

**Does outcome-focused intervention for frail older  
people provide better quality care than current ‘time  
and task’ models?**

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## **ABSTRACT**

This thesis reports on a study of outcome-focused care for older people in one English local authority. The aim of the research was to examine whether altering the delivery of care to an outcome-focused model would improve service delivery and save money for the organisation in the long term. In order for this to be established, a longitudinal study was conducted over 18 months, utilising a mixed-method design. The sample consisted of 40 service users aged 65 years and over who all had critical and substantial care needs. The study also included interviews with and observations from social services staff responsible for the commissioning and delivery of care. The focus of this case study was to examine the impact of two models of home care delivery for older people, and how these two models impact on the older persons' self-reported well-being. The research established that there was a greater improvement in well-being in the group receiving outcome-focused care, when compared with the comparison group receiving the traditional task-focused model. Managers' and social workers' perceptions were also that outcome-focused care improved service users' sense of well-being, in comparison with those receiving task-focused care. The overall cost (service provision only) of providing the new style of intervention was 17% more than the traditional task-focused model. The main conclusion was that outcome-focused care allowed a meaningful relationship to be established between the home care worker and the service user, whereas the opportunity for such relationship building was limited in the traditional task-orientated model.

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## INTRODUCTION

This thesis will examine the implementation of an intervention involving care for older people in a metropolitan authority based in the north of England. The overall aim of this study will be to provide a holistic overview of a model of intervention and to consider how all the actors involved in its implementation and delivery have had an impact on its ability to affect change in the lives of the participants. The genesis of this thesis was a pilot evaluation conducted by myself in which I explored the effectiveness of outcome-focused care, as opposed to the existing 'time and task' model of home care delivery. Outcome-focused care in this case study was defined as the delivery of home care that was focused on meeting the agreed outcomes of the local authority and the service user. The time and task model of home care delivery was the traditional model used and focused on the completion of care tasks within a designated time frame. This original limited study led me to consider that it was necessary to conduct further investigations to fully understand the mechanisms that operate and which apparently make outcome-focused care a more effective method of care delivery. This thesis utilises a case study design to achieve this, and uses a realistic evaluation approach in order to establish an understanding of the different mechanisms operating at the macro level of social policy arising from the political context affecting social care in 2008. The case study utilises focus groups and interviews with social care staff to understand the organisational (meso-level) context in which the intervention was being delivered. However, the main focus of this thesis is an attempt to understand how, at a micro level, this model of outcome-focused care impacts upon the service users' subjective view of their well-being, compared with a comparison group. This is assessed by the use of questionnaires, interviews and participant observation. It is hoped that the use of these different types of data collection will allow a comprehensive understanding of the impact of the intervention to be developed. This case study is based on data from both the initial evaluation and the subsequent extension of the research. In order for the thesis to consider the different factors which influence the intervention, the following research questions will be considered:

*Does the provision of outcome-focused interventions improve individuals' levels of physical and emotional functioning compared to the current time and task model?*

*What mechanisms are in operation at the micro, meso and macro levels that might hinder and assist the new model of care, at both an individual and agency level?*

In order for these questions to be considered, Chapter 1 will provide an overview of the literature surrounding older people generally. It will then focus on home care policy and specifically consider how home care has been shaped in the post-war period by successive governments with differing ideological persuasions. The chapter will then continue by considering the work that has taken place on the development of outcome-focused care (Qureshi *et al.*, 1998), and the subsequent evaluation of this form of intervention by Glendinning *et al.* (2008). Knowledge of the work of these authors will provide an understanding of the intervention and how the design of this study is appropriate for examining the outcome-focused model of intervention.

Chapter 2 outlines the methodological framework of the case study. The decision to use realistic evaluation will be considered and an overview will be provided of the main theorists favouring this method: Pawson and Tilley (2006) and, more specifically in relation to social work, Kazi (2003). Following this, Chapter 2 will next consider the mechanics of how the data gathering was conducted and will include an overview of the quantitative and qualitative techniques used in the case study. An account will be provided of how the themes will be developed from this data for analysis and subsequent explanation.

Having provided a general overview of the study, the third chapter will provide an explanation of the quantitative findings and present the results from the two questionnaires. The two questionnaires employed are the Measure Yourself Concerns and Well-being (MYCAW) questionnaire (Patterson, 2007), and the Measure Yourself Physical Well-being (MYMOP) questionnaire (Patterson, 1996). This chapter will provide some descriptive statistics on the sample group and culminate in the use of inferential statistics to analyse the data generated by the intervention itself.

Chapter 4 considers the service users' perspective by presenting an analysis of the data derived from the semi-structured interviews with the service users. This is followed by the findings from the participant observations conducted on the process of care delivery with the home-care workers and the service users. The intention is that these two different techniques will generate data which enable an in-depth qualitative analysis to be undertaken of the micro level mechanisms that are operating within this social programme.

Chapter 5 examines the professional perspectives of the senior managers on the effectiveness of the intervention that they had decided to pilot and implement at the shop floor level. The intention of this section of the case study is to provide the

professional context for the intervention and how this context and the actors within it impacted upon the delivery of care.

The overall conclusions of the case study will then be considered and developed in the concluding Chapter 6. This final chapter aims to provide an understanding of the findings on the effectiveness of this model of intervention. The themes arising from each of the chapters will be drawn together and the relevance of the study for the development of social work knowledge will be considered, as well as areas of development for further research.

# **CHAPTER 1: SETTING THE CONTEXT OF CARE FOR OLDER PEOPLE**

## **1.1 Review of the Background Literature**

In order for this thesis to develop a coherent and informed argument about whether outcome-focused care improves well-being and care quality, this chapter will explore and review the literature surrounding the provision of home care delivery to individuals categorised as older people. The literature review will start by examining the concept of old age itself and how this concept impacts upon the development of home care (some authors refer to this as ‘domiciliary’ care), whilst also briefly examining the concepts of well-being and quality of life in older age. The socio-political processes that have impacted upon the development of social policy affecting home care will then be examined in some depth, demonstrating how the micro-provision of care and the macro levels of society and care provision are inextricably linked.

Once the political and social framework has been established, this chapter will examine the body of research developed around home care for older people. It will focus on the development of home care within England and Wales and also look at the research that has been influential in the development of outcome-focused care, and its critiques of the time/task model of home care provision. The penultimate section of this chapter will also examine the literature around subjective well-being which is a core theme of this case study. The literature review will then synthesise the different topics surrounding home care development and delivery. The conclusion to the chapter will show that a number of different forces have led to the development of home care provision. At a macro level there is pressure to develop cost-effective methods of delivering home care services to an increasingly significant proportion of the population and a need for services to meet the performance indicators set by the government of the day. It has been established from the research on home care that at an individual level there is growing dissatisfaction amongst service users who receive home care with the standardised models of care they receive, and they seem to want a more person-centred approach to their care and to exert some control over the service they are both paying for and receiving.

This literature review needed to consider the theoretical and empirical literature around the concepts of old age, subjective well-being and home care, specifically outcome-focused home care. In addition to the theoretical and research literature it was important to establish the political and social policy context within which home care had been

delivered in the post-war era. Thus the search strategy was to conduct a key word search. A key word search strategy was employed to identify the literature in the key areas of home care, outcome-focused care, subjective well-being and older people and finally social work. Different combinations of keywords were used in a range of different search engines in order to ensure all appropriate sources of information were uncovered. The main search tool used was 'Discovery' which identified which search engines would be the most useful for each given subject area. Literature on home care, social work and outcome-focussed care was provided by Ebsco host, Scopus and Social Work Abstracts. PSYCH info was found to be the most useful source of information regarding literature on the concept of subjective well-being. The Social Policy Research Unit at York University provided in depth information on their research into outcome-focused home care. The Social Care Institute for Excellence website also provided information on the recent social policy agenda affecting older people.

The literature on the concept of old age was more theoretical in make-up and has been used in order to provide an overview of the overall study and contextualise views of old age within the UK. This aspect of the review focused on social gerontological literature and some key authors in this area. The second element of the literature search focused on government policy and legislation that had had a direct impact upon the formation of social policy with regard to home care provision and also gave some overview of the political ideology that has been a driving force for change in the area of home care services. Further themes were the literature surrounding the development of outcome-focused care and the concept of subjective well-being. The focus of these two elements was to draw together key findings from the existing body of research, notably the work of Hazel Qureshi and Ed Diener who are the main researchers in their respective fields of outcome-focused care and subjective well-being.

## **1.2 The Social Context of Old Age**

Old age is in itself a contested concept. Pre-modern society viewed death as an external and mysterious phenomenon that tended to occur with old age, and did not convey the concept of old age as a period of internal death focused on the failure of biological systems, but as having a sense of veneration and achievement. With the advent of science and the discipline of gerontology, however, old age began to be seen as a period of degeneration and loss, as noted by Katz (1996). De Grey (2003) sees ageing as a damaging three-stage biological process, firmly likening old age to an incurable disease needing to be treated. This move to a more negative view of old age was explored

further by Foucault (1973), who believed that the power of medicine and its increasing intervention in the lives of older people ensured that old age was perceived by society more generally as a period of degeneration and loss with negative consequences for society. If a cultural analysis (Wuthrow *et al.*, 1984) is applied to the debate on old age it can soon be seen that the concept is full of symbolic boundaries often enshrined in legislative frameworks which dictate how society perceives the individual as they grow older. Wuthrow *et al.* expanded on this in the belief that tangible behaviours can be observed in everyday life in how older people are referred to or how they are marginalised within a capitalist society that is focused on the need for each individual to be a productive member of society. In this context, older people are perceived to be a burden on the young and on society as a whole. This negativity brings with it discriminatory forces which impact upon all members of society as they age and have been termed 'ageism'. Butler (1975) described ageism thus:

*...in the case of those who have reached an arbitrarily defined retirement age...Ageism is manifested in a wide range of phenomena, both on individual and institutional levels- stereotypes and myths, outright disdain and dislike or simply subtle avoidance of contact; discriminatory practices in housing, employment and services of all kinds; epithets, cartoons and jokes (p.12).*

Given that old age is increasingly perceived as a period of loss, degeneration and social isolation, the terminology of well-being and quality of life may initially appear to be misplaced. How then are the concepts of well-being and quality of life applied to the care of older people and subsequently measured? Laslett (1996) has challenged the traditional gerontological model of Townsend (1981) which highlights the process of marginalisation from society in old age, as well as increased disability and poverty. Laslett (1996), Banks and Emerson (2000) and Blundell and Johnson (1998) present the concept of a 'third age' and point to social indicators suggesting that individuals can experience ten to twenty years of relatively good health after retirement, with an increasing number living in some affluence or at least financial comfort. Therefore, rather than age being a period of degeneration and poverty, it can present individuals with an enhanced lifestyle free from the pressures of work and raising of a young family; however, the third age concept of old age does accept that this period ultimately gives way to some degeneration and possibly dependency upon others. The third age reconciles the apparent extremes of an enhanced quality of life in early old age with dependency in the later stages of old age. Therefore, an individual's place within this continuum is likely to be influenced by their current social circumstances and their

experiences throughout life. This concept does accept, however, that social status in earlier life has an impact on quality of life in older age, with individuals who have primarily worked in manual or working-class occupations experiencing a lesser sense of well-being and quality of life than their middle-class counterparts. The third age allows for the integration of well-being and quality of life to be considered alongside the process of eventual degeneration and loss and one's eventual death.

However, the staged model presented by Laslett, and specifically the concept of the fourth age, have been challenged by a number of writers including Bury (1995), Lloyd (2006), Twigg (2004) and Jyrkama (2003). Jyrkama sees the concept of the fourth age as following a traditional view of ageing that focused on the withdrawal of the older person from society and a decline into decrepitude. Jyrkama sees this view as no longer reflecting the reality of age in most modern Western societies where older people represent a much larger proportion of the population and the concept of their withdrawal is called into question. A further critique is provided by Bury, who sees the presentation of a third and fourth age as elitist, being underpinned by middle class values and a concern for the healthy and wealthy older person. The failure of the fourth age to adequately explain the position of the older person who is suffering from ill health or a lack of wealth or a combination of both leads to a narrow view of old age that excludes a large proportion of the older population.

Both Lloyd (2006) and Twigg (2004) approach a critique of the fourth age from perspectives that have a particular resonance with the study of home-care encapsulated within this thesis. Lloyd examines the fourth age from a feminist perspective in particular, seeing the fourth age as wrongly presenting older people as a homogeneous group ignoring gender differences. She postulates that Laslett's (1996) concept of the fourth age fails to consider that the provision of care in old age is laden with negative and patronising stereotypes of a dependant older person in their later life. Lloyd argues that the uniqueness of human relationships such as love, trust and compassion are not considered or explained by Laslett. The failure to consider gender is a particular problem in deep old age where both the older person and the carer are predominantly female. Laslett also fails to adequately explain the period of an individual's later life and their eventual death. The Ethics of Care provides a feminist perspective in support of Lloyd, recognising that it is the relationship which is the most important element in the care process and that a true ethical and caring relationship must include attentiveness, responsibility, competence and responsiveness (Tronto, cited in Phillips,

2010:43). These authors argue for more attention to diversity within the experience of old age than is captured by Laslett's homogenous 'stages'.

Twigg (2004), views old age through a sociological perspective on the body. She argues that it is the onset of infirmity that marks the point of transition from one age to the next. The infirmity is then allowed by society to swamp the individual persona and the narrative around the individual is focused on the physical body, with society losing sight of any non-physical aspects of the individual. Therefore the older person experiences the physical process of ageing and how society views them as an ageing body.

### **1.3 Background to Home Care Services**

Home care within the United Kingdom developed historically around a domestic model of household chores. These chores would involve the provision of cooking and cleaning and would be seen as tasks of care which avoided the undertaking of activities that could be considered to involve any element of emotional care. This left the completion of tasks considered to be of an intimate and emotional nature (what might be termed 'caring') to the remit of the family, with an underpinning belief that social support and intimate care would be provided by the female members within these families (Leece, 2003). In situations where families could no longer look after their elderly relatives the expectation was that the voluntary sector would support the individual out of 'neighbourliness' or a sense of 'doing good'. Therefore it was hoped that communities rather than the state would provide support to the family. If these two models of home care failed then the individual would be placed into some form of residential care provided by the local authority (Means and Smith, 1998). During the post-war period the welfare state continued to take on more of the responsibility for care to reflect the changing structure of the family and the profound social changes in the structure of communities and individuals' increased life expectancy.

The combination of the growth in the population of those who were considered elderly and the subsequent increased cost of caring for this population led to a need for changes in the way in which home care was provided. In 1968, in a response to the increased need for home care provision, the government formalised the provision of home care with the passing of the Health Services and Public Health Act of 1968 (OPSI ,2010). This specific piece of legislation gave the local authorities the power to make arrangements to provide non-residential community care services for older people and it can be viewed as the birthplace of the current system. Despite its introduction, this



particular piece of legislation was not fully implemented until after the major changes to social care which resulted from the Seebohm Report (DoH, 1968) were acted upon which brought into being social services departments. Initially, home care and district nursing existed within the same structure (i.e. the local authority) and this remained the case until 1973, when community nursing was moved into the remit of the National Health Service, with the passing of the National Health Services Act of 1973 (OPSI, 1973). This separation of home care from nursing left it as a poor relation within the social services department, with no professional status. There was also an increase in the profession of social work which began to dominate and exert control over the previously nursing-led home care provision. Home care with its unqualified staff had the lowest status in a sector which in itself was afforded lower regard than health provision by both politicians and the public generally. Once home care was established, there continued to be a steady increase in the use of its services, which over the years led to its size burgeoning from 13,800 to 34,000 home care workers (Audit Commission, 1986). This increase was placing continued pressure on an already overstretched welfare state combined with the projected growth of an ageing and potentially unproductive population

#### **1.4 Enter the New Right**

New Right thinking, as considered by Harvey (2005) and Cunningham and Cunningham (2008), embraced the original ideas of a 'home help' in assisting the individual by supporting the family to meet the tasks of care for their elderly relative but not to take over the emotional support or responsibility for their care. This led to a move away from what was perceived to be the nanny state's erosion of family responsibility and from state provision, to the more market-driven policies of Margaret Thatcher who initiated a number of New Right policies which formed the foundations of the market-driven home care provision of today. These initiatives followed on from previous governments' attempts to move away from institutionalised residential care in favour of care based within the community. For this change to continue there was a requirement for further changes in community care policy and in particular, a need for community care to be enshrined in a statutory framework to allow for the market focus of its provision. This perceived need for change was based on Thatcherism's concerns about the growth of government and the burgeoning cost of the welfare state, caused by the demographic changes which lead to an increase in demand for residential home care. The aim of this policy shift was to ensure that families took on the role and cost of caring for older relatives, and that this was supported rather than totally provided by the

state. The Conservative government took a number of policy initiatives based on the Audit Commission's report *Making a Reality of Community Care* which was published in 1986, and which heavily criticised the existing fragmented provision of community care. This report was subsequently supplemented by the Griffiths Report in 1988 (DoH, 1988). These two documents had a profound effect on the services provided by social services departments, by limiting their role from the provision of services to the enabling and purchasing of services. These changes altered the way in which social services departments functioned and ensured that central government exerted considerable control over the meaning of what constituted care and the provisions provided to ensure care needs were met.

The Griffiths Report and the Conservative government's White Paper *Caring for People* (DoH, 1989) introduced a number of important objectives which directly impacted upon the provision of home care:

*The development of domiciliary, day and respite services to enable people to live in their own homes wherever feasible and sensible and to promote the development of a flourishing independent sector alongside good quality public services* (DoH, 1989, para 1.11).

These objectives were then translated into legislation in the form of the National Health Service and Community Care Act of 1990 (DoH, 1990). This legislation could be perceived as the start of the current time and task model of home care delivery. This Act set a managerialistic framework for the delivery of home care services (Clarke and Newman, 1997; Newman, 2000) in that concerns about efficiency and effectiveness constrained the shape of home care provision to individuals in their own home. The emphasis of home care moved towards the completion of physical activities and borrowed from a nursing model of care which was focused on activities of daily living (Roper *et al.*, 1996). This process partitioned off 'emotional labour' (James, 2004, p.262) with the net result that issues of love and intimacy were not included in care packages and continued to remain within the domain of the family and not the paid care worker. In order for the process of home care provision to be monitored and measured, intensive management and accounting systems were put in place. These systems fragmented care into countable components that could be traded as a marketable commodity (Fotaki & Boyd, 2005).

These changes brought with them problems that were highlighted by Twigg, inasmuch as both local and national policies lent a "disembodied, etherealizing quality to the

delivery of care,” (Twigg, 2000, p.5). This resulted in the start of the formulation of false boundaries between doing care and being caring. This meant that tasks that contained an emotional component were perceived to be messy, time-consuming and difficult to account for, and therefore this model of personal social services could impact adversely on the personal lives of service users, insofar as previous emotional activities were now perceived to be outside the remit of the paid care worker (Mooney, 2004).

The cornerstone of the National Health Service and Community Care Act (NHSCC) of 1990 was the process of care management. Bochel *et al* (2005) see this Act as the ‘single most influential piece of legislation affecting policy and practice in the personal social services passed by the Conservative governments of 1979 to 1997 (p.120). This Act gave two new processes to the delivery of social care with the introduction of marketization and managerialization (Clarke and Newman, 1997). This legislation again marked a profound move towards the continuation and expansion of care in the community with an emphasis on the importance of domiciliary care.

The introduction of the purchaser/provider split and the creation of what Bartlett and *et al* (1998) and others have termed the quasi-market provision of care, resulted in market forces being unleashed into a falsely constrained market. This purchaser/provider split made a profound change in how the domiciliary care market was structured. Prior to the introduction of the NHSCC Act, 1990 there was no real market provision of home care and it took some time for this market to be stimulated (Hardy & Wistow, 2001). In 1992 virtually all home care was provided in-house by local authorities, but by the turn of the millennium (2000 onwards), 56% of domiciliary care was provided by the independent sector with the majority of this home care provision being purchased from the private sector.

The quasi-market focus was based on the concept that services could be allocated a cost and delivered in a Fordist production line fashion (Parton, 1996). This Fordist provision required segmented and time-allocated tasks to enable the new care manager posts, which were created by the NHSCC Act 1990, to allocate costs to the timed services provided to the service user once their needs had been assessed. It was believed that this framework would enable local authorities to account for the real cost of social care. Therefore the individual’s needs would be required to fit into time-allocated slots, ensuring all the assessed needs were met. This model still assumed that acts of kindness and emotional care fell within the remit of the family, as did the meeting of social and

psychological needs. A mental health problem, being seen as a medical condition, was considered to fall within the remit of the state. However, the increased numbers of individuals experiencing Alzheimer's disease brought additional pressure to the model of time and task provision, mainly due to the chaotic nature of this condition meaning that rigid time schedules were unable to meet service users' needs.

### **1.5 Problems in the Market**

The Conservative governments prior to the election of New Labour in 1997 believed that quality of service would be driven by the market and that poor, costly provision would be forced out of the market, with the service user as the customer driving quality. This does not appear to have happened. Drakeford (2000), examining the quasi-marketization of community care, believed that the post-1993 system of adult social care was deeply flawed. The concept of the customer as rational and demanding driving change failed to materialise in the quasi-market system. Therefore the control of domiciliary home care by the customer was not a reality. This view was supported by Le Grand and Bartlett (1996) and Charlesworth *et al* (1996), who both established that political, financial and organisational decisions impacted upon the decision-making process of commissioners of care, with the decision taken by the purchasers of services having little relation to the needs of the service users. These difficulties created by the quasi-marketization of care and its complexities were summed up thus by Mannion and Smith (1998) with language more familiar to business:

*Envisaged, the product is multidimensional and evolves over time. It is impossible to specify complete contracts. An intermediary is purchasing on behalf of the beneficiary (p.115).*

Prior to the election of New Labour, the delivery of domiciliary care had radically altered from a virtual public service monopoly to predominantly private sector for-profit provision, with the commissioning of services still being maintained within the public sector and being commissioned mainly by social workers in a new role as care managers.

### **1.6 Post-1997**

New Labour believed that choice and the role of the community were essential tenets for the delivery of local personal social services, as opposed to consumer sovereignty and the market. It could be argued, however, that this was more a variation on a theme than a distinct sea change, with continuation of privatisation and fragmentation in social

services enabled through the use of the concept of partnership working. The delivery of choice would be achieved through a process of personalisation and individualisation of social service delivery, with the service user being responsible through a process of responsabilisation for the design of their personalised care package (Ferguson, 2007). The concept of personalisation originated in the world of information technology, but has been adapted for use in government social policy (Bonnet, 2001). Leadbetter presents the logical move from the market to the personalisation of care:

*Privatisation was a simple idea: putting public assets into private ownership would create more powerful incentives for managers to deliver greater efficiency and innovation. Personalisation is just as simple by putting users at the heart of services, enabling them to become participants in the design and delivery, services will be more effective by mobilising millions of people as co-producers of the public goods they value (2004, p.19).*

### **1.7 Recent Developments**

The 2005 Green Paper, *Independence, Wellbeing and Choice* (DoH, 2005) believes that the goals of well-being, choice and independence are best achieved when social care providers have ‘clear outcomes’ and see these outcomes as allowing the measurement of well-being and choice against the experience of those individuals receiving care. It states; “Clear outcomes for social care are needed, against which the experience of the individual can be measured and tested” (p.25). The outcomes proposed dovetail with those set by Qureshi *et al.* (1998) when discussing the development of outcome-focused care, which is discussed in more depth later on in this chapter. The Green Paper proposed: improved health; improved quality of life; making a positive contribution; exercising choice and control; freedom from discrimination or harassment; economic well-being; and personal dignity as potential outcomes. Outcomes have also been seen as central in the *UK Strategy for an Ageing Population* (DWP, 2005; Annex 1) which also sets broad quality of life domains. The importance of outcomes was central to the Wanless review (2006) too, which was concerned with the future costs of social care provision. The central plank of the Labour Government’s thinking on how to modernise social care incorporates and makes central the importance of outcomes, and subsequently the need for these outcomes to be measurable.

This piece of legislation also presents the concept of ‘domain areas’ not dissimilar to those in the central research considered in this thesis (Qureshi *et al.* 1998). The Green Paper states the importance, among other factors, of quality of life, choice and control,

and particularly individual dignity. This theme of choice and the importance of service user-focused outcomes were also enshrined in the *UK Strategy for an Ageing Population* (DWP, 2005) and were seen as essential for older people to receive quality services that would enhance their quality of life. The use of the concept of outcomes was also introduced as a method to measure service performance in the 2006 White Paper *Our Health, Our Care, Our Say* (DoH,2006), with the ability to achieve outcomes affecting the performance indicator score given to and prized by local authorities. These policies, however, had the effect of focusing local authorities on the meeting of performance indicators rather than the provision of services focused around the individual.

Despite the change of government in 1997, there has been a continued growth in domiciliary care services contracted outside of local authorities and provided by the private and voluntary sectors. Glendinning *et al.* (2008) in their review of the implementation of outcome-focused care to date, highlighted that in order for this model of care delivery to work there needed to be in place highly effective channels of communication between users, families, front-line staff, service commissioners and contract managers. In addition to this, contracts would have to be constructed with independent providers that allowed for the outcome-focused aspirations of service users to be met.

Outcome-focused care had to a degree become subsumed into the New Labour choice agenda and was seen by local authorities as being an evidence-based model that enabled choice for service users and assisted in the delivery of the personalisation agenda and individualised budgets. Therefore local authorities saw Qureshi and Henwood's (2000) domain areas as providing a framework to fulfil the demands of the Green Paper *Independence, Well-being and Choice* (DoH, 2005). The Green Paper contained the Labour government's social care agenda for the next fifteen years and continued the theme of previous legislation of extending individual responsibility by enabling choice and control over the individual's care. This is ultimately achieved by individualised budgets which are seen as the tool for pulling together different public resources in order to meet the desired outcomes of the individual by making each care package bespoke. The individual achieves this by gaining access to funding streams across departmental boundaries (Hasler, 2003; CSCI, 2004). Arksey *et al* (2000), however, perceive this policy as still seeing the individual as an active consumer of public services with an ability to exercise enhanced choice over how their needs are met and

also how they control their own lives and therefore not as radical a change from the market-driven care market as New Labour presents.

### **1.8 Time and Task Model of Home Care**

From the literature presented thus far it can be established that the time/task model of domiciliary care has arisen out of the need for care to be provided as an identifiable commodity that could be bought and sold. One of the major concerns of this time/task model of care delivery was the difficulty it caused older people in the formation of meaningful relationships with those who provided their care tasks. Research conducted by Raynes *et al.* (2001) clearly showed that the establishment of a relationship with individuals who provided their care was highly prized by service users. The often highly intimate and personal nature of domiciliary care provision meant that that service users often felt disturbed and upset by the impersonal nature of their care delivery. This research emphasised that people felt that services needed to be centred on them and to be flexible. This flexibility was required not only during the time the task was completed but also in the tasks which were completed. These findings were also supported by a report written by the Joseph Rowntree Foundation (2003) that established that the continuity of the care delivered had a direct impact upon the individual receiving the care, giving a sense of well-being, and that the flexibility of the care provided was also regarded as essential for the individual's sense of control over their life. This report also established that a hidden care agenda arose between the service users and the domiciliary carer. These 'acts of kindness' arose out of the need for service users' needs to be met outside clearly identified tasks. These acts of kindness could be perceived as something simple, such as making a cup of tea or putting the bin out, but because they were not identified and priced, their completion occurred in an unwritten care plan that could only continue with the goodwill of the care provider. This unwritten care was also highlighted in two other studies (Henwood *et al.*, 1998; Sinclair *et al.*, 2005), which established that older service users found domiciliary care workers' lack of autonomy to make decisions and be flexible frustrating. Sawyer (2001) analysed the provision of domiciliary care and established that highly prescriptive, short, task-orientated visits were increasingly commissioned by social workers, which robbed the care providers of any flexibility in the care they delivered. The prescriptive nature of the care plans meant that services were unable to maximise independence. The rigidity of the time/task approach only continued to reinforce individuals' sense of a lack of control over their own lives. All the studies mentioned above established that there was a disconnection between the commissioners of services, the providers of services and

the wishes of the service users receiving the services which many were either paying for or contributing to. It is interesting to note that in 2010 the Conservative Party's proposal for domiciliary care for the elderly involved a return to the basic provision of maintenance tasks of home care. The pre-election Conservative proposal was that individuals make a one-off payment of £8000 when they reach state retirement age to receive free domiciliary care. Bakewell (2010), the then Labour government's czar for older people, points out that this money would only guarantee that individuals receive support to be washed, fed, dressed and assistance in getting up in the morning. This can be seen as a sea change from both the previous Conservative government's plans for consumer choice and the New Labour plans to focus on self-identified outcomes. This basic level of care, as we can see by the research conducted thus far, would not meet the wishes of older people receiving domiciliary care.

### **1.9 Outcome-Focused Care**

The concept of outcome-focused care has arisen, and has subsequently been adapted into a model of intervention, following research conducted by Qureshi *et al* (1998), Raynes *et al.* (2001) and Qureshi and Henwood (2000). This initial research identified three clusters of outcomes that were considered important to older people who were in receipt of social care interventions. These clusters covered maintenance outcomes, prevention outcomes and change outcomes. The process for meeting these outcomes was identified by Qureshi as being dependent on the way services and interventions were delivered to older people. These core clusters were then divided into subsections of domain areas of care needs.

The first of the core clusters was given the label of 'maintenance outcomes' and covered the vast majority of outcomes that older people perceived to be the most important in their lives to enable them to achieve a sense of well-being. This subsection of outcomes included the meeting of basic physical needs that could also be considered to be the main elements of the time/task model of home care. These included receiving food and drink at appropriate times, being physically comfortable, and also being clean and presentable. The importance of maintenance outcomes and the common themes identified above is supported by a considerable body of research (Gwyther, 1997; Coleman *et al.*, 1998, Raynes, 2001; Bamford and Bruce, 2000). Although some of this research is over ten years old, more recent research continues to support the high regard given by older people to the importance of maintenance outcomes. Gabriel and Bowling (2004) conducted in-depth interviews with a number of individuals of mixed gender



aged 65 and over. Maintenance of the home and independence were consistently rated as important in enabling respondents to experience a sense of well-being and quality of life. These findings were also supported by research conducted by Parry *et al* (2003) on behalf of the UK government, as well as earlier research conducted by Tester *et al* (2003).

The next cluster of outcomes was described as 'preventative outcomes'. These also have some elements that are entwined and overlapping with aspects of maintenance outcomes. The importance of low-level preventative services for older people was recognised in research conducted by Clark *et al* (1998), inasmuch as the sense of feeling safe and having a clean tidy environment had a significant impact on older people's self-esteem and sense of well-being. This sense of well-being, including feeling sufficiently safe to leave the house and one's house being clean enough to receive guests, was also highlighted by service users in a report by the Joseph Rowntree Foundation ('Shaping our Lives', 2003). It was noted in this study that tasks that were sometimes outside the remit of the time/task model had a profound impact upon how the older person felt about themselves and how they believed others viewed them. These tasks for example, might involve the home care worker plumping cushions or dusting an ornament before the older person received a visitor; this ability to divert tasks with very little notice was highly regarded by the older person receiving the care.

The final clusters involve change and are named 'change outcomes' accordingly. It was established that older people attributed a high value to interventions that assisted them in a process of change and adaptation. In their simplest form, change services could be seen as services that change outcomes which are viewed as important by the individual and could be very different from those identified in their care plan. According to Qureshi *et al.* (1998), older people tended to group these changes into physical symptoms and mobility, and improvements in their mental health. Since the initial research conducted by Qureshi and others at the Social Policy Research Unit (SPRU) based at York University, a number of follow-on research projects have reinforced their findings about how these identified domain areas have a significant importance for the individual's ability to control their self-defined outcomes and consequently have a greater sense of well-being.

### **1.10 Review of Existing Services**

The SPRU carried out a review on the development of outcome-focused care services for older people within England. Glendinning *et al* (2008) examined the implementation

of outcome-focused care in six localities throughout England. This research used postal surveys, case studies and interviews to measure the progress and problems involved in the implementation of this new model of home care. Their review differed from this study by employing a qualitative methodology rather than a mixed approach. Glendinning *et al* define outcomes and outcome-focused services thus:

*Outcomes are defined as the impact, effect or consequences of a service or policy. Outcome-focused services are therefore those that meet the goals, aspirations or priorities of individual service users (Glendinning et al., 2008, p.5).*

The important distinction they made in considering whether a service is truly outcome-focused is if there is a difference between service goals and the service users' self-identified outcomes. Service-driven goals ensure a standardised model of delivery, regardless of the individual circumstances presented by the service user. They are also dominated by the decisions of the commissioners of services and have little involvement with the service user. Consequently outcome-focused care fits in with the previous Labour government's objective of personalised care as defined by Leadbetter (2004), in that outcome-focused services are therefore personalised by implication:

*The introduction of outcome-focused care models is closely aligned to the impact of the government Green Paper Independence, Wellbeing and Choice (DoH, 2005). This particular document expresses the need for outcome-focused services to be such that the experiences of individuals can be measured and tested (Leadbetter 2004, pp.25-26).*

The majority of those services considered to be outcome-focused by Glendinning *et al.* (2008) were small initiatives focused around the delivery of home care services to individuals receiving intensive support following hospital discharge. A review of these services established that in order for outcome-focused care to be delivered effectively, processes needed to be in place that allowed a clear flow of information. This required staff, documentation and processes that fitted into the cluster areas identified in Qureshi *et al.*'s initial research in 1998. The importance of the need for appropriate assessment methods was also established by Nicholas *et al* (2003). This research examined the impact of outcome-focused care on the process of carers' assessments. Nicholas *et al* established that staff needed to make a profound conceptual change when completing assessments and to note the importance of understanding the transfer of decision-making from the professional more towards the service user and their carers. It was also necessary that once outcome-focused care was introduced, social workers received

sufficient training in recording the identified outcomes, combined with the need for constant communication between all stakeholders to ensure that outcomes continued to be reviewed and met throughout the delivery of care. One of the barriers identified by Glendinning *et al* (2008) was the single assessment process (SAP; DoH, 2001). The SAP is a common framework currently used throughout adult health and social care in England, with Wales having an equivalent ‘unified assessment’ process. This Labour Government policy aimed to streamline and provide a common framework for assessing adult needs across disciplinary settings. Glendinning *et al.* (2008) found that because this document was needs- and problems-focused it did not lend itself to being used to establish self-identified outcomes, which complicated the implementation of outcome-focused care and required the duplication of the assessment process to allow for outcome-focused care to be assessed. This additional form of assessment is then confronted by resistance from commissioning staff because it is seen as yet another bureaucratic exercise, duplicating their own work for little benefit. This is why both Glendinning *et al.* (2008) and Nicholas (2003) identified the need for adequate training throughout the process of implementation. This issue of the organisation’s structure and ability to respond to the individual service user’s self-identified outcomes links in to the importance of process outcomes. Process outcomes are defined thus:

*...the experience of seeking, obtaining and using services. Process outcomes are important to the extent that they can enhance or undermine the impact of services that would otherwise appropriately address maintenance outcomes (Glendinning et al., 2008, p.7).*

These process outcomes are more focused on how the individual feels about the services they are receiving, including how valued and respected service providers make the service receiver feel and how much control they can have over the services they receive and whether the statutory services are able to dovetail with, and complement, the informal care the individual may also receive. Francis and Netten (2004) conducted a small-scale study examining which factors were important to service users when they assessed the quality of the home care they received. They established that quality services were reliable and flexible, providing continuity of care and allowing the service user to have access to effective systems of communication. It was also considered important that staff had the correct skills and knowledge and, most importantly, a caring attitude towards the service users in their care. This clearly demonstrates that the process outcomes are essential if outcome-focused care is to be delivered in a manner

that meets the aspirations of the individual service user. These findings were also supported in the research conducted by Baldock and Hadlow (2002).

Outcome-focused care, although driven by the desired outcomes of the service users, is highly dependent upon the political ideology of the day, and the consequent structures of the local government systems that are responsible for the delivery of care services to older people. Glendinning *et al.* (2008) and Nicholas (2003) both highlight the need for effective communication and more importantly cultural change within the organisation for the care package to be truly outcome-focused. Another major barrier to the delivery of outcome-focused care is the commissioning process that is in place and how commissioning budgets are delivered. Ware and colleagues (2003) examined the commissioning of services for older people in seven local authorities and used methods similar to Glendinning *et al.* by combining the reviewing of case files with interviews with both care managers and the relevant service users. They discovered that the fostering of personal relationships, which appear to be important to service users for them to be enabled to express their desired outcomes, becomes subordinated to the organisational need for tasks to be short-term to allow for throughput in the assessment stage of care. Care managers were encouraged to limit their involvement with service users and to pass the care delivery to other agencies, allowing them to close the case and open up fresh referrals. This short-term pressure led to another problem for effective outcome-focused care delivery in that the process of assessment and care delivery became fragmented with a lack of continuity.

Ware *et al.* (2003), Glendinning *et al.* (2008) and Qureshi *et al.* (1998) have all considered that it is the personal nature of the relationship between the assessors of care, the deliverers of care and the service users that was essential for the individual being cared for to have achieved a sense of control and quality of life in the care process. Therefore it is the effective delivery of social policy at the micro level that enables outcome-focused care to operate efficiently. Current processes of commissioning fit with the delivery of time/task care and the Fordist model of care delivery; although this method may be cost-effective, its impact upon the end product (the service user) needs to be fully assessed. This fits in with the research of Lewis (2001) and Sawyer (2005) that also identified the task-orientated nature of care as a barrier to independence. These authors believed that greater service user satisfaction would be achieved by providing providers with greater autonomy in order for them to establish a more effective caring relationship with the older person. The current time/task model tended to foster an adversarial relationship between purchasers and providers, with the net result of

marginalising the relationship with the older person. If the older person does not experience a sense of quality of life and is purely being maintained at the basic level of need identified by Maslow (1967), then the end product, working from a Fordist perspective, is not fit for purpose.

The importance of the micro level of care was also highlighted in Glendinning and colleagues' (2008) review of outcome-focused services. This was very apparent when the research examined the process of change and change outcomes. It was again the personal nature of the outcomes identified that allowed the care process to be effective. An example of this was commented upon by a service user:

*'One of my aims was to walk the dog, so they allowed him to come and see me-it was very helpful... it made all the difference in the world...I have a good quality of life now and I know I can get better still'* (Glendinning, 2008, p.16).

Therefore here was an example of a task that was clearly outside any time/task approach and which was concerned with the maintenance of the individual's physical state, but one that had a profound impact upon the service user's sense of quality of life and emotional well-being. This was only achieved by the close relationship of the professional carer with the service user and would only have been permitted through the process of an outcome-focused care plan. Glendinning *et al* (2008) found, however, that initial outcomes were not maintained when care provision in this particular case was moved from the rehabilitative services to the long-term care support team. Glendinning *et al*'s review of outcome-focused provision clearly highlighted that in order for outcome-focused care to be delivered, the commissioning and care planning processes had to be altered to enable providers to develop new strategies for service delivery. Three service areas reviewed had radically changed the process of commissioning. This change involved the care plan identifying desired outcomes and agreeing a probable length of time for these needs to be met, with the care plan providing a shell enabling the service user to negotiate day-to-day delivery with the home care provider. This flexibility appeared to allow the providers the ability to respond to new priorities set by the older person, including the flexibility to change rapidly should a service user's health deteriorate or they experience other unexpected problems.

This review of services, as well as other research (Sawyer, 2005), demonstrates that the structure and model of service delivery has a profound impact on the way adult social workers practise. It involves a considerable shift in the power relationship between the commissioner (in most cases social workers) and the service user and providers. In

order for this power shift to be enabled, a trusting relationship is required between all agencies involved and the service user. It requires effective channels of communication which enable outcomes and cost arrangements to be altered quickly. Finance departments also need to develop strategies in line with the outcome-focused model of care delivery. Glendinning *et al* (2008) found that where effective trusting relationships had been established, service user satisfaction increased, as did home care staff job satisfaction. Previous research conducted by Sawyer (2005) also found increased job satisfaction amongst home care staff when outcome-focused care was implemented. This contrasted, however, in Sawyer's study with the difficulty experienced by care managers who struggled with a move from assessing need to the assisting of service users to identify and state their own desired outcomes. This feeling of a loss of control and power interfered with their effective development of a new pivotal role as facilitators of care delivery.

Manthorpe *et al* (2008) reviewed the progress made by the implementation of the *National Service Framework for Older People* (DoH, 2001). This policy aimed at achieving a cultural change to enable older people and their carers to be treated with respect, dignity and fairness. This piece of research utilised a mixed methods approach in ten different localities and examined what older people said about social workers' roles and activities, which included the managing and commissioning of home care services. It established that both social workers and older people found the task-focused role of care management reductionist and impersonal. Older people desired the establishment of a relationship with the social worker and favoured a more person-centred approach. This research established, however, that the quality of social work was seen as poor by a lot of older people. Social workers appeared to be reluctant or fearful about passing power to the older person and the need to take qualified risks to enable people to remain independent was an issue. This task-orientation of social work and lack of trust are opposite to what was established as working by Glendinning *et al* (2008) in their research, and therefore the lack of trust-giving and over emphasis on risk management by social workers would appear to present a barrier to the true implementation of outcome-focused care.

An earlier review of the implementation of outcome-focused care that has already been referred to in this review of the literature is that conducted by Sawyer (2005). This research also examined ten areas where outcome-focused care was being implemented. It established that the interpretation of what constituted outcome-focused care varied considerably across the different areas. Again, the services that used outcome-focused

care as a method of meeting service needs were less successful at establishing user satisfaction than those organisations that embraced the model as a change in ethos. The issue of trust also arose and again the major barrier appeared to be social workers' distrust of the private sector organisations, and the anxiety raised by them about the lack of oversight of service delivery. Interestingly, this research found that home care providers that were in-house or closely linked to social service commissioning struggled to adapt to the new model of working and suffered from the loss of structure provided by the time/task-centred approach. The areas that experienced the greatest success were those that implemented an entire system change and a change in the contracts with the service providers. Those areas that focused only on the providers' contracts and not the ethos of social service care planning were less effective at implementing this new model of working.

### **1.11 Subjective Well-being**

The study of happiness and the concept of the good life have been considered mainly within the field of philosophy up until the 1960's with a focus on the attainment of happiness by the individual. The initial focus on the concept of well-being was provided by Wilson (1967), and marked a move away from a simple concept of happiness towards a multi-faceted idea of well-being. He argued that an individual needed a number of components in their life to be satisfactory in order to achieve a sense of well-being and therefore a state of happiness. Wilson presented the idea that once an individual had their basic needs met, only then might they be able to move to a higher state of satisfaction in life and achieve a sense of well-being. Because individuals have their own unique view of the world and unique living situations, any view of one's quality of life will be subjective. Wilson saw satisfaction of needs as essential and argued that "prompt satisfaction of needs causes happiness, whilst the un-fulfilment of needs causes unhappiness" (1967, p.302). This marked a move away from viewing well-being and happiness in purely philosophical and metaphysical terms and led to the scientific study of well-being within the field of psychology.

However psychology had not yet developed an effective scientific technique capable of measuring the true cause and effect of an individual's subjective well-being. The inability to measure cause and effect had been one of the most fundamental problems in undertaking research on SWB. A major breakthrough was achieved in the study of SWB by Diener (1984), who brought together the original needs approaches of Wilson and the multi-faceted components of the individual's personality. He developed a life

satisfaction scales process which enabled researchers to identify the individual's personality traits and the external factors which impacted on them to give a measure of SWB.

Diener's development of global scales (which is discussed more in Chapter 2) has had a huge impact in the studies of health, happiness and psychological well-being. The scales have been used extensively across the Western world with the result that a robust correlation has been established between health and happiness (Diener & Seligman, 2004; Subramanian, Kim, & Kawachi, 2005), and this is an important consideration for this thesis. The participants were all experiencing poor health, with the majority suffering from chronic health conditions. It was therefore important to measure the individuals' physical well-being alongside their psychological well-being as poor physical well-being could present a confounding factor that could skew the measurement of the effectiveness of outcome-focused care. Thus it was the need to measure physical and psychological well-being alongside one another that led to the choice of instruments that were utilised in this thesis which will be covered in the next chapter.

The well-being of an individual is affected by external factors such as government policies. This chapter has previously mentioned the social policies that have been developed in an atmosphere that is traditionally negative towards old age and the potential non-productive burden of older people on the state. In addition to this, the individual's well-being is also seen as very much the domain of the family. It is against this background that social policy towards home care has been developed and implemented. However, the concept of subjective well-being does allow for the individual's well-being to be examined. Therefore assessing how a different model of home care delivery impacts on a person's well-being requires an understanding of what constitutes well-being. One aspect of quality of life is subjective well-being (SWB), which is based on the individual's own evaluation of his or her life. This may be an evaluation of the individual's whole life or a breakdown of the individual's life into domains in order to enable SWB to be assessed (Smith *et al.*, 2004). Life satisfaction is seen as a global judgement of life assessed against certain criteria (Shin and Johnson, 1978).

## **1.12 Summary**

It is important to remember that issues of caring for the older person are partly a result of individuals living longer, social changes in the family, and the acceptance of



responsibility by the state through the creation of the post-war welfare state. This literature review has described how numerous governments of differing political persuasions have attempted through various processes to ensure that responsibility for care of the elderly should rest with the family, whilst in most cases not accounting for the fragmentation of family life caused by an increasingly diverse labour market. Therefore policies appear to want to limit the cost to the state whilst maximising the control of individuals over their care. These policy debates have occurred against an ageist backdrop, which perceives old age as a negative period in an individual's life and one that places a burden upon the state and the more productive members of society. Therefore the agenda from the state's perspective is to pass control back to the individual through the individualisation agenda; however, most local authorities in England pay a lower hourly rate to those individuals on an individual budget as opposed to other service users whose budgets are managed by social workers. Therefore control also brings with it cost savings. This calls into question whether outcome-focused care and passing control to the individual are the main driving force behind their introduction or whether they are an effective vehicle for the government to roll out personalisation and achieve cost reductions.

The governmental policy debate therefore has to be set against the rising pressure from service users, carers and voluntary sector pressure groups, in order for care delivery to be developed in a manner that is more people-centred. The growing evidence of dissatisfaction with the delivery of home care and concerns about its quality led to the body of research outlined within this literature review. The basis of outcome-focused care can be seen to be focused on control over what is 'done for' the individual and how this fits with what 'they want' (outcomes). It can be seen by the studies of its implementation that system issues still hinder the ability to alter how care is delivered.

The conflicts of various government policies (e.g. SAP) and the fragmentation of service delivery present barriers to the implementation of outcome-focused care. Most concerning from a social work perspective are the barriers presented by social workers themselves. Social work, a profession that is supposedly service user-focused and concerned with empowering the individual appears to be one of the major stumbling blocks. The lack of trust in service user judgement and the retention of a paternalistic power role questions the effectiveness of social work training in instilling social work values in social workers. Therefore the measurement of well-being and quality of life issues for the older person not only impacts upon the practices of home care staff, but also those commissioning services, who are usually social workers. The issues raised by

this literature review will be interwoven in the analysis of the data gathered. This thesis, by utilising a realistic evaluation approach, which will be explained in the next chapter, will differ from the existing research by considering the mechanisms in operation in the delivery of outcome-focused care.

## CHAPTER 2: METHODOLOGY & METHODS

### 2.1 Methodology: Research Design

This chapter will outline the rationale for the choice of methodologies used in this thesis. It will demonstrate and explain why there was a need to adopt a pragmatic approach in this thesis, rather than adhering explicitly to one clearly bounded epistemological framework. The nature of social work means that it straddles a number of social science disciplines in order to develop a body of knowledge that it can claim relates to practice. This knowledge has mainly been developed (within the UK, at least) predominantly through the use of qualitative methods to study interventions with service users. I am persuaded, however, by Qureshi *et al.*'s (2004) argument that this has led to an over-emphasis on qualitative methods and either a rejection of quantitative methodology as a result of an ideological standpoint or, at best, an under use or ignorance of this competing methodology. This argument was also developed by Kazi (2003), who proposed that in order to fully understand social interventions, a process of realistic evaluation needs to be applied. This thesis accepts this premise and will develop his views in more depth later on in this chapter. Therefore, in order to measure the effectiveness of outcome-focused care, there is a need to use a mix of methodologies in order to measure the effectiveness of outcome-focused care on promoting the SWB of the participant group. The use of mixed methods will also assist the analysis of the complex interactions that occur in social work interventions, as outlined by Cheetham *et al.* (2000), who believed that interventions occur at the interface between the individual and the social. Therefore an understanding of this interface is essential as it is at this level that any interaction between the individual and the intervention is influenced by the multiplicity of factors shaping the phenomena being observed. In order to capture the multiplicity of interactions, this thesis will draw on established studies in the fields of outcome-focused care and well-being. These two different concepts have been developed in two very different disciplines. Outcome-focused care has been developed within the discipline of social work by Qureshi *et al.* (1998) and others who have employed an interpretive approach. However, the study of well-being has been developed within the discipline of psychology, with the use of deductive quantitative methodologies. Diener (2009) has placed well-being firmly within a positivist quantitative paradigm, where the emphasis has been placed on the development of reliable instruments for the measurement of well-being. Diener *et al.* (1999), in particular, have worked on the measurement of subjective well-being. This has led to an increased focus on well-being within the disciplines of psychology and medicine. This,

as has been stated earlier, can be contrasted with the general direction of British social work research, which is predominantly interpretive and qualitative in nature. Qualitative methods were the main methods used in the research carried out by Qureshi *et al.* (1998) and Glendinning *et al.* (2008) who are the main researchers in the field of outcome-focused care, with the production of evidence for the effectiveness of outcome-focused care being based on interpretivist inquiry with older people. In order to bring together these two different viewpoints, it has been necessary to adopt a realistic and evaluative perspective and apply a mix of methods to the research design, with the aim of working with dual paradigms within a coherent framework in order to allow the data to be analysed effectively.

### **2.1.1 Scientific Realism and Realistic Evaluation**

Scientific realism can be seen to have its roots in the realist traditions of the philosophy of science and in the works of Hesse (1974), Harre (1986) and Bhaskar (2008). These authors attempted to put in place a scientific explanation that avoided the traditional epistemological debates surrounding positivism and relativism, and which instead placed the focus on the explanation of the mechanics of the processes of the phenomena being studied. This theme has been developed by Pawson and Tilley (2006), and more specifically by Kazi (2003) in the field of social work. It has been established partly to counter the arguments of Reid and Zettergren (1999) and others, who are particularly critical of most social work knowledge and the under use within social work research of randomised control trials. Reid and others argue that social work knowledge is weakened by its lack of scientific rigour, and that rather than ignoring empirical techniques, they should be used to strengthen its rather weak knowledge base. This need for effective evaluation and for social work to prove its worth, and possibly its existence, is also a reason to apply realistic evaluation to the research process. Cheetham *et al.* (2000) believe that as society is continually changing, there is an increasing demand for social work interventions to demonstrate their effectiveness and financial worth. This was particularly the case in this piece of research. Outcome-focused care was perceived by the local authority as a method of intervention that would enable them to meet the external targets imposed upon them by central government. This model of care would also assist them to meet targets concerning personalisation and to address the perceived shortcomings of social work as a whole. In addition, social workers and care workers underwent an internal conflict surrounding the effectiveness of their existing model of intervention (time/task). There was also concern about the perceived need to prove their worth through the use of evidence-based practice to

funders and their health counterparts as a response to criticism that their practice was weak as it lacked an evidence base. Realistic evaluation requires that scientific rigour should be applied to an evaluation, but that a mixture of paradigms can be used to evaluate the processes that occur in social settings. This realistic evaluation will take place within a case study design.

A case study was chosen for this particular thesis as it enables me as the researcher to have an overarching framework to work within in order to understand the complex social phenomena that are taking place in the real-life situations being studied. This case study is concerned with the interactions and decisions of the participants, both professionals and service users, and how these decisions impact upon the effectiveness of the intervention. The nature and purpose of the use of a case study is summed up by Schramm as:

*'Case studies try to illuminate a decision or set of decisions: why they were taken and implemented and with what results'* (Schramm, 1971, cited in Yin, 2003, P.12).

This research also has a fit with a number of requirements of a case study as it is being undertaken on one local authority and is therefore defined by a geographical boundary and organisational structure that make it a unique entity to be studied. This unique entity, due to a combination of political, organisational and individual variables, means that the real-life phenomena being studied do not have easily defined boundaries between the phenomena and the context. Therefore the understanding of the different contexts within which outcome-focused care is being delivered is an important element of this study, especially as the research strategy of realistic evaluation has only a limited ability to control the context within which the different model of care is being delivered. Although a comparison group has been used, no experimental design was possible, and any findings without a greater degree of control over the context can only provide a partial understanding of what mechanisms are operating within the phenomena being studied. The multiplicity of variables, due partly to the number of different participants and the complex interactions produced by human relationships, means that the number of data collection points will produce rich data that can only be understood fully within the context of a case study.

The combination of a case study design and the use of realistic evaluation and statistical methods have been outlined by Koenig (2009) and also Flyvbjerg (2011). In their separate papers they present the view that the key principles of a case study are:

- Depth
- An understanding of the context and processes involved in the phenomena
- Also the understanding of the causes and outcomes that are involved in a phenomenon

These key principles can be enhanced by the combination of the case study design with the use of realistic evaluation and statistical methods as these methods allow the case study to provide more breadth and counter some of the weaknesses in the case study design, inasmuch as Flyvbjerg (2011) perceives that case studies provide a weak understanding of the wider significance of the occurrence of the phenomena in the population and that generally any statistical significance of the findings are left unclear. The use of these complementary methods will be covered later on in this chapter. This research therefore has utilised a case study design to provide a framework for the study to take place and in order to provide clear boundaries to the scope of the research being undertaken.

This case study is therefore undertaking an evaluation of a social programme. Pawson and Tilley (2004) note that these social programmes are used for a purpose, which in this case study concerns correcting deficiencies and alleviating inequalities in the provision of home care services. The purpose of outcome-focused care, it is hoped by those implementing it, is to improve the current social intervention (time/task model of care). Therefore, the hypothesis that this outcome-focused care programme will improve older persons' sense of well-being has been tested. Using realistic evaluation in the study of outcome-focused home care will provide a sound base for any larger studies to be conducted with a larger and more ethnically diverse sample group.

This thesis therefore could be considered as following a post-positivist perspective; one that accepts that the true nature of cause and effect is hard to establish in social settings, but believes that in order to establish *and* understand the effectiveness of an outcome (and in particular, that of a social intervention) the use of realistic evaluation has the best fit. By applying realistic evaluation to this thesis, this type of evaluation could be considered to be a 'white box evaluation' (1994:369); one in which the inner workings and the operation of the component parts are analysed to see how they are connected (Scriven, 1994). In this thesis, there are a number of complex interactions that needed to be considered, and only by using realistic evaluation can a full explanation be devised for the phenomena being explained. These processes involved the interactions between the two models of intervention and how these models were actually implemented by

care staff, social workers and their higher managers. Therefore the question arises: did the intervention as it was actually perceived by the professionals truly reflect the effect on service users that was expected? And, conversely, did the intervention as it was perceived by the participants have the same shape as the outcomes desired by the professionals?

Pawson and Tilley (2006) present realistic evaluation as a way of establishing ‘what works’ in social programmes. This is appropriate for a social care context. Social programmes are merely a cause of social change. If we consider outcome-focused care to be a social programme, then the following would be applicable: As outlined in Chapter 1, Qureshi *et al.* in their research from 1998, established that older people wish for and benefit from having control over the outcomes that are generated by the care delivery process. In this case, the local authority and professionals wish to change the way in which care is currently delivered and have therefore taken the decision to implement the process of delivering outcome-focused care. Therefore, the method of care delivery is an attempt to socially engineer the outcomes of the care process. In this particular case study, it is the local authority that dictated the context within which the process of social change occurred. Pawson and Tilley (2006) highlight that what is considered to be a successful social programme is only relevant if the appropriate mechanisms are applied to the correct context.

### **2.1.2 Rationale for Mixed Methods**

In order to capture the key elements of realistic evaluation, this thesis will use a mixture of qualitative and quantitative methodologies. The use of a mixed methodology has gathered pace over the last 20 years, and has been driven by a need for a pragmatic approach to social inquiry in order, in the words of Datta (1997:33), “*to fully understand the social world from both viewpoints of generality and particularity.*” Research practitioners who are predominantly based within health and education need to have a distinctive methodology that allows for a combination of dispassionate neutrality, whilst allowing for such democratic ideas as equity and justice to be integrated into the analysis of the research results. This pragmatic worldview is derived from the work of Pierce, James, Mead and Dewey (cited in Cherryholme, 1992, p.14), who present the need for a research process that is dominated by a pragmatic consideration of what works in real world social settings as opposed to a strict adherence to any one paradigm. Therefore, this thesis takes the stance of Patton (2002) and Reichardt and Cook (1979), in accepting that traditional paradigms are logically

independent, which enables them to be mixed and matched in various combinations to allow for the demands of the particular context being researched. This pragmatic approach has been chosen for a number of competing reasons. This thesis aims to examine the effectiveness of a method of intervention on older people's sense of well-being, and is concerned with exploring whether it could be suggested that the model of intervention combined or influenced by other factors in the care relationship that affect the individual's sense of well-being.

This pragmatic approach is also important if the research findings of this thesis are to influence policy makers, or at least inform the debate on the provision of home care within the UK. David Blunkett (2000), the then Labour Minister for Education, expressed his frustration with the amount of research that was produced that had no real relevance to people's lives or the policy debate that had an impact upon people's lives. This perceived divide often meant that policy makers did not take research into account when making policies. Stone (2002) and Parsons (2002) believe that policy makers increasingly require research to have good validity, and that the cultural interpretations of knowledge, which are seen as valid by policy makers, tend to involve recognised scientific techniques. Therefore, the use of different research methods should allow for the dissemination of the findings to be understood by both policy makers and practitioners. Policy makers prefer easy-to-digest measurements of the effectiveness of interventions which are best displayed by the use of quantitative methods. The aim of this thesis is to provide these measurements, but also to develop a deeper understanding of what these findings mean to the individual by the application of qualitative techniques, in order to facilitate a more well-rounded debate.

In order to ensure that this thesis develops a logical theme that allows for the application of a mixed methodology, the framework outlined by Tashakori and Teddlie (2003) was followed. This framework divides the research design into primary and secondary dimensions. This particular piece of research will follow a concurrent embedded strategy (Creswell, 2009), which is identified by its use of a single data gathering phase, as occurred in this research. The participant interviews enabled the questionnaire data and the qualitative data to be collected simultaneously and this was undertaken for a number of practical and ethical reasons. The nature of the participant group (older, frail adults) meant that participating in the interview process could be extremely taxing and tiring and although all of the individuals had consented and also had the capacity to be interviewed, a conscious decision was taken to limit the intrusion into their lives by the research process, which, as a longitudinal study, was conducted over a long period of



time. Therefore, the necessary data for both the qualitative and quantitative aspects of this research were gathered at the same time via semi-structured interviews (see Table 2.1). By following the concurrent embedded strategy, the database was divided into two parts: the primary and secondary sections. The primary method in this thesis was qualitative and followed the process outlined by Tashhakori and Teddlie (2003), with the element of the research examining a different set of questions from the secondary database (quantitative), which involved the use of a questionnaire covering a different group of questions.

Therefore, the data gathered from the participants' interviews were divided into quantitative and qualitative, with the vast majority of the data being considered as qualitative. However, this thesis also gathered data from different groups outside of the intervention itself. These elements of the case study (interviews and focus groups) were again mainly qualitative, with the exception of an analysis of the cost of the different types of intervention. The final process of data gathering involved participant observation whereby home care workers were observed providing direct care to the participants.

The non-service-user component of this research started with the one-to-one interviews with the social workers responsible for the commissioning of services for the participants taking part in the research. The social workers also took part in two focus groups, and data were generated through the use of qualitative methods. In addition to this, a number of unstructured interviews took place with senior managers and the individual directors responsible for the commissioning of services for the local authority. All of these interviews were unstructured and qualitative with the data from these observations once again gathered through the use of qualitative methods. Therefore, although this thesis follows a mixed methods framework, the majority of the data gathered and analysed were qualitative.

Both the service user elements and the focus group conversations were recorded and transcribed at a later date. However, a high proportion of the older participants did not want their conversations recorded and in these cases the interviews were noted and transcribed within a few hours of the interviews.

### **2.1.3 Rationale for Choice of Research Tools**

By adopting a mixed method approach, this study needed to use research tools that would allow for the data collected to complement each other rather than stand alone as

separate data sets. With this in mind the study utilised interviews and questionnaires. The purpose of the interviews was to develop a deeper understanding of the experience of the service users and how the differing interventions might impact upon their experience of care. These qualitative interviews, as outlined by Kvale (2009), were used to attempt to understand the participants' 'point of view', in order to unfold the meaning of their experiences. These experiences provided data for the analysis of how the intervention has or has not had an impact upon the subjects' own subjective well-being. The advantages of interviews are that they enable the interviewer, when considering emotions, to experience the feelings expressed by the participant during the interactive process. As Wallbott and Scherer (1986) highlight, this experience cannot easily be derived from quantitative questionnaires. Kvale (2009) describes a semi-structured interview as "*an interview with the purpose of obtaining descriptions of the lived world of the interviewee with respect to interpreting the meaning of the described phenomena*" (p.8). Interviews, as outlined by Walcott and Scherer (1986), are the most comprehensive way of obtaining self-reports on emotional and personal experiences as they allow the interviewer to explore an emotional experience (in this case well-being) through the use of interactive questioning. It is the interactive nature of interviews which makes them incredibly flexible as a source for generating potentially rich data on individuals' self-expressed interpretations of their worldviews. Interviews, as noted by Brown (1992), have a perceived advantage over questionnaires and other techniques in that they allow the researcher to have direct contact with the interviewees' lived experience, and because they facilitate a rapport with those individuals participating in the research process.

However, it is worth highlighting that there are a number of shortcomings involved in the use of interviews. Interviews are costly and time-consuming, and it is for these reasons that the number of in-depth interviews was limited to ten participants in each group (intervention and comparison). In addition, Walbott and Scherer (1989) believed that the personal nature of interviews could possibly prevent the participant from presenting a true view of their lived experience, instead providing the researcher with a worldview that they believe is what the researcher wants to hear. This issue was identified specifically by Hall *et al.* (2009) when conducting research on older people in residential care. Hall *et al.* found whilst conducting qualitative interviews that older people were reluctant to make comments about their care as they were concerned about the impact this might have upon their relationship with those caring for them. This is an issue that I also need to be aware of when analysing the data gathered via interviews,

although explaining the process of anonymisation to the participants did appear to overcome their initial reluctance to comment on the care they received. This issue was also highlighted by Kvale (2009), who sees the interviewer's data-gathering skills as essential in order to counter this risk. Therefore, taking these concerns into account, the use of both questionnaires and interviews should limit the risk of the data being too skewed.

The quantitative tools used the MYCAW and the MYMOP were developed by Paterson (1996:2007). The first MYMOP questionnaire was initially for use by practitioners in primary care settings in order to measure patients' self-identified physical well-being. Paterson accepted that (medical) outcomes belong to the patient, and it is how the patient experiences their physical illness that will determine what they consider to be the most appropriate medical outcomes. The nature of illness, especially with older people's medical conditions, means that it is rarely a one-off occurrence, and therefore any measurement tool needs to measure changes in the subject's condition over time. Although the MYMOP questionnaire was not primarily designed for use with older people it presents a number of key strengths that makes this questionnaire highly appropriate for use as a data-gathering instrument for this thesis. The MYMOP questionnaire uses Likert scales (as does the MYCAW questionnaire) as the main means of measurement in the questions set, and this therefore makes the questions quick to answer and allows for measurement between different completion points. The outcomes were self-reported which allowed the participants to express how they viewed their physical health, rather than using the views of health professionals or carers. As the subjects' physical problems were self-identified this allowed for a wider spectrum of physical problems to be expressed and did not require the researcher to have any in-depth medical knowledge. In addition, Paterson wanted this tool to be used by researchers from a wide variety of disciplinary backgrounds due to the self-identified nature of the subjects' physical condition, which allows the tool to be used by different health and social care professionals.

The interesting factor, when reviewing Paterson's (1996) overview of the considered usage of the MYMOP tool, was the lack of any involvement of social workers in the teams using the MYMOP questionnaire. This reflects the stark division between what is considered to be health and social care. Lewis (2001) sees the boundary between health and social care in the UK as the most problematic within the Western world. As was outlined in Chapter 1, home care is considered to have a low status within the field of social work, which already has a low status. This division between health and social

care will become more apparent in Chapter 5 when it becomes clear that social workers did not tend to view any of the participants' physical concerns as coming under their remit, whilst most of these physical needs were met by the salaried home care staff they had commissioned. This seems to present a real dilemma as the people responsible for purchasing care ignored a major element of individuals' well-being as they perceived this to be within the remit of district nursing, even if a district nurse was not currently involved in the individual's care. Therefore, this research also included the gathering of data on physical health in order to gain a wider view of the participants' sense of well-being.

The second of the two questionnaires, MYCAW (Paterson, 2007) has a similar format to the MYMOP document and has been used in various settings. Initially, it was used to follow cancer patients through their treatment, and more recently, it has been used with patients receiving palliative care (Paterson *et al.*, 2007). The 2007 questionnaire is an amended version of the MYMOP questionnaire, and was initially piloted in 2003 at two centres used by patients experiencing cancer. Following these pilots, the questionnaire was amended. This version was then administered to a further 157 patients, and eventually 345 patients completed both the initial administration and then a follow up session. The provided coding tool required each participant to answer three questions. The participant was asked to identify their two main concerns, and then to rank these concerns using a Likert scale. They were also asked to answer a question about their well-being which was again scored using a Likert scale. Therefore, both the MYMOP and the MYCAW questionnaire have been administered to vulnerable individuals experiencing chronic or even terminal illnesses. Bearing these factors in mind, the questionnaire was designed to be administered in less than 10 minutes in order to minimise any impact that being questioned would have on the participant. The use of the MYCAW questionnaire in this thesis was also intended to allow older participants to express two concerns, which were not primarily related in any way to their physical condition. The data in these two questionnaires provided a base for the semi-structured interviews and were therefore a useful common component in both the qualitative and quantitative sections of this thesis.

## **2.2 Methods**

A full overview of the research timetable is outlined in Appendix 3; with this timetable showing that prior to the commencement of the main study a pilot study was undertaken as a commissioned evaluation with 10 service users. This mini study's purpose was to

test out the practicalities of undertaking the wider study of outcome-focused care, and adapt the research design accordingly. This pilot only focused on the data-gathering process from the older participants and did not involve any data gathering from the social care staff or the undertaking of any participant observation. The 10 participants were divided into an outcome-focused care group and a time/task comparison group. The MYMOP and MYCAW questionnaires were piloted with the additional questions (see appendix 2) and these subsequent data were analysed to see whether the data-gathering process was effective for the research questions posed. Also, ethical oversight was provided on this pilot that led to the development of clear ethical protocols for the researcher to raise any ethical concerns with the local authority and a clearer process for reporting potential abuse or neglect. From this study the data from four service users were used in the wider study. These four individuals were given an additional interview once the main study had started so that the data-gathering timescale fitted with the larger study, as the follow-up interviews were conducted at the six-month stage as opposed to at 13 weeks in the pilot. The remaining six participants either chose not to continue or the data could not be used due to their ill health or unfortunate death.

### ***Main Study***

Table 2.1 below displays a breakdown of the type of data gathered and at what points this information was obtained throughout this case study.

**Table 2.1 – Data Gathering**

Data Gathering	Initial	Follow Up	Data Type
Participants	April to July 2008	Up until April 2009 (Nov 2008 Pilot participant)	Qualitative/Quantitative
Social workers	August 2008	N/A	Qualitative
Participant Observation	Sept/Oct 2008	N/A	Qualitative
Focus Groups	September 2008	N/A	Qualitative
Senior Managers	October 2008	N/A	Qualitative
Cost of service	April 2009	N/A	Quantitative

The table above shows how the participant interviews enabled the questionnaire data and the qualitative data to be collected simultaneously, and this was undertaken for a number of practical and ethical reasons. The nature of the participant group (older, frail adults) meant that participating in the interview process could be extremely taxing and tiring, and although all of the individuals had consented and also had the capacity to be

interviewed, a conscious decision was taken to limit the intrusion into their lives by the research process, which, as a longitudinal study, was conducted over a long period of time. Therefore, the necessary data for both the qualitative and quantitative aspects of this research were gathered at the same time via semi-structured interviews. By following the concurrent embedded strategy, the database was divided into two parts: the primary and secondary sections. The primary method in this thesis was qualitative, and followed the process outlined by Tashhakori and Teddlie (2003), with the element of the research examining a different set of questions from the secondary database (quantitative), which involved the use of a questionnaire covering a different group of questions.

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The non-service-user component of this research started with the one-to-one interviews with the social workers responsible for the commissioning of services for the participants taking part in the research. The social workers also took part in two focus groups, and data were generated through the use of qualitative methods. In addition to this, a number of unstructured interviews took place with senior managers and the individual directors responsible for the commissioning of services for the local authority. All of these interviews were unstructured and qualitative, with the data from these observations once again gathered through the use of qualitative methods. Therefore, although this thesis follows a mixed methods framework, the majority of the data gathered and analysed were qualitative.

Both the service user elements and the focus group conversations were recorded and transcribed at a later date. However, a high proportion of the older participants did not want their conversations recorded and in these cases the interviews were noted and transcribed within a few hours of the interviews.

### **2.2.1 Selection of a Sample Group**

The research took place over an 18-month period and involved 69 service users. The length of time for which the users had been using the service was dependent upon their level of need. The sample group consisted of individuals over the age of 65 years who could be considered as vulnerable adults and whose vulnerability included physical needs but excluded any mental health incapacities, due to ethical considerations. The sample group included individuals with varying levels of need but excluded anyone experiencing any form of incapacity such as dementia.

The sample was purposively selected by social services and not the researcher; however, for operational reasons, social services were not prepared to randomise the sample groups. This decision was mainly down to the practicalities and difficulties in trying to ensure that randomisation occurred, and the local authority was concerned that it would be time consuming and costly. This raises a number of problems: social services may have introduced a potential bias through their selection of individuals who may have been selected for their ability to comply with the new method of intervention and may have excluded those who may have been less compliant. The matching of the comparison group was also the decision of social services, and therefore there is a risk that these participants may have been chosen because they presented a more negative view of their care, possibly resulting in a more positive appearance of the new method of care delivery. In order to limit this problem, the project's steering group compiled a pro-forma listing the different characteristics of the service users to be selected for the evaluation. This was applied to both the intervention and the comparison groups. In addition, the speed at which individuals were attached to the project was dependent upon the allocation of resources to increase the size of teams delivering the new model of care.

The nature of the sample group meant that this research had a high attrition rate for a number of different reasons in addition to a personal wish to withdraw being expressed by the participant. Due to the age of the sample, unfortunately, five individuals passed away during the research process and therefore only provided partial data and had to be excluded from the final results. Other members of the sample group experienced deterioration in their physical health, which caused a period of hospitalisation or residential care. The local policy dictated that after a period of two weeks in hospital or a residential setting the service user was withdrawn from the project. This affected 11 participants who were also excluded from the final dataset. Four of the service users

also started to experience the onset of conditions affecting their mental capacity, which also excluded them from continuing in the research process as they could not be considered to have provided informed consent.

### **2.2.2 Access to Participants**

Access to the professional participants and the service users was enabled by the adult social services department who required a service evaluation of the effectiveness of their provision of this new intervention, namely outcome-focused care. I had strong links with this particular department of social services as my university at the time provided training to their care and professional staff. This relationship was used to develop an agreement that I would provide a small evaluation for the service if the service would allow access to participants for some further research towards a doctoral thesis. This evaluation was used as a pilot study for this doctoral thesis, and was built upon in order to provide a more in-depth study. However, given the vulnerable nature of the service users, before any access took place, I was required to submit details of the data-gathering exercise to the local authority's ethical approval officer who also required monthly research reports. In addition to the reports, I also attended an ethics meeting every three months in order for my activities to be scrutinised by the local authority's ethics committee members. More details of the ethical considerations will be provided in the next section of this chapter.

### **2.2.3 Ethical Considerations**

This group of participants is defined as a vulnerable group under the 2005 Mental Capacity Act (MCA; DoH, 2005) which came into effect on 1st April 2007. Therefore, this required careful consideration to be given to the research design. The Act provides a statutory framework to empower and protect vulnerable people who are not able to make their own decisions; it states who can make decisions on behalf of people who lack the capacity to do so themselves, and enables people to plan for a time when they may lose that capacity. The Act also sets out the following regulations regarding social care research involving people who may lack capacity:

- Research involving or relating to a person lacking capacity may be carried out if an 'appropriate body' agrees that the research is safe, relates to the person's condition and cannot be carried out effectively with those who have mental capacity;



- The benefits to the person taking part in the research must be greater than any risks or burdens. If the purpose of the research is to gain new scientific knowledge, there must be minimal risk to the person and minimal intrusion or interference with their rights;
- Carers or nominated third parties must be consulted and agree that the person would want to take part in the approved research project;
- If a person shows resistance or indicates that they no longer wish to take part, the person must be withdrawn from the research project immediately.

The research complied with all of the criteria defined above. A decision was made not to include any individuals whose mental capacity could be brought into question; therefore all participants were assessed as having full capacity. This however did exclude a large number of potential participants and is an area requiring future research. In addition to the ethical concerns raised by the Mental Capacity Act 2005, there are a number of other ethical considerations that took place prior to and during this case study. These participants as defined in the policy document No Secrets (DH 200) were considered to be vulnerable adults and this piece of research would be examining a model of care that was intimate in nature. To protect the participant an ethical panel was set up within the local authority which oversaw the research process. The panel met on a monthly basis initially and then moved to a three-monthly basis once the initial data gathering had been completed. A protocol was established so that participants could report concerns to their care managers about the researcher or the research process, and it was made clear to the participants that they could withdraw from the project at any point. In addition to this, the researcher met with each participant prior to the research taking place to explain the project and also to assure them about what would happen if any concerns they might raise especially around abuse. Serious concerns would be dealt with via the local authority's Vulnerable Adults Procedure and, if necessary, the research project would be suspended.

The introduction of outcome-focused care was being piloted in the hope of improving the lives of the older people who would be in receipt of this model. This raised an ethical dilemma that was solved through protracted negotiations between the researcher and the local authority. The project was time limited and, if considered by the local authority to be a success, would be continued and expanded across the adult care sector within the metropolitan borough. However, if the local authority decided not to continue with the project then some service users would have had their lives improved by outcome-focused care only to have it removed at some arbitrary date in the future.

Agreement was gained from the local authority that, given the small sample size, individual care packages would be agreed with the participants to ensure that a similar service to the outcome-focused care model would be continued if the service user so wished.

The sample consisted of individuals aged 65 years and older who, according to the Department of Health: *Fair Access to Care* document fulfilled the criteria of critical and substantive need. It is likely that the majority of the research sample met the first criteria. The exact sample size was 69 participants, 40 of whom were used in the final data analysis. The twenty five participants who were not included in the final analysis either left the study through choice or as a result of their deteriorating health leading to hospitalisation or sadly due to their death.

#### **2.2.4 Quantitative Methods**

The sample was divided into two groups; an intervention group (outcome-focused) and a comparison group receiving the traditional model of care (time/task), with data being gathered from both groups. Both groups were asked the same set of questions and completed identical questionnaires. The data were then analysed in order to develop any core findings. This quasi-experimental method was chosen for a number of reasons. The data were gathered in a real-life setting where randomisation was not an option and therefore it was impossible to design a study that could account for all the confounding variables that would have an effect on the outcome of the intervention. Therefore, the aim of the statistical analysis was to identify the probability that the type of intervention had influenced the individuals' sense of self-identified well-being, whilst accepting that these findings were gathered in an imperfect, non-randomised study.

Questionnaires were chosen as the main source of data for the quantitative part of this thesis. They have a number of strengths which make them effective for gathering data, especially when dealing with frail individuals. They are time-limited and also require the individual to provide a limited response, and they provide a platform for the interviewer to use in order to frame the interview and enable him or her to ask consistent questions across the sample group. In order to gather measurable data on a subjective issue such as well-being, the data-gathering process needs to provide a level of consistency that allows for individual differences to be measured within a broad band.

A key issue for this research was whether the model of intervention employed affects subjects' self-identified sense of well-being and their overall quality of life, and therefore an accurate tool with which to measure well-being was essential for this thesis. Well-being and studies of the emotional state of happiness have mainly developed in the post-war period. A common theme throughout these studies is their dependence upon the use of first-person reports using numerical scales. These scales have been validated across a large number of studies and are considered to possess an adequate level of convergence and validity (Diener, 1984; Diener & Oishi, 2000; Diener, Lucas, & Suh, 1999). The main thrust of well-being research has focused on the measurement of well-being as an effective measure of efficacy and the impact of intervention on individuals' overall health, with well-being and happiness being seen as key measures.

### **2.2.5 Qualitative Research**

The overarching research strategy for this thesis is the use of a case study design. The phenomena being identified in the case study in this thesis are the various effects of different methods of care delivery, the interaction between the actors involved (care staff and service users) and the impact of this interaction upon the recipient's self-identified sense of well-being. Yin (2003) notes, that the case study design is highly relevant when considering 'why' and 'how' questions.

The qualitative data-gathering process involved the use of one-to-one interviews with service users who were receiving the provision of either time/task or outcome-focused home care. This component comprised the data from social workers and was drawn from two focus groups and four individual interviews conducted with the same social workers who were the commissioners of the home care services for the sample group. The penultimate component of the qualitative data-gathering process involved two unstructured interviews with the Director of Adult Social Care and the Head of Commissioning for Adult Services for the local authority.

Another element of the qualitative data-gathering process occurred through the use of participant observation, explored in depth in Chapter 4. This method was used to examine the qualitative data linked directly to the intervention participants and to those paid carers who are delivering the care.

The data from the participants were drawn from the use of semi-structured interviews and the questions can be broadly grouped into five areas, as shown in Table 2.2. Once these initial questions had been posed to a participant, the interviewer developed

unstructured questions in order to develop a picture of the phenomena that was unique to each individual participant. These in-depth interviews, as outlined by Sennett (2004), allowed the interviewer to probe deeper into the responses of the interviewee.

**Table 2.2 - Questions & themes**

<b>Structured questions</b>	<b>Themed area</b>
Do you have family and friends that you visit or that visit you?	Family-based and informal care and support
How often do you see your family?	Level of contact
When your family visits, how long do they stay for?	Level of contact
How far away does your family live from you?	Family-based and informal care and support
What has been the most important thing about the care you have received?	Formal paid care issues
How long does your paid home care worker stay with you on each visit?	Formal paid care issues
<b>Questions developed from the MYCAW questionnaire</b>	
How would you rate your general feeling of well-being?	Emotional sense of well-being
What has affected your concerns?	Emotional sense of most pressuring concern

The interviews used in this thesis allowed the themes which were ascertained in the quantitative element to be developed, as noted by Pawson and Tilley (2006), in order to provide an understanding of the mechanisms that occur in a programme of social intervention and how these different processes affect the effectiveness of an intervention. Qualitative interviews enhanced the overall dataset by facilitating an understanding of these processes. Therefore, the interviews gave the research the capacity to add richness and depth to the initial quantitative findings and to present a more rounded view of the phenomena being studied. The findings generated through the quantitative data analysis (Chapter 3), and the qualitative data analysis (Chapter 4) enabled the identified themes to be developed and analysed to create an understanding of the context, the processes and the mechanisms which occurred in this intervention, as is appropriate for the application of realistic evaluation (Kazi, 2003).

It was mentioned earlier in this chapter that the data would be considered in a staged approach. This chapter will now move on to consider the service user qualitative data-gathering process, which involved the direct observation of the interaction between

service users and the paid carers during the process of paid care delivery. This part of the research utilised the methodology of participant observation. The form of participant observation used in this study can be described by Gold's (1958) typology of participant observers' roles as 'the observer as participant'. In this form, the researcher has minimal involvement in the social setting being studied. I was known to the participants as the initial semi-structured interviews had already been conducted, however I would be drawn into conversation and therefore could be considered to influence the phenomena occurring. This method could be best described using Wolcott's (1990) definition of 'micro-ethnography', as this form of ethnography allows the study to focus on a particular aspect of the intervention, which in this case was how paid care was delivered in a practical sense.

This method was chosen as it enabled the micro-relationship between those being cared for and those caring to be observed. This form of research has some advantages, as highlighted by Bryman (2008); it allowed me to be immersed in the social setting within which the care was delivered, and it facilitated regular observations of the interactions between the individuals involved. Most importantly, this method allowed non-verbal interactions to be observed, which make up the majority of human interactions. The precise details of these observations will be covered in part two of Chapter 4.

The next part of this chapter will focus on the non-direct care professionals' views on outcome-focused care. The purpose of this stage is to ensure a 360 degree view of the intervention process, from those responsible for making the decision to implement and fund the process, to those who were responsible for commissioning the service on behalf of the participants. This aspect of the research was also broken down into different elements. The first elements involved one-to-one unstructured interviews with social workers (service commissioners), the service director and the Head of Commissioning Services. These interviews were one-off events, designed to capture the views of the professionals at the beginning of the intervention. The timing of the interviews was not within my control, but had to take place within a limited timeframe as the service was undergoing a process of reorganisation, which meant that a number of individuals were only available for interview for a limited period. This was also the case when using the method of qualitative data-gathering focus groups, which will be examined next.

## 2.2.6 Focus Groups

One of the main advantages of the use of focus groups is that they allow data from a large number of individuals to be gathered simultaneously and within a relatively short timeframe. This method also allows for an understanding of the occupational culture which can be displayed in group settings. This is particularly relevant especially when conducting research into social care. The social workers were about to be redeployed and therefore their contact with the participants' day-to-day lives would be lost. In addition, social workers tend to be out of the office for long periods and can be called out on emergencies. This meant that individual interviews would be time-consuming and, if time was limited, may not generate particularly beneficial results. The main purpose of the focus group questions was to illicit what the service commissioners actually understood to be outcome-focused care and how, given this understanding, they had selected the participants for the service. Finally, the focus groups aimed to elicit from the commissioners (social workers) what they considered to be the main strengths of these interventions. The two focus groups were limited to one hour each and took place in the meeting rooms of a Social Services office. Actually getting all of the relevant commissioners together required separate sessions in two different localities. In order to ensure consistency across the different groups, the commissioners were given four main structured questions which are set out in Table 2.3.

**Table 2.3 – Focus groups**

<b>Subject being examined</b>	<b>Questions used</b>
Perceptions of the model	What do you understand by the term 'outcome-focused care'?
Perceptions of both models	Can you explain what the difference is between outcome-focused care and the current time/task model?
Establishing changing perceptions	Do you see these models as having different strengths and weaknesses?
Understanding process	What factors influenced your decision to select your clients for the new model of outcome-focused care?

The findings from the focus groups and the interviews will be provided in Chapter 5, when the impact of the intervention will be analysed from the perspectives of these professionals

### 2.3 Analysis

The analysis of the quantitative data was conducted using the computer software package PASW statistical analysis version 18. This software in 2010 was the current version of the long-standing SPSS package which is widely used in social science research. The initial analysis of the data that were gathered involved the production of frequencies to provide some descriptive statistics. The data were initially examined as a whole, with the primary focus being on the establishment of the sex and age distribution of the sample. Once the nature of the sample group was established, the set questions from the questionnaire were analysed by examining the responses to the questions which did not involve the use of a Likert scale. The distribution of the participants' answers was then analysed in order to establish whether any findings could be drawn from their responses. The results of the MYCAW and the MYMOP questionnaires were analysed by the application of a paired T-test. This choice of statistical test was determined partly by the small sample size ( $n=40$ ) and because it fulfils the criteria stated by Dancey and Reidy (2007) for an appropriate statistical test when the following elements of the study are present: there is some attempt to manipulate the independent variable which, in this thesis, is the introduction of a different model of care (outcome-focused); the analysis occurs between an intervention group and a comparison group; the analysis uses a process of comparison; and finally the sample group is not randomly selected and there is limited control over how or to what group the participants are allocated. The application of this test enabled the measurement of variance in the scores established by the use of the MYCAW questionnaire and established whether or not there is an association between the type of intervention provided and the individuals' self-reported sense of well-being.

The qualitative themes in this thesis were developed from an initial reading of the textual data in order to provide an overarching structure of codes (theoretical codes established from the questions). These themes were then placed in categories and sub-categories for the remaining data to be analysed within. This process of coding and template development was dynamic, as the templates were constantly being altered as a result of the analysis of the textual data. The coding structure was developed using a hierarchical process of themes and sub-themes. This process allowed the exploration of the possible relationships and trends within the themes.

## **2.4 Conclusions**

The aim of this chapter has been to provide an explanation for the decision to conduct a longitudinal case study utilising quasi-experimental design within the framework of realistic evaluation. This chapter has provided an overview of the staged approach utilised in order to gather data from the service users and professionals involved in this evaluation of outcome-focused care. To summarise, this thesis has involved the use of participant observation, semi-structured interviews, focus groups and questionnaires. The aim of this research was first to enable some of the most vulnerable and socially-excluded members of society to express their views on the care services that are provided and how they have affected their sense of well-being. The thesis also sought to make sense of the interactions that occur in the provision of home care and how the context and mechanisms involved in home care delivery lead (or not) to the outcomes that those who implement policy (senior managers) seek to achieve. This chapter has summarised how realistic evaluation has been utilised to answer the ‘what’ and ‘how’ questions about outcome-focused care.



## **CHAPTER 3: QUANTITATIVE FINDINGS**

### **3.1 Introduction**

Chapter 3 will present the analysis of the data gathered via the questionnaires completed by the service users. This section of the thesis will primarily provide descriptive statistics in order to provide a scoping overview of the service user group. It will firstly present the findings from descriptive statistics and the application of statistical tests, (Paired T-test) to analyse the data on physical and subjective well-being. The purpose of this analysis will be to examine patterns in the frequency data and whether there is any difference between the intervention group (outcome-focused) and the non-intervention group (time/task) in terms of the individual participants' well-being. This chapter will also present the data analysis around the themes of social isolation and the level of family involvement in the participants' lives and, additionally, it describes how the participants view their paid care provision. The hypothesis posed in this research is that the intervention of outcome-focused care will in some small way have impacted upon an increased service user self-reported sense of SWB. Therefore conversely, the null hypothesis would be that the type of intervention provided to service users did not have a differential impact on their SWB.

### **Findings**

An analysis of the data established that there was a significant association between the outcome-focused intervention and an improvement in the individuals' sense of well-being.

### **3.2 Data Gathering**

The quantitative data were gathered from two validated questionnaires: Measure Yourself Medical Outcomes Profile (MYMOP: Paterson, 1996) and Measure Yourself Concerns and Well-being (MYCAW: Paterson *et al*, 2007). These two instruments have been validated extensively in primary health care and were based on the larger SF-36 health survey (Ware and Sherbourne, 1992). The designers' purpose in developing these two questionnaires was to provide a tool that would enable practitioners to measure changes in self-identified outcomes of patients, and to establish what factors impacted upon their sense of physical and mental well-being. In addition to the questions posed in the MYMOP and MYCAW questionnaires, some additional questions were used to

enable the study to measure the level of social isolation and satisfaction with the paid care provided

The questionnaires were administered during face to face interviews by the same researcher. Face to face interviews were chosen to cover a number of considerations. As mentioned in the previous chapter, given the frailty of the client group, it was considered important to limit the amount of data gathering in order to have the least possible impact on each participant's physical and mental health.

Two interviews were conducted, one at the beginning of the intervention and one six months later. Identical questions were asked at each data gathering point to allow for a comparison between the participants' scores. Prior to the main data-gathering exercise, the questionnaires were piloted on service users to check that the questions gathered data in a consistent manner. Only once the piloted document had been validated were the final questionnaires administered. The interviews lasted around an hour, dependent on the participants' physical ability to maintain concentration. None of the interviews lasted less than one hour and none exceeded 1 hour and twenty minutes.

### **3.3 Sample Profile**

The sample size consisted initially of n=69 participants. However, after some participants' unfortunate death or deteriorating ill health, the final sample size was n=40. The sample was divided into two cohorts, one cohort being the intervention group: outcome-focused care (n=20) and the other group being a comparison group: time/task (n=20). All participants were over the age of 65 years and were assessed as having care needs that were critical and substantial (Fair Access to Care Services, DoH, 2003). The sample participants were selected by social workers according to need and service capacity. Service users were allocated the different care services with places being allocated on a first come first served basis. However, given the nature of this client group the majority of the service users were experiencing severe physical difficulties which impacted upon their ability to self-care and ultimately live independently. No service users were accepted onto the study if they were considered to lack mental capacity as defined in the Mental Capacity Act, 2005. Table 3.1 provides a breakdown of the individual characteristics of each participant in the intervention group, including age, sex and physical condition, and shows that the group are all experiencing some form of physical incapacity. This incapacity is considered to be at such a level that they would be unable to live independently without the support of paid carers. The participants themselves have described their physical mobility and physical health

problems. The majority of the service users have severe difficulty moving around and a number could only be moved either with the use of hoists or by two members of staff who have been trained in moving and handling techniques. This group reflected the overall make-up of service users receiving the support of local authority funded care services. However, because this particular piece of research has excluded individuals experiencing mental capacity issues, it has precluded a large proportion of the local authorities' service users group and especially those suffering with dementia. Although these service users were also receiving the new model of intervention (outcome-focused care), ethical approval was not sought to investigate this group and this remains an area requiring further research. The MYMOP questionnaire allowed the service users to identify two physical problems that were of the most concern to them. These physical incapacities could be broken down into three main categories: the first category could be seen as physical mechanical problems induced by degenerative bone conditions and the severe pain this induces (n=8); the second category could be seen as physical mobility problems induced by neurological conditions such as strokes, and balance or dizziness issues caused by circulatory problems with these combined conditions (n=8); and the final main category revolved around the loss of sight (n=3), with one service user's mobility problems being attributed to clinical obesity.

**Table 3.1 - Outcome-focused group participant profiles**

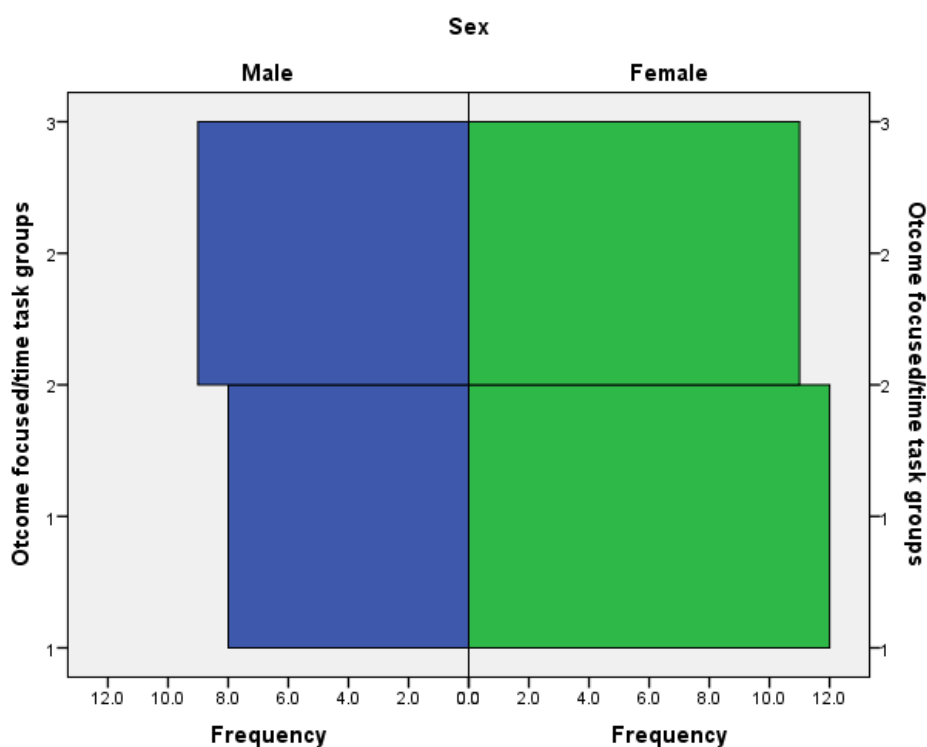
<b>Participant ID</b>	<b>Age</b>	<b>Gender</b>	<b>Physical health 1</b>	<b>Physical health 2</b>
OFAG75	75	Female	Severe arthritis	Leg/joint pain, severely restricted mobility
OFAL80	80	Female	Hip pain	Severe mobility problem, inability to walk
OFAJ65	65	Female	Post stroke (full mental capacity)	Inability to walk, difficulty communicating
OFGJ79	79	Male	Back problem, intermittent paralysis	Lack of upper body strength
OFMB77	77	Female	Lack of mobility (housebound)	Severe pain
OFMJ89	89	Female	Poor sight	Severe back pain
OFBN92	92	Female	Balance issues limiting ability to walk	Poor sight
OFPC80	80	Male	Inability to stand for prolonged periods	Breathlessness
OFDL74	74	Male	Heart condition	Breathlessness and mobility problems
OFAT73	73	Male	Joint pain, poor mobility	Breathlessness
OFRB66	66	Male	Post stroke (full mental capacity), inability to support weight	Communication difficulties
OFST81	81	Male	Poor eye sight	Joint pain leading to poor mobility
OFNB69	69	Male	Post stroke leading to partial paralysis	Short term memory problems
OFFB78	78	Female	Dizziness, causing inability to walk distances	Short term memory loss
OFPB70	70	Female	Lower paralysis (wheelchair bound)	Circulation problems
OFVK88	88	Female	Osteoporosis	Pain walking and sitting
OFAS96	96	Male	Loss of sight in one eye/partial sight in remaining eye	Short term memory problems
OFEL76	76	Female	Double amputee	Circulation problems
OFBF77	77	Female	Post stroke (full capacity) Partial paralysis, left side	Inability to support weight
OFFB82	82	Female	Clinically obese	Mobility problems

**Table 3.2 - Time/task participant profile**

<b>Participant ID</b>	<b>Age</b>	<b>Gender</b>	<b>Physical health 1</b>	<b>Physical health 2</b>
TTMF70	70	Male	Post stroke, inability to support weight	Speech difficulties
TTGL97	97	Female	Non-specified lack of mobility	Severe mobility problem, inability to walk
TTIA72	72	Male	Hip and joint problems, limited mobility	Inability to walk, difficulty communicating
TTLT74	74	Male	Heart condition	Short term memory loss
TTDB71	71	Female	Lack of mobility, inability to walk long distances	Severe joint pain
TTRH76	76	Female	Poor sight	Walking causes severe joint pain
TTEH69	69	Female	Severe headaches and dizziness	Hip and joint pain
TTLO73	73	Female	Lower body paralysis (wheelchair user)	Weakness and poor muscle strength
TTHT78	78	Male	Mobility problem, inability to walk long distances	Poor eyesight
TTRAM81	81	Female	Arthritis, joint pain, poor mobility	Short term memory
TTHH69	69	Female	Severe balance problems caused by dizziness, hypertension	Inability to walk long distances
TTBB81	81	Male	Poor eyesight	Joint pain leading to poor mobility
TTLS78	78	Female	Partial sight	Short term memory problems
TTAS79	79	Male	Post stroke, weakness on right side	Short term memory loss
TTBB69	70	Female	Degenerative nerve disorder, poor coordination	Walking difficulties
TTLN72	72	Male	Post stroke, limb weakness	Dizziness
TTRE73	73	Male	Hip and joint problems, limited mobility	Severe joint pain
TTMH66	66	Male	Heart condition, circulatory problems	Short term memory loss
TTMW86	86	Female	Mobility problems, severe joint pain	Dizziness
TTRS67	67	Male	Post stroke, coordination difficulties	Short term memory

Table 3.2 provides a breakdown of the comparison group. The self-identified physical problems can again be broken down into the same three categories as the outcome-focused care group: the first category was physical mechanical problems induced by degenerative bone conditions and the severe pain this induces (n=8); the second

category was physical mobility problems induced by neurological conditions such as strokes, and balance and dizziness issues caused by circulatory problems with these combined conditions (n=9); and the final main category was loss of sight (n=3). Therefore there appears to be a similar distribution of incapacities between the two groups. This allows for some confidence that the groups' physical profiles are similar and that the two groups are, at least with regard to physical health, reasonably representative of the wider elderly population of social services users.



**Figure 3.1 – Gender distribution within the groups**

The sample of 40 service users consisted of 22 females and 18 males. The two sub-groups had a similar distribution (Figure 3.1). The outcome-focused group consisted of 12 females and 8 males, whereas the time/task group had an even split of 10 participants in both gender groups. The overall distribution of men and women in the whole sample is as expected, given the mean age of the sample (76.45 years), as women tend to live longer than their male counterparts in the UK. This division of gender is also supported by the research of Scharf and colleagues (2001), who examined the quality of life in old age with 58% of their sample being female and having a similar mean age of 71.53. This allows for some confidence in the sample despite its limited size, and that these findings might have the potential to be generalised to the wider older population.

This age distribution would be expected of referrals to social services who fulfill the fair access criteria for home care services. The majority of the participants had profound

physical or social care issues that limited their ability to care for themselves. Therefore it can be established that the sample group are predominantly female and in the latter end of the third age. Baltes and colleagues (1997) propose that old age goes through a series of stages, with the third age starting with retirement and individuals moving into their fourth age in their early to mid-80s. Baltes and colleagues (1997) conducted research on subjective well-being, as did Smith and colleagues (2003), and both of these research papers established that the individuals' subjective well-being decreases with the move into the fourth age. Therefore, based on these predictions, we would expect the 12 participants over the age of 80 to have a lower subjective well-being score than their younger counterparts. This will be considered later on in this chapter when the individuals' subjective well-being scores are analysed. However, this chapter will initially focus on the questions that are not directly related to the individuals' rating of their subjective well-being.

The questions that were not part of the MYMOP or MYCAW questionnaire were also asked during the semi-structured interviews and focused around five different areas affecting the older persons' lives. The first area to be examined was not related to subjective well-being but was concerned with the participants' level of social interaction. These questions were sub-divided to look at the levels of family and social interaction other than with the home care staff. The second area of non-MYMOP or MYCAW questions were focused around the delivery of paid care itself, as delivered by the home care workers. Therefore, before this chapter examines the findings of the MYCAW and MYMOP questionnaires, these supplementary questions will be analysed. The purpose of this staged analysis will be to establish what additional factors might be present and could be affecting the individuals' quality of life. This is important as high levels of social interaction, or the lack of it, might have an impact on the participants' sense of well-being and possibly skew the findings. It is with this in mind that the analysis of the MYMOP and MYCAW questionnaires has been left to the end of the quantitative analysis process. As mentioned earlier, the first area to be examined was not related to subjective well-being but focused on the participants' level of social interaction with individuals other than the paid home care staff.

### **3.4 Family and Informal Care and Support**

The questions asked under the heading of family and care were designed to capture data around the level of family and social support the individual received, regardless of their level of paid care. This was important in order to consider how other variables acted

upon the individuals' sense of well-being, other than the type of care intervention they were receiving.

The first question asked was: *“Do you have family and friends that you visit or visit you?”*. As can be seen in Table 3.3, the majority of participants did have some form of contact with family or friends, with 67.5% (n=27) stating yes and 32.5% (n=13) stating no.

**Table 3.3 – Family or other informal social contacts**

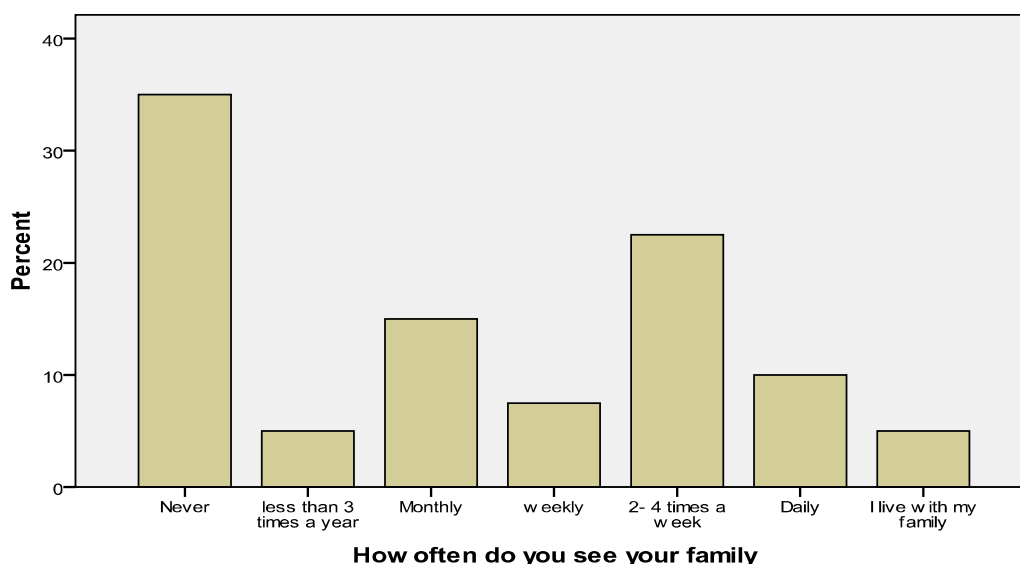
<b>Do you have family and friends that you visit or visit you?</b>	<b>Number of Participants Responding</b>	<b>Percentage of Respondents</b>
Yes	27	67.5
No	13	32.5
Total	40	100.0

Further analysis of this question was conducted by examining the level of contact according to the individuals' gender. This was important to establish, as the majority of participants, as demonstrated earlier, were females, and consideration was given to whether the gender of the participant had any impact upon their level of contact. The analysis showed that when consideration was given to whether the gender of the participant had any impact upon their level of contact with family or friends, the majority of both males and females do appear to have some form of social interaction with either friends or families or both. Therefore the findings from this analysis suggest that gender is not a determinant factor in the level of social interaction an individual experiences and that the gender make-up of the sample should not have a profound effect on the overall level of social contact.

These data gave the initial impression from the 'yes' and 'no' questions that social isolation was not an issue for this particular group of older people which would be surprising given the level of paid support they were receiving. However, the next set of questions provided more detail on social contact, by focusing on the level and frequency of these interactions. The frequency of family visits varied greatly. The first finding demonstrated that 35% of the participants (n=14) claimed they never received visits from their family, although some did receive an occasional phone call on birthdays or at Christmas. Included within this group were also some participants who had no living family or friends. The themes around isolation developed in this section of questions led to more in-depth follow-up questions being asked during the qualitative interviews.



These themes will be analysed in the next chapter where a qualitative analysis of these data will take place. Only a minority of 37.5% of participants received regular contact of more than one visit per week. This helps to unpack the initial finding that social isolation was not an issue with this group of older people. The more detailed data demonstrated that for most of the participants, who initially stated that they have regular contact with their family and friends, this contact is still very limited. Figure 3.2 presents a breakdown of the length of each visit received by the participants.



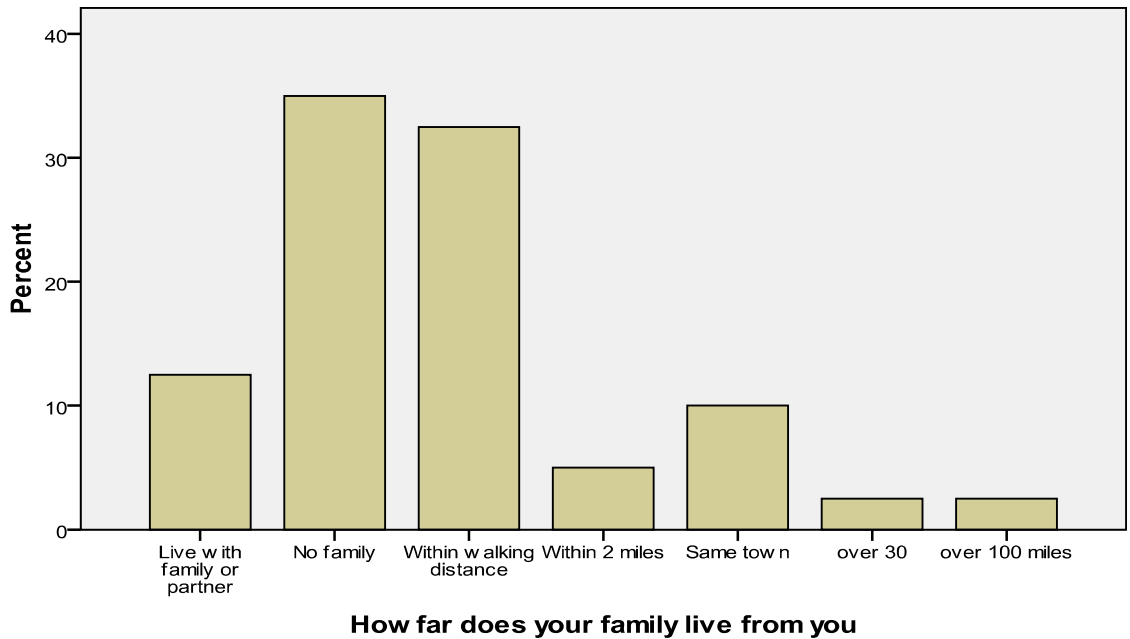
**Figure 3.2 – Frequency of visits**

The subject of social interaction was then developed further with the next question focusing on the level and duration of social interactions: “*When your family visits how long do they stay?*” The figure for ‘never’ is consistent across all the questions posed, at 35% (Table 3.4). The striking finding is that 52.5% of participants either don’t receive any visits or if they are visited then the visit lasts for less than an hour. This shows a pattern regarding the prevalence of social isolation within this group, which responses to the first question (‘do you have friends and family that you visit or that visit you?’) had masked. Therefore the majority of the participants either spend their lives in total isolation with the exception of the paid carers, or with very limited social contact.

**Table 3.4 – Duration of family visits**

<b>When your family visits how long do they stay?</b>	<b>Number of Participants Responding</b>	<b>Percentage of Respondents</b>
Never visit	14	35.0
Less than 1 hour	7	17.5
No more than 2 hours	9	22.5
Up to 4 hours	7	17.5
5 hours or more	2	5.0
Overnight stay or weekend visit	1	2.5
<b>Total</b>	<b>40</b>	<b>100.0</b>

The questions raised so far indicate that the majority of participants have family and friends, but that the level of social contact they receive from their family is limited. Therefore the next question asked was concerned with whether the low level of visiting was partly caused by the structure of modern society and families being dispersed throughout the country for various reasons, for example the need to find paid work. The participants were asked: “*How far does your family live from you?*” The results were surprising, given the low level of visiting (Figure 3.3). Rather than the majority of families living a great distance away from the participants, the majority lived in the same town. Only 5% (n=2) lived more than 30 miles away with 47.5% (n=19) living within the same town, and the majority of these (n=30) living within walking distance of the participants. The findings from these questions begin to demonstrate that simply having family nearby does not have as great an impact upon the participants’ level of social support and isolation as would first have been imagined, given the high percentage of participants stating they had contact with their family and friends. The reason for these apparently low levels of family visiting will be explored and developed more in the qualitative analysis conducted in the next chapter.



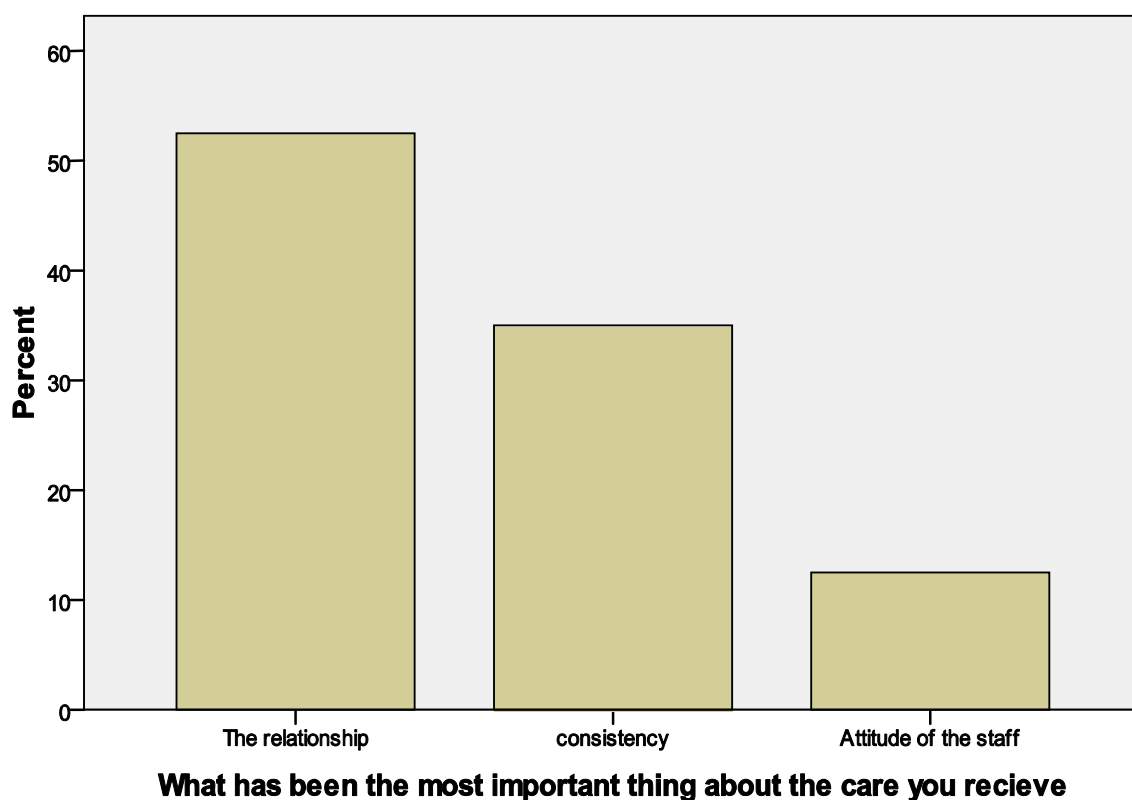
**Figure 3.3 – Distance from family**

One of the weaknesses in this study was the lack of any analysis of the participants’ economic status as there were no credible data available. Whether these data would have any bearing on the overall findings remains uncertain and this is an area to be considered should further research take place. The decision not to examine this area was the result of an ethical decision taken by Adult Social Services who felt that passing on financial information would require a new process of ethical approval, since initial feedback from the participants was that they did not want to share this information with the researcher. However, the socio-economic circumstances of the 40 individuals who were observed by the researcher did give the impression that their socio-economic condition was not a factor impacting on the individuals’ social isolation; rather, it was their physical condition that limited their ability to move or be moved with assistance. Even where individuals appeared to have sufficient funds for taxis or other forms of private transport, their physical difficulties meant that transporting them required either additional family members or professional support, or, in some cases, the use of specialist vehicles.

### **3.5 Analysis of Paid Care**

The next theme to be developed was an examination of the type and level of social care interaction that took place between the participants and the paid carers. The participants were asked the following question: “*What has been the most important thing about the*

care you receive?” These results reinforce the findings from other qualitative studies that have shown how much older people value the quality of relationships.

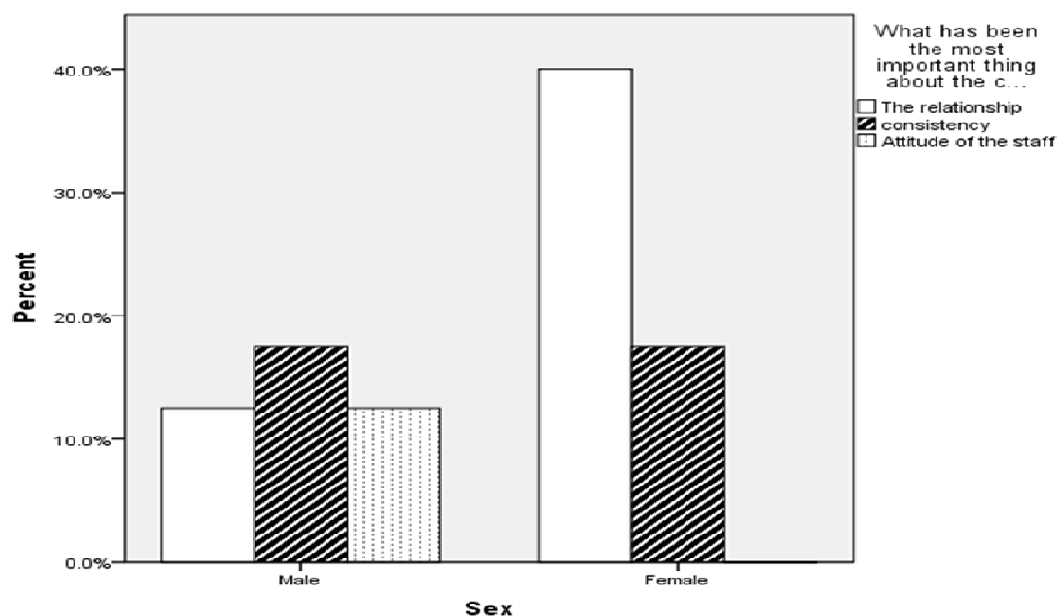


**Figure 3.4 – Important factors in the receipt of care**

Figure 3.4 and Table 3.5 show that the most important factor for the participants was the relationship they established with the paid caregiver, with 52.5% (n=21) of the participants rating this as the most important aspect of the care they receive. However, when this result was broken down according to the participants’ gender (Figure 3.4 and Table 3.5), there appeared to be a distinct difference between the sexes in what they valued about the care. The female participants rated the relationship as by far the most important factor, as expressed by 69.6% (n=16) of the female participants, whilst only 29.4% (n=5) of the males rated the relationship as the most important factor in the care they received. Males gave more importance to the consistency of care than to the relationship, at 41.2% (n=7), and gave equal importance to the attitude of the staff, 29.4% (n=5).

The male participants, however, had a larger proportion rating consistency as more important to them than the relationship (30.4%), with none of the females giving any importance to the attitude of staff. Whilst these results demonstrate the importance of the relationship, especially for females, the small scale of the sample size makes it

difficult to generalise these results to the wider population. Additional questions around the gender of the staff or the type of agency, established that none of the participants considered the gender of the staff or the type of agency (private, third sector or local authority) they came from as important.



**Figure 3.5 – Breakdown of results by gender: the most important aspects of care**

**Table 3.5 – Most important components of paid care**

<b>What has been the most important thing about the care you receive?</b>	<b>Number of Participants Responding</b>	<b>Percentage of Respondents</b>
The relationship	21	52.5
Consistency	14	35.0
Attitude of the staff	5	12.5
<b>Total</b>	<b>40</b>	<b>100.0</b>

The next area to be considered was the length of visit. This is important as it was established earlier that, even given support from friends and family, it is probably the paid care workers with whom the participants spend most of their daily time (Table 3.6).

**Table 3.6 – Duration of paid care visits**

<b>How long does your home care worker stay with you each visit?</b>	<b>Number of Participants Responding</b>	<b>Percentage of Respondents</b>
Over 1 hour	3	7.5
45 minutes to 1 hour	29	72.5
30-45 minutes	7	17.5
Less than 30 minutes	1	2.5
Total	40	100.0

Ninety two point five per cent of the service users received visits of 1 hour or less (n=37) with only 7.5% (n=3) receiving visits that last over an hour. The shortest length of any visit was 6 minutes, which merely involved the delivery of food.

### **3.6 Individuals' Self-Reported Physical and Subjective Well-being Scores**

This section of the chapter will now focus on the results of the MYCAW and MYMOP questionnaires. However, I will first re-present Diener's concept of SWB and some background to its utilisation with older adults. As has been mentioned in the previous chapter, Diener's (2009) concept of SWB is an accepted measure for the measurement of well-being in old age. The Berlin Ageing Study (BASE) (Baltes & Mayer, 1999) conducted longitudinal studies of well-being in old age utilising Diener's concept of subjective well-being. The study by Baltes and Mayer focused on a similar age group to this study (70+ years), with an emphasis on the examination of well-being in participants in their third and fourth age. The sample size was large (n=517) and looked, as does this thesis, at psychological, social and physiological factors impacting upon older people and their sense of subjective well-being.

The MYCAW questionnaire also utilised Diener's single item question on well-being and then added two further questions allowing the participants to self-identify their two main non-medical concerns. The purpose of the MYCAW concern measure was to provide a multi-item scale when considering the individuals' SWB, and to allow a deeper analysis of the factors that were impacting upon emotional well-being. This chapter will also examine physical self-identified well-being with the MYMOP questionnaire, in order to consider if the changes in the individuals' physical health have either a positive or negative association with how the individuals rate their SWB.

Multi-item scales are considered to provide a more accurate measure of well-being than single item scales. A number of multi-item assessment tools have been developed to

assess older people's SWB, these being the Geriatric SWB scales developed by Kozma and Stone (1980) and Diener (1984), with Diener in particular arguing that scales that are particular to a client group are more effective in establishing SWB in particular age ranges. These scales, although considered to be effective in measuring SWB in older people, are quite lengthy and are designed for the general older population. As this particular piece of research was concerned with frail older people, it was felt that these larger scales would be overly intrusive and difficult to complete in the allotted timescale stipulated by the local authority's ethics committee. However, the fact that Diener's concept of SWB has been applied across national boundaries and to different population groups, which has resulted in consistent findings being established, gives some confidence that the use of scales in the MYCAW questionnaire based on Diener's work will provide some face validity to the findings. This also allows for the findings from this research to be compared to other research on older people utilising the same scale.

The first questionnaire to be considered is the MYMOP; this required the participants to identify concerns about their physical health. The scores for the MYMOP questionnaire required the participants to rate themselves against their concerns as follows:

- 0= As good as it gets
- 1= Very good
- 2= Good
- 3= Neither good nor bad
- 4= Not good
- 5= Poor
- 6= As bad as it gets

When the outcome-focused care group initially rated their physical condition at baseline using the MYMOP questionnaire, the mean score was between 'poor' and 'not good' (4.50). The time/task group also initially rated a similar mean score (4.60), also placing their physical condition between 'not good' and 'poor'. This suggests that the two groups had similar levels of self-rated physical incapacity at baseline, and there is therefore no difference between the groups on the level of their physical disability. This is important to establish, as the groups were not randomly selected and there was the possibility that a bias could have occurred during the allocation process that may have skewed the data. The social workers might have consciously or unconsciously placed more severe physical conditions in one group rather than the other, which could have meant the individuals had different starting points when considering their physical well-

being. However, the findings also demonstrate that the two groups' self-rated physical conditions did change over the period of the intervention. Given the nature of the client group, frail older people, there is an expectation that over a period of time their physical condition will either be stable or continuously deteriorate. A slight deterioration occurred in the outcome-focused care group. However, their mean score (4.75) still places their physical health rating between not good and poor, with a move nearer to poor. The mean of the time/task group (4.3), however, showed a slight improvement in their self-rated physical health, with a movement towards the 'not good' rating.

The MYCAW questionnaire asked the participant to give an overall general score for their SWB, and this section of the questionnaire will be discussed later on in this chapter when a statistical analysis will be conducted. The MYCAW questionnaire asked the participants to identify two specific concerns in addition to a question on their self-rated measurement of general well-being. These have been categorised in Table 3.7 and Table 3.8. The participants could choose anything that concerned them and subsequently each response was very individual and subjective. Therefore, in order to be able to analyse these results, each response was placed within three broad categories, which are displayed in Table 3.9 and Table 3.10.

The concerns can be broken down into a number of categories. Some respondents will be represented twice in some categories as they may have had different concerns in their answers to concerns 1 and 2. The first category, which had the highest number of respondents (n=9) was the inability to go out, either to visit friends or participate in activities such as church-going or visiting the pub. The second highest category was that of loneliness (n=7). The third highest category (n=6) was concern about the ability to care for oneself or others, or the home/garden. As the MYCAW questionnaire allowed each individual to identify two concerns unique to themselves within the defining categories, any analysis of their data is difficult from a quantitative perspective, but they have still been listed in Table 3.9 and Table 3.10. Because of the unique nature of each concern, more emphasis will be placed on these concerns in the qualitative analysis that will occur in the next chapter, when an analysis of the qualitative data will allow for a more in-depth probing of the individuals' responses in the interviews.



**Table 3.7 – Outcome-focused intervention group: participants’ self-identified concerns**

<b>Participant ID</b>	<b>Age</b>	<b>Gender</b>	<b>Concern 1</b>	<b>Concern 2</b>
	75	Female	Not having family support	Inability to go out
OFAL80	80	Female	Not getting out into the garden	Having someone who understands me
OFAJ65	65	Female	Constantly different staff	No relationship with the staff
OFGJ79	79	Male	Not being able to care for my wife	Not being able to lift my wife and her having to go into a home
OFMB77	77	Female	Loneliness	Not being able to go to church
OFMJ89	89	Female	Not being able to look after myself	Not being able to go out everyday
OFBN92	92	Female	Not being able to go out and meet friends	Not being able to be involved in church activities
OFPC80	80	Male	Being stuck in the house	Not being able to meet friends in the labour club
OFDL74	74	Male	Not being able to read or watch TV	Not going to my local pub
OFAT73	73	Male	People constantly asking me questions	Different people visiting everyday
OFRB66	66	Male	Being dependent on others	Feeling lonely
OFST81	81	Male	Not going out	Becoming so ill I can’t stay in my own home
OFNB69	69	Male	Feeling a burden to my family	Feeling lonely
OFFB78	78	Female	Inability to visit my husband in the care home	Feeling lonely
OFFB70	70	Female	Inability to go into the garden	Not being able to go out and meet up with friends
OFVK88	88	Female	Not being able to hold my grandchild	Not being able to look after my sister
OFAS96	96	Male	Lonely, not being able to go out	Not being able to watch TV
OFEL76	76	Female	Not being able to care for my pets	Loneliness
OFBF77	77	Female	Not being able to cook	Not being able to go out and shop for clothes with my friend
OFFB82	82	Female	Loneliness and becoming totally housebound	Not being able to go to church

**Table 3.8 – Time/task group’s concerns**

<b>Participant ID</b>	<b>Age</b>	<b>Gender</b>	<b>Concern 1</b>	<b>Concern 2</b>
TTMF70	70	Male	Not having relationship with my wife	No dignity, different people washing and showering me
TTGL97	97	Female	So lonely	No activity in my life
TTIA72	72	Male	Not being able to go to the pub	Forgetting things around the house
TTLT74	74	Male	Not being able to keep on top of the garden	Losing contact with friends as I can’t get out as much
TTDB71	71	Female	Inability to look after my dog	Loneliness
TTRH76	76	Female	Can’t go out on my own	Not being able to read any more
TTEH69	69	Female	Very lonely	Not being able to visit friends in their nursing home
TTLO73	73	Female	So lonely	Not being able to get to church
TTHT78	78	Male	Not being able to get to watch the football, so lonely	Walking with a stick makes me feel weak
TTRAM81	81	Female	My lifestyle, unable to meet friends	Feeling low and sad
TTHH69	69	Female	Losing touch with the outside world	Boredom and loneliness
TTBB81	81	Male	Difficulty watching TV or reading	Not being able to visit my daughter and granddaughter
TTLS78	78	Female	Not being able to go out on my own	Difficulty watching TV or reading
TTAS79	79	Male	No major concerns except not being able to go to the pub	Having to be dependent on others, especially care staff who are always changing.
TTBB69	70	Female	Not being able to walk any distance	Isolation, being stuck in too much
TTLN72	72	Male	Not being able to wash myself, the lack of dignity with different staff doing it all the time	Isolation, not being able to go out
TTRE73	73	Male	Loss of independence	The stigma of walking with a frame
TTMH66	66	Male	Not being able to drive	Loneliness
TTMW86	86	Female	Not being able to look after my dog	Loneliness, not having any friends and family left
TTRS67	67	Male	Not being able to look after myself	Not being able to care of my grandchildren.

**Table 3.9 – Self-identified concerns 1**

<b>Categories</b>	<b>Descriptors for Concern 1</b>	<b>Outcome-Focused</b>	<b>Time/Task</b>
Category 1	Inability to go out	6	6
Category 2	Loneliness	3	4
Category 3	Inability to care for self or others	5	6
Category 4	No clear category	5	4

Table 3.9 shows similar findings to the responses to the question posed in the MYCAW questionnaire.

**Table 3.10 – Self-identified concerns 2**

<b>Categories</b>	<b>Descriptors for Concern 2</b>	<b>Outcome-Focused</b>	<b>Time/Task</b>
Category 1	Inability to go out	10	10
Category 2	Loneliness	7	8
Category 3	Inability to care for self or others	7	8
Category 4	No clear category	5	4

Table 3.10 shows that the responses across the two groups are very similar, with the inability to leave the house scoring the highest number of responses, followed by similar scores for loneliness and the inability to care for self or others. The greatest concern is the inability to go out, followed by loneliness. Therefore, consideration needs to be given to the type of activity that the different types of intervention provide, for example, if the outcome-focused intervention allows more time for the individual to get out of the house, is it this that might explain whether it was this aspect of the intervention that had the greatest impact? Again, this was not a question posed in the questionnaire but this issue will be discussed in the next chapter on the basis of the qualitative data. The responses in the ‘no clear category’ were varied and, as can be seen from Table 3.7 and Table 3.8, these cannot be easily analysed in this section of the thesis, so again, these will be considered in Chapter 4.

The self-identified concerns as identified from the first questionnaire measurement were given as a mean score and this mean score was then compared to the mean measurement of the second questionnaire score. When this was completed, the outcome-focused care group showed a slight improvement in their level of concern compared to a decline in the time/task group mean score. This divergence with an improvement in the concern

levels for the outcome-focused group and a decline for the time/task group dovetails with the individuals' self-reported SWB and is shown in Table 3.12 (low mean score indicates an improved state of SWB). This analysis does appear to show a strong association between the type of intervention the participants receive and their SWB score. Further analysis of the variables might show whether there has been an improvement in either their physical health or their self-identified non-health concerns. These concerns were established in order to allow a further understanding of the concerns the individuals had in their individual life which they believed had the greatest impact upon them beyond their physical health. It appears a number of factors were at play during the research period.

### Inferential Statistics

The choice of statistical tests for this case study was limited due to the small sample size. The aim of the test was to examine if changes in the individuals' subjective well-being were of some statistical significance over time and therefore a paired samples T-test was deemed to be the most appropriate. In order to perform this statistical test on this group, an analysis was first carried out to ascertain if the sample had a normal distribution with regard to well-being. Figure 3.6 below shows that this sample had a normal distribution, thus confirming that a paired sample t-test was the most appropriate statistical test.

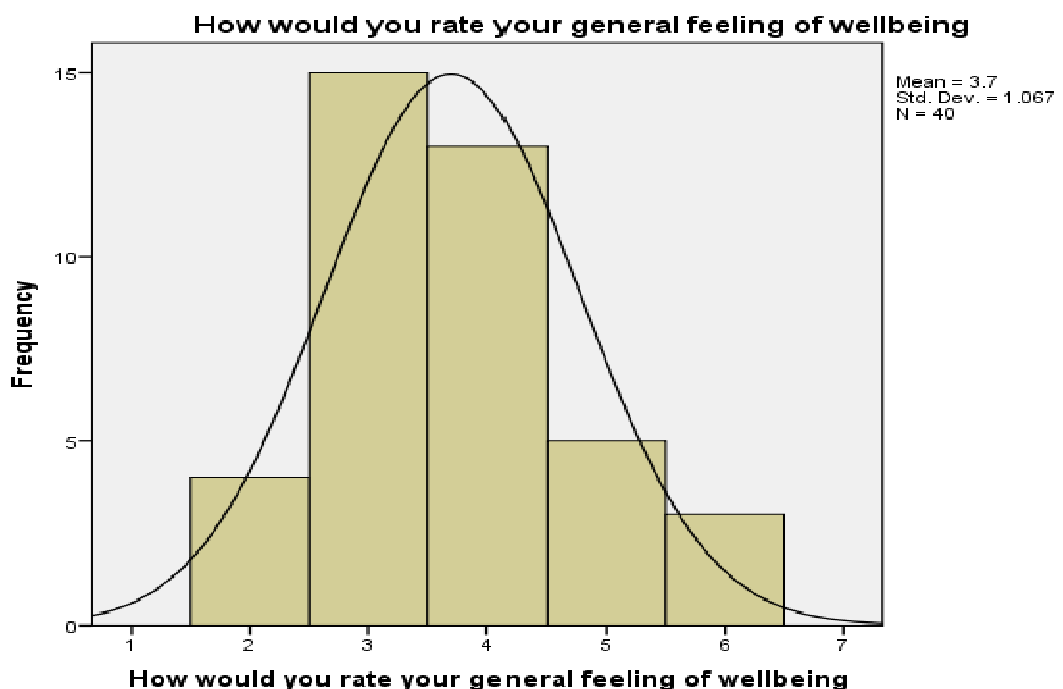


Figure 3.6 - Distribution in relation to well-being

The MYCAW questionnaire required the respondents to identify their two main concerns not related to their physical health. The results of this are displayed in Tables 3.9 and 3.10. The mean scores given by the respondents' showed that the time/task group had a slight decline in their concern score and remained in the 'not good' category, whereas the outcome-focused group had a marked improvement with a move from 'poor' to 'neither good nor bad'.

**Table 3.11 – Mean scores for responses to concern questions**

<b>Group</b>	<b>Initial Response Mean Score</b>	<b>Follow up Response Mean Score</b>
Time/Task Concern1	4.00	4.30
Time/Task Concern 2	4.00	4.40
Outcome-focused Concern1	5.45	3.50
Outcome-Focused Concern 2	5.35	2.90

Further analyses were conducted to examine whether the improvement (in the case of the outcome-focused group) or slight decline (in the time/task group) of individual concerns was reflected in their scores for subjective well-being. The mean scores displayed in Table 3.12 and show a correspondent response between subjective well-being and the respondents' concerns.

**Table 3.12 – Results from analysis of MYCAW: self-reported well-being**

<b>Group</b>	<b>Initial Response</b>	<b>Follow Up Response</b>
Time/Task	4.00	4.35
Outcome-focused	5.05	3.05

The responses were analysed using the paired t-test which appeared to demonstrate an association between the type of intervention received and an improvement in the individuals' self-reported subjective well-being.

**Table 3.13 - Results from the Paired sample T-test**

<b>Variable (MYCAW)</b>	<b>T statistic</b>	<b>df</b>	<b>Sig (2 tailed)</b>
How would you rate your general feeling of well-being?	3.943	38	0.001
	3.943	30.782	0.001

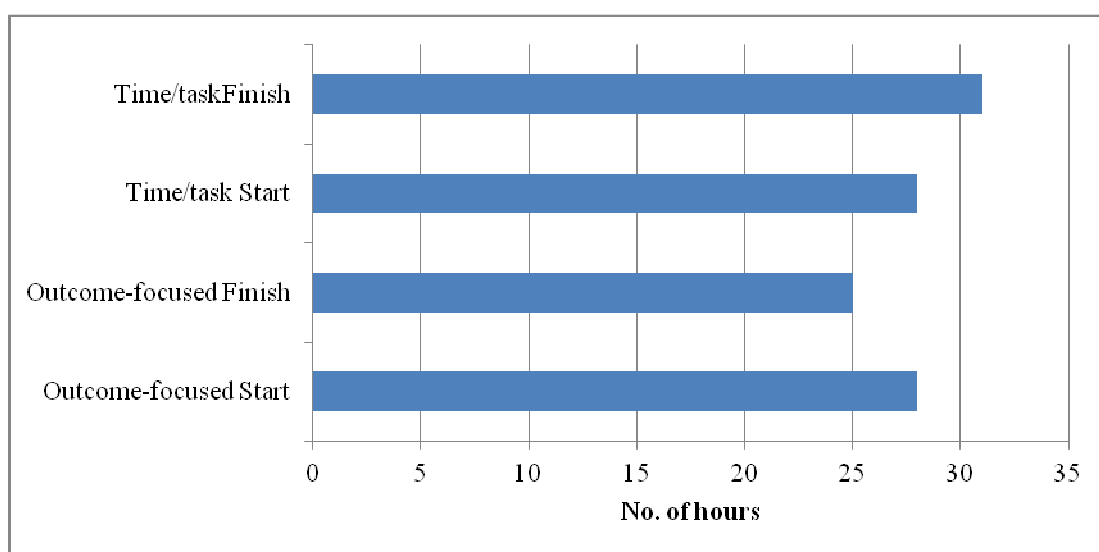
<b>Variable (MYMOP)</b>	<b>T statistic</b>	<b>df</b>	<b>Sig (2 tailed)</b>
How severe would you rate your physical well-being.	-330	39	0.743
	-176	38	0.723

The mean scores as shown in Table 3.12 demonstrate that the improvement in the outcome-focused group was quite pronounced compared to the slight decline in the time/task group. This also shows that the initial self-rated well-being was slightly lower in the outcome-focused group than the time/task group, making the improvement in well-being more substantial. Interestingly, when the mean scores were analysed between the two groups as to how individuals' self-reported physical well-being (MYMOP) over the last week, the initial measure demonstrated that the outcome-focused group's condition had deteriorated slightly, whereas the time/task group showed a slight improvement. This finding appears to indicate that the individuals' physical health slightly declining or improving has not had an impact upon self-reported well-being. However, this raises the question as to whether the intervention had contributed to the physical decline. It could have been that the outcome-focused group, in choosing to prioritise more social outcomes were effectively reducing other kinds of help which would have maintained their physical health. However when this was analysed, via a paired t-test, there did not appear to be an association

### **3.7 Costs**

A basic economic analysis was conducted in partnership with the local authority's commissioning finance department. The areas analysed were the actual unit costs of the two interventions, and also whether the outcome-focused provision led to a reduction in

hours required. The assumption made by the local authority was that based on un-researched anecdotal evidence from other local authorities, the provision of outcome-focused care led to a reduction of care hours from service users, as they were more selective over the hours they used and the unnecessary provision of tasks could be eradicated. The first area considered was the pure financial cost of the two provisions. The finance department tracked the cost of six service users (per group) from the outcome-focused group and the time/task group. Service users were selected who had spent at least eighteen months receiving their care packages and the number of hours used were measured at the start and finish point of the intervention.



**Figure 3.7 – Average number of hours used per participant during the intervention period**

The hours used by this small sample of service users did support the anecdotal evidence that the number of hours used by the service user was reduced more within the outcome-focused group than with the traditional time/task model. These data were gathered from the time sheets completed by the home care workers which identified how long they spent completing tasks with the participants. However, what is masked by these findings is the method of recording. In Chapter 4, the participant observation of the home care staff will be considered and involved following staff from the two different intervention teams as they delivered the care packages. It was noted that the time/task intervention workers recorded each task completed against a 15-minute time allocation, even if the task took less time, whereas the outcome-focused group recorded the time actually spent with the participant.

Figure 3.7 indicates the actual time spent with the participants and the time allocated, with the data being based on the findings of my observations. It should be noted that these data do not represent the group average.

**Table 3.14 – Duration of paid care visits – based on the observations of eight home care workers**

<b>Worker</b>	<b>Allotted time with participant in hours</b>	<b>Actual time spent with participant</b>
Outcome-focused home care worker 1	4	4
Outcome-focused home care worker 2	3	3
Outcome-focused home care worker 3	3	3
Outcome-focused home care worker 4	4	5
Time/task home care worker 1	3	1.5
Time/task home care worker 2	4	2.5
Time/task home care worker 3	4	2
Time/task home care worker 4	4	2.5

Table 3.14 clearly shows a difference in the time spent with service users on the day observed by the researcher. From this small sample it would appear that this makes outcome-focused care more expensive than the time/task model for the service provider. The time/task provider is therefore able to see more service users in a day, and in this particular example the group of time/task home care workers, by cutting corners on time, would be able to see two more service users in their working day. This in turn allows the agency contracted to lower their unit costs as they are being paid for more hours than they are completing. However, because the care plan stipulates tasks rather than hours to be completed, the agency is not breaching its contract. Therefore, according to the local authority's finance department, when considering services allocated based on time, as in this case, outcome-focused services were 17% more expensive, even after the reduction in hours used by the outcome-focused group. This data was calculated by



the finance department of the commissioners, based on written paperwork returns which I have not been supplied with and have not seen the way the calculations were made. The findings from this analysis show that outcome-focused care participants receive considerably more human contact time with the home care staff than do the time/task group participants. Because of the limited number of participants involved and because the calculations made to arrive at the cost figures were not supplied, it is impossible to explore this more here, but further analysis will be conducted in part 2 of Chapter 4.

### **3.8 Key Findings**

This chapter has established that the participants have a mean age of 76 years and are all experiencing severe physical problems induced by either physical disease, neurological impairment, or the loss of one or more of their senses. These incapacities have severely restricted the individuals' independence, so that the participants have a high level of dependency in order to live in the community and interact socially in the wider community. Interestingly, an important finding was that, despite having family nearby, the majority of participants experienced very low levels of social contact, with their paid carers being their main source of social contact. The participants also demonstrated that the ability to establish a relationship with their carers was very important to them.

The findings from the MYCAW and MYMOP questionnaires were also interesting. The questionnaire demonstrated that despite individuals within the outcome-focused group indicating a decline in their physical well-being (MYMOP), they also demonstrated an improvement in their sense of SWB. More importantly, these data also demonstrated what appears to be an association between the type of intervention and the participants' SWB that could not be explained by chance, inasmuch as those receiving the intervention of outcome-focused care showed a significant improvement in their self-rated SWB. Finally, the analysis of the costs of the service revealed that despite the same amount of time being purchased for participants in both the outcome-focused group and the time/task group, the amount of time actually being delivered to these two groups varied considerably.

### **3.9 Key Themes to be Developed**

A number of themes have been developed throughout this chapter that will be analysed further in the remaining chapters of this thesis. These themes are:

- Social interaction

- Loneliness
- Relationship with paid staff
- Well-being concerns identified by the participants.

These themes were developed as domains for the qualitative data to be analysed within in the next chapter. This approach allows for a deeper understanding of the mechanisms that were operating for each participant, independent of whether they were receiving the intervention of outcome-focused care or not. This emphasis on the mechanisms provides an understanding of which aspects of the outcome-focused intervention worked that were not also provided by the traditional time/task model of home care delivery.

### **3.10 Conclusions**

This chapter has focused mainly on the ‘does’ (i.e. does it work?) question of realistic evaluation. In examining the ‘does’ question, it has been established that there is an association between the type of intervention the participant receives and their self-rated well-being. However, it is not clear why this is the case and therefore the next chapter, by applying realistic evaluation throughout, will allow for the mechanisms and the context to be considered in greater depth to establish why this intervention appears to have an impact upon SWB.

## **CHAPTER 4: THE SERVICE USERS' PERSPECTIVE**

### **Part 1: What Works, and For Whom?**

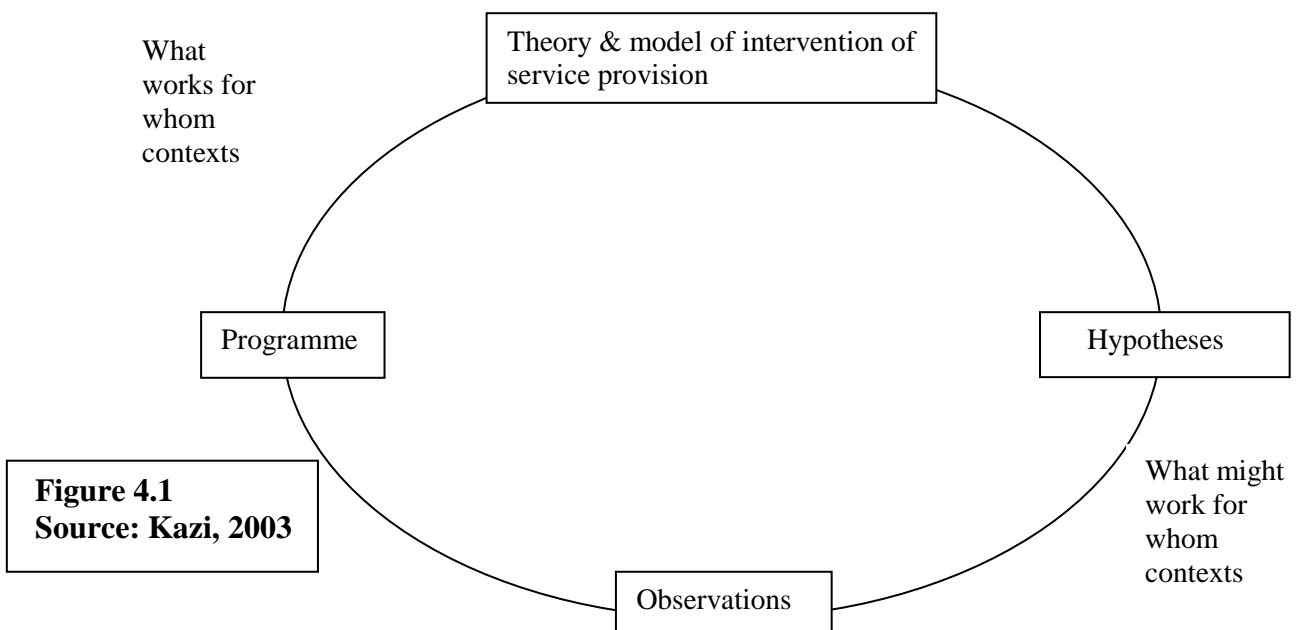
#### **4.1.1 Introduction**

The previous chapter has suggested that the outcome-focused intervention has possibly improved the SWB of the intervention group receiving this service. This chapter will continue to develop an analysis of the service users' perspective and will be concerned with the data generated by the semi-structured interviews undertaken with the service users at the start and six month stage into the intervention, and the participant observation of the home care staff. This realistic evaluation case study has used the last chapter to focus on the 'does' question of realistic evaluation methodology and in doing so has established that a desirable outcome of the programme of intervention (outcome-focused home-care), was the increase in some of the participants' sense of SWB. This increase in SWB occurred despite some of the participants' continuing decline in physical health. This section of the case study will therefore be aimed at developing an understanding of the "how" and 'why' questions used as part of the realistic evaluation methodology. How was it that this particular intervention improves the individuals' sense of SWB and why did this happen for some participants and not for others? It will focus on the identification of the mechanisms that are working for the outcome-focused group of service users that allowed this intervention to improve the individual participants' SWB, and also consider whether it was the absence of these mechanisms in the time/task group that prevented any positive change.

This will be the largest chapter within the case study and will therefore be divided into two sections. Part one will focus on the data gathered during the semi-structured interviews conducted with the service users participating in the intervention (outcome-focused) and the comparison group (time/task). The second half of this chapter will be used to examine the data generated from the participant observation conducted with the home-care staff who delivered both the outcome-focused care and the time/task care. This analysis will be conducted in order to see if the actual delivery process and individual worker style has an impact upon the desired outcome.

As previously mentioned, the overarching methodology being used in this case study is realistic evaluation. This methodology follows a circular process of evaluation which is shown in Figure 4.1. The first stage of this methodology's research cycle is focused on the development of the theory and the subsequent model of outcome-focused care. This

has been intensively developed by Qureshi and colleagues (1998) and has been covered in some depth in Chapter 1. The second stage of the process (model testing) occurred in Chapter 3, which suggested that the hypothesis that the outcome-focused care model would improve SWB was possibly true. The focus of this chapter and the remaining chapters of this thesis is on the why and the how stage of the cycle. So what, for example, was it about the individual service users' experience of the intervention that assisted an improvement in the outcome-focused group that was not replicated by the comparison group? It is hoped that analysing in-depth the data from the qualitative interviews and conducting an examination of the individual context within which the intervention occurred, will help to illuminate how and why the intervention worked. This analysis will examine the responses of the participants to the questions posed in the semi-structured interviews. These interviews were structured to use the questionnaires to provide a starting point, and the themes were then expanded throughout the remainder of the qualitative data gathering interview. This process allows for an understanding of which mechanisms were operating for each individual and hopefully also of how the individualised context within which the care is being delivered impacted on the effectiveness of the home-care.



**Figure 4.1 – The realist effectiveness cycle**

Multi-method data collection of mechanisms, contexts, outcomes, Source: Kazi, 2003.

In order to develop the analysis of the ‘what works’ and ‘why’ elements of this realistic evaluation, this section will use a number of key themes which were developed in

Chapter 3. These themes will form the core for the analysis of the qualitative data in this section of the research. These core themes are:

- Social interaction
- Loneliness
- Relationship with paid staff
- Well-being concerns identified by the participants

These core themes were analysed and placed within a hierarchy of themes and sub-themes which are shown in Table 4.1. The analysis of the qualitative research will start with the core themes and then develop to include the sub-themes which are also shown in Table 4.1. This will hopefully assist in the identification of the mechanism that occurred within this programme of social work intervention.

**Table 4.1 - Themes developed in the interviews**

<b>Core Theme</b>	<b>Model of Care</b>	<b>Well-being concerns</b>	<b>Social Interaction</b>	<b>Relationship</b>
<b>Sub Theme</b>	Issues raised about outcome-focused care	What concerns were expressed	Family social isolation	Informal care
	Issues raised about time/task care		Formal carers	Trust and a sense of intimacy

#### **4.1.2 Model of Care**

The first core theme to be examined will be the model of care, which will be analysed in an attempt to understand why the outcome-focused model of care had an impact on the individuals' self-reported SWB and the existing model of time/task care did not. In order for this to be evaluated, a re-examination of what is considered to be outcome-focused care is required. This will provide clarification as to what constitutes an outcome. An operational definition of an outcome is provided by the Social Care Institute for Excellence (SCIE) and is the one used within this research:

*'Outcome' refers to the impacts or end results of services on a person's life. Outcome-focused services therefore aim to achieve the aspirations, goal and priorities identified by service users in contrast to services whose content and/or forms of delivery are standardised or a solely determined by those who deliver*

*them. Outcomes are by definition individualised, as they depend on priorities and aspirations of individual people.’ (Glendinning, et al., SCIE, 2006, p.1)*

Interestingly there is no formal definition of what constitutes time/task care. I believe the definition developed by myself gives a sound overview of its component parts:

*“Time and task home care is the division of assessed care needs into time allocated components, and is measured by the completion of tasks rather than assessed outcomes.”*

This longitudinal case study was concerned with change over time, and in order to measure this change the study focused on the individual participants’ self-identified concerns at the start of the intervention and also at the end. This measurement element has mainly been explored within Chapter 3 through the use of the MYCAW questionnaire. However this measurement did not reveal why the change had occurred for the outcome-focused group. The interviews enabled data to be gathered as to why the participants felt change had happened following outcome-focused care and also why change had not happened using the traditional model of time/task provision. Tables 4.2 and 4.3 show the main concerns expressed by the participants; concern 1 is their main concern expressed and concern 2 is their secondary concern.

**Table 4.2 – Self-identified concerns 1**

<b>Categories</b>	<b>Descriptors for Concern 1</b>	<b>Outcome-Focused Group</b>	<b>Time/Task Group</b>
Category 1	Inability to go out	6	6
Category 2	Loneliness	3	4
Category 3	Inability to care for self or others	5	6
Category 4	No clear category	5	4

**Table 4.3 – Self-identified concerns 1 and 2 combined**

<b>Categories</b>	<b>Descriptors for Concern 1 and 2</b>	<b>Outcome-Focused Group</b>	<b>Time/Task Group</b>
Category 1	Inability to go out	10	10
Category 2	Loneliness	7	8
Category 3	Inability to care for self or others	7	8
Category 4	No clear category	5	4

### 4.1.3 Developing Concern Themes

The inability to go out was a major concern expressed by both groups of participant. This concern was explored further to see whether the model of care has had any major impact upon promoting and meeting individuals' desire to be able to leave the home. Before examining what has changed, it is worth considering how the participants felt about this concern in their initial interview, before the intervention had the opportunity to have an impact upon the inability to go out.

The first question put to those participants who scored the inability to go out highly in either concern 1 or 2 was:

*You have identified that the inability to go out is a major concern of yours, could you tell me a bit more?*

The first group of responses to this question were from the outcome-focused group.

*"It's not that I am so disabled I can't go out, but I couldn't manage it on my own. Before \*\*\*\*\* passed on (neighbour) she would drive me to the newsagents on a Sunday, it would take about an hour, the shop's only five minutes in a car. \*\*\*\*\* would support me over the step and guide me around the shop, that's all I need. But never going out, apart from the hospital I haven't left this house for six months.*

This interview progressed and the individual identified that he had attempted to go out himself but that this had resulted in a fall. His social worker, he felt, was too worried for him to go out even with support and he felt cross at her lack of trust in him. The next participant was also in a similar situation.

*"My eyesight isn't so clever now, it is knowing the different heights of things like steps, and I just need someone to say it's a step now \*\*\*\*\* watch yourself. If I had that I would be fine."*

These two individuals both benefitted from the outcome-focused care. They were able to bank up time to enable them to go out once a fortnight. Although the two outings a month appear quite limited, they had a profound impact upon how they both felt about not being able to leave the house. This is apparent in their responses to the following question:

*"When I called to see you last time you expressed your main concern was the inability to go out. You haven't identified this as a major concern this time. What has changed?"*

Both individuals had identified in the second interview differing concerns. They stated that they felt their initial concern had been met by their outings.

*“Well it is great I get one and a half hours every fortnight. I went to the park last week and the newsagents before that. John is still running it and remembered me which was nice. I felt that I was still part of things when John recognised me it was great.”*

The second participant also had a similar feeling of connection.

*“We went to the legion it was great, the barman joked about me having a younger woman (Care worker). I had a chat about Man U with him, I feel human again.”*

This was followed up in a further conversation, where both individuals felt that actually somebody in the wider world knew about them and they could engage with them. These highly limited visits provided the two men with a purpose to get dressed up for and provided a focus that enabled them, as they stated, to get through the mundane existence that age had brought upon them. Both of the men stated that if this pilot was to stop they would consider saving enough money to pay for these visits to take place.

Similar findings were also reported by two female participants whose physical frailty made it impossible even with the introduction of quality time to have enough staff hours to allow them to leave their home. One woman chose to use her banked time to sit out in the garden and talk to the care worker whilst watching school children play in an adjacent playground. Visits were planned with the care worker to correspond with the children’s break time. The other female participants just used the time to sit on her patio and talk with the care worker about her family.

*“It’s not just the chat it is the feeling of air on your face and the way the tea tastes different outside.”*

The second female participant also made similar remarks about the feeling of fresh air but then commented on watching the children play;

*“The children are so full of life one cheeky lad shouted got any sweets grandma, the girl (carer) said she will check with school if I can give them some sweets, I am so excited.”*

Both the responses of the male and the female respondents were similar. It was the idea that there was a connection between them and the wider world, that their existence was recognised and in all the cases, a real surprise that people either remembered them or were prepared to interact with them. The most exciting development for the women who lived by the school is that although they asked her not to give sweets, they did get



parental consent for her to provide the children with cartons of drink. This was only facilitated by the care worker as the drinks were purchased through the school tuck shop and given out by the participant with a member of the playground staff present (the garden literally adjoined the school playground). However, the ability to deal with a participant's concern about the inability to go out was met in a different and innovative way by one of the care staff. A neighbour who also had mobility problems was enabled to visit the participant by the use of quality time. The fellow flat resident was wheeled from her flat to the participant's flat in order for her to visit the participant for half an hour per week. Again this had a huge impact on the person's concern about the inability to go out. This participant was asked the following question:

*I notice from your response that the ability to go out is no longer your main concern what has happened to change this, as you have told me that you haven't been able to get out?*

She responded:

*“Well \*\*\*\*\* (care worker) explained that it would be impossible to get enough staff to get me out (clinically obese) or even to see my friend \*\*\*\*\*. So she said if it's ok with Doris (wheelchair bound) I could bring her to see you. I haven't seen Doris since her stroke, although we talk on the phone. It took a bit of sorting but I see Doris every week, so I don't feel so isolated.”*

This was not as straightforward a process as it would first appear. There was considerable resistance from the two social workers involved in the two service users' care. The first resistance was based around if Doris was being enabled to see her friend whether this would have to come out of Doris's care package (time/task) which was not sufficiently flexible to allow for this task to be conducted. The other was that the care agency for the non-participant was different to that of the outcome-focused participant and therefore the individual care worker was not insured to enter the home of a non-client and provide care. This issue was only resolved by the non-participant and the participant funding the care worker jointly for forty five minutes to enable her to allow the visit to take place. This resolution was provided by the care worker's agency and not the social worker's as the latter would not compromise on this issue. This point will be developed in Chapter 5 when the social workers were involved in the focus group and some participated in individual interviews.

The data generated from the outcome-focused group suggests that this intervention improved the individuals' sense of well-being concerning their inability to go out, and this was achieved in most cases by actually enabling the individual to get out of the home, go into the garden or receive visits. This was achieved by the ability of the intervention to be individualised to each service user's context. Therefore an underlying mechanism operating here is the ability to micro manage the care package around the service user's context in order to meet the service user desired outcome. This is in stark contrast to the response of the service users receiving the time/task model which will be considered next. The same initial question was asked of the service users receiving the time/task model of care:

*You have identified that the inability to go out is a major concern of yours, could you tell be a bit more?*

These were some of the responses:

*"I'm a little unsteady on my feet since I had the stroke; my muscles are weak on one side. I do miss going out. It gets you down after a while just staring at the same four walls."*

*"I use to love going to the coffee mornings at the church I really miss that."*

*"My eyesight isn't so clever now I need some help, but I am fit apart from that. I like being out amongst people, you know just hearing them."*

*"I slipped last winter and did my hip, so I need a chair now, the staff say they can't get me into the garden they don't have time."*

These concerns were very similar to the initial concerns expressed by the outcome-focused group. However the responses of the time-task group in the follow up interviews were very different to those of the outcome-focused group.

*When I called to see you last time you expressed your main concern was the inability to go out, you haven't identified this as changing?*

*"Well it's not on my care plan, so nothing has changed. I spoke to the social worker after your last visit; she said I would have to fund anything like that myself, and she would arrange it. But she hasn't been back since, and she never responds to my calls. I'm so fed up I need to get out."*

This individual was in a similar situation to those individuals in the intervention group in that she could get out of the house if someone could steady her. The social worker was asked about the service user's request, but she stated that the case was now closed and if this was to be followed up then the service user would have to make a fresh referral. This inflexibility was also observed with another service user, who stated:

*"I ask the girls all the time when it is nice could they just help me to sit out for 10 minutes, but they just say if it's not on their schedule (care plan) they can't do it."*

This group of individuals felt they were disengaged from the care they received, and this was acutely felt by those individuals who had no additional visits from families and friends. These service users expressed a view that they were just going through the motions of existence, without any attachment to the world and society around them. The concern of loneliness will be examined later in the chapter under the themes of social isolation and well-being. This lack of engagement *experienced* by the service users receiving the time/task model of care was also evident in another major concern about the model of care; consistency. This lack of consistency was a major concern to both groups in the initial interviews. However, there was a very different response when the second stage interview took place. None of the outcome-focused group expressed lack of consistency as an issue. In fact, they commented on how the consistency of the paid care staff had significantly improved their sense of well-being and satisfaction with the care they had received. They also started to speak about paid care staff by their first name, which did not occur with the time/task participants. This lack of mentioning of staff by name led to my decision after conducting two follow up interviews to ask the participants:

*How would you describe your relationship with your paid carers?*

Table 4.4 shows the responses from five participants from each group during their second stage interview.

**Table 4.4 – Responses from second stage interviews**

<b>Outcome-focused</b>	<b>Time/Task</b>
<i>“Really good I know all about them and they know about me and my past it’s lovely.”</i>	<i>“Well it’s distant they are like robots, it’s almost as if I was a machine that needs to be maintained. I couldn’t tell you their names.”</i>
<i>“I didn’t like it at first, being spoken to by my first name, and all the questions. But I feel I have some companions, not friends, but they know what team I support (football) and they have a crack with me, especially if Man City loses, Dave and Jennie are reds (Manchester United Fans).”</i>	<i>“They rush in rush out it’s like they are changing the hamster’s cage. They never ask me how I am or even give me eye contact.”</i>
<i>“Good it is the best thing best about this care, you get the same people and you feel you can trust them. They said to me one morning. We are a bit concerned about another lady, we will call back later if that’s O.K.I knew they would because I trust them, and I thought that’s nice that they worry about us, the other lot didn’t.”</i>	<i>“Some are better than others, the good ones are good they smile and there is gentleness about them, others you feel they really don’t care and it just a job like stacking shelves at Tesco. I make a point of getting their names it breaks the ice.”</i>
<i>“Well I know that they are not friends, but they feel like really good neighbours”</i>	<i>“I don’t have a relationship with them, they are like the dustmen, you don’t know them they just do the work and go.”</i>
<i>“It is so different to the previous lot (time/task), I see the same faces regularly and they know my little ways and it good, yes a good relationship I think.”</i>	<i>“What relationship?”</i>

None of the time/task group felt they had a relationship with the care team, which was very different from those receiving outcome-focused care. Therefore one mechanism that is apparent is consistency and this improves the ability of the individuals to form an interactive relationship with those who care for them. The consistency of the care staff was a bi-product of the intervention. Such consistency had only been provided as it made it easier for the staff providing the new intervention to be managed. There was no long term plan to ensure consistency should the project be expanded to the rest of the older people’s provision.

The last concern to be examined in this section of the chapter is the inability to care for self or others. This, as with the concerns dealt with earlier, displayed a difference between the two groups of participants. Neither of the two interventions appears to have

made a major impact upon this concern in any material sense; however, the outcome-focused group appeared to feel they had improved psychologically in this regard. These were the comments received from the participants in the initial interview in response to the following question; *“You say that you are concerned about looking after yourself and others can you tell me more?”*

*“I worry about Betty (dog) she isn’t getting walked now and the social worker is concerned about my ability to look after her, I couldn’t bear to lose her, she the only company I have.”*

*“I’m worried about the garden it is getting a mess and I can’t afford a gardener.”*

*“I want a shower, I can’t do it and the staff say it’s not OK ’cos of health and safety “*

*“The house needs some work and I can’t do it now, I am worried about builders they rip old people off.”*

These four individuals were all receiving the outcome –focused intervention and this is one of their responses to the following question posed in the second interview.

*“You are still showing your ability of to care for yourself and others as a concern, has anything changed, since we last spoke?”*

*“Yes, things are better with Betty (dog) \*\*\*\*\* (care worker) when she comes lets Betty in the garden, she leaves her there till she comes back at lunch. I have banked up my time so I can go to the park once a month with \*\*\*\*\* and Betty, so Betty has a good run around, and I get some fresh air.”*

The participant still expressed this as a concern as she was aware that the intervention was a pilot and feared that if it came to an end things would revert back to how they were.

The individual concerned about the garden and the lady wanting a shower reported no change in their concern. The lady concerned about her house however was assisted. This was enabled by the care worker ensuring that she was present when the builders called to support the lady whilst males unknown to her were in her house. The care worker also obtained a list of approved builders from the local Age Concern office, and this enabled the work to take place. This had the additional benefit to the participant that she was able to chat with the builders as they completed the work. The mechanism operating here was that of autonomous decision making, that permitted the individual

care workers, in conjunction with the service users, to find an appropriate solution to problems in order to reach the desired outcome.

This flexibility was not possible within the task-orientated care provision and hampered those providing the care in effecting change, as every decision was passed back to a supervisor who would then cost any action to the social worker, who in most cases would see any deviation from the minimal task as outside the remit of the agreed funding. This, as stated earlier, led to both the care staff and the participant feeling that the care was operated outside of their control; this was summed up by one participant as “*the computer says no*”. This is a remark from *little Britain*, a situation comedy in which an official constantly refuses requests from the public, without giving a reason for the decision.

#### **4.1.4 Social Interaction**

In Chapter 3 it was established that the majority of the participants’ families lived in the same town as the older person, although the level of actual social contact was limited. Once the 14 individuals who had no living friends and family are excluded, the remaining 26 only had very limited contact with any informal carers and of this sub group, five from each cohort participated in the semi-structured interviews.

Starting with the outcome-focused group, the initial question of ‘*How often do you see your family?*’ was followed up by a series of sub-questions. The first of these follow up questions was designed to establish if the nature of the visit followed any pattern or provided any consistency. The first question posed asked:

*“Do the visits you receive have any regularity or pattern?”*

This question was then broken down to ensure that the participant was able to answer. The responses were quite surprising. Most visits followed a very rigid pattern and would only be changed if family circumstances required. From the ten individuals interviewed (five from each group) the majority tended to receive a family visit of a Sunday, with these visits normally being around lunchtime and often involving the female members of the family (daughters and granddaughters). Men appeared to visit less regularly and in a lot of cases would visit just once a month. The visits tended to be focused around the performance of small chores that were not completed by the paid carers, and also provided an opportunity for the older person to catch up on family gossip, and have some food brought to them. These visits also facilitated some contact with grandchildren; however, they tended to be relatively short - between 1 and 3 hours.

The weight given to these visits by those asked was immense, as can be seen by the following statements:

*“When they visit its great it’s like the house lights up. I spend the entire week planning what I am going to say to them the next time they come.”*

*‘I don’t think I could go on if they didn’t visit. I hate it when they go on their summer holiday it’s so lonely.’*

The main thrust of the responses was about how the possibility of a family visit provided a focus for the older person and a reason to feel they had a purpose in life. The interviews then went on to develop a further discussion with the participant about their sense of purpose and their reasons for going on. This theme was developed not through any particular question, but by an expression of disconnection and loss of role and purpose. This feeling of a loss of role or purpose was also expressed by the wider group and was especially prevalent in those individuals who had no family contact and were totally dependent upon the paid carers. This theme of a lack of purpose and disconnection from the world was very prevalent. The sense of disconnection and isolation was clearly expressed by one of the participants:

*“Until my last stroke I had a purpose, whether it was the garden, a visit to get the paper. I’ve been on my own for about 10 years and this never bothered me, but now, the total isolation really gets me down.”*

*“I can see the world on the TV and through my window, and you realise you have absolutely no point.”*

This individual was receiving the outcome-focused intervention and this response was at the initial interview stage. This individual’s response was the most pronounced change of any participant. This is important when considering how the mechanism of what works and for whom within the cycle of evaluation. This was the response in answer to the question:

*What has changed for you since my last visit?*

*“I feel I have my life back. \*\*\*\*\* (home care worker) has arranged that when I bank up enough hours he comes round and watches some games with me (football matches) it is only once a month, but every time he visits we chat about the forthcoming match. You have got to be able to focus on something or else you might as well give up.”*

The model of intervention appears to have made a difference in this individual's case as it has allowed for a relationship to be developed that has provided a focal point, as was demonstrated in the discussion previously with participants who receive family visits. The main concern expressed initially by this participant was focused around his inability to go out. However, although this concern was expressed in his follow up interview, it had become a focus of his rehabilitation following his stroke to be able to watch a football match in his local pub with his home care worker.

This expression of a purpose that was provided by the flexibility of outcome-focused care was expressed by seven out of the ten participants who received this kind of intervention. The main concerns that were expressed around social isolation and the inability to go out appeared to be addressed to a degree by the outcome-focused model of intervention. This was not apparent in the interviews conducted with those participants receiving the traditional time/task model, which will be followed up later on in this chapter. Table 4.5 encapsulates the general responses of the group receiving outcome-focused care around the theme of social isolation compared to the responses from the time/task group. The responses within this table have a similar theme to those the participants mentioned earlier. The ability to have the capacity to structure their care in order for interests or a focus beyond the physical care to be developed, and improved well-being in the outcome-focused group, compared with the time/task group. This theme was closely related to the theme of relationships and the level of interdependence between these two themes is discussed later on in this chapter.



**Table 4.5 – Development of personal focus in the outcome-focused group**

<p><b>Outcome Focused: Individual responses</b></p>	<p><i>“I lie in bed and about 4.30 in the morning; I don’t sleep that well at my age. I get excited Joyce is coming I think what am I going to tell her today, I wonder if her latest grandchild has arrived yet. The difference having Joyce has made is huge.”</i></p>	<p><i>“Billy has been great he is a man U supporter its great talking about the match, especially Cantona! He was the best you know. I have a daughter I see her once a month, it’s nice but I miss the pub talk. So I’ve banked up my time and next week we are going to watch the match in my local. I’ve not been in it for 6 years. I can see it through the window, and I think what has my life come to I can’t even walk 300yards.”</i></p>
<p><b>Response from Participants</b></p>	<p><i>“Jenny is good this new care thing oh it is good. The difference, I have been seeing the four of them for the last month I feel I have my life back. They talk about their family and I talk about mine (even though I never see them) I am really worried because they say it is only temporary. I dread going back to how it was before, that was so hard they just didn’t really talk.”</i></p>	<p><i>“Do you know it upset me to see the state of my husband’s grave it was all overgrown. But Andy (carer) reassured me. He said next time we come he would bring my gardening tools and tidy it. He did you know what a lovely man.”</i></p>

The same set of questions was raised with the participants in the time/task group (Table 4.6). The older people being interviewed made constant reference to the fact that the paid carers were either very rushed, disinterested or constantly changing. These three factors impacted upon the older person’s ability to form a relationship and this lack of a relationship then also prevented the older person finding a focal purpose to be linked to their paid care visits.

**Table 4.6 – Development of personal focus in the time/task group**

<p><b>Time/Task Response</b></p>	<p><i>“It’s terrible you know I watched the derby (football) this weekend and it’s good. I still get excited about the football, but I miss my mates coming round and having a good talk about it. The ladies are nice, but there are different ones every day, there just not interested in many things and they just rush in. I try and talk to them. Some will talk but others are really rude they say “can’t you see a person in a rush.” I think you wait till the day that no one cares about you and you feel so lonely you wonder if is worth waking up.”</i></p>	<p><i>“I do think what the point is now. I have had my life. You know I stare at Stan’s picture (deceased husband) and say what it was all about. I feel like the pigs (used to be a farm worker) when you muck out a pig you don’t think what are they thinking. It’s the same for the girls (care workers) I’m just a pig to them.”</i></p>
<p><b>Response from Participants</b></p>	<p><i>“I was really looking forward to you coming today. Since your last visit it’s the only chance I get to talk. The workers come in without a bye nor leave, I’ve had a terrible bunch this last month they are really rough. One lady smokes all the time. I can’t stand smoke. I said to her I don’t like smoke. Do you know what she said? “What you going to do about it you, don’t be a cow.” Oh I cried why you would be so rude to an old lady like me.”</i></p>	<p><i>“I think they just think I am not paid enough for this. One of the girls told me she had done 12 hours straight to cover sickness. She looked worn out.”</i></p>

Table 4.6 gives an overview of how the time/task participants lacked the sense of connection that had been enabled by the outcome-focused intervention. This was particularly relevant for the individuals who received the time/task model and who had no other family support. This consisted of five individuals, three of whom took part in the formal semi-structured interviews. The importance of this theme led to the two individuals who were not part of the extended formal interview being followed up and interviewed to develop this theme of focus and its interaction with the theme of social interaction. This group of individuals could be considered to experience extreme social isolation. They were unable to develop what I consider to be focal relationships with their paid carers and had no other interaction to supplement this. This does raise an issue of priority consideration as to who should receive outcome –focused care as it is a more expensive and time-intensive resource. The mechanism that appears to be in

operation when the two models are examined as to their effectiveness on SWB, is the ability of outcome-focused care to provide a focal relationship for those experiencing extreme social isolation. This appears to occur even though the actual interaction time between the individual and the paid carer still represents a small proportion of the older person's week.

As previously expressed, a major concern of the older people was their sense of social isolation. This appears to have been the one concern that displayed the most discernible difference between the two models of intervention noted during the final interviews, where participants were asked:

*“Thinking back to your initial concern you expressed about being isolated, can you tell me if you think the paid care you received has made any difference?”*

The three responses provided in Table 4.7 are representative of the wider of responses.

**Table 4.7 – Impact of paid care**

<b>Time/task</b>	<b>Outcome-focused</b>
<i>“No nothing has changed it just the same.”</i>	<i>“Its’ great I feel I have a new set of friends, I know them all by name and they are reliable, you can’t imagine the difference it has made, don’t take it away.”</i>
<i>“Well I’ve just given up trying to make a relationship; they either can’t be bothered or keep changing.”</i>	<i>“It has made all the difference I feel I can trust them.”</i>
<i>“A little better I have had the same girl for the last month she’s nice, but she goes next week, they never stay.”</i>	<i>“Yes a lot, because they know me and I know them.”</i>

#### **4.1.5 How do the Participants View their Subjective Well-being?**

Before these data are discussed it is important to re -state the operational working definition and concept of SWB being applied in this case study. SWB is firstly divided into *emotional* and *cognitive* components, with this study being concerned with the emotional component (Diener *et al.*, 2009, p.157). This particular study has therefore not attempted to measure cognitive components such as personality traits of the individuals or their individual cognitive thought patterns. Ed Diener, a leader in the field of SWB within psychology sees emotional well-being as characterised by the individuals’ experience of pleasure and the infrequent experience of unpleasant

emotions. The context within which the participants live would appear to have more of a balance towards the experience of unpleasant emotions. Therefore this is an important factor that needs to be taken into account when considering the impact of the intervention on the older people's SWB. The findings of Diener are reinforced by the findings of Derryberry and Reed (1994). These researchers established that if individuals' basic needs are not met then SWB will rapidly decline. However, once these basic needs are regularly met then an individual's SWB rapidly returns, and the individual will then focus on their social relationships. This appears to be the case with this model of intervention. The outcome-focused care model has met the basic needs of the respondents and this has allowed them to move to the next level of social relationships as identified by Derryberry and Reed. This was demonstrated in the responses of the outcome-focused care group who spent a large amount of time in the interview referring to their relationship with the paid carer.

#### **4.1.6 Relationships**

In considering the theme of relationship, the main focus of the analysis will be on the participants' relationship with the paid staff and the sub-themes of trust and a sense of intimacy. The area of trust was a reoccurring issue throughout the actual interviews. A number of clients felt they had been let down by the paid carers in the past and sometimes they felt they were abandoned by them. Interestingly, a major theme for those individuals who felt let down was the failure of care staff to pass on concerns to either the social worker, doctor or district nurse. This feeling was more acutely expressed by those participants who did not have family or friends that were involved in their care.

*"It went on for nearly two months, I was in pain when I passed water, so I ask the girls to phone the Doctor. I struggled with the phone due to my eyesight and arthritis. I did try but I forget things I couldn't remember the number. In the end one day I was in so much pain I told the girl to phone an ambulance. I was in hospital for two months, they said if I hadn't have phoned I could have died. I had a blockage in my water works and I was slowly poisoning myself!"*

This was followed up with the social worker who informed me that no care staff had passed on this message and that this had subsequently been investigated as a case of neglect, although no one was identified as being responsible. The problem was seen as a breakdown of communication. This was an interesting case as the lady received three visits a day, each conducted by a different member of staff. When the care records were

reviewed, 21 different staff had provided her care. This was similar across the time/task group with multiple visits being conducted by a wide range of staff and sometimes multiple agencies. The purchase of multiple agencies was due to a shortage of time slots for the putting to bed service, and therefore any agency with gaps that week would be used. This was in contrast to the outcome-focused group where the participant received visits from a consistent team of four staff who would all come from the same agency.

This lack of consistent and regular visitors was demonstrated by the response to the following question:

*“Can you tell me the names of the staff who visited you yesterday?”*

The outcome-focused care group could all name their care staff by their first name, whereas only two of the ten time/task group could give the first name of one of their carers. This lack of intimate knowledge and constant change led to the development of detachment by the participants from the paid care staff. This interestingly was also reflected during the participant observation of the care delivery which will be analysed in part two of this chapter. The outcome-focused group and the care staff had managed to develop quite knowledgeable relationships of each other over the period between the first interview and the second. During the second interview, the service users were asked to tell me about their paid staff. I have already mentioned they were asked to identify the paid care staff’s first names and this was followed up with additional questions. The aim of these additional questions was to establish the human level of their relationship, and to develop the issues raised in a more subtle and less threatening, gentler manner. This is important, especially when considering a topic such as trust as Manthorpe *et al.* (2008) found that older people were nervous about discussing their carers with researchers for fear of a negative response from the care staff who they were in some cases totally dependent on. Once they had been asked to tell me the name of the care staff they were asked to tell me anything they knew about the paid care staff. This was achieved by asking the following question:

*“What do you know about your paid care staff?”*

The outcome-focused group all knew a great deal about the paid care staff, which is summarised in Table 4.8.

**Table 4.8 – Relationships with paid care staff**

<b>Outcome-focused group</b>	<b>Time/task group</b>
All first names of care team	Only two out of eight could name staff by their first name
Knowledge of family relationships with care staff	Extremely limited knowledge. Some were able to say that care staff had children
Had knowledge of the ages and number of children and grandchildren of the paid care staff	No knowledge expressed of details of family composition
Knowledge of hobbies interests such as football teams supported, favourite TV soaps	Some limited knowledge mainly of football teams supported
Discussion about life histories with the paid care staff	No evidence of discussion focused around life histories with paid care staff.

The responses to the questions reinforce the lack of depth in the relationships developed by the service users receiving the time/task model in comparison with the outcome-focused model of care. This lack of depth in the relationship will be developed further when I analyse the direct delivery of care in part two of this chapter. The inability of the time/task group to establish a relationship also limited their ability to have trust in those who delivered their care. As already mentioned, the lack of trust in the ability of those caring for them to pass on information was a recurrent factor in the interviews. The lack of trust in the time/task group to complete tasks was mainly affected by the lack of consistency in the individuals who provided the care. This is demonstrated by the two following comments:

*“They promise that they will do something and then you never see them again, someone else turns up they promise and guess what you never see them again.”*

*“I don’t think it’s the girl’s fault I just think they see that many people that they can’t remember what they have promised to do.”*

This is quite starkly contrasted against the comments of the outcome-focused group who emphasised how they could trust their home care staff. This lack of relationship and consistency seems to have had the greatest impact upon the process of care delivery as viewed from the service users’ perspective.

The data analysis presented within this chapter so far has found that the relationship and consistency of care have a substantial impact on the effectiveness of the intervention.

#### **4.1.7 International Perspective**

Realistic evaluation is concerned with the context within which a social programme occurs. The national perspective has been covered in Chapter 2 and will be considered further in Chapter 5; however, it is worth considering how other countries structure their home care. Arksey and Kemp (2008) have examined from an international perspective the structure of home care, with a specific focus on the different countries' methods of funding care for the elderly. These funding methods are often termed 'cash for care'. Arksey and Kemp looked at both Europe and the USA and examined how cash for care schemes are designed to provide the service user with the cash to purchase services and to have control over their own care plans. The concept of outcomes was found in all the countries studied, with the main thrust of the findings being that the use of cash for care schemes had psychological benefits for the service users. These benefits were most striking when the national scheme enabled the service user to purchase services that allowed control of the timing of visits and services that could be tailored to the individual service user's lifestyle. The analysis of data throughout this chapter would support the findings of Arksey and Kemp (2008) in that having control over the care that is delivered improves outcomes for those who receive them. However my research did not really provide any in-depth consideration of the relationship between those being cared for and their informal carers.

It is important to emphasise that Qureshi *et al.*'s (1998) care model is distinctive from the overall thrust of the debate focused around cash for care, or in the UK direct payments and personalisation. Personalisation may be a method of delivery that is more focused on the individual, but may still provide a depersonalising experience, whereas outcome-focused care is achieved by a joined-up approach between the care assessment and the delivery of care. The time/task approach appears from this case study not to have suffered from a lack of structure, but from a fragmentation of delivery and a disconnection from the wants of the service users. These issues, as Arksey and Kemp have viewed in other countries, are not simply solved by giving the recipient the control of the budget. Appropriate outcome-focused services would need to be available to be purchased.

#### **4.1.8 Summary of Findings from Semi-Structured Interviews**

The findings from this chapter will be summarised using the realistic evaluation methodology of context-mechanism and outcome as outlined by Pawson and Tilley (2006). The context within which the care was delivered was similar between both

groups; however, the mechanisms generated by the outcome-focused model of care appear to have had a profound impact on the individual participant's SWB. The three primary mechanisms in operation in this particular intervention were;

- Consistency of care
- Ability to establish a relationship
- Flexibility of task completion

The main differences between the two groups being studied were that the outcome-focused group had the same consistent care staff. This consistency allowed for more individualised planning of the care delivery and made the care delivery more unique to the individual service user. This lack of consistency from the traditional time/task model of care meant that the service users received a very fragmented and impersonal model of care. Lines of communications were made difficult by the use of different care staff and especially when multiple agencies were involved in the delivery of care tasks.

The second identified mechanism was the ability of those being cared for to establish a relationship with the paid care staff. This will be developed more in part two of this chapter during the analysis of the participant observation. Consistency allowed for a depth of relationship to develop between the outcome-focused participant and their paid care staff. This enabled the passing of personal information and the use of first names between the two groups. This was particularly important for those service users who had no other human contact than their paid care staff, and these individuals displayed the most pronounced improvement in the individuals' SWB. The opposite findings were established with the time/task group: there was a very limited traffic of personal information, and this was felt most acutely by those service users who had no other family contact.

The final mechanism identified was the flexibility of the paid care staff. Although this has not been developed as a specific section within this chapter, it was present in the outcome-focused group who had the ability to switch the task completion schedule without having to consult with managers or social workers (within agreed parameters). This meant that the service user had some control over their daily routine and a sense of involvement with those who provided the paid care. This mechanism was absent in the time/task provision as the delivery of care tasks were prescribed and allowed for little variation in their deliver.



## **Part Two: Participant Observation**

### **4.2.1 Background**

This section of the chapter will report on the participant observation conducted with the home care staff. As this is participant observation, the remainder of this chapter will be in the first person. These observations took place over a four-day period, and involved myself accompanying four home care workers whilst they delivered home care to sixteen service users. Two of the home care workers were delivering the outcome-focused model of care and two were delivering the time/task model of home care. The observations totalled 24 hours. The staff were accompanied by me in their own vehicles, which allowed for the observation of the complete process of care delivery. Four service users were not observed at their request due to the intimate nature of the care they received. This observation occurred in a naturalistic setting, and where possible I tried to limit my interaction in the process. However, I had already conducted the semi-structured interviews with the service users and was known to them. I was also known to the staff who were delivering the care. The observations took place after the initial semi-structured interview, but prior to the final interview visit. I took the role as defined in Gold's (1958) typology as '*observer as participant*'. This involved me accepting that my presence and previous knowledge of both groups would impact upon the objectivity of the observation and that this would have some impact upon the behaviour of both groups, and it is with this in mind that the findings are reported here. The workers will be referred to as Time/Task 1 (TT1) and Time/Task 2 (TT2) and outcome-focused 1 (OF1) and outcome-focused 2 (OF2). This observation will be analysed using the core themes developed during the analysis of the semi-structured interviews in the first part of this chapter.

### **4.2.2 Models of Care**

The models of care varied in how the day was structured for the home care staff. The team members who were delivering the time/task model of care had to report to the supervisor at 6.30am in order to pick up their rota for the day and also to collect a work mobile phone. Therefore the home care staff only knew who they were delivering care to on the day of the visits. This was different from the provision of outcome-focused care, where staff were in designated teams of four with a lead worker responsible for day-to-day coordination. The visits were planned between the staff and they rang the schedules through for the following day to the office. The staff knew that they would be working with a group of up to sixteen service users, all of whom they knew. Staff did

not have to report to the office but rang to check if any alterations had been made. This meant the staff delivering the outcome-focused care had some degree of autonomy; this was not the case for those delivering the time/task model. Both groups of staff had the same length of working day (7.5 hours). The outcome-focused staff had between five and seven visits depending on the length of the designated visit and a half an hour for lunch. The time/task group were given seven visits regardless of the length of the designated visit. This meant that home care visits exceeded their working day in some cases. I asked the time/task staff about this and they explained that not all the visits took as long as prescribed so they could complete more visits. The length of time spent with the service users has been examined in Chapter 3, but this difference in delivery meant the outcome-focused staff completed the designated time regardless of task, whereas the time/task staff completed the task and then utilised the extra time to complete more tasks or as one worker confessed, finish early. This therefore incentivised the time/task team to either take longer to ensure they were not given extra work or to rush the tasks so that they could go home. I noted from joining the staff that there was a palpable difference in the sense of pressure to complete the schedule. The time/task team appeared rushed from the moment they commenced visiting, whereas the outcome-focused team appeared more relaxed. This sense of pressure was further exacerbated by the time/task workers' phones constantly ringing to check on their location and also for them to be given altered or additional working tasks. Whilst observing the time/task group, both workers were given an additional three visits to cover due to staff sickness, and both workers confirmed that this was normal practice. Therefore, although on the surface both models of care appeared to be similar their management and practices were quite different and different mechanisms affected the two models: control and function.

### **4.2.3 Control**

Both agencies' purpose was the completion of the required number of contracted visits in the given time frame; in addition, both workers had to complete the tasks according to the care plan. However, the time/task model did not identify the social interaction occurring between the carer and the cared for person as important. Therefore although it was not intentionally ascribed, the outcome-focused model did allow control to be delegated to the care staff and this subsequently provided flexibility in the care delivery, which in turn enabled increased social interactions. This mechanism dovetails with one of the designated service process outcomes identified by Qureshi *et al.* (1998). Qureshi and colleagues in their original research established that control over service delivery is important for the individual receiving the care in order to allow them to feel respected

and that the services they receive constitute value for money. This is important as most of the service users were making some financial contribution to the cost of their care.

#### **4.2.4 Function**

Both models of care involved the completion of direct care tasks and the provision of intimate personal care. However, the mechanism termed by myself as ‘function’, operated differently in the way the two models were delivered. The time/task model was totally focused on the completion of tasks in as short a time as possible; therefore the tasks were done to the individual service user. The outcome-focused tasks were completed as part of a process of care delivery and were done with the individual service user. These tasks were completed within the allocated time frame which then allowed other social interactions (or tasks) to be completed outside the immediate remit of the care plan. This meant that if the tasks were rushed then they allowed time for other activities. This difference was reflected in the way the staff recorded the care they delivered. On entering homes, TT1 and TT2 normally started by looking at a task card and instructing the service user to get ready for the completion of the tasks and the following introductions were noted when the workers initially entered the properties: “*Hiya, I am Becky let’s get you washed*” or “*I’m Michelle, where are your clothes you’re wearing today?*”. In all the cases no attempts were made to strike up any conversation that was not directly focused on the task, inasmuch that a significant amount of care was delivered in silence, with this leading to a feeling of detachment between those being cared for and the home care staff. This observation was followed up with staff during the intervening car journeys between visits. Both time/task workers were asked the following question:

*I noted that you tend to focus on the task and this sometimes means you don’t interact in conversation with the service user much, why is this?*

*“You have got to. These old dears will chat non-stop, they just don’t realise you got to get things done, and it slows you down too much.”*

*“You just don’t have time to chat and it means you appear less professional chatting, I learnt that when I was a nursing assistant, don’t get involved with the patient, keep your distance.”*

This was very different from the way the care was delivered to the outcome-focused group. The staff always referred to the individual by their first name, and all interactions involved conversations that were not focused around the completion of tasks. Below are

some examples of the introductory conversations between the outcome-focused home care staff and the service users:

*“Hello Doris how are you, did you see Coronation Street on Sunday?”*

*“Hiya David it’s only me, it’s cold today do you need your heating adjusting?”*

*“Morning Irene what shall we do first today, do you want your breakfast or do you want to get dressed first?”*

The focus operating here was about the relationship between the carer and the cared for. Tasks were constantly negotiated, added or deleted, with a large amount of time focused on general conversation. This did not appear to be an intentional outcome, but a by-product of the way the care was structured, and they would spend a set time that could only be filled with another activity or conversation. Therefore, the unplanned function was relationship-building. This would appear to shed some light on why the outcome-focused model of care had an impact upon the individuals’ SWB as opposed to the traditional time/task model. The care being observed appear to show that there was a connection between the actors that was not present in the observations of the time/task care. This interaction and allowing the older person, who in a number of cases had no external interaction except with the paid carers, to feel connected, which was a desired outcome identified in Qureshi *et al.*’s (1998)

initial research and the follow up study conducted by Glendinning and colleagues (2008). One of the major concerns identified by the service users in the completion of the MYCAW was social isolation, therefore the development of a relationship allows for the social isolation of the older person to become less total, which was not the case with the time/task model which actually could be seen to reinforce the sense of disconnection and isolation. This leads us to the next theme to be developed which was social interaction and relationships.

#### **4.2.5 Social Isolation and Relationships**

The concern around social isolation was a major concern of the participants in both groups, and it was demonstrated in Chapter 3 that the outcome-focused group appeared to show the greatest improvement in this area. However, Chapter 3 did not demonstrate conclusively what the mechanism operating was that caused this improvement. This observation therefore focused on the development and depth of the social interaction that was taking place between the home care workers and the service users. In order to

measure this I decided to record the length of the conversations between participants and the home care workers. In addition, the content of these conversations was broken down into four categories;

- Dialogue predominantly focused on care.
- Dialogue focused on both care and non-related subjects.
- Dialogue focused on topics other than care
- No conversation

This was achieved through the use of a simple tally system with a tick being given during the conversation for each change of topic and the results are given in Table 4.9. When a topic was mentioned then a cross was made, and when the topic changed or stopped a further cross was added. These were combined with the start and finish time for the conversation. The total numbers of topics were added together at the end of the conversation and are displayed in Table 4.9 according to each service user. This was completed for five service users in each group.

**Table 4.9 – Topics of conversations**

Participant Group (Conversation over 1 hour period)	Dialogue predominantly focused on care (in minutes)	Dialogue on both care and non-related topics (in minutes)	Dialogue focused on topics other than care (in minutes)	No convers ation	Time total of conversation
Time/task	20	05	00	35	25
Time/task	30	07	03	20	40
Time/task	18	07	00	27	23
Time/task	15	10	00	35	25
Time/task	38	00	00	22	38
Outcome/focused	10	15	20	15	45
Outcome/focused	15	10	30	05	55
Outcome/focused	16	8	30	06	54
Outcome/focused	11	10	35	04	56
Outcome/focused	20	06	23	09	51

These observations reveal some interesting differences occurring during the social interactions taking place whilst the physical care was being delivered. The outcome-focused group displayed more social interactions not related to the care being delivered than the time/task group. The atmosphere generated during this process felt more

inclusive and personal, and generated what felt to the observer as a more positive attitude and personal feeling to the whole process of care delivery. These findings appear to support the responses of the participants during the second stage interviews. The interaction during the outcome-focused care was more akin to a conversation between acquaintances or neighbours who knew a little information about each other, but did not have the depth of knowledge that would be seen in a friendship. The process of care delivery therefore differed in content. I observed a variety of different levels of knowledge about the service users. The entire outcome-focused group had been seen consistently over the last eight to ten weeks by the same team of four workers. The level of contact varied greatly amongst the time/task group, with some service users having never met the staff, to the staff having met the service user on more than six separate occasions. Therefore the fact that workers in the time/task group were seldom allocated the same round of visits meant that the staff tended not to form relationships with the service users. This contrasted with the outcome-focused group who saw it as essential to establish some depth to their social interactions with the service users.

Therefore there was a mechanism operating of relationship forming within the outcome-focused group that was not present in the time/task group. This social interaction, combined with some of the outcome-focused service users having social outings, meant that the main concern of social isolation was addressed in a way that it was not in the time/task model. In addition, the way the time/task delivery was structured meant that the process of care delivery actually acted against the forming of relationships. This is important inasmuch as the consistency of care provided by the outcome-focused team was an unintentional management by-product rather than a key element of the planned intervention. The original plan had not involved the use of the same staff to be organised in a designated team. Therefore although the social outings would have taken place, the arguably most important mechanism of relationship forming would not have been present. This lack of social relationship may well have had a profound impact upon the service users' well-being and the improvement in SWB might have been different; it may have been that outcome-focused care was not significant in improving SWB. The actual process of the delivery of care, if altered to promote consistency by a worker being regularly allocated to the same service user, could potentially achieve an improvement in SWB without the additional costs (17%) that were identified by the commissioners.

#### **4.2.6 Findings from the Observations**

Qureshi and Henwood (2000) in their initial research identified the outcomes that were valued by older people, with these outcomes being developed into outcome-focused care and implemented by various local authorities. The implementation of this model was the focus of a review undertaken by Glendinning and colleagues (2008), where it was found that the delivery of Qureshi and Henwood's model of care tended to be fragmented and that more holistic practices needed to be developed. This does not appear to be the case with the outcome-focused model of care being observed in this research, which appears to be holistic and to have an impact on the outcomes identified by Glendinning and colleagues. One of the specific outcomes which the participant observations illuminated is the impact of service process outcomes on care delivery, with this outcome defined as:

*“The ways that services are accessed and delivered, including feeling respected and treated as an individual: having a say and control over services: good value for money and compatibility with other sources of help: respected for religious and cultural preferences.”* (Glendinning *et al.*, 2008, p.2)

The outcome-focused model as outlined by Glendinning *et al.* that has been utilised in this piece of research does seem to have met all the requirements of the outcome stated above. However, value for money has not yet been established and will be considered in Chapter 5. In addition, the last outcome with regard to religion and cultural preferences has not been fully developed due to the make-up of the sample group being all white Europeans, so its application to more ethnically diverse populations might need to be considered as a topic for future research. The observations did allow me as the observer to see that the outcome-focused group were treated with more respect and were viewed as individuals, as opposed to the rather impersonal and technical delivery observed in the time/task model of care. The process of negotiation about the completion of daily care tasks was apparent with the outcome-focused group and gave the impression of the care being done with the individual service user, in contrast to the time/task model which gave an impersonal impression of being done to the individual service user.

#### **4.2.7 Overall Summary**

In order to establish any relationship between this research and the existing body of knowledge this summary will consider the analysed data from the interviews and the

observations under the headings considered in the original review of outcome-focused care conducted by Glendinning and colleagues (2008).

The first of these headings is the ability of outcome-focused care to have an impact upon independence, well-being and choice, and the following criteria were identified in relation to this:

- Improved physical and mental health, and support in managing long-term conditions
- Improved quality of life, including access to universal services, and safety and security inside and outside the home
- Being able to exercise choice and control
- Economic well-being, taking account of social activities and special needs
- Personal dignity and choice

In considering the first outcome - improved physical and mental health, and support in managing long-term conditions - neither the interviews nor the observation have established an improvement in physical health or the management of long-term conditions. However, the improvement in SWB suggested that there appears to be an association between outcome-focused care and an improvement in mental health in the form of SWB. The overall measure of service users' quality of life had a significant improvement in the case of the outcome-focused group, with no significant improvement being experienced by the time/task service users. The outcome-focused group through the ability of the model to enable activities away from the home also saw improvements in service users' access to services. The service users in the outcome-focused group also felt more secure in their relationship with the care staff and their ability to maintain their independence and live in their homes for longer. The outcome-focused care participants, from both the interviews and the observation findings, appear to have been treated with more dignity and respect by the care staff; in addition, the process of care delivery has allowed both the worker and the participant in the outcome-focused care group to exercise more choice and control over the care process. The major difference between the two models of care was the more positive experience of the outcome-focused group with regard to social activities.

In summary, the outcome-focused model was superior to the existing model in improving the service users' quality of life and meeting the outcomes identified by Glendinning and colleagues (2008). However, it was also established that a lot of these improvements were down to the process of delivery rather than the alternative model of



care. Therefore the existing time/task model could be improved if it incorporated more consistency in the staff team delivery and concentrated on staff developing relationships with those in their care.

## CHAPTER 5: THE PROVIDER PERSPECTIVE

### 5.1 Introduction

Thus far, this case study has considered the impact of intervention upon the service user's well-being. The focus of this chapter, however, is concerned with examining the provider perspective on the effectiveness of outcome-focused care. The data for this section have been drawn from focus groups and interviews undertaken with staff from within the services responsible for the commissioning of home care on behalf of the local authority and the director responsible for providing services. The chapter begins with the analysis of the data generated from social workers via two focus groups (SW1-10 and FG1-2) and four individual interviews with the social workers and two interviews with the team managers (TM1, TM2). This is the key group of staff who commission outcome-focused care for individual service users. The final section of this chapter analyses the data from the interviews with the Director of Adult Care and the Chief Commissioner for the local authority.

The overall objective of this chapter is to establish how those responsible for the commissioning and implementation of this programme of intervention (outcome-focused care) conceived its effectiveness in improving the well-being of those service users who were in receipt of it. The analysis attempts to highlight what mechanisms were in operation from the providers that enabled this particular programme to possibly have some impact upon the SWB of the intervention group. The findings from all the different sources of data will then be drawn together in the concluding discussion.

#### *Thematic analysis*

The core theme 'model of care' which has been established in Chapters 3 and 4, will also be the main theme being examined in this chapter. The questions were focused around this core theme and were delivered to both the social workers and senior managers in order to measure their views of outcome-focused care. Throughout the process of data analysis three other sub-themes were developed:

- Power
- Control
- Marketization

The findings from the interviews with the social workers and team managers will also be analysed under these sub-themes.

### *Constitution of the Focus Groups*

The two focus groups were composed of two adult care fieldwork teams, who were responsible for the assessment of service users' needs and for the subsequent planning and purchasing of services to meet these assessed needs. The focus group sample was comprised of ten social workers (per group), whose experience varied from under one year to 30 years fieldwork practice. The focus groups were recorded and each member stated their name prior to commenting, which allowed for identification of the different respondents during the process of data analysis. A decision was made by the local authority for the team managers not to participate in the focus groups, as it was felt that this could inhibit the social workers' ability to speak freely. However, the managers' perspectives are also considered in this section of the chapter. The focus groups were both planned to last no longer than one and a half hours. This was due to constraints on staff free time and problems booking meeting rooms within local authority premises for any longer periods.

### **5.2 Model of Care**

The first question asked in both the individual and focus group interviews aimed to determine what the social workers and the managers who would be commissioning the service viewed outcome-focused care to be. The first focus group appeared to have received no training on the new model and had only been supplied with a one page memo informing them about the pilot study of outcome-focused care. The second group had received a very different model of training which they termed as cascade training. This system of training involved two members of staff attending a national training event and then passing on this training to the team. Given the varied level of training on outcome-focused care, the first question was to ensure that both teams of social workers provided their understanding of what constitutes this model of care and asked:

*“What is understood by the term ‘outcome-focused care?’”*

Table 5.1 provides the responses of some of the group members to this question.

**Table 5.1 – Responses to: What is understood by the term ‘outcome focussed care?’**

Focus Group One	Focus Group 2
<p><i>“It is about passing the planning to the service user rather than the professional, with a focus on the outcomes rather than the need; I don’t like the look of it.”</i></p>	<p><i>“Outcome-focused care Is exactly what it says on the tin. It is focused on the outcomes that the service user feels need to be met.”</i></p>
<p><i>“It is basically doing what we used to do before they introduced care management. Sitting down with the person to see what they want from us, instead of one size fits all.”</i></p>	<p><i>“It is about the person not the task, a much more human way of dealing with people, I prefer it.”</i></p>
<p><i>“It’s about the end results, what you want to achieve from the care plan.”</i></p>	<p><i>“I and Bev attended a workshop provided by the institute (SCIE).It was a two day workshop and we were told about the model and then we practised devising outcome-focused care plans. The social workers and the providers did separate care plans and the next day we had to compare them. They were very different. We then came back to the team and did workshops with them. It is about a more equal approach to delivery focussing on the individuals’ human wants and needs.”</i></p>
<p><i>“It’s just about the outcome – what we want to achieve.”</i></p>	<p><i>“It’s a very different way of doing a care plan, I’ve been in social work nearly 30 years and it reminds me of how we case managed before care management, you negotiated more, this seems to be similar.”</i></p>
<p><i>“It’s about the whole person, rather than just working along with the home helps. We normally go in and ask what needs to be done. We say right that takes fifteen minutes, that takes five and that takes ten, it’s very simple really.”</i></p>	<p><i>“Initially I thought outcomes were set by me, then I realised it was by the service user, which felt more natural more what I want from being a social worker.”</i></p>
<p><i>“I think it is actually when the service user identifies the outcome and our job is to assist them in getting there. You know what they want, it might be totally different to the time/task.”</i></p>	<p><i>“Outcomes or tasks are all the same, it is just a different spin, just an excuse to privatise it all.”</i></p>
<p><i>“It is much more flexible.”</i></p>	<p><i>“I feel this model is really person focused and yes I have less control but that is a good thing.”</i></p>

These are the responses of the team managers to the same question:

*“Well I have read the SCIE (SCIE, implementation framework) blurb, and I see it as basically allowing the service user to choose services more, rather than having as we do now a very limited check list.” (TM1)*

*“That’s a good question. I have been in social work for a very long-time, and I realise it’s a roundabout. You move from one fad to another. Outcome-focused care is very much about the individualising of care as we did in the eighties prior to care management. You worked closely with the home-care worker and you case managed your clients so everyone knew everyone else. This meant that we set the outcomes although we didn’t call it that then. This fitted in with the service user and their family’s needs, although the families were more involved then.” (TM2)*

It is apparent from the responses above and subsequent discussions that the teams did have a basic understanding of the purpose of the model they were implementing. The managers appeared to be better researched and briefed on the model of care than the social work staff and on face value appeared to approve of outcome-focused care. However, none of the staff had read the original research or could even mention who the authors were. Neither could they claim to have read any social work research since qualifying. In similar findings, Kirk (1990) noted that social workers made little use of research studies. This is an important factor for the profession, in terms of ensuring that practitioners are aware of best practice in their fields, and that research is not read by a small elite. However, Rosen *et al.* (1999) and Reid (2001) in a review of social work publications found that only between six and eight per cent of social work research studies actually referred to the evaluation of interventions.

The individual interviews with the social workers gave a slightly different insight into the understanding of the model. The social workers referred to the model as being a person-centred approach to care delivery and constantly referred back to social work theories they had learnt in initial training and revisited in their post-qualifying awards in social work.

### **5.3 Power and Control**

The focus groups had a sometimes heated discussion, which led to the first sub-theme of analysis about who was in control of the care package. The following thread displays the participants’ views concerning the outcome-focused model of care over the existing time/task model which took place in focus group 1:

*“The outcomes are defined by us the social worker or you would have no control over the care package.”(SW1, FG1)*

*“Yes I agree it is still our package of care as assessed by us, with some adaptations by the service users.”(SW3, FG1)*

*“It is our assessment so the outcomes are dependent upon what we assess is needed.”(SW4).*

The majority of the respondents in the first focus group agreed with the statements made above, taking the view that social workers should have some control over the care package. However, two out of the group of ten strongly opposed the views of their colleagues;

*“No I don’t agree. It is about us passing over control of the care package to the service user, so that they can set the agenda or outcome to suit them. We are just there to hold the ring and facilitate the care.” (SW2, FG1)*

*“Yes, it is about us brokering the care and ensuring that what the person wants is what they get. We are not the experts in control; we are like the shop assistant showing the different shoes to the customer, they just choose them.”(SW6, FG1)*

The conversation continued within the group, with anxiety about the loss of control and fear that the social worker would be accountable for the poor or misguided choices of the service users. It was apparent from the conversation that the workers who were used to a heavily procedural structure of care delivery felt unsure of a system whose boundaries were less well defined.

The second focus group also expressed their concerns about how outcome-focused care would impact upon their control over their caseloads. Interestingly, this group used the term ‘power’ rather than ‘control’. The term power was expressed as the ability to influence the process, rather than with the first group where the analogy was used by the group of steering a car - social workers needed to ultimately drive the care and not the service user. The following thread of conversation demonstrates a similar level of anxiety to the first group:

*“I’m worried that as we give all the power and control to the service users that we will be left with all the responsibility but no power to influence decisions being made.” (SW1, FG2)*

*“It is typical management undermining, this is a new way of working, you have no power in it and we (the local authority) don’t care.” (SW3, FG2)*

*“I agree it is linked to this management culture, and what that means is we (social workers) are powerless to do anything but watch our jobs disappear down the plug hole.” (SW8, FG2)*

The overall impression from the question posed was that this group of professionals had a limited knowledge of the new model of care and felt it was an imposition made by senior managers, with the overall goal of undermining the role of social workers. There was very little mention about the model – apart from the initial benefits to the service users – or of its impact upon their quality of life. The conversation was very internal in its focus and linked to the fact that all decisions were top-down, with little input, as the social workers described it, from the shop floor.

This finding was somewhat contradicted in the individual interviews where the social workers said they liked the ability to be able to establish a more long-term relationship with the service users and felt their jobs were enhanced by a sense that they could have some individual impact upon the service users’ lives rather than just being an assessor and purchaser. It is hard to establish the reason for this difference in responses and whether the organisational flux in the organisation led to more negative group thinking as displayed in the focus groups, which was not felt by individual workers in their practice.

The second question was focused on getting the social workers to identify any differences between the two models of home care. The data generated the theme of flexibility that has been covered in previous chapters, with the outcome-focused model being perceived as having the most flexibility. The social workers in the individual interviews also picked up on the theme of consistency or relationship forming as being the strength of this model. This is the question that was put to the social workers and team managers:

*Can you explain what the difference is between outcome-focused care and the current time and task model?*

These are the responses from the first focus group:

*“The time/task model is easier to operate, it focuses on basic needs, and it is much easier to manage.” (SW10, FG1)*

*“Time/task is pretty inflexible whereas outcome-focused model has the ability to be flexible.” (SW3, FG1)*

*“It is very difficult to get the time/task model to engage with a service user’s emotional or psychological needs.” (SW9, FG1)*

*“The outcome-focus model allows the home care worker to have more independence, as opposed to the time/task where everything has to be in the care plan or it doesn’t get done.” (SW10, FG1)*

The second focus group gave the following responses to the same question:

*“Time/task is more quantifiable than the outcome-focused care and it can be the best if the individual has a lot of social support. However, if the person is quite isolated then I think outcome-focus is the preferred option; it allows the home-care worker to complete tasks outside of the more rigid care structure of the time/task.” (SW1, FG2)*

*“Outcome-focus is weak is open to interpretation by the worker and the service user; however I would prefer it, if I was receiving home care. Although it is going to be a nightmare to manage.” (SW7, FG2)*

*“It’s the rigidity of the time/task model that is both its strength and weakness. Another problem is the way a lot of the home care agencies interpret it to the letter with absolutely no flexibility.” (SW4, FG2)*

*“Yes I think the home care model, sorry outcome model, is more human and inclusive.” (SW5, FG2)*

Generally, the two groups agreed that the outcome-focused model allowed for more flexibility and initiative to be used by the home care worker delivering it. The comments of the social workers dovetail with the findings from the service user interviews and the direct observation of service delivery. Therefore, these three different data sources allow for the use of triangulation in the analysis. Bryman (2008) sees triangulation as the use of multiple data sources for a cross check, when analysing a phenomenon. In this particular case study, the three different groups of respondents all reported that they found outcome-focused care a flexible approach, which assisted in the promotion of emotional well-being. This supports the findings of the statistical analysis. The triangulation of the different data sets is considered in more detail in the concluding chapter. Therefore, the main difference identified by the social workers between outcome-focused care and the existing time/task model is the ability to individualise



care plans in order to be flexible. The responses given by the team managers to the same question were:

*“Well that is dependent on whom you consider it to benefit, for the service user definitely outcome-focus, for me as a manager the time/task. The time/task is far easier to manage, i.e. clearly defined goals and time limits. It also makes the audit trail easier, you know the dreaded accountability.” (TM1)*

*“I think on paper the outcome-focus looks best and the workers say the service users prefer it. But I think it has too much potential for abuse by the care agencies. It is going to be a nightmare to manage, not to mention the mess personalisation is going to bring. So I hope it is a fad that will disappear like all the other rubbish the governments impose upon us.” (TM2)*

The responses reveal the managers’ concerns about the difficulty of overseeing the change in the home care model. They express similar views to the social workers in the focus groups; there is an acceptance that the new model appears better for the service user, but express more concern about how this change will impact upon them. This is interesting given the value base of social work and its person-centred nature; both managers and workers have a heavy investment in maintaining the procedure of statutory social work, and little investment in championing change that will improve the lives of the service users. Another theme that developed was the managers’ concern about the impact of personalisation, which is considered in the conclusion of this chapter.

#### **5.4 Perceived Strengths and Weaknesses of the Two Models**

Having established the social workers’ views on the difference between the two models of care, the questions proceeded to consider the perceived strengths and weaknesses of the care provided by the social workers. The two focus groups, managers and individual social workers were asked the following question:

*Do you see these two models as having different strengths and weaknesses?*

*“The time/task has a lot of downtime.” (SW8)*

The facilitator then asked the respondent to clarify what was meant by the term ‘downtime’. The group explained that the time/task model led to problems with staff experiencing high demand around peak times such as mornings, lunch and the putting to bed services (late evening). However, mid-morning and afternoon periods often meant

staff being paid for conducting no visits, with the group feeling that it was these periods that could be used for emotional visits or psychological support for service users. The problem, however, was that as visits were time allocated, any additional use of time would be charged, against the individual's care plan even though the staff were available and already being paid whilst being under-used. This demonstrates how bottom-up decision-making could enable more quality time for service users without additional costs to the commissioner. The group believed if the procurement conditions altered from the set tasks to allocated time, agencies would use this downtime more effectively. The group also stated that private agencies tended not to have downtime, but were more flexible over how late a service would be delivered. This had led to problems with service users being put to bed as early as 7pm and then not receiving the morning service until 10am, meaning that they could be in bed for over 14 hours a day. The general feeling was that outcome-focused care would help to eliminate some of these practices and service users would receive a better service overall. The groups felt that this flexibility and individualisation of service was one of the strengths of the outcome-focused model of care. However, the groups also felt the time/task model has some significant strength, particularly from a commissioner's perspective. The identifying of exact tasks meant that it was easier to check if care plans were completed and if not to establish who was responsible for their non-completion. The time/task model also made the management of resources easier to allocate as every item was timed and could be priced by the social worker more effectively.

Interestingly, the issue of power and control arose again at this stage in both focus groups.

*“A weakness of the outcome-focused model is that there is a lack of control over the care by us (social workers). You have these untrained home care workers and some very frail clients making day to day decisions without talking to the social worker.”* (SW3)

*“Yes I am uneasy specially when private agencies are involved you need tight oversight with them and the time/task makes that easy allowing them to have control over daily tasks is very scary.”* (SW7)

Even more pessimistically one social worker stated:

*“it’s part of a long-term plan to scrap social workers with this and personalisation, you set your own outcomes and then you go to a private agency and get it, why does a social worker need to be involved at all?” (SW2)*

The managers had similar responses:

*“One has a rigid framework within which you divvy up the needs according to the activities of daily living (time/task) and you use this to manage the time and cost of the care. The other (outcome/focus) is woollier; you agree wants with the service user and you then develop the care plan around these.” (TM1)*

*“That is easy, time/task is a sausage factory, you have the maximum turnover and productivity for the least cost, it is very much like a production line. The social worker has a minimal involvement so they can assess more service users; the care is then sold on to the agencies. This so called new model (outcome/focus) is much more time intensive as the social worker has to continually manage the case to ensure the outcomes are met and changed accordingly. We tried to follow the old system with this pilot of shutting cases once the care had been delivered but it hasn’t worked, you have to keep an eye on it.” (TM2)*

*“Well that’s a good question. I suppose as I have already said the time/task is much easier to manage. However, from what I am being told by staff and some carers the outcome-focus model is much preferred by the people receiving the service because it is so flexible and individual.” (TM1)*

*“Well the time/task is the stronger it is easy to manage and is much cheaper. The outcome-focus model is far too loose. It will lead to problems with its management. Although I accept if I was an older person and in three years I will be retired I would prefer the outcome-focus model.” (TM2)*

## **5.5 Contradictory Messages**

Throughout the process of data analysis, contradictory messages were produced by the individual interviews. These interviews were less structured with the social workers (there were two interviewees from each of the focus groups) and they were asked why they had chosen the new model of care for some of their service users:

*“When considering the models, I had a number of clients whom I felt the model was more appropriate for, as it has a flexibility that the time/task doesn’t. \*\*\*\* (service user) is very isolated and I felt needed the extra contact that the model of care delivers.*

*Her physical condition is very changeable, with some days being so good that she can leave the house with support and others she is so wracked with pain she can't leave her bed. The outcome-focus model would allow the care staff to fit the care to her condition rather than just a standard delivery that wouldn't suit either occasion.” (SW1 FG1)*

*“\*\*\*\* (service User) is a very, well how I shall put it, ‘challenging lady.’ She resents the intrusion that the home care staff make in her life, but unfortunately she wouldn't be able to live independently without it. So I thought the flexibility of the outcome model and giving her more control would make it easier for all parties, and it has. \*\*\*\* has been able to get out of the house and establish a better relationship with her care staff. I met her last week and asked her what was different she told me she feels she is treated like a person and not an inconvenience.” (SW2, FG2).*

These two comments are interesting as they contradict the concerns expressed by these social workers in the focus group and as mentioned earlier this could be due to group processes impacting on the individuals' ability to speak. The actual practice of the social workers was very person-centred and showed that they believed the model of care that fitted the needs of the service user was important. In the individual interviews none of the four social workers expressed any concern about a loss of control. However, there was concern about being accountable if things were to go wrong:

*“This outcome-focus model only works if you have a tight overview. If you don't I feel it could become a mess. This pilot is small and easily managed, but if it is spread out I could see that we would need to change the way we work, more from being purchasers as we are now to really being a broker and a regulator of the care.” (SW3, FG2)*

*“We have become more and more paperwork focused over the last 20 years that I have been in social work. I am worried that the care is going on a daily basis with little oversight. We normally do three monthly reviews, but I don't feel that will be enough with this model, I would feel happier every four weeks.” (SW6, FG1)*

This was a theme that had already been raised in the focus groups; social workers would be blamed when things go wrong. This is not surprising, as at the time of the interviews the Baby P case was very prevalent in the press, with social workers being publically criticised in the media due to their perceived failures. This also brings into focus the market concept of the purchaser-provider, where currently the expert purchases on behalf of the recipient, and is therefore accountable. This model is now counterpoised

against the more nebulous concept of personalisation where the service user is the expert, leaving social work with an ambiguous and yet to be defined role.

This theme of power and powerlessness is interesting given the focus of social work education on the person-centred approach to care delivery. Social work practice is dominated by the concepts of empowerment and anti-discriminatory practice. However, a number of social workers were concerned that by empowering the service user their status and role would be undermined. This concern about power and control within the profession has been considered by a number of authors, including among others, Ackroyd (2007), Harris (1998) and Franklyn (2000). Ackroyd *et al.* (2007) argue that social services settings tend to be highly bureaucratic and managed, with the professionals less able to assert their professional autonomy. Both Harris (1998) and Franklin (2000) come to a similar conclusion that within social services the professionals and the social workers have very little control over the domain of service delivery. This could be seen in this case study with the imposition of the new care model based on top-down management decisions, and not the best practice judgement of the social workers. The sense of powerlessness felt by social workers was identified by Sakamoto and Pitner (2005), inasmuch as social workers often felt marginalised within society and their organisations, and that they needed to develop a critical consciousness to empower themselves before they empowered others. Therefore, this new model of care was perceived by some as a threat to their professional status, and as highlighted by Dominelli (1996), a continuation of the de-professionalization of social work, rather than an opportunity to further empower the lives of the service users. This change in dynamics in the service user and service relationship that is enabled by the outcome-focused model, coupled with the personalisation agenda (Leadbeater, 2004), should be viewed as a step forward in empowerment. However, the social workers seem to reflect the de-coupling from control of the time/task service users inasmuch as they perceive they are 'done to,' by different governments, their employer and now the service user. This shows a crisis in role brought about by changes in both funding and the delivery structure.

The responses of the social workers need to be placed in the policy context of 2008. Both the Adult Social Care Green Paper (DoH, 2005) and the Strategy for an *Ageing Population* (HMG, 2005) had proposed an extension to direct payments and the introduction of individual budgets, with these changes receiving further endorsement in the 2006 White paper *Our Health Our Care Our Say* (DoH, 2006). The social workers did not understand or communicate how these changes would alter their existing role as

care managers, assessors and procurers of services. All these documents spoke of choice, and more importantly in the social workers' eyes, of control being clearly passed to the service users. The personalisation agenda was raised by both the managers and staff.

The responses by the team managers and the social workers in both the focus groups and the individual interviews presented a confusing and contradictory overview of the care models. Implicit in some of the responses is an acceptance that outcome-focused care is more service user-focused and less impersonal than the time/task model. In addition, the outcomes are decided with the service user, and this model of care would fit in more easily with social work values. However, this positive aspect appears to be rejected in the interests of both the social workers and the managers, in order to remain in control of the care, and in the case of the managers, the resources. This fear of a lack of control appears to sway the interviewees into a more disempowering position over the service users, due to their own insecurities at being disempowered and losing control. This resistance by social care staff was also found by Glendinning *et al.* (2009) in a review of personalisation and individualised budgets. Glendinning and colleagues found that staff were resistant to the implementation of individual budgets as it was felt it was a move toward privatisation, and this change was also seen by some social care staff as undermining their role. Therefore, although at the time of this research this particular local authority was at the early stages of implementing the personalisation agenda, this was the back drop within which this pilot was being implemented. This research was also conducted prior to the economic downturn in the world economy when resources were less restricted. It would be interesting to question the teams about their views now following the change in government in 2010, and this could be an area for future research.

## **5.6 Senior Managers' Perspective**

Two interviews were conducted with senior managers. The first was with the head of adult care for the local authority (ACM) and the second with the head of commissioning (HC). Both men had been involved in the decision to pilot outcome-focused care in the local authority. The interviews were semi-structured in that they were asked similar questions. The first question directed at the two interviewees was:

*Why did you decide to pilot outcome-focused care?*

*“We needed to find a unique selling point for our in-house home care provision, which is going to be floated off as a social enterprise and become a wholly owned company, and I suspect eventually privatised as a social firm. Our concern was that our services are more expensive than our competitors. An agreement has been reached to protect our local authority contracts for two years, after this period we will be open to market forces. So myself and \*\*\* (HC) attended a conference and there was a presentation by a provider who had implemented the outcome model, we listened to it and felt that we could use this as our unique marketing point, to set us apart from our competitors.”* (ACM)

The interviewee was then asked as to what he understood outcome-focused care to be.

*“Well that has put me on the spot! I see it as us being able to do more than we can now. We should have the ability to be able to meet more of the service users’ needs than we do now and also to be able to set ourselves apart from the others we also have to take into account latest White Paper.”* (ACM)

The language used reflects the on-going move of social work as a pointed out by Harris (2003) to being a marketised business operating within a quasi-commercialised setting. The concept of competition for the providers (home care provision) was real. The then in-house provision was about to become a social enterprise and have to compete for contracts with both private and third sector providers. At this stage the personalisation agenda was yet to be fully enacted within the local authority and the customer was still the commissioner of services with a local authority who were introducing rate reductions in the hourly rate paid to providers for the provision of home care. This in turn would limit the agencies that social workers could purchase from.

In addition to the commercialisation of home care provision, was the ACM’s consideration of the White Paper, *Commission for Social Care Inspection* (DoH, 2006), which meant that local authorities’ performance outputs would be assessed against outcomes. Therefore, the provision of this model of care would have a better fit for the commissioners.

Given the very broad nature of the response, the interviewee was then asked more specifically what research or other written information he had read before the local authority implemented the pilot study.

*“Some of my managers have attended training by SCIE and have liaised with your university to develop the project based on research that I hope you will check out for us.” (ACM)*

This response was interesting when considering how research forms the basis of a programme in order to change social work and social care practice. None of the respondents, neither the social workers nor the senior managers, were aware of the original research or had read any material about the concept of outcome-focused care. They acquired their information at a conference from a social care provider, who had implemented the policy guidance developed by SCIE based on Qureshi *et al* (1998) and other original research. This shows that SCIE, a relatively recent body, was an effective conduit for passing on research findings for actual practice. However, there appears to be only a limited understanding of the model by both the managers implementing the service and the social work staff responsible for commissioning it on behalf of the service users. This lack of knowledge was even more striking when the second interviewee, HC, was questioned. He deferred any operational details to AMC. HC was also asked the question;

*What do you understand by the term outcome-focused care?*

*“Well \*\*\* (AMC) explained it too and I saw the presentations on it. My understanding is that it’s about a move away from just tasks completion to more completion of the whole care experience, so that we do things slightly outside the box. I think it will give us a unique selling point when the services are privatised later on. Social care needs to understand it is a market now and that you have to compete, we are hoping with this that we will compete on quality. So your time/task will be your Sainsbury basic range and your outcome-focus will be your ‘taste the difference’.” (HC)*

HC was then asked a follow up question.

*Are the considered changes a response to government policy?*

*“I believe the move is towards a very mixed market within social care especially here. We are a conservative authority. By a mixed market I mean private companies and the third sector. The in-house service if it is to survive in any form has to be a high end provision that people will pay for. This is very much linked to the personalisation of adult care; we won’t recognise the sector in 10 years from now.” (HC)*

The main thrust of the conversation was the organisational requirement to meet the challenges involved in a dynamic operating environment. The concept of benefits for



the service user appeared to be a side issue that was again a by-product of the need to adapt to a marketised social care sector. Therefore, practice change was a top-down imposition very loosely based on research. As already mentioned, this is at odds with the thrust of social work teaching which views social work as a profession always striving to empower the disadvantaged in society. Given the much commercialised language of the managers, I asked the two men how they perceived the role of social workers in this new non-statutory world.

*“That’s something we have been considering. At present the legislation requires them. So we need to change the legislation and with it their role. The authority did look at privatising the assessment side, having them form some form of brokerage scheme or moving them into the third sector, but health are resisting this at the moment. I am not sure there is a long-term need for them with personalisation in their existing form.”*  
(ACM)

*“There is a real time-lag between the personalisation and changes and the current role and I suppose training of social workers. They need to have more commercial savvy. I think if they survive it will be as brokers running their own practice. There might remain a statutory role for them as regulators in adult care but I think that is it.”*(HC)

These responses are from only two individuals, and therefore, it is difficult to extrapolate these views to the wider field of social work. However, it does provide a background to the organisation’s internal politics which will have an impact upon the provision of a new model of intervention. The direct provision of home care within this local authority will become totally the domain of the private and third sector, with an increase in market competition. At present the social workers are the indirect customers of these services, assessing need and purchasing care on behalf of the service users and this might be viewed as a form of brokerage. However, this role, with the passing of the direct purchasing to the service users, leaves social workers in an uncertain position, and therefore the wider policy is unsettling for them. The ‘agency’ move to outcome-focused care is an attempt to marketise the provision, with the secondary benefit of increasing quality. This helps to make sense of the contradictory messages provided by the social workers in the interviews and the focus groups. This could be seen as the social workers saying *‘this is better for the service user and for my practice, but where does that leave me if I lose control over the day to day management of the care delivery?’*

The two senior managers were finally asked what they perceived to be the strengths and weaknesses of the two models of care being researched.

*Considering the two models of care what do you think are their strengths and weaknesses?*

*“Well it is clear that time/ task is potentially cheaper and is more easily accounted for, so that is its strength, as for its weaknesses I suppose is that it is one size fits all approach and does not individualise the care to any extent. The outcome-focus model as I see it fits with the move to personalisation and allows us to individualise the care, I suppose its weakness is that is potentially more costly to administer.” (ACM)*

*“Time/task as a manager is the easiest to account for and clearly demonstrates how the local authorities resources are being spent. The outcome-focus model really ticks more of the policy objectives for us. Therefore, the flexibility of the model allows for more of the authority’s objectives to be met, and when we are inspected we know that what we provide ticks the right box.” (HC)*

The managers’ concerns were very upward looking, concerned with how their actions would comply with the government’s targets. Therefore, the overall context of the care environment was one that was driven by policy rather than needs. However, outcome-focused care is a well-researched model and at the time of this case study its provision was being reviewed by Glendinning *et al.* (2008). The decision to change the model was an imperative practice not generated by the practitioners and best practice, but based on marketization and government targets. This further emphasises the social exclusion of the service user group and how they had no impact upon the profound changes to the care they were receiving.

## **5.7 Overall Summary**

This chapter has, through the use of focus groups and interviews with practising social workers and their senior managers, allowed for a context to be given to the provision of outcome-focused care. As Kazi (2003) and Pawson and Tiley (2006) highlight, there is a need to understand the organisational context within which a social programme is delivered, and this is achieved, as Ferguson (2007) notes, by recognising the continued marketization of social work and the role of the personalisation agenda in England. The process of the marketization of the welfare state that fits in with the senior managers’ view of the world is outlined by Breen:

*Just as welfare regimes acted to decommodify individuals, by seeking to make their life chances to some extent independent of market forces, the decline of arrangements that hedged against market-based risk is bringing about the opposite—namely ‘re-commodification’.*

(Breen, 1997, p.473)

This market-based risk not only impacts upon the service users but also on their role. If all provision is to be customer-driven and provided by non-state agencies where does that leave the social workers who for years have been the state’s agents, rationing resources according to need and mitigating risk? As Dominelli (2000) has outlined, risk management is moving from the state, back to the individual and the private sector providers. However, both the state and the media are quick to pass blame to professionals when things go wrong. The social workers constantly expressed concerns about the accountability of risk and who would be held to account, as they increasingly operated in a less well defined care setting. In the UK the reduction of the statutory welfare state has left an unclear role for the assessors of care, rather than the providers, and this was reflected in the findings.

The decision to implement the outcome-focused care model was primarily in response to the need to meet a political agenda and implement a policy that was market driven. This meant the local authorities in this study would need to compete for business in the quasi-marketplace of social care. The local authorities were reacting to the then Labour government’s Green Paper, *Independence, Well-being and Choice* (DoH, 2005). Therefore, the intervention took place in an organisation moving from a socialised model of care delivery to an individualised consumer-driven model of care, and a requirement to measure outcomes and well-being. Outcome-focused care, whilst proving to be a more effective way of promoting well-being amongst older people and also appearing to meet the value base of person centred services, was actually being imposed, as Butler and Drakeford (2001) argue, at the behest of politicians and policy makers and not out of the need to improve social work practice. However, the move for personalisation originated with the disability movement (Beresford, 2007), although primarily from the demands of younger disabled service users rather than as a demand of older people. The social work task force in their final report (SWTF, 2009) made the following observation of the impact of change on social workers:

*The profession is being asked to respond to change: for instance, adapting to the new agenda for personalisation in adult services; responding to heightened public concern*

*about child protection; and playing an effective part in integrated working between different agencies.*

(p.3)

This would reflect the views and concerns of the social workers about accountability and control of this new model and their role in it. In the individual interviews with the workers it was apparent that rather than diminishing their role the new model would require increased oversight. This view, however, was not reflected by the managers who believed that the need for social workers was in question or at least the role required remodelling.

Despite these concerns, the different data sources – service users, social workers and managers – did allow for the triangulation of the findings, which confirmed that all groups believed that outcome-focused care was a more effective way of meeting the expressed needs of older people.

## CHAPTER 6: DISCUSSION

This concluding chapter will now draw together the findings of this case study and will consider how the research might impact upon social work practice and contribute to the body of knowledge drawn on by social workers. This final chapter will also discuss how these findings might inform social policy decisions affecting the lives of older people and the provision of home care in an environment of ever-decreasing resources.

Studies of the effectiveness of outcome-focused care conducted by Glendinning (2008) had only previously utilised qualitative methods. The use of a realistic evaluative framework allowed for the existing qualitative research from social care to be studied alongside quantitative tools developed in psychology and medicine to enable the participants to self-identify the concerns that impacted upon their SWB (MYMOP and MYCAW questionnaires) in order to measure the impact of outcome-focused care upon it. The main purpose of Chapter 3 of this case study was to analyse whether changing the model of home care delivery to an outcome-focused care model would improve the quality of life for the individual receiving it. In completing an analysis of the MYCAW and MYMOP questionnaires in Chapter 3, an association was established between an individual's increased sense of SWB and the receipt of outcome-focused care. Given these findings, this concluding chapter will initially focus on the service delivery and service user experience of the intervention. In doing so it will examine the mechanisms in operation in this intervention by reviewing the findings discussed in Chapters 3, 4 and 5. The next section of this thesis will start with an examination of the core themes developed in Chapters 3 and 4.

### **6.1 User Perspective**

Chapters 3 and 4 developed the main themes from the direct service user data in this case study, with these being: social interactions, loneliness and the relationship with the paid home care staff. The first themes to be considered in this user perspective section are social interaction and loneliness, this section will then go on to examine the model of care delivery in more depth and examine the findings from part two of Chapter 4 which contains the data generated from the participant observation.

#### ***Social interactions and loneliness***

The analysis of the data in Chapter 3 focused on the level of social interaction and social connection of the older participants in this study with their friends and family and the

wider community. It established that although most of the participants had some form of social interaction with either friends or family, the actual level of social isolation was quite pronounced. The impact of social isolation has been studied in older people and in particular has been studied in some depth in the post-war era, with the initial research of Sheldon (1948) and Halmos (1952) identifying social isolation, and specifically loneliness, as a problem in later old age. However, it is important that in reviewing the findings from this case study, we have a clear definition of loneliness and social isolation, as in the literature these terms have a tendency to be used interchangeably. This case study has taken the view that they are two distinctly different phenomena, and has used the definition of social isolation as set out by Wenger and colleagues (1996):

*The objective state of having minimal contact with other people, whilst seeing loneliness as: the subjective state of negative feelings associated with perceived social isolation, a lower level of contact than that desired or the absence of a specific desired companion.*

(p.333)

The participants in this study are probably some of the most socially excluded and isolated within society. This differentiates them as a group from the wider population of older people, on which research has more usually been conducted. This is important to note as a number of large studies in both the US (Harris, 1974) and Europe (Tornastam, 1981) have indicated that the level of loneliness in older people is not significantly different from the level of loneliness in other age groups within society. Although virtually all the participants in both the time/task and outcome-focused groups studied in this research lived on their own, Hadley and Webb (1974) and Bury and Holme (1990) have established that living alone does not have a direct correlation with experiencing loneliness. These studies demonstrated that living by oneself per se was not necessarily an indicator of being socially isolated; rather a lack of relationships outside of the family was a better indicator of social isolation. The participants in this case study only had relationships outside of the family with their home care workers; therefore their level of social isolation differentiates them from the wider body of society termed as older people. Loneliness was also much more prevalent in this case study than was found in the Bangor Longitudinal Study of Aging (Wenger and Burholt, 2004, BLSA) which studied the general older population. The BLSA study considered loneliness to be present if the following indicators were found:

- Feels lonely much of the time
- Does not see enough of friends or relatives

- Does not meet enough people

The BLSA longitudinal study of 543 older people was conducted over a period of 20 years with the final data set being gathered for the last time in 1999. This final data set involved the study of the remaining group of older people (n=63), who were subdivided into those living in institutional care and those living independently within the community. Those living in the community (n=47), equate to a similar sample size to the combined cohorts in this thesis (n=40); however, the reported levels of social isolation in this case study and the BLSA study were markedly different. The BLSA cohort only reported feeling moderately lonely (29%) or very lonely (9%) compared to 40% of the sample in this case study who considered themselves to be very lonely. When the level of social isolation is considered for the sample group in the BLSA case study with the BLSA measure of social isolation (spending 9 hours or more without social interaction), only 34% were moderately isolated with a further 6% considering they were very isolated. In this case study, combining both the intervention and comparison group, over 73% of the participants were found to be very socially isolated and met the same conditions for isolation as the BLSA study inasmuch as they:

- Were living alone
- Were alone and isolated for more than nine hours a day
- Never left the house

This shows that there is a significant group of highly isolated older people living in the community whose level of social isolation warrants a different method of intervention that not only maintains their ability to continue to live in the community, but also limits their sense of social isolation and loneliness. It would appear from the responses to the MYCAW questionnaire that the way outcome-focused care was delivered in this case study meant it seemed to be effective at mitigating the negative psychological experiences of this group of older people, enabling the older person to feel less isolated. This was in stark contrast to the existing model of task-focused care that did not assist older people to reduce their sense of social isolation. However, these findings have to be considered within the limitations of a quasi-experimental design and the inherent inability to account for all the variables impacting upon the individual. The mechanism operating here of increased social interaction and the opportunity to form relationships may well have brought about the reduction in the concern expressed by the participants about loneliness and social isolation. This was evidenced by the responses given by the participants at the second interview, where none of the outcome-focused care

participants rated social isolation or loneliness as their prime concern, although it is important to note that although the individuals felt a reduction in social isolation the majority still wished for more social interaction with the community around them.

This chapter will now consider the findings from the case study with regard to the formation of relationships with the care staff and how these relationships link with the way the care was delivered as was observed during the process of participant observation. It will be demonstrated that it was this process of care delivery that appears to be one of the major factors that allowed for the environment to be created assisting in relationship-forming.

### ***Relationship***

The social workers involved in the commissioning of care constantly referred to person-centred care as being a way to improve the quality of care and meet the older person's desired outcomes. Nelson and colleagues (2002) see this concept as; "*an often quoted but ill-defined concept that regardless of this has a considerable influence on policy practice and academic literature*" (p.46). These authors saw that client-centred concepts would become the watchword for assessing the quality of care in the early half of this century. Although Nelson *et al.*'s research into care was concerned with the quality of nursing care; it has parallels to the delivery of home care. These parallels are partly due to the origins of home care stemming from district nursing, and therefore the intimate nature of the tasks undertaken by the home care worker. Tresolini and colleagues (1994) drew upon the idea of what they termed "*relationship centred care, which is focused on the importance of the interactions amongst people as the foundation of any therapeutic or healing activity*" (p.22). This concept of relationship-centred care fits in well with what actually happened with the relationships between the home care staff and the service users receiving the outcome-focused model of home care. This view is particularly illuminating and beneficial when applied to home care than the rather ill-defined and nebulous concept of person-centred care.

The important differentiation here is that person-centred care, and by implication personalisation, is concerned with the service user having control over what outcomes are achieved in their individualised care package. However it omits one of the most important elements of home care delivery, which is the interdependency of the paid home care staff and the older person. Every encounter has an inseparable and subjective element impacting on all involved, and on how they construct their social world. This construction is dependent upon the nature of the dialogue between both parties and the



subsequent micro relationship that develops. The literature on relationship-centred care is highly medicalised in its terminology (Tresolini *et al.*, 1994; Mulrooney, 1997; Nolan *et al.*, 2004). Thus there is an argument to describe this relationship centred care differently when applied to social care and social work interactions, where it would be best described as 'relational social care'. The use of the term relational social care is drawn from the concept of a *therapeutic mutually beneficial relationship* (Tresolini *et al.*, 1994) but this relationship is not dependent on the healing process. Nolan *et al.* (2002) refer to the senses framework which includes similar aspects that are important in outcome-focused care delivery, such as; security, continuity, personal goal setting and a feeling of significance - a feeling that you matter. These aspects, especially the sense that you matter seemed to be absent from the existing model of time/task focused care.

The outcome-focused care group's improvement in SWB appears to be associated with the ability of the participants to form a meaningful relationship with the individuals whom provided their paid care. Chapter 4 considers the responses to questions about the paid care staff, and develops the argument that the consistency of care delivery was the underlying mechanism that allowed for the development of an interpersonal relationship to occur. This consistency of contact enabled by a small and consistent team of four staff responsible for the delivery of home care facilitated the cared for and the paid carers forming an attachment of significance, which allowed for an improvement in the SWB of the cared-for person. This consistency, however, also appears to be combined with the use of time with the participant as having to spend time together meant that space was provided for a relationship to form. The time/task service users were denied the mechanisms necessary to form meaningful relationships with their care providers. The constant change in care staff meant that the delivery of care was fragmented, and the pressure on those delivering the care to be as quick as possible meant the formation of meaningful relationships was limited. This structural inequality in care delivery compared to the outcome-focused care group meant that regardless of the quality of the paid care staff and their potential willingness to form relationships with the service users, the care delivery structure simply prevented this from happening. However, it is important to note again that the consistency element of outcome-focused care was a by-product of a management decision to form small care teams out of the need to easily manage the pilot. The importance of consistency for an older person in the delivery of care was noted by Qureshi and colleagues (1998); Gabriel and Bowling (2004); Francis

and Netten (2004) and Glendinning *et al.* (2008), and all observed that older peoples' perceptions of good quality services are services that were;

- Flexible
- Reliable
- Have continuity and good communication between care agencies, staff and service users and their families

It is the combination of the above factors and time spent together that enables relational social care to occur and this seems likely to be the mechanism that produced the improvement in the participant's SWB. It could be argued therefore, that outcome-focused care that is flexible, reliable and provided with continuity may fail to deliver relational social care if the size and constitution of the teams was too large to enable service users to form relationships with their care providers. In this study the outcome-focused care teams consisted of only four staff, which made forming meaningful relationships achievable for the service users and the home care staff. It is not clear whether an improvement would have been achieved with the existing task-focused model had it been adapted to provide for the ability of those being cared for to form a relationship by the use of small teams, even if they did not have full control over the outcomes that were set on a daily basis. The huge disparity in the actual time spent with the service users in the different groups, as was established in Chapter 3 (Table 3.6) also appears to be a significant factor in the formation of relational social care. However, it is unlikely that improvements would be noted unless the length of the care visits provided sufficient time for a social interaction, with enough depth to allow for a relationship to develop. This moves the discussion on to a consideration of the delivery of home care discussed in Chapter 4, part two.

The process termed as 'function' mentioned previously in this thesis, demonstrated how the system of care delivery directed how the relationship, or rather in the case of the time/task model, the interaction occurred. The focus on the task in hand directed the mind-set of the worker to the completion of this task and stripped away the opportunity to enter into a dialogue outside of the process of completing the task. Table 4.9 clearly shows that the time/task model delivered a lot of the care to the service user in silence, whereas the outcome-focused group never delivered care in silence. The difference in interaction is interesting when you consider that both groups of workers had been trained by and worked in the same agency, and until this pilot study, the same individuals now providing outcome-focused care had previously delivered the time/task

model. This meant that the social interaction and conversation that occurred was more akin to that of an acquaintance or neighbour than the mechanistic Fordist production line delivery of care.

### ***Model of Care***

This case study has examined the impact of the model of outcome-focused care with this particular section of the conclusion focusing on the service users' perspective. In doing so it has been established that outcome-focused care appears within the limitation of a quasi-experimental design (where participants were not randomly allocated to study groups) to be more effective for the psychological well-being of those who receive it than the time/task model. In Chapter 1, the model of outcome-focused care was outlined. It was noted that Qureshi *et al.* (1998) divide their model of care into different clusters of outcomes, these being;

- Maintenance
- Preventative
- Change outcomes

This particular intervention (outcome-focused care) appears to have had the most impact on the process of change and therefore the change cluster. This change in improvement in SWB has enabled the individuals involved in this pilot study to change how they view their connection with their paid care staff and the wider community around them. It has assisted them to move away from their concerns about isolation to other issues, such as the maintenance of the new social relationship in order to prevent a return to their previous isolated state.

However, change does not only appear to have occurred for the service users, but also for the home care staff involved in the delivery of this new piloted model. The participant observation noted that the framework of care delivery actually changed the way the home care staff interacted with the service users. They were more focused on the ability to interact with the people in addition to purely meeting the physical needs dictated by the task. The staff spoke about the service users by their first names and referred to their family situations and how they were enthused about meeting the desired outcomes of those they cared for. This is a striking development as six months earlier, this same group of staff had been delivering the time/task model of care. They also expressed that they felt more valued as they had the ability to exercise some control over their working day and the activities that took place during their interaction with the

service user. The mechanism of control which was originally assumed to empower the service user also empowered the home care staff. As was discussed within the first chapter, this group of staff had always experienced a low status and felt that they were at the behest of care plans devised by social workers or in some areas district nurses or occupational therapists, and under the time/task model, were heavily censured for going outside of the remit of the care plan.

The service users had benefited from developing a sense of connection with their care staff and with the wider world outside the confines of their home. Qureshi and colleagues in their original research spoke about how outcome-focused care would allow for what they termed as 'acts of kindness' to be officially accepted into the care process. This included acts like moving a wheelie bin, buying something from a shop or just doing something that the individual felt was important, however small. This was bought into sharp focus for me during the undertaking of this research. A wheelie bin had been emptied and left on the pavement for days outside one of the participants' homes. The level of stress this caused the older gentleman was palpable, to such a degree that I moved the bin so that the gentleman could focus on the interview. This minor act really changed the man's state of mind; because this man was house-bound, he had spent days staring at the bin, seeing local children mess about with it, which only reinforced his sense of helplessness, and as he stated, the realization in his view that he was no longer a man capable of looking after his property. Social isolation for individuals with full capacity and no one to communicate with provides space for rumination on small issues, and as in this case, can lead to a real state of distress. However, the time/task model this man was receiving, and the roles as the care workers perceived them, had no flexibility to account for the human state being experienced and caused by an event outside of the remit of the service user's care plan.

The home care workers who were responsible for the delivery of outcome-focused care still only had indirect contact with the social workers responsible for the commissioning of home care. However, at the request of the service users, the home care workers' visits were planned to coincide with the social worker review visits. These visits were normally attended by the social worker and a manager from the care agency and excluded the most important relational professional for the service user: their home care worker. Forming this link enabled a relationship to develop between the social worker and the direct care staff. This was not possible with the time/task model, as the inconsistency in home care staff prevented a relationship between the home care workers and the service user from being formed. This in turn prevented the home care

workers and the commissioners from forming a relationship, thus rendering relational social care impossible. The importance of this relationship is also a significant factor in limiting the potential for elder abuse. The current process of production line time/task provisions removes the humanity of the cared for and the paid carer from the process. The lack of consistency prevents any meaningful relationship from developing that could provide a protective factor for interactions between the service user and those who might be the only link s/he has to the outside world. This lack of a relationship has been found to be necessary for institutional abuse to take place as it has been established that in order for a perpetrator of abuse to carry out the act they need a self-justification, which as Anderson (2006) highlights, dehumanises the victim; *“This justification allows the offender to dehumanize the personhood of the elder victim...”* (p.139).

## **6.2 Social Workers’ and Managers’ Perspectives**

It was agreed in both the interviews and the focus groups with the staff that outcome-focused care was a better way of working for the home care workers and provided a more positive service user experience. This viewpoint was also reiterated by the managers involved in the decision to implement outcome-focused care and to purchase it on behalf of their service users. However, this acceptance of the benefits of this model was set against the agency context of division and a sense of disempowerment by the social work staff. This is reflected in the way that the focus groups and the individual interviews gave a conflicting view of how the social workers perceived the pilot of outcome-focused care and their connection to it. The focus groups demonstrated that the social workers felt disempowered because they felt that decisions were imposed from above and that they were merely the delivery agents for the plans of managers. Interestingly, this was also the view of the social work role expressed by both the home care workers and service users involved with the time/task model. The social workers were right in the assertion that they were delivery agents in a top down approach and this perspective is echoed in the research of Harris (1998), Franklyn (2000) and more recently Ackroyd and colleagues (2007), which noted that social work departments are highly bureaucratic and managed organisations with the professionals (in this case the social workers) having little control over the model of service delivery. The social workers’ views also endorsed the findings outlined in separate studies by Kirk (1990) and Bilson (2005), who found that social workers tended not to be the developers of new working models of social intervention and therefore these interventions tend to be introduced via a top down process. This is in stark contrast to other related professions, such as medicine, whereby practitioners are the instigators of change. Therefore it could

be argued that the existing structure of local state social services and the lack of engagement with their practice development led to the social workers' real sense of powerlessness. However, it would be unfair on the social workers not to consider the organisational reasoning for the imposition of this social programme. The senior managers were very much concerned with the on-going pressure by the then Labour administration towards personalised social services, whereby services should be led by the service user and not the service. The senior manager's comments demonstrated that the aim for service improvement was not primarily driven by a wish to utilise the most up to date and relevant evidence based practice, but to ensure market survival in an increasingly marketised social care environment. This is reflected in the language used which is more akin to the commercial market than traditional social care, as the director put it "*a unique selling point.*" The agency referred to by the director has since this study been floated off as a social business and is having to compete in a market of private and third sector organisations, which with the increase in the use of personalisation will be competing for customers, i.e. service users.

However, it is important to note that although the findings from the focus groups and the interviews with the managers present the view of an inward and upward looking organisation, rather detached from the service user experience, the individual interviews with social workers did reflect a much more user-focused perspective on the model of care. The social workers clearly evaluated effectively the need to provide flexible services that empowered the service users, and appreciated that the outcome-focused model did improve the service users' experience of the care process. The outcome-focused model in addition to the relationship development between the home care worker and the service user also had an impact upon the relationship between the social worker and the older person being cared for. The outcome –focused model required that the case was kept open, which was in contrast to the majority of the time/task service users, whose cases were closed once the initial set up of the care package had occurred and were then only periodically reviewed by the duty social worker on an ad hoc basis. The process of having to keep cases open meant that a relationship also developed between the service user, home care worker and the social worker. This triangulated social care relationship was crucial for relational social care to function. It enabled an interconnection between service users, care staff and the commissioners of services, that ensured the service user receiving the care felt connected to the process of care delivery and all those involved had some control over the process. However, this case study did establish that some of the social workers were very concerned about giving power back

to the service user and home care staff, mainly because of the fear that ultimately they would, as one social worker put it “*have the accountability with limited control.*” This concern regarding accountability needs to be seen in the context of the fall-out on social workers following the Baby P inquiry (Ahmed, 2009).

The individual interviews demonstrated the alterations that had been made by the social workers themselves to the assessment process in order for them to construct a different framework for the assessment of need which was driven by the need to be more relationship-based for the participants of the outcome-focused model. The assessment of older people and their needs has been examined in some depth by Richards, (2000), Challis *et al.* (2007) and Powell *et al.*, (2007), with these different studies stating that the process of assessment frames the narrative of the service user, leading to problems in the social worker’s ability to accurately assess the care needs of older people. This problem has been examined in particular by Weiner and colleagues (2002), who identified that the construction of the service user by the assessment process normally focuses on the physical aspects of the individual and strips away the human element of the person. The social workers constructed a more in-depth assessment which assisted them to develop a more personalised overview of the whole needs of the service user in order for the model of outcome-focused care to be of benefit to them. The assessments carried out in these cases (outcome-focused) were more aligned to a ‘citizen-based approach’ (Ware *et al.*, 2003; Postle and Beresford, 2007). This citizen-based approach is characterised by the use of an assessment of needs based on a process of negotiation rather than purely being built on the pre-determined categories that have been designed in order to meet the needs of the service. Thus, even before the service had been delivered, a relationship has to have been developed to allow for the process of on-going assessment to occur, and it was this relationship that was absent from the time/task model’s assessment process.

### **6.3 Policy Context in 2008**

The main policy drivers for the local authority at the time this study took place were the Green Paper; *Independence, Wellbeing and Choice* (DoH, 2005) and the White Paper; *Our Health, Our Care, Our Say* (DoH, 2006). These documents clearly stated that social care providers needed to set identifiable outcomes which allowed for the measurement of well-being. It was this directive which prompted the local authority to consider undertaking an evaluation of outcome-focused care. However, the local authority’s interest in conducting an evaluation about the service was based on their

need to meet targets rather than a wish to improve services per se. This decision was about the local authority's need to measure how the outcomes they had set for themselves achieved well-being rather than how the outcomes for the service user were achieved and measured. In the 2005 Green Paper, the term 'well-being' represented a global view of both physical and social well-being, with the 2005 Green Paper stating; *"Clear outcomes for social care are needed, against which the experience of the individual can be measured and tested"* (p.25).

However, the areas requiring measurement as stated in the aforementioned Green Paper did not include the importance of the micro relationship between the cared for and the paid home care worker and whether this might be one of the main outcomes desired by the older person. This document pushed social care providers to measure against areas such as improved health, quality of life and exercising choice and control, as well as personal dignity. It was perceived that it would be possible to meet these areas through the personalisation of services and for these services to be more caring. However, without consistency in the delivery of care the opportunity for the service user to form a meaningful relationship could be missed. These broad statements also fail to take into account the different levels of isolation experienced by these socially isolated housebound older individuals. It would be unfair to see these outcomes as not being an attempt to improve care. Historically, policies have been based on the state's ideological position that the family should care for their aged relatives and have not taken into account the small number of individuals who have little or no family support and are therefore socially isolated.

Once managers were being measured against targeted outcomes they attempted to clearly define ways of measuring outcomes that would be easily managed and identified. These measures were defined by the service without really giving consideration as to how the service needed to be fundamentally altered in order for the true delivery of outcome-focused care to take place. In addition to the government policies on service user focused outcomes, the local authority was also implementing individualised budgets and direct payments, which presented local authorities with a sea change in how their organisations needed to be structured. This organisational flux caused by the then policy context, with the pressure of measurement against outcomes as a target to be met, presented an inhospitable and unsettling environment for both agencies and service users, and a potential block to the development of truly relational services.



## 6.4 Policy Context 2012

These findings although over three years old will now be considered within the contemporary context of the Coalition Government's policy in order to determine if current policies enhance or inhibit the use of outcome-focused care. The Coalition Government has published a raft of literature aimed at changing the delivery of social care to older people. The government's documents, *A Vision for Adult Social Care: Capable communities and active citizens* (DoH, 2010) and *Transparency in Outcomes: A framework for quality in adult social care* (DoH, 2011), have both focused on the need for services to be provided that are personalised and focused on the desired outcomes of older people. These documents also focus on the importance of building relationships and enabling older people to participate fully in society. However, the emphasis here is on the development of informal relationships, as was the case with the former New Labour government's policies. Iain Duncan-Smith (Guardian, 2012) has highlighted the need for limited resources to be targeted towards poor elderly individuals and the need to assist families to care and communities to act out of neighbourliness to support an increasingly ageing population. This demonstrates that the original framework of the post-war era (as outlined by Leece, 2003 in Chapter 1) is still the dominant ideology today: that family and communities are the ones who should provide emotional support. This artificial separation of the need to perform tasks (state) and the need for emotional support (private) was challenged by the outcome-focused model of care, which demonstrated that in certain cases the delivery of care needed to be re-modelled to provide both. This family and neighbourly model of home care can be seen to have failed the individuals who participated in this case study as it fails to take into account the small numbers of highly isolated individuals.

This case study focused on long term home care teams. However, since the case study has taken place, long-term outcome-focused services have been phased out in favour of short term re-enablement teams. The emphasis of these new teams is still outcome-focused and they aim to speed recovery and limit bed blocking. This move to outcome-focused short term re-enablement services has occurred throughout England and was noted by Glendinning *et al* (2008) in their review of services. Early indicators are that short term re-enablement services appear to be successful and are liked by those receiving them. However, service users are then passed back to traditional time/task services which are still the normal model of home care delivery provided in England today. Combined with the emphasis on personalisation (with a focus on control and not relationships), this makes it difficult to see how relational social care could be placed at

the core of home care delivery and to truly provide outcome-focused care that improves the SWB and emotional state of socially isolated house-bound service users in the long term.

## **6.5 Reflexive Account**

Undertaking this project had a profound impact upon me as a researcher. Prior to the commencement of the case study I had limited exposure to the field of social work for older people and made a false assumption that the nature of the work would be similar to my experience of working with younger adults. The profound isolation and vulnerability of those involved in the project were brought home to me on a number of occasions. This was particularly profound when I observed the direct provision of care to the participants, as the intimate nature of this type of care showed how vulnerable the recipient was to the actions of the paid carer. The manner in which this care was delivered in some cases stripped the individual receiving the care of their human dignity due to the matter-of-fact manner in which that care was delivered without the wish to engage with the older person as a fellow human being. This really reinforced the need for tight ethical scrutiny throughout the project and also raised questions about the ethics of undertaking research with such vulnerable people. My initial focus was too limited around the area of data gathering with not enough focus on the need for me to develop a relationship with the participants in order to establish trust. The research structure had given little thought to the possible impact of this research on the individual relationships between the participants and those delivering their care. This was particularly the case where the participant had no other human contact outside of the professional care team. This research was asking the individual to comment on those individuals on whom they were totally dependent. In retrospect I might perhaps have allowed more time for myself and any research team to build up a relationship with both the participants and those responsible for their direct care delivery. This would allow for the concerns and potential fears of the participants to be fully expressed and a more in-depth appreciation of the power imbalance between participants and those responsible for their care delivery.

I feel I will learn from this research and develop a different approach in both research design and the data gathering process. If I was to repeat this research, I would focus my efforts on ensuring more time was afforded to the participants. Although the initial decision to limit the time spent with the participants was to protect them, I found that they valued having the time to talk through their experiences of being in receipt of care I

feel that the more time spent with each participant would have given a richness to the data.

## **6.6 Summary of Findings**

This case study has suggested an association between outcome-focused care and an improvement in the individuals' SWB. It has also established that the level of isolation experienced by this particular sample was high because the level of family contact amongst participants was minimal. It appears from the findings that the use of a MYMOP questionnaire and an enhanced MYCAW questionnaire was an effective and time efficient way of measuring an individual's self-identified concerns and SWB over time. Finally, the use of realistic evaluation has enabled an analysis of the mechanisms that were operating during the application of this social programme. The main finding with regard to mechanisms is the importance of the ability of those being cared for to form a meaningful relationship with their paid carers, who in some cases are the individual service users' only contact with wider human society.

The small scale and quasi-experimental nature of this study means that the ability to generalise these findings is very limited, if not impossible. However, the concept of relational social care is an important consideration in these times of austerity and increased demand on limited services by a growing aged population. Therefore outcome-focused care could be a service that can be highly targeted to the most isolated and socially excluded within society.

## **6.7 Future Research**

This research was limited by the resources available and the size of the sample group. Quasi-experimental research design is always questionable when used in social settings as to its ability to truly establish what is occurring. Given this consideration I believe there is the need for a larger observation of how home-care is delivered. This small study did establish some interesting observations about the mechanical level of care delivery in home care and its potential impact upon the well-being of the recipients. Additionally, the initial findings from the use of the MYCAW questionnaire would benefit from being studied in a larger sample group and with a more ethnically diverse population.

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# APPENDIX 1



## Outcome Focused Care – INTERVIEW CONSENT FORM

**INTERVIEWER**

**INTERVIEW NUMBER**

I AGREE TO TAKE PART IN THE INTERVIEW.

I have had the research project explained to me and I have been given an Information Sheet.

All my questions have been answered.

I understand that if I take part in the interview, my name will not be recorded and that it will not be possible to identify me in any reports.

I understand that I have the right to leave the interview at any time or to refuse to answer particular questions.

I understand that if I give any information about abuse or harm to either myself or any other person, that some-one will talk to me about it before any further action is taken.

I agree to the information gathered in the interview being used in connection with the research project and doctoral Thesis for the University of Cardiff.

Signature of participant

.....

Date .....

*What if I change my mind?*

You have the right to withdraw from the research at any time.

## Information Sheet (outcome focussed)

### *What is the research?*

This research is looking into whether having some input into your choice of care assists you and improves both your physical health and sense of well-being. Also we will also be considering whether this form of care is cost effective.

### *What does it involve?*

It will involve you meeting with a researcher who will ask you some questions in order to complete a questionnaire. You will be asked these questions whilst you are with the service and when you are about to leave the service or at the six month stage. These meetings will be designed to fit in with you and will be no more than 1 hour in duration.

### *Who will have access to what I have said?*

Everything you have said or written will have the identity changed to ensure that your identity has been protected. The information will be used in a report and might be published in academic journals or in a research thesis. No details of your name and address will be contained in this or any other published document. All electronic information will be securely stored and again identities changed to ensure confidentiality. The research will also be conducted in line with the local Authorities Adult Cares confidentiality policy.

**\* MYMOP/MYCAW Initial form**

Full name .....

Today's date .....

Please circle the number to show how severe your problem has been IN THE LAST WEEK. This should be YOUR opinion, no-one else's!

0= As good as it gets

1= Very good

2= Good

3= Neither good nor bad

4= Not good

5= Poor

6= As bad as it gets

SYMPTOM 1: .....

**As good as it gets**

😊 0

1

2

3

4

5

6

☹️

**As bad as it gets**

SYMPTOM 2: .....

**As good as it gets**

😊 0

1

2

3

4

5

6

☹️

**As bad as it gets**



**Wellbeing:**

**How would you rate your general feeling of wellbeing now? (How do you feel in yourself?)**

**As good as it could be**

**As bad as it could be**

😊 0 1 2 3 4 5 6 😞

**Other things affecting your health**

The homecare that you have received here may not be the only thing affecting your concern or problem. If there is anything else which you think is important, such as changes which you have made yourself, or other things happening in your life, please write it here.

**What has been most important for you?**

Reflecting on your time with ..... , what were the most important aspects for you?

(Please continue overleaf if you need more space)

Thank you for completing this form.



**\* MYMOP/MYCAW Follow up \***

Full name .....

Today's date .....

Please circle the number to show how severe your problem has been IN THE LAST WEEK. This should be YOUR opinion, no-one else's!

SYMPTOM 1: .....

**As good as it gets**

😊 0 1 2 3 4 5 6 😞

**As bad as it gets**

SYMPTOM 2: .....

**As good as it gets**

😊 0 1 2 3 4 5 6 😞

**As bad as it gets**

Today's date .....

Look at the concerns that you wrote down before.

Please circle a number to show how severe each of those concerns or problems is now:

**Concern or problem 1:**

**As good as it gets**

😊 0 1 2 3 4 5 6 😞

**As bad as it gets**

**Concern or problem 2:**

As good as it gets

As bad as it gets

😊 0 1 2 3 4 5 6 😞

**Wellbeing:**

How would you rate your general feeling of wellbeing now? (How do you feel in yourself?)

As good as it gets

As bad as it gets

😊 0 1 2 3 4 5 6 😞

**Other things affecting your health**

The Homecare that you have received here may not be the only thing affecting your concern or problem. If there is anything else which you think is important, such as changes which you have made yourself, or other things happening in your life, please write it here.

**What has been most important for you?**

Reflecting on your time with ..... , what were the most important aspects for you?

(please continue overleaf if you need more space)

Thank you for completing this form.

## APPENDIX 2

### Outcome Focused Care/Time/Task

**DW D0010** (*Names and locations changed for confidentiality*)

Codes –Yellow - Care

Green - Family

Pink - Health

Red - Neglect/Abuse - Concern

INT: Hi Barbara you will recall I came and saw you last month to explain the project and what I was going to be doing.

B: Yes

INT: Can I just check that you are happy for me to ask you some questions and also complete this questionnaire?

B: I won't be able to read a questionnaire my eyes aren't too clever now.

INT: Are you happy for me to read it out to you and write down your answers?

B: Yes duck that's fine.

INT: OK then Barbara so can I just ask you, your date of birth if you don't# mind?

B: 21<sup>st</sup> of April 1936.

INT: OK and I shouldn't ask a lady's age but how old would that make you?

B: Gordon Bennett, yeah, 72.

INT: 72? Can I ask when you first started having care workers coming to look after you? (Care system for six months)

B: Yeah, last April, yes cos we're, we're now, we're coming up to December aren't we? I've worked you know I am no scrounger.

INT: And what work have you done, throughout your life?

B: Oh, insurance.

INT: Oh, right.

B: Typing and, insurance work.

INT: At what age did you stop work?

B: Oh my, that was in 20 years after, I got married and my son was born. He was born on 19<sup>th</sup> of May, 1966.

INT: Oh, right.

B: So that's when he was born. So I stopped about coming up to him being born so I suppose I – he's how old?

INT: And how old is he now? 76 that would make him...

B: 33.

INT: 33? Does he live local your son?

B: Australia.

INT: Oh, does he, that's not local is it? (No support from children)

B: Can't go...

INT: Oh, wow, my gosh. Do you have any grandchildren?

B: Not to my knowledge yet, he'd have phoned me to let me know but, erm...

INT: Is that him there then?

B: Oh, yeah, he was a – he's a baby, he's a, he's a youngster there, erm...

INT: Do you have any other family nearby?

B: Yeah, I've got a sister in Anytown.

INT: Any other family?

B: And a sister in, err, erm, one in Holland Drive, Anytown.

INT: Anytown ?

B: Yeah, so...

INT: OK and how often do you see your sisters?

B: Oh, not very often really cos one is always at work anyway, the eldest she does a lot of with her daughters baby. (Siblings very little family support. Recent bereavement/ loss of mother)

INT: Are you the oldest of the sisters or the youngest?

B: No, the middle one.

INT: You're the middle one.

B: Yeah, and a brother.

INT: You've got a brother as well?

B: Got a brother he's in Anycity. He's now divorced but he's with somebody else and he's got two, three, three children. My mother died earlier this year.

INT: Oh, sorry to hear that. How old was your mum?

B: She was, oh, 92.

INT: And how, how often did you used to see your mum?

B: Oh, well, because I can't just get there, cos I haven't got a car and don't, I would depend on my sister to take me.

INT: Ah, right. Can I just ask you some of the questions from the questionnaire?

(Refer to questionnaire re: family support)

B: Yes that's fine.

INT: Now I know you have said you would have difficulty reading this, so I will

read out the questions and the choice of answers and if you could tell me, which one you think is best to tell me about yourself.

B: Yes, Ok.

INT: Just to remind you Barbara, if you don't want to answer any questions that's fine, or you don't understand them just stop me and I will move on or explain the question.

B: Yes, OK.

QUESTIONNAIRE COMPLETED SEE TTBF76 (1).

(Note: Check answers and compare interview findings)

INT: Thank you for doing this, we have been talking for about 40 minutes are you are you ok to continue.

B: Oh yes, it is lovely to have a man in the house, chatting.

INT: Ok, can I ask you a little more about your contact with your family?

B: Yes.

INT: **How about phone contact with your sister, do you have a phone conversation with her quite regularly?** (Limited phone contact, quite socially isolated despite family nearby.)

B: Oh yeah, but not as regular as I did with mum.

INT: **How often did you speak to your mum?**

B: **Daily for about an hour, I do miss her I feel quite lonely now she is not here anymore** (Recent loss of mother, further social isolation. Loss of main interaction.)

INT: So do you and your sisters speak more now that your mum has passed away?

B: **... gone more down and down and down. So we speak to one another, maybe once a month, just to say hello and, ask if everything is OK and, err, we're not chatting.** (Family interaction limited to phone calls.)

INT: Right, so how long do you think your phone conversations are?

B: She's older than me, so we have never talked much, five minutes.

INT: Your younger sister, would that be once a week or once a month or...?

B: About once a month.

INT: Once a month?

B: Yeah, something like that but cos me, my other sister, my younger sister, perhaps it's more than once a month, certainly once a month, certainly more than once a month and I don't know, I mean, I don't, I don't know if she works now or she – I know she never seems to, she's got a horse to see to as well.

INT: Oh, right.

B: She does all that really, not long, far away from where she lives and – in Anytown. (Family within two miles.)

INT: OK, so thinking about your health now, what would, what are your main health concerns? What are your main issues with your health?

B: Mainly, it's – I've got repeat, err, prescriptions and I've got teeth to put in but...

INT: Oh, right.

B: ... I have to put glue in as well anyway. I put those in; they'd go in now, you...

INT: Sure.

B: ... they, they go in there but I, I need glue to make them, they don't ...erm stick.

INT: To make them stay?

B: Yeah, they don't stay there, I, I need that but, and oh my hip, a bit wobbly. (Main issue identified hip/lack of mobility.)

INT: So what's your mobility is that you're hip?

B: This is what's been done (points to operation point on hip).

INT: So when did the problems with your hip start.

B: I don't know how it all happened, that's cos I fell, I did fall and what's caused all this but it seems to be going, going better some days and some days it, it's not and some days I go...

INT: So, so how long have you had a problem with your mobility, more than a year or less than a year?

B: Oh, no, more than a year.

INT: More than five years?

B: No, no, I'm, oh, Gordon Bennett, I can't, remember.

INT: **It doesn't matter. Is it between three and – about three years?** (Mobility issue three years.)

B: **About three years, I'd say three years, yeah.**

INT: How limited is your mobility? How far can you walk?

B: **Well, I can walk, I can walk round to the shops which is only round the corner anyway as you know...**

INT: **Yeah, about 200 yards?** (Comment highly limited can move with frame.)

B: ... but – yeah – but I go round there anyway for my paper. I like to go out just for a bit of fresh air as well, just – but, erm, oh, I'll go round there but I walk very, very slowly and carefully because I go careful because these paving stones anyway are all crumbling and they're all crum-, er, er, crumbling and then you might fall. (Problems going out on own due to uneven surfaces.)

INT: **Right. So how often do you go out to the shop now?**

B: **I don't since my glasses broke.**

INT: **I can see the glasses, how long have they been broken?**



B: **Three Months.** (Concern re: care lack of glasses.)

INT: Have you told your family or the care staff they need repairing or that you need to see an option. (Not told family for support, has informed care staff.)

B: Not my family, but I tell the care staff every day.

INT: What do they say?

B: Well they keep saying they will pass it on but nothing ever happens.

INT: What difference does it make to you, not having your glasses?

B: A lot I can't go out because I can't see the differences in the road and I tried it and fell on the path, it really hurt.

INT: Did you hurt yourself?

B: Yes I was in pain for weeks.

INT: Did you tell the care staff?

B: Yes, they just told me not to be so silly and not to try it again.

INT: Did you or they phone a Doctor to get some advice?

B: Well that's the other problem without my glasses I can't see the numbers or the telly or read anything.

INT: **So you have not been able to leave the house, watch TV or read for three months?**

B: **Yes.**

INT: **Barbara I am concerned about this, would you mind if I raised this concern with the social work team, as it feels like you have been neglected?**

B: **No I don't mind.**

INT: **Someone will come and speak with you about this; I will speak to the social worker today. What is their name?**

B: She is called \*\*\*\*\* (Lack of care has caused severe restriction in quality of life.)

Follow up possible Neglect; Vulnerable Adult Procedures!

INT: That's OK then? (Possible impact upon subjective well-being re-examine MYCAW second interview. Follow up if glasses replacement made. Impact for Barbara.)

B: Yes.

INT: This has taken a little longer than I thought are you happy to continue?

B: Oh yes, you can move in if you like.

INT: That's very kind; can I go back to your mobility?

B: Oh yes I am alright in the house as the floors are smooth.

INT: Just – if it's a smooth surface, if it's smooth and there are no problems.  
How far do you think you can walk? (Mobility limited due inability to walk on uneven surfaces. Follow up interview consider if able to go out with another person.)

B: Well, I can walk OK as long as it's, it, it's careful and smooth like that but – I don't really know how long I...

INT: It doesn't matter.

B: ... yeah, I just, well, because I can walk, I'm, I'm better off, well, once I get home, I'm, I'm glad to be home because I can sit down, yeah. Erm, I can walk just, just walk carefully and I'm holding on to this you see, I walk on my walking – well, that's my walking frame which I've got. I'll fall so careful I go and I walk in the shop because they're up and down aren't they, the shops round here? You're not just like, it's flat like that, you have to get up, you know?

INT: Yes.

INT: So just thinking about the care, how often do you get your carers come in?

B: Two, twice a day. (Twice daily visits.)

INT: And what do they do?

B: **Five, seven days a week, five days.** (Care provided seven days, check with social worker Re care plan. No putting to bed service?) – everything that I want, erm, like whether I want, erm, sommat to eat, it's like I've had some dinner now or me breakfast or, or I do my own breakfast if I'm hungry and really starving and she – cos sometimes she comes at just gone nine or sometimes it's been nearer 10 o'clock. It's because, I suppose, elsewhere she's been here, you know, yeah.

INT: Between nine and ten. What time would you prefer them to come if you had a choice?

B: Nine o'clock.

INT: Oh, so around 9. (Times appear very late for a getting up service .Check whether this is common. How does this compare with outcome focus?)

B: Oh, yeah, yeah.

INT: And, and when do they come again, is it in the evening?

B: Yeah, well no, well yes, she, she comes about dinnertime so about half 12, half 12, one o'clock, but, but. (Times crunch together, check with care plan if this is as a result of time allocated slots or an assessment of need.)

INT: Yeah, sure, so 10 and 1? Is the 10 meant to be a getting you up service?

B: Yes.

INT: So what time do you wake?

B: Early about six.

INT: Are you happy with them coming so late? (Four hour delay in waking a getting up service arriving.)

B: So I'm not happy with that, but they say that's the only time they can make it.

INT: And they do your meals for you and do they clean for you?

B: Oh, yeah, when they do – I do what, what I can do myself, I can do bits and pieces, just to keep myself sort of moving and, err, things after that, I don't really – she'll do anything for me that I, they'll do what they can, they Hoover for me. (Tasks do not involve intimate care in this case, more supportive roles and assistance getting dress with mobility issues.)

INT: How about shopping?

B: Yes, they do that, yeah.

INT: They get shopping for you?

B: Yeah, on a Saturday, yeah.

INT: OK, do they go shopping with you or for you?

B: For me.

INT: Would you want to go? (Service done too rather than done with service user.)

B: Oh yes it would be lovely

INT: Are they very busy and are they always on time?

B: Oh, yeah, yeah, she's got a lot to do, always in a rush for the next visit.

INT: Right.

B: Need to get on with, the next lady or the next chap or, erm, the next person, yeah, to see to them. (Service delivered appears rushed, check with other responses to similar question/compare time/task to OF on this see any difference.)

INT: So your time with her is – you feel that it's time limited and that she's got to go somewhere at some point?

B: Yes, hurry up, hurry up I've got to be somewhere else. I've got nothing to hurry up for.

INT: And do you have the same lady all the time or is it different?

B: No, it's different ones.

INT: How often is it, is it different every day or...?

B: Well, when, when they come like once it's in a morning, it's twice a day, it's the same person and mainly it's the same one tomorrow or something like that. Depends on I suppose when, when they're off for two or three days...

INT: How many different people might you have in one week?

B: Oh, well, that, I've lost count about twenty or so I think cos sometimes it's been two, two people for two or three days then perhaps the next one if it's been a different two, if it's been changed. (High level of turnover of staff, possible limitation on the ability to form relationships check with other interviews, compare with OF.)

INT: Sure.

B: Then, then again but I, about two or three days.

INT: So you have – you don't have regular people; you've never had a regular person?

B: I've had regular ones because, err, two or three days and then they'll be off or something like –

INT: Yeah, sure.

B: So it's, it's...

INT: Do your carers come from the council or from a private agency? (Clarified with social worker, private - three different agencies.)

B: Well, I don't really know now, I think, I put it all down to now a council, a council.

INT: And, when they come in, if it's a new person, they'll always introduce themselves by name?

B: Yeah.

INT: Do they always ask yours– they, they refer to you by your name?

B: Oh, they do, they know my name, and they know who I am that they're coming to.

INT: And how do you tend to find them with you? Are they...?

B: Very different.

INT: They're polite? (Generally seen as polite, do refer too and offer service user name.)

B: Yeah, they're all very, very nice, yeah. Some are nicer than others. Personally, I think that – some make you feel a bit less nice.

INT: What, what makes a good one?

B: I don't know, I suppose they – just, just talking to me, just the way, and the way they're talking about me personally. Just about me generally and what, what problems I've got and, erm, what I'm talking about and that. I don't know, I can't really...

INT: So is it that they listen to you and... ?

B: Oh, yes, yes, yes cos some seem to be listening more but listening as though they're listening, they're listening to the person, they're listening more than (Ability to be listened too, outside of care task appreciated by service user.)

INT: I think I understand what you're saying. Some of them really are listening to you, they're not just, oh, yes, oh right like that.

B: That's right, yeah.

INT: OK. Does it makes any difference – are some or do some smile at you more or give you more, eye contact than others or...?

B: Yeah, they do generally speaking, they're all pretty much the same but I don't feel that way, that more want to do, feel, I feel that way that more are giving me eye contact. (Highlighted smile or eye contact important, social interaction important to service user in the care process.)

INT: Sure. Some people you feel more comfortable with than the others?

B: Yeah, that's right.

INT: OK.

B: That's right.

INT: If you had a choice, would you have the same person giving you care or, or do you like a mix of people?

B: (Pause). No, I think that, that the same person. (Prefer same person.)

INT: The same person.

B: Mmm, mmm.

INT: So why is one preferred?

B: Just because I think it's just, erm, I just feel better as though I'm getting on better with this one.

INT: Yeah, I, I understand what you're saying.

B: I don't often...

INT: Is it, tell me if you think I'm, I'm wrong and is it that you feel that you should have a relationship with the person?

B: Yeah, I'm happy that they know me, erm, so I can be me and know what to say, I'm saying is understood.

INT: OK.

B: ... happy with this one person, I feel happy with, oh, yes, yeah.

INT: If you could, you'd prefer to have the same person coming every day...?

B: Mmm. Yes.

INT: So I'm just thinking, if you had to say now what your major concern was for yourself, so let's say my major physical concern was, I, I've got a bad knee at the moment. My major concern is my knee, my knee hurts when I walk...

B: Oh, what have you done?

INT: OK, I don't know what I've done to it. That's my concern at the moment. What would you say is your major concern at the moment?

B: Hip.

INT: Your hip, OK.

B: My left hip which is, that's what these operated on, on the 27<sup>th</sup>, 27<sup>th</sup> of September.

INT: What is it about your hip?

B: It stops me going out. I love going out seeing people and feeling the fresh air. If I could get out my life would improve greatly.

INT Well I have reached my time limit Barbara, thank you for seeing me. Is it ok if I come back again in six months to see you?

B: Oh yes I would like that.

## END OF THE INTERVIEW

### Notes

High level of turn-over with staff.

Problems with consistency and potential relationship forming.

Poor practice possible abuse re glasses.

Visit times seem to be problematic

High level of social isolation and recent loss.

Nearby family but limited support.

Service users likes tasks outside main care plan completing.

Eye contact/smile seen as important.

# APPENDIX 3

## Outcome-Focused Care – Research Schedule

Month	Nov 2007				Dec 2007					Jan 2008				Feb 2008				March 2008				April 2008				
Week Number	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	
Research Student (primary)																										
Research Steering Group																										
Ethical oversight meetings																										
Pilot Study (questionnaire piloted)																										
Data Analysis of Pilot Study																										
Main Study Initial Interviews (Service)																										
Main Study Follow Up Interviews																										

Month	May 2008					June 2008				July 2008				Aug 2008					Sept 2008				Oct 2008				
Week Number	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	
Research Student																											
Research Steering																											
Ethical oversight																											
Main Study Initial																											
Main Study Follow																											
Participant																											
Focus Groups																											
Individual Interviews																											
Interviews Team																											
Interview ;Director																											
Interview; Head of																											



Month	Nov 2008				Dec 2008					Jan 2009				Feb 2009				March 2009				April 2009							
Week Number	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76				
Research Student (																													
Research Steering Group																													
Ethical oversight																													
Main Study Initial																													
Main Study Follow Up																													
Feedback to service users																													
Feedback to staff																													

## **APPENDIX 4**

### **Demographic Characteristics of the Metropolitan Borough Council Being Research**

280,600 people live in Anytown Metropolitan Borough Council (MBC). 18% (49,400 people) are aged under fifteen years and 17% (48,200 people) are aged 65 years and over.

The MBC contains areas of significant deprivation. People in these areas are more likely to experience disadvantage and poor health.

In 2001, 2.1% of the MBC population were Asian and 0.4% were Black,

The MBC is one of the healthier places in the North West. Life expectancy figures for 2004/2006 show that a male born in Anytown can currently expect to live for 77 years while a female can expect to live for 82 years.

Major causes of death include heart disease and cancer; together these account for two-thirds of all deaths.

#### **Health**

Life expectancy is significantly reduced in deprived areas – people in the most deprived areas on average live 12 years less than those in wealthy parts of the MBC.

Healthy life expectancy is also significantly reduced in deprived areas – people in some wards are likely to experience 12 years of ill health before they die whereas people in more affluent wards will only have six. People in the deprived wards can expect to become ill in their early 60s and die in their early 70s, before people's health in other wards even begins to deteriorate.

The MBC has an ageing population– with 18% of the population being 65 years or older.

The research took place in 4 wards with 20% of the sample living in the most affluent wards. The remaining 80% lived in wards that were considered to be deprived. The split of types of housing was: owner occupiers 25 %, privately rented 15% and Housing Association 60 %.

The Sample was 100 % white. This fits with the demographic make-up of these wards as the two wards not researched house the majority of the ethnic minorities in the town.