budget. • Staff have time and information to explore options outside their own agency. • There is evidence of using community resources in support planning. • Performance management measures creativity, the achievement of person-centred outcomes and value for money. • Older people and their carers score highly on the Senses Framework. • Flexibility is built into the system at all levels. • Rigid time/task care planning is abolished. • Staff own and address the 'little things' that are important to older people. • Service deficiencies are noted and addressed in commissioning.

Table 2: Findings from project workshops (continued)

<p>8. There is no unnecessary duplication of recording.</p>	<ul style="list-style-type: none"> • UA recording dovetails with minimum standards recording. • Information is shared on a need-to-know basis. • Support planning documentation is co-produced. • Review documentation is linked to contract monitoring and feeds into commissioning through clear service-deficit mechanisms.
<p>9. Staff are motivated and feel good about their work.</p>	<ul style="list-style-type: none"> • Staff score highly on the Senses Framework. • Staff undertake a variety of tasks, for which they are well trained and well resourced. • Staff have choices in what they do and can be creative. • The focus of work is outcomes, not processes. • Success is celebrated and best practice is shared.

the relationship-centred and collaborative approach may be one way of getting the degree of understanding and ‘buy-in’ required to do this. Secondly, it is hoped that the focus on locality planning and community capacity building within the All Together Now project may also help in addressing the need to prioritise the outcomes identified by older people themselves, rather than just strategic outcomes or those deemed eligible for local authority funding. Thirdly, a collaborative and relationship-centred approach may be a good way of supporting individuals to think outside the box in terms of how we might best support the needs of older people and their carers, as it gets participants talking and sharing ideas from a wide range of perspectives.

The approach being developed in Swansea does have similarities with the wider personalisation agenda in England (HM Government, 2008), although one of the major catalysts for change in that country appears to be the introduction of Individual Budgets to fund what is termed ‘self-directed support’. However, a recent evaluation report on the Individual Budget pilots in England states that:

‘...a potentially substantial proportion of older people may experience taking responsibility for their own support as a burden rather than as leading to improved control. Older people

satisfied with their current care arrangements - particularly when this involved an established relationship with a current care worker - were reported to be reluctant to change, so differences in outcome would be minimal.’ (Glendinning et al, 2008b)

It would be interesting to compare whether positive outcomes for older people are better achieved by taking a relationship-centred and collaborative approach, rather than the individualistic, budgetary-driven approach commencing with self-assessment, which is at the heart of the ‘in control’ model of self-directed support in England.

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