A series of research projects about health and social care for older people

Final report 2013

Carer's assessment and outcomes focused approaches to working with carers

A joint project between Midlothian Council Community Care team and VOCAL, Midlothian Carers Centre

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P·R·O·P
PRACTITIONER RESEARCH: OLDER PEOPLE

crfr
centre for research on families and relationships

IRISS
Institute for Research and Innovation in Social Services

An Overview of the Practitioner-Research: Older People Project

Project overview

The PROP practitioner-research programme is a partnership between the Centre for Research on Families and Relationships (CRFR) at the University of Edinburgh and the Institute for Research and Innovation in Social Services (IRISS). It was funded through the Economic and Social Research Council. This programme also received support from the Scottish Government's Joint Improvement Team.

CRFR and IRISS partnered with a group of Scottish Local Authorities, NHS, third and independent sector organisations to produce this practitioner-research programme. The partners include NHS Lothian, West Lothian Council, Glasgow City Council, Alzheimer Scotland, and Scottish Care and VOCAL Midlothian and Midlothian Council.

This project is underpinned by two key premises. The first recognises that to improve care for older people there is a need for an improved evidence base that relates directly to the needs of those providing services and those developing policy. The second premise is the need to better share this evidence base through greater use of this resource by key audiences and users. One way to achieve both objectives is through the co-production of knowledge between academic researchers and those involved in delivering care.

The PROP project brings together a team of practitioners in health and social care provision, academics and specialists in evidence-use and knowledge media from IRISS and CRFR. Collectively we have synthesized existing evidence, generated new evidence and improved the use of this evidence with the partner organisations. Our aim is to promote a culture of evidence-informed inquiry with the hope that this supports improvements in the lives of older people across Scotland.

Project Aims

Through the delivery of a practitioner-research programme, we aim to achieve the following:

- Improve the volume and quality of research produced by those delivering health and social care for older people
- Increase awareness of, and improve access to, research created by those involved in providing care for older people
- Support greater engagement and collaboration between researchers and practitioners involved in researching and delivering care for older people across health and social care contexts
- Extend theoretical and practical understandings of the knowledge translation, brokerage and exchange processes that are effective between academics, users, policymakers and practitioners when sharing good practice in the production and utilisation of findings relating to the health and social care of older people

About Practitioner Research

Practitioners undertake a considerable amount of research, in fact Mitchell and colleagues estimate that 'practitioner research in social work probably occupies a major part of the total volume of research activity in this field' (Mitchell et al, 2010: 8).

There is evidence to suggest that practitioner research can be a valuable approach for strengthening the use of research not just for the individual practitioner undertaking research but potentially for the organisation and perhaps even the sector in which they are based. These benefits vary depending on the support available for the practitioner and how the research endeavour is structured; which can for instance involve support being provided by other practitioners, academics or research colleagues based in-house or in external organisations. Some of the benefits of practitioner research for the practitioner and their organisation can include:

- Delivers research of direct relevance to practice concerns
- Improves research capacity of individual practitioners and organisations

- Strengthens the active role of the practitioner in the research process
- Brings the worlds of policy, practice and research closer together
- Helps an organisation develop the capacity for critical inquiry and a "learning orientation"
- Supports the desire for and the use of research done by "outsiders"
- Reduces the distance knowledge has to travel from research to practice
- Provides a starting point for further research-practice collaboration

(Armstrong and Alsop, 2010; Roper, 2002; Anderson and Jones, 2000: 430)

However, we are not necessarily maximising the impact of research undertaken by practitioners in social services and health for three main reasons:

1) Practitioner researchers often lack professional support and training related to the use and application of research methods and theory.

2) Practitioners struggle to access existing evidence related to their work, thus potentially affecting the quality of what they are able to produce.

3) Practitioners engaged in conducting research into their own team, service or organisation do not usually have the time or capacity to disseminate their research findings or to support its use in other services or organisations.

The PROP Practitioner-Research Programme

This Practitioner-Research Programme (PRP) was delivered between May 2012 and August 2014. Over this period, the nine practitioners involved in the PROP project designed and carried out an empirical research project directly related to their practice and the theme of care for older people.

The partner organisations (Alzheimer Scotland, Glasgow City Council, Midlothian Council, NHS Lothian, West Lothian Council, and VOCAL) made a commitment to support selected members of staff to participate in the PRP. Practitioners were allocated ½ day/week for research, six days for research training and two days for knowledge exchange seminars.

Each practitioner-researcher was allocated a mentor from the University of Edinburgh, NHS Lothian or IRISS. This mentor supported the research design and analysis in the project and provided guidance on how best to use research findings to develop policy and practice.

A series of six training sessions was delivered between July 2012 and February 2013. These full-day events focused on six areas of research practice: (1) resources for research, (2) project management and research planning, (3) research design, (4) generating evidence, (5) analysing evidence, and (6) knowledge exchange.

Knowledge exchange events were held in October 2012 and May 2013 to facilitate learning from these research projects within and across the stakeholder organisations. These events supported practitioners to share and disseminate research findings and provide evidence to partners and stakeholders about best practice.

Project Outputs

The project outputs focus on two areas: (1) improving the care of older people and (2) improving the use and usefulness of research for those involved in providing care. These include:

- 8 completed practitioner-research projects, including final reports and summary postcards
- 1 summary booklet of the PROP programme of practitioner-research
- 2 knowledge exchange events
- 2 peer-reviewed journal articles about improving the use and usefulness of research for those involved in delivering services
- An evaluation briefing paper about the practitioner research project

For more details, please see our website: http://blogs.iriss.org.uk/prop/

How to Reference this Report

When making use of this material, use the following reference for this report:

Tsegai, A. and Gamiz, R. (2013) 'Carer's Assessment and Outcomes Focused Approaches to Working with Carers: A Joint Project between Midlothian Council and VOCAL Midlothian Carers Centre'. Scotland: CRFR/IRISS.

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Contents

Executive summary

Carers who provide unpaid support to family or friends are the largest provider of care nationally, without whom the UK's health and social care system would not be sustainable, particularly in view of the UK's increasingly ageing population. However, the provision of this care can affect individual carers' health, employment, economic well-being, social relationships, and quality of life. Caring Together: The Carers Strategy for Scotland 2010-2015 recognises the 'strong case based on human rights, economic, efficiency and quality of care grounds for supporting carers' (2010, The Scottish Government, p.4).

Midlothian Council and VOCAL Midlothian ('Voice of Carers Across Lothian', a Carers' Support Centre) provide support to unpaid carers in Midlothian and aim to improve personal outcomes for carers. Personal outcomes are things defined by the individual as being important to them, as opposed to outcomes which are predetermined by the service. There are a number of benefits in a personal outcomes approach, both to the individual carer, and to the service itself.

This practitioner-research project aimed to examine how different approaches to assessment and working with carers affects the personal outcomes achieved. Focus group discussions and document analysis were used to explore the carer and practitioner experiences of different approaches, and to identify how personal outcomes are identified and reviewed. Four comparative themes emerged from this data: the differing roles of voluntary and statutory organisations, the impact of the conversation and tool, self-assessment as compared to practitioner-facilitated assessment, and importance of the profession or continuity of worker. The research findings stem from these four themes and have implications for both organisations, as well as for future joint working.

The research identified that while flexibility of approach was appreciated by carers, there were some fundamental components which enabled positive outcomes: conversation with a worker which focuses on outcomes and the carer as an individual, as well as a clear action plan and review process. Key findings included the need for the carer's assessment process to shift the focus from the service user to the carer at both an organisational and individual level. This includes the provision of clear information for workers and carers about the process and potential benefits. A focus on conversation, as opposed to specific tools, was seen to be the key enabler for workers and carers to identify and work towards personal outcomes, and importantly, it was found that the conversation can in itself lead to positive outcomes. However it was also seen that outcomes-focused conversations require considerable skill at an individual level, as well as support at an organisational level, to create an environment for individuals to reflect on and develop their practice. It was further found that capturing process outcomes was more challenging than change outcomes, and that there remains a need to shift the focus from deficits and services to personal outcomes. The impact of continuity of worker, or the profession of worker, on outcomes achieved was inconclusive and may warrant further exploration.

The research project has also highlighted the benefits of practitioner research being conducted jointly across organisations in order to examine and develop practice, and it is hoped that this will benefit personal outcome-focused approaches to working with all carers as well as with other client groups.

Introduction

A carer is someone of any age who provides unpaid support to family or friends who require additional help due to illness, disability, mental ill-health or a substance misuse problem (Carers Trust). Carers and personal outcomes are the central themes of this research project, which examines carer and practitioner experiences through the lens of the Midlothian carer's assessment and VOCAL's outcomes focused tool. The key aim of the project is to explore how these two approaches enable carers to identify and achieve personal outcomes.

Midlothian Council works to support carers and has a statutory obligation to offer a carer's assessment to a carer 'who provides or intends to provide a substantial amount of care on a regular basis' to someone over the age of 18, even if the person who they are caring for declines help for themselves (Community Care and Health (Scotland) Act 2002). It is within this context that the carer's assessment tool is used by Midlothian Council. Across community care services, including services and support for carers, there

has been a significant and ongoing investment in developing an outcomes focused approach at an individual and organisational level. This shift in approach should better support service users and carers to identify, achieve and review their identified personal outcomes.

VOCAL is a carers' centre affiliated to the Carer's Trust; the Midlothian Centre is one of two branches of the service in the Lothians. VOCAL provide a non-statutory service which aims to support carers in all family or relationship settings by providing information, advice and emotional support, training, advocacy, counselling and groupwork. VOCAL are not directly involved in the carer's assessment process, although they do provide information and advice about the assessment and how to access it. Over recent years VOCAL have developed an outcomes focused approach to their work with carers. The focus of the approach is on conversation, through which personal outcomes are identified and reviewed with the carer.

This shift towards an outcomes focused approach to assessment is reflective of practices across Scotland. In both health and social care significant investment has been made in recent years to adopt practices which focus on the outcomes important to people using services and support and their carers (Alisa Cook and Emma Miller 2012). Cook and Miller define outcomes as 'what matter to people using services, as well as the end result or impact of activities, and can be used to both determine and evaluate activity.'

The aim of this research project was to improve understanding of how approaches to working with carers can affect the outcomes. The data resulted from four focus groups comprised of workers and carers from both organisations and a document analysis of Midlothian's carer's assessment form and the VOCAL outcomes tool. This data was used to:

- Explore the experience of carers and practitioners of Midlothian Council's carer's assessments (self-assessment and practitioner-facilitated assessment) and VOCAL's outcomes approach.
- Examine how personal outcomes are identified and reviewed within these three approaches.
- Provide information and evidence which could improve the outcomes achieved with carers through carer's assessment and VOCAL's outcomes approach.

The following research questions were identified and applied to the data:

- What are carers' and practitioners' experiences of different models of engagement: carer's assessment (self-assessment and practitioner-facilitated assessment) and VOCAL's outcomes approach?
- Do carers and practitioners feel that personal outcomes have been achieved through these approaches?
- How are personal outcomes recorded and reviewed in these approaches, and how could this be improved?
- What barriers or enablers to identifying and achieving outcomes do carers and practitioners identify in these approaches.
- What is the impact of the profession of the practitioner on the outcomes that are identified and achieved with carers (i.e. social worker, OT, CCA, VOCAL carer support worker)?

Background information and literature review

As a practitioner-research project we have outlined the local practice setting relevant to this project, as well as local and national policies which affect carers and which inform the move towards personal outcomes approaches. Relevant literature and pre-existing research was also consulted and considered as background to this project. The majority of the data referred to in this summary focus on carers within the context of the carer's assessment rather than on the carer's experience of caring and support as a whole.

Background of the organisations

The authors are aware that approaches to carer's assessments vary across Scotland's local authorities, and wish to outline local practice within Midlothian. The nature of VOCAL's outcomes focused approach and the accompanying tool is also specified.

Until September 2012 the assessment tool used by the Midlothian Community Care team was the 'carer's assessment form' which was completed in one of two ways. It could be filled in by the carer independently (self-assessment); or it could be completed in discussion between the carer and a professional, either a social worker, community care assistant (CCA), or occupational therapist (OT) (practitioner-facilitated assessment). Throughout this report the terms 'self-assessment' and 'practitioner-facilitated assessment' are used in reference to these specific processes. The 'carer's assessment form' was developed in conjunction with carers in Midlothian, and was designed to meet the National Minimum Information Standards (The Scottish Government, 2007). The tool is described as being designed to: inform social work about the work the carer does for the person they care for, say what services the carer needs to support them in their caring role, and look at what the carer needs to remain in good health and to have a good life of their own (Midlothian carer's assessment self-assessment letter).

As of September 2012 the Community Care team changed their practice and now offer carer's assessments through the 'carer's conversation form'. It has been proposed that this is something which should now be completed through a practitioner-facilitated face to face conversation and is intended to be outcomes focused. Self assessment will no longer be an option. The team is also now conducting a pilot of outcomes focused assessments across all adult community care services and are engaging with VOCAL to finalise a new outcomes focused carer's assessment tool which is based on Talking Points (Cook & Miller, 2012).

VOCAL's outcomes focused approach was developed in conjunction with carers and staff to identify the outcomes which carers wish to achieve through working with VOCAL. In order to develop this approach VOCAL undertook a programme of staff engagement and training and examined how to implement this approach as a part of its service. As a part of this transition VOCAL designed an outcomes focused tool which consists of two documents: a 'baseline' document (used to record the presenting issues raised by the carer in the initial conversations) and a 'review' document (used to record the difference that support has made to the carer). The tool is used by carer support workers within VOCAL Midlothian to shape the support offered to an individual carer. At an organisational level it is used by VOCAL to capture and evidence outcomes across the organisation and to inform the service planning and delivery of VOCAL and other providers (p.1 VOCAL carer outcomes tool, Guidance Notes – v1.6).

VOCAL is currently looking to develop its outcomes focused approach further and is moving from an existing database to a new Carer Impact Shared System (CISS). Plans for future working include using shared baselines across VOCAL's different services, such as training, advocacy, and carer support. At present, a baseline and review is completed by any VOCAL service that a carer is in contact with, so if a carer receives carer support, attends training sessions, and receives advocacy support, outcomes are recorded for each service, however all the services may be contributing to the same set of outcomes. In the new system, a baseline may be completed by a worker in one service, but the review could be completed by a worker in another service, and looks at the total difference that all the support has made. VOCAL has also been working with the Thistle Foundation to develop staff skills in solution focused techniques, and implement this across its services for carers, and look at ways to use these skills in other areas such as staff supervision and appraisal. It is felt that this is the next step in VOCAL's journey towards being outcomes focused.

National and local policy background

Caring Together: The Carers Strategy for Scotland 2010-2015 highlights the important role of assessment in supporting carers, and a key recommendation is to improve the uptake and quality of Carer Assessments (2010, The Scottish Government, p.4). It also highlights that assessment and support should be conducted 'in a personalised and outcome-focused way and on a consistent and uniform basis' (p.4). The Scottish Government aims to continue working with partners to advance carer's assessments as a means of ensuring better outcomes for unpaid carers in Scotland.

Locally in 2011 a Carers Strategic Planning Group for Midlothian was created across statutory health and social care services, and public and voluntary bodies to examine the existing services and support for all carers in Midlothian, and how to develop and strengthen this further. The Midlothian Carers Strategy and Action Plan 2012-2015 was therefore developed and sets out the key priorities for carers in Midlothian over the three years (Midlothian Council, 2012). The interest of this group intersects with the other local and joint planning structures in Midlothian, including the joint planning groups for Learning Disability, Mental Health, Older People, and Physical Disability, as well as the partnership forum group Carers Action Midlothian.

The Midlothian Carers Strategy sets out the aspiration that 'Carers are valued as equal partners, feel supported to effectively manage their caring role and are able to have a life outside of caring' (p.4). This reinforces at a local level the key statement in 'Caring Together' The Carers Strategy for Scotland 2010-15. The Midlothian strategy survey data sources have provided different estimates of the number of carers in Midlothian ranging between 10.1% (in line with the Scottish average) and 17.5% of the population. In relation to older people this research project considers both the carers of older people, and carers themselves, who are older; the strategy outlines that in Midlothian the majority of carers provide care to a parent (likely to be an older person), and that of carers themselves 21.3% are aged over 60. Other data sources also agree that in general as carers get older they take on more caring responsibility and hours of caring increase, for example it is thought that a quarter of carers aged 75 or over provide 50 hours or more of informal care per week (Department of Work and Pensions, 2009; in 'Invisible but Invaluable', 2010, Age UK).

The Carer's Strategic Planning Group analysed current provision in Midlothian against the recommendations in 'Caring Together', and outlined a number of areas for improvement including: 'ensuring carers are involved in planning and developing services' and 'Improving access to and the quality of information on services for carers'. These priorities informed the action plan for 2012-2015 and carer's assessment was cited as a key mechanism for achieving these improvements.

Background literature

The Joint Improvement Team have been advocating a focus on personal outcomes – the difference that assessment and care planning has made in someone's life and have developed a framework of outcomes for carers and service users called 'Talking Points' (Miller & Cook, 2011). This move towards outcomes is welcomed by The National Carers Organisations in Scotland (Briefing). Within the Talking Points Personal Outcomes Approach, outcomes have been divided into three types: quality of life outcomes, change outcomes, and process outcomes (Cook & Miller, Joint Improvement Team, 2012).

Table 1 Talking Points Outcomes Framework (Cook and Miller 2012)

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

Research has further identified the outcomes which carers specifically highlighted as important to them, and distinct from outcomes for the person they care for; these can be classified as quality of life for the cared for person, quality of life for the carer, managing the caring role, and process outcomes (Nicholas, 2001).

Table 2 Outcomes Important to Unpaid Carers (Cook and Miller 2012)

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

There has already been a significant amount of literature written and research conducted on the topic of carers and several are relevant to this research project. One such study looked at the relationship between carer's assessments and positive outcomes through a systematic review of interventions for carers in the UK. This study found that the achievement of positive outcomes as a result of assessment seemed to vary considerably (Victor, 2009). The review identified that some of the variation was related to the relationship between carer assessment and service provision: for more than half of carers, assessment did not result in additional provision of services, and for those who did receive additional services they were not necessarily satisfactory. The process of assessment itself led to outcomes for carers such as feeling more recognised, valued, and supported; however this was determined by factors such as different assessment processes, practitioner skills, carer characteristics, and review of the assessment and ensuing contact. Thus this review highlights that assessment approach does have an impact on the outcomes achieved with carers. A key recommendation of this review is that 'the current focus of local authorities on meeting performance targets for the number of carer's assessments achieved needs to be matched by concern with the quality of these assessments' (P11).

Victor also reviewed studies which examined self-assessment (2009). Self-assessment was not found to have any link with satisfaction with the services provided subsequently. However, carers found that practitioner-facilitated assessment provided greater recognition and validation. It was also found that many carers, and particularly older carers found it difficult to complete assessment forms independently, this was due to the fact that people found it hard to answer questions about what they wanted, when they did not know what might be available. Self-assessment was seen to be useful as preparation for a practitioner-facilitated interview.

Victor's review also examines the outcomes achieved through carer support worker (non-statutory intervention from carer support centre) interventions, and again classifies this as an intervention to support carers to access services (2009). These interventions involved emotional support, facilitating access to information and services, and some more specialist services focused on specific conditions such as dementia or stroke. Again these interventions were associated with a range of outcomes, including improved emotional well-being, feeling recognised and increased confidence in caring. Variation in the achievement of outcomes was attributed to factors such as the individualisation of the service, preferences for telephone or face-to-face contact, continuity and length of contact with a worker, and worker qualities. Barriers to the achievement of positive outcomes included a mismatch between the service and cultural and family dynamics, mismatch between participants and service providers' perceptions of the service, and conflict with the wishes of the cared for person. The review also advocates further research into the 'relative value of different models of helping carers to access support including carer assessment and carer support workers' (p.11).

There has also been some research into the barriers for practitioners, and the reasons why carer's assessments do not always take place and why some practitioners are not as engaged in the carers' agenda and the direction of government policy (Scourfield, 2005). 'Practitioners work in such a maelstrom

of competing discourses, for example users' rights, carers' rights, risk, abuse, efficiency, adult protection, independent living, empowerment, partnership and so on, that there is a genuine feeling of confusion and of being deskilled in their work with carers' (p.26). Scourfield argues that 'if the contentious and complex nature of carers' issues is acknowledged more fully within organisations, then not only the quantity but also the quality of carer's assessment will improve' and advocates the idea of separate specialist carer teams within health and social care. Some of the reasons why carer's assessments do not always take place also relate to carers' perception of the process and recent data from Northern Ireland suggests that many carers have declined assessments because they didn't see it as beneficial (Carers Northern Ireland, 2012).

There is also evidence from practitioners' views of best-practice working in relation to carer's assessment and support (Valios, 2007). Practitioners advocated a range of principles including: providing carers with information about the assessment process, allowing carers to identify their desired outcomes, ensuring carers are given an opportunity to feedback on the assessment process, and use of an outcomes-focused assessment tool. Practitioners also highlighted the need for staff training on outcomes-focused work, with the inclusion of carers as trainers.

Methods

Data collection

The research questions were addressed using two different sources of data: semi-structured focus groups with carers and practitioners, and document analysis of the blank and completed tools used by each organisation. Criteria for data sampling were that carers were either caring for an older person, or were an older carer themselves, and had participated in a carer's assessment or VOCAL outcomes focused approach within the 12 months from September 2011 until September 2012 (for the purpose of data analysis, this was later extended to the 18 months preceding September 2012 due to a lack of data). For ethical reasons, carers who had worked directly with either of the practitioner-researchers were excluded from the sample.

Four semi structured focus groups were held as follows:

- Group 1 - 6 x social work practitioners (2 OTs, 2 social workers and 2 CCAs)
- Group 2 - 2 x VOCAL workers (small group due to size of organisation)
- Group 3 - 4 x social work carers, who matched the project criteria
- Group 4 - 4 x VOCAL carers, who matched the project criteria

Invites were sent to all carers who had either had a carer's assessment through Midlothian who met the data sampling criteria. There was no further selection process and all carers who responded positively attended the groups. The discussion which formed the focus groups was audio recorded and transcribed for analysis and all individuals who attended the groups were asked to sign a consent form before participating. It is acknowledged that the groups were small in number and this was particularly felt during the VOCAL practitioners group for which, due to staffing levels at VOCAL Midlothian, it was only possible to involve 2 workers. However, through engaging with a range of staff and carers from both organisations, and using cross-organisational analysis of the data, the authors feel that there is depth in the data and some degree of rigour in the analysis.

In the document analysis a total of 26 documents were analysed using a list of pre-agreed questions. Firstly each organisation's blank tool was analysed to examine what information the documents enables workers to capture. 12 completed tools from each organisation were then analysed to examine how the documents are used and what information is actually captured in practice. An equal number of practitioner-facilitated and self-assessment carer's assessments were sampled from the Community Care team, including two facilitated by each type of professional (i.e. 2 by social workers, 2 by occupational therapists, and 2 by community care assistants). It was intended that a larger sample of documents would be analysed from each of the three types of professional, however the limited amount of data available, particularly in the form of OT facilitated assessments restricted this. From VOCAL a

sample was selected of four documents from each of the three workers, which approximately ranged across the twelve month period.

Data analysis

Documents were considered and analysed as a reflection of the processes and experiences which are taking places in these approaches between carers and workers (May, 2001). Grounded theory formed the basis of the approach to the data analysis, for both the document analysis and focus group data, in order to enable theories to emerge (Glaser and Strauss, 1967, in Robson, 2011). The data analysis included qualitative data from both the focus groups and the document analysis, this was augmented by quantitative information from the document analysis. Having two researchers analyse the data meant there was a need for agreement on a consistent approach, for this reason several steps were built into the method. First an overarching coding frame was agreed, which was based on the five research questions. From a joint analysis of the first focus group transcript sub-codes were then agreed which were felt to be applicable across all the data. This coding system was then applied across the remaining focus groups. Through the process new sub-codes emerged from the data and were recorded. However, the use of an overarching coding frame informed by the research questions, maintained a consistent approach despite the fact that due to time constraints, the three remaining focus groups were split between the two practitioner researchers for analysis.

The key recurring codes which emerged from this grounded theory approach across the entire analysis could clearly be grouped into the four overarching themes which naturally became the basis of the findings of this research project. These were: the differing roles of voluntary and statutory organisations, the impact of the conversation and tool, self-assessment as compared to practitioner-facilitated assessment, and importance of the profession or continuity of worker. The findings were therefore grouped in accordance with these four comparative elements.

Method limitations

In the 18 month period covered by the document analysis only 25 carer's assessments were identified which met the criteria for the project. This is likely to be an underrepresentation of the number of carers who have contact with the social work department in Midlothian and resulted in a limited pool of data for analysis. Small sample numbers in some of the focus groups, and in the data analysis, particularly in the attempt to discern patterns in the documents written by different professionals were also recognised as limiting this study. An additional complication arose due to the fact that it was not possible to share completed tool information between the two organisations without obtaining individual consent due to data protection issues. This meant that the document data could only be analysed by the worker working for that organisation whereas the data from the focus groups could be cross analysed to achieve a greater accuracy.

As a practitioner-research project it has taken place against the background of a real and ever-changing environment. During the course of this project one of the focuses of the research, the carer's assessment, was itself replaced by the carer's conversation. This altered the focus and potential impact of the project and also led to new and unexpected themes emerging from the focus group, as understandably staff wished to talk about this transition. Equally, VOCAL's plans to implement shared baselines across its services has arisen during the life of the project and some of the findings of the project address this, however it was not considered in the research proposal or design. Therefore, the document analysis only considered data from the VOCAL Midlothian team, and did not include data from other VOCAL services such as advocacy or carer training with whom baselines may be shared in the future.

The potential for bias as a practitioner-researcher was also acknowledged, as it is difficult to extricate one set of views and knowledge from another. However, it was felt that this heightened awareness of the risk of bias was as likely to lead to a hyper-critical approach as an uncritical one. The knowledge and experience brought to the project as practitioners also lends a complexity to the research process which may be as much an advantage as a limitation. The benefits of being a joint research project were also utilised, and through discussion the practitioner-researchers were able to reflect on the roles and the influence of this on relationships with carers and practitioners who participated in the project.

Ethics

As a result of the practitioner-research project each organisation developed its own process for ethical clearance. VOCAL and Midlothian Council both created Codes of Practice for Research, and a self-audit was submitted to VOCAL. These processes were deemed sufficient by the corresponding organisation to allow the research project to go ahead.

The ethical processes examined a range of issues, but particular consideration was given to the running of the focus groups. Many carers have emotional feelings in relation to their caring role and the possible implications of speaking about experiences relating to the caring role in a focus group environment were considered. The facilitators tried to emphasise that carers should only disclose or discuss what they felt comfortable sharing in that environment. It was also important to highlight to focus group members that participation in the focus group would not prejudice the service they otherwise receive from the organisation and that although the workers are practitioners within the organisations, that they were present in their capacity as researchers. Attention was also given to the data sampling to reduce the risk of carers being inhibited in expressing their views, or possible bias in the document analysis of the practitioner-researchers. Therefore none of the carers invited to the focus groups or whose information was included in the document analysis had worked one-to-one with the researchers in their role as practitioners.

A range of ethical considerations also arose out of the role of practitioner researcher. As practitioner researchers the venues available without incurring additional cost tended to be linked with the organisations in question. It was felt that being in an environment linked to a service could inhibit the ability of people who use that service to voice honest views about it. Therefore, the focus group for social work carers was held on VOCAL's premises, and as it was also felt that social work offices may have certain connotations even for those who do not use that service the focus group for VOCAL carers was held on the premises of another third sector organisation.

Attention was given to the anonymisation of the focus group data to protect the identities of the workers and carers who participated, due to the ongoing nature of their involvement in the services.

Findings and discussion

Four comparative elements have emerged from the data and analysis which affect how personal outcomes are identified and achieved with carers. These are: the differing roles and perception of statutory as opposed to voluntary organisations, the focus on conversation and outcomes compared to a focus on paperwork and outputs, the impact of self-assessment compared to practitioner-facilitated assessment, and the importance of the profession and continuity of the worker. The findings of this research project have been structured according to these four key emerging themes. However, some of these comparative elements relate primarily to Midlothian Council, as VOCAL do not use self-assessment, and do not have a range of different professions working with carers. For these reasons some of the findings and implications for practice are weighted more heavily towards Midlothian Council.

The different roles and perception of statutory and voluntary involvement

A number of different themes related to the differing roles and perception of statutory and voluntary organisations. How far the approach focused on the carer was a key theme and this also related to information about the approaches, prioritisation, and time. The differing perception of these different agencies also seemed to affect the nature of the relationship between the carer and professional. Accessibility of the service, communication, and function as a source of information also related to the comparison of statutory and voluntary agencies.

Focus of the approach

A difference was identified in how workers and carers from the two organisations perceived the focus of their approach. VOCAL staff were very clear that the carer is the focus of the intervention is carer led:

We still are absolutely bound by the carer's direction, where they want to go and what they see as being important.

This was echoed by carers, who felt that the support provided was for them not for the cared for person, and that they were the focus:

It was nice to have this person who sort of focused on me and was interested in how I was doing and how I was coping.

She was my carer, that's how I looked on it, she was there for me.

This was something which VOCAL described as fundamental to being a carer led organisation, and both workers and carers saw this as an enabler to achieving personal outcomes. Further to this, workers saw their role as being sometimes directive and to actively advise carers, "we will advise a carer if they're going down a road that we think might be disruptive [...] but again we advise rather than give clear instruction and direction".

VOCAL carers described some of the outcomes they achieved, all of which appeared to be to the benefit of the carer, without necessitating change in the cared for person. For example, one carer talked about becoming computer literate and learning how to send and receive emails with support from VOCAL. Another described the support to regain the confidence to drive and the other two participants talked about gaining confidence in themselves and an awakening to the things that they could do for themselves. The document analysis generally reinforced the view that VOCAL's approach is carer-led; baseline and review comments generally seemed to reflect the view of the carer, with some use of direct quotations from the conversation. However, workers also acknowledged that sometimes the initial focus needs to be on the cared for person:

What we'll tend to find is that the carer might not be able to move forward until the person they're caring for has things in place, so holistically we look at supporting the carer to get that in place, but it wouldn't necessarily be the views of the cared-for, because we're very much there for the carer and the carer's views.

This was not seen as being in anyway a conflict, but rather, as a necessary precursor to focusing on the carer.

This focus on the carer was also connected to the process outcome of feeling listened to, and having someone who is listening and who understands being a carer was raised by VOCAL carers several times:

I thought "This is great, this is someone who understands"', 'They're very aware of your own situation and your health as well I think'.

VOCAL carers contrasted this sense of feeling understood by VOCAL with how they feel about other agencies and even family and friends,

"I was saying to her on the phone the other week [...] "I don't know how long I can put up with this" and she said to me "Just get on with it". People haven't got a clue", "you talk to your friends and you see their eyes glaze over, even family.

In contrast, social work carers and practitioners all acknowledged a tension between a focus on the carer and focus on the cared for person. Workers attributed this to the interrelatedness of the carer's assessment and community care assessment, it was also noted that one should inform the other, and this was seen as good assessment practice:

At the first visit you'll usually meet the carer as well and the first visit can be for 2 or 3 hours and you draw them into the conversation a lot. I think the carer's assessment is simpler after that because you can kind of pull in information from the community care assessment.

However, they also emphasised that they see the differentiation from the community care assessment as important: "I always try and emphasise that they are free to ask for an assessment in their own right at any time, I think it's important to keep that separate from the cared-for person". Despite this separateness practitioners described that many times they had already met many of the carers declared needs through the actions resulting from the community care assessment. This therefore seemed to create a lack of

clarity for both workers and carers as to why there should be a separate carer's assessment. This was reinforced by carers who felt the focus to be significantly placed on the cared for person, or persons:

> *It was very much focused on my parents and definitely focused on [my child], rightly so. But for a carers part, it didn't seem to be separate from everything else.*

The carers described the benefits from the carer's assessment mainly as being outputs in the form of services for the cared for person (e.g. respite). One carer explained: "it's not as if I can say that because of the assessment [...] it gave me access to the gym or time to myself or offered anything. I haven't been offered anything". This was also evidenced in the document analysis, which showed that out of the 8 carers (out of a total of 12 documents analysed) for whom there was evidence of change occurring linked to their assessment, 7 of these changes were achieved through a service for the cared for person i.e. respite, a benefits check for the cared for, additional support hours. In only one case was there a record of a standalone action for a carer being carried forward from a carer's assessment and this was in the form of a referral to VOCAL for support to reduce stress. Carer's themselves also described a tendency not to focus on themselves "I don't think about myself, I think about mum, dad and [child]". This further highlights the complexity of focus and the need address this in order to enable carers to identify and achieve the outcomes that matter to them.

Social work staff did describe the benefit of joint working particularly with VOCAL in encouraging the carer to see themselves as a carer, and therefore increase the possibility of the carer going on to achieve other outcomes:

> *The wife didn't see herself as a carer [...] and we encouraged her to take the time to engage with VOCAL, which has been so worth it. [...] I've spent time with the carer and encouraged them to think of themselves as the carer and the carer's assessment is useful for doing that.*

Both social work and VOCAL practitioners felt that this partnership working led to positive outcomes for carers and were keen for it to continue and to be expanded upon.

Time and timing

The timing of the carer's assessment generally as a 'spin off' from the community care assessment may also fuel the belief that the process is focused on the cared for person. The document analysis found that 11 out of the 12 sampled carer's assessment documents had been completed in this way. This timing was mentioned by workers in the focus group, in that often outcomes for the carer had already been achieved as a result of the support plan from the community care assessment, by the time the carer's assessment was complete. This was also evidenced by the document analysis where in 3 of the practitioner-facilitated assessments the agreed actions were already underway at the point of the carer's assessment as they involved putting in services for the cared for person. The assumption can be made that these needs were identified at the point of the community care assessment. It would therefore seem that although actions resulting from the community care assessment may be of benefit to the carer, this alone does not result in carers feeling that they have identified or achieved their own personal outcomes.

There also appear to be a number of pressures and organisational processes which reinforce this focus on the cared for person, and inhibit a focus on the carer. It was highlighted that work pressures are compounded by the lower prioritisation of the carer's assessment in comparison with work that is done with the cared for person: "Pressure of work is a barrier to the carer's assessment, yes. I mean, ideally on a day to day basis, completing a carer's assessment should be a priority but that's not currently possible, it's just not".

> *Even with our allocated cases, making the time to see your client can be difficult in itself, and if you're having less time with the client it's even more difficult to look at the carer's assessment.*

Allocation procedures and management priorities were also cited as a barrier:

> *There's no way my line manager would allow me to keep a case open for the sole purpose of doing a formal review of a carer's assessment.*

I think for management audit purposes, the work we do with a carer's assessment isn't at the forefront, managers aren't always looking for information on that piece of work.

Time and prioritisation was not discussed by VOCAL workers as a barrier to their work with carers, and this may be due to the differing roles of the two organisations. As a carer led organisation VOCAL's primary focus is the support of unpaid carers, and workers and carers reflect a clear sense of this. Whereas Midlothian Council have a wide range of statutory obligations, including that to carers, and workers and carers identified tensions, or competing priorities in this.

Time was also a factor which was perceived differently by the two groups of carers, both in relation to the time they felt the worker was making for them, and the time they felt able to give to themselves. VOCAL carers discussed the benefit of time and not feeling in anyway under pressure:

So many people phone you in a hurry, but there was this phone call that was your time and there was no rush off the phone, it was just your time, you know.

VOCAL carers saw it as important to take time for themselves, and attributed a large part of this realisation to their conversations with the VOCAL worker, with one carer describing that she was able to 'kick off my slippers and [lie] on the sofa'. In contrast, social work carers described feeling that their own time and caring situation was so pressured that it became difficult to focus on their own needs, and take time to engage fully in the assessment process:

Even though you're sitting talking to someone, in my experience I'm sitting thinking about all the things I need to do [...] I'm mentally going through "I still have to [...].

Perception of different agencies

The difference which being a voluntary organisation makes to the relationship between the practitioner and carer was described by VOCAL staff:

> They feel because we're not a statutory service, they're maybe a little bit more open in giving us the information [...] carers do say that they feel more relaxed when they're talking to us rather than social work or other practitioners because we're not associated with those agencies.

This is likely to affect the way in which personal outcomes are identified and was also raised by the VOCAL carers in relation to their experience of working with statutory staff (NHS):

> I think to myself, if I blow up will it affect the care [of the cared for person]?

It suggests that carers may suppress some views or issues due to concerns about the consequences for the cared for person if the carer doesn't maintain a certain relationship with staff. Similarly one of the carers described, talking about the community care assessment process, that 'it's continuously reassessed and I'm never actually sure that the help is still going to be there in 6 months or a year'.

It was felt by social work practitioners that carers often believe it's their ability to care which is being assessed. This suggests that concerns about the power or actions of statutory agencies may affect the way carers interact with professionals and may be linked to practitioners describing the fact that refusal of a carer's assessment, or disengagement from the process, is fairly common:

I always offer a carer's assessment to a person but in actual fact it's often refused. Quite often people don't want the carer's assessment at all.

Reliable communication was also seen as very important. VOCAL carers in general described this as an enabler "they always did phone back if you phoned, they always followed it through." Whereas they felt that with other organisations "You might get told 'OK I'll phone you back' and then sometimes they don't [...] Then they'll maybe phone at 2 o'clock the next day"; carers described breakdown in communication such as phone calls not being returned as "disrespectful". Carers highlighted the importance of communication, and how breakdowns in communication can lead to a breakdown in trust and a feeling of being left alone. VOCAL carers did highlight an experience of a breakdown in communication when a worker had left:

There was no phone call to say '[VOCAL carer] left, I'm going to be taking over your case if that's OK'. There was absolutely nothing.

This raises an issue about transitions in staffing, and how well the episodic nature of support is communicated to carers (as opposed to ongoing support). Some of the VOCAL carers referred to workers as a 'friend' and saw the support as a continual process with an expectation to continue a relationship with one worker. Perhaps the role of the worker and their relationship could be better communicated to carers in order to manage expectations around transitions in staffing, which is a natural process.

Knowledge

The findings suggest that a lack of knowledge and lack of information about carer's assessment are barriers to the uptake of carer's assessments. Workers found that carers often think it's an application for Carer's Allowance or as described above an attempt to assess the carer's ability to care. Workers felt that carers had a "lack of understanding about" the carer's assessment: "she was consistently saying the assessment was for her husband". Carers explicitly stated that information about carer's assessment was lacking and implied that they would find such information beneficial: 'there was no information pack or a remit of 'you have a carer's assessment and this is what will happen'". This lack of information is likely to compound carers' lack of knowledge about assessment.

A lack of information or knowledge for workers about the processes for carer's assessment was also evident. For example, workers felt unsure about the process in instances where there are multiple carers, and in cases where a carer's assessment might be requested in isolation. Improved information for carers as well as workers may be of benefit in increasing uptake of assessments. Interestingly, VOCAL carers and staff did not discuss the absence of any information about the process or see this as a barrier. This is likely to be a reflection of the perceived role of each service and possibly aided by the invisibility of the VOCAL approach (as no explicit information about the outcomes tool and process is given to carers) and that for both staff and carers it feels like a naturalistic conversational interaction.

The accessibility of the services was discussed across all four focus groups and timely referrals and response times in addition to accessible information were seen as key enablers:

It was only when it was referred to the Social Work Department that these big bolted doors slightly open up and suddenly there's utopia at the other end, someone to help you, someone to come and speak to you and offer what things are available for you.

Many carers felt that there was too long a delay between diagnosis, or start of the caring role, and finding out about available services: "I would like to have known that Vocal was there years ago, but I never knew". Once aware of the services, VOCAL's accessibility was viewed as an enabler "when I've needed help from Vocal I've had it". Carers also saw the quick response and accessibility of social work to crisis situations as an enabler: "within 10 minutes, a social worker phoned me. [...] that was me saying 'I've had enough, I can't do this anymore and you need to get somebody here right now'". However carers felt that the slower response or delay in non-crisis situations was a barrier to early and preventative outcomes.

Carers felt strongly that social workers should play an important role in providing information and signposting effectively to other services and resources:

There should be a lead professional, somebody that can tap into all the resources

Someone that can co-ordinate the rest of the services

and they're trained, they know what they're talking about, they know the services in the area"

This was seen as particularly important by an older carer, who described the difficulty of 'trying to get that information and when you're in your 70s'. Carers particularly valued workers having knowledge about more local services relevant to smaller areas. VOCAL carers felt that VOCAL was a good source of information and opened doors to other services. Carers also described feeling better linked into informal networks, training, social groups and events. However, carers did highlight that because many courses are held in Edinburgh, or are funded for Edinburgh carers only, that the travel and time and access can be a barrier to inclusion.

VOCAL carers highlighted that their experience with other services had shown them that the timing and repetition of information was crucial. Carers recognised that this is because of an information overload, combined with the stresses of the caring situation, which can affect people's ability to take in information: "at the beginning you get so much information, there's only so much your head can take in". Carers suggested that information should be reinforced "after a week or two, asking 'Do you understand all this?'" This theme was also emphasised by social work carers, who felt that the load of information being given and the stresses and demands of the caring situation not only affected their ability to take in information, but also their ability to engage in conversation and the assessment process. All services should be aware of the importance of delivery, timing and repetition of information for carers.

A focus on conversation and outcomes compared to a focus on paper work and outputs

The second comparative element which emerged from the data concerned a focus on conversation as a tool, compared to a focus on the tool content as the driver for the interaction.

The tools

Practitioners from the two organisations saw the role of the paper tool differently. VOCAL workers emphasised heavily that documentation is for the purpose of recording, and it is "the conversation [which] is the tool". Indeed the tool itself was considered to be virtually invisible by workers:

> *It's almost like the conversation is the clock face and all these bits of paper or electronic are the workings, the kind of wheels and cogs in the background that nobody sees, nobody needs to see that, they only need to see the clock face.*

However, workers felt that they did find the tool somewhat useful as a reminder or record for prompting discussion:

> *When you're reflecting back and looking at the baselines you've pulled out, see 'oh, I've not gone back and gone over the relationship aspect of it.' So for that, it's maybe a trigger but [...] it's never brought out in front of a carer, it's irrelevant to the approach.*

This perception was reinforced by VOCAL carers, although they acknowledged that the worker was gathering information, there was no awareness or interest in how this was being recorded at an organisational level "and she continued to ring me up every week, sort of asking me different things". The minimal nature of the VOCAL tool itself (i.e. the document) seemed to provide a high degree of flexibility, enabling the worker to record information which reflected the key issues of the carer, rather than it dictating the topics of conversation. The guidance notes specify that 'the tool should never get in the way of the conversation but rather help to facilitate, focus, and capture it'. The analysis of the completed tools showed that under each topic heading it was possible to record a wide range of different issues, and that this can be highly individualised to the carer's situation. However, despite the fact that the blank tool enables workers to record information freely, in the analysis of the completed tools it was seen that workers tended to record information about the key issue as a problem, rather than focusing on the outcome that the carer hoped to achieve or their skills and resources.

Social work staff and carers saw the tool as the document or 'paperwork', and felt alongside being a place to record the conversation and assessment; the tool could facilitate the conversation by lending it 'structure':

> *I use the paperwork to structure the assessment, we sit with the form and ask the person if there's anything they want to discuss and we write everything down […] I think the process of that gives more of a sense of purpose and you're able to summarise, bring it all together and move on.*

Workers did not describe feeling constrained by the tool, but discussion about the need to change or rephrase some of the questions suggests that because of the visibility of the tool to carers the content has more impact on the approach and direction of conversation.

From the document analysis it was evident that the form offers a set of predetermined outcomes for carers with little scope to record truly personal outcomes which are identified by the carer. Furthermore it uses jargonistic language, and perhaps even reinforces a service focused mindset (e.g. asking carers to state areas of 'unmet need'). However, the document itself was seen as having some importance, and practitioners felt strongly that this is something the carer should be able to sign, in order to 'acknowledge the carer's importance'.

VOCAL workers emphasised the skill involved in outcomes focused conversations 'our toolbox is our conversations' this included skills which were very much facilitative rather than directive, such as active listening, summarising and reflecting. It was felt that this gives:

> *People the opportunity to observe what's happening in their life and say it out loud.*

And this in turn 'leads into outcomes being reflected and being open'. Carers seem to agree that the conversational techniques were in themselves beneficial 'it was just a lifeline that somebody was there listening to me, listening to how I felt'.

Social work practitioners also acknowledged the importance of technique and skill in how the conversation is conducted:

> *When you speak about the carer's assessment you need to do it where the conversation widens rather than it being a question and answer session, which might get the carer feeling stressed*

Social work practitioners were concerned that if people feel that they are being questioned it can be a barrier: 'A lot of the time people don't want to be asked questions.' VOCAL workers particularly stressed the need for a jargon-free style and identified it as key to the quality of relationship with a carer:

> *So we're very careful that that language is not a part of our conversation [vocabulary such as baseline, review etc.] because we recognise the shut-down that carers will give to other practitioners when that language is used.*

Workers were also aware of deliberately reflecting back the carer's own language, particularly to enable carers to reflect on and recognise change and personal outcomes. 'We talk layman's because that gets the best information from the carer in a more relaxed situation, but we actually use their language to reflect back on their progress as well.'

For VOCAL carers there was a connection between their conversations with a worker, and the outcomes which they identified and achieved:

> *She just made me realise I had to go out on my own and not spend 24/7 hours with (the cared for person). She made me aware of the things I could do for myself.*

It seems that this sense of being listened to is important and may stem from the nature of the conversational approach. They described building trust and confidence in their worker, as a source of support, through these conversations and acknowledged that 'being listened to' was a key element 'I could talk to her if I needed her. She was there at the end of the phone'.

The particular challenge of recognising yourself as a carer was discussed by both carer groups 'I know it sounds stupid, but I don't actually see myself as a carer', 'I think when you become a carer, you don't realise you're becoming a carer.' This challenge was also recognised by social work staff, 'They're like "well, it's just what I do"', rather than seeing themselves as a carer which can be a huge difficulty. VOCAL carers in particular described transitions in beginning to focus on their own needs as carers and prioritise themselves. This journey is considered by carers to be an outcome itself, but also an enabler to other outcomes:

> *I love it, because I never went anywhere, you know, I always focused on [...] all the time and I just feel through VOCAL it's helped me to say to myself "I'm entitled to this time, it's mine", whereas I wasn't before, it was massive guilt feelings.*

Only one of the VOCAL carers throughout the whole focus group mentioned a service as means to achieving an outcome. This reflected what was said by VOCAL staff who emphasised that it was

important to not automatically resort to services, but to use conversation to identify first what natural supports and strengths are already present:

> *You're asking the carer [...] what's helped in the past, what's supporting them at the moment [...] So it is about the openness of the conversation, you're not leading, you're not necessarily advising in that conversation, you're giving the opportunity for the carer to identify where things either can improve or possibilities of achieving.*

Social work carers were not as clear about what engaging in a carer's assessment should mean to them or what it could help them achieve as individuals. They largely viewed it as a gateway to services:

> *If you fill this form in, you can then have these services. I don't mean services as in huge things, I just mean when you fill out a carer's assessment, this can give you this, this could happen.*

They were, however, also able to describe the difference the worker made to them through the process of engagement such as: 'I feel a constant support', 'it lifts an awful lot of weight off your shoulders'. but they were not able to identify the difference that any conversations or completing a carer's assessment had made to their caring situation or to their life:

> *I have no idea what a carer's assessment is. I know I have a role as a carer, but what does that mean to me? The implications of me sitting and filling that form in, I have no idea and I still don't know.*

Recording and reviewing outcomes

On the carer's assessment form there is a space to record the action plan following assessment and all of the completed documents analysed had information recorded in this section. The social work carers expressed that having a visible plan was important for them, however, this was a step that they felt was missing from the process:

> *There's the carer's assessment, this is your plan. That's what I think is missing, the action plan from the carer's assessment, because we all talk about the people we're caring for, but this is specifically for me, so where is my plan, what I need? I think for me that's the part that's missing.*

A possible explanation could be that unlike community care assessments a completed copy of the carer's assessment is not shared as standard practice with the carer or signed by the carer, they therefore may not be aware of the recorded action plan. This (sharing the assessment) was something that social work practitioners believed should be made standard practice.

VOCAL carers were largely unaware of information being recorded and staff stressed that it is through conversation that an action plan should be agreed with the carer. The document analysis showed that the 12 VOCAL baseline documents, similarly to the social work practitioner-facilitated assessment, all identified the main issues the carer presented with during the first conversation. Also similar to the social work tool there was no clear action plan to link the baseline to the review, however, this may exist within case notes. The fact that this step in the process of recording agreed actions is not present in the documentation could have implications for VOCAL as they move towards shared baselines where the worker recording the baseline may not be the worker who reviews that baseline. VOCAL carers, themselves, saw their involvement with VOCAL as an ongoing support and not necessarily first and foremost as a vehicle for change. They did not discuss the need for or awareness of an action plan in the same way that the social work carers did; however, again this may be due to the 'invisibility' of the approach, and that carers have different expectations of VOCAL as a service.

In relation to reviewing of outcomes, all 12 of the analysed VOCAL tools contained evidence of reviews, with all bar one having had multiple reviews over a period of months or even weeks. Carers were largely unaware of the review process or the fact that they had taken part in a review. When asked about this one carer answered 'I don't think we ever actually went back over history, it was more a case of "What's bothering you just now, let's deal with that, anything else you want to talk about?"' However that same carer noted that 'I think what [VOCAL worker] used to say near enough at the end was:

Have you found that helpful, do you think you'll get any benefit from that?' and yes, 9 times out of 10 I would say yes.

This was not recognised by the carer as a review but it was these types of conversations that VOCAL described as the backbone to their review process:

It's not like you're saying "we're going to review now", it's not done in that kind of language, it is a case of reflecting back, like saying "when we spoke a few weeks ago, this is what you were going to be doing" and it is kind of helping the carer recognise what they've done and what they've achieved.

VOCAL staff also described that their reviews are very rarely time triggered and are normally a natural progression of a conversation or set of conversations:

We do have a time triggered review, which is at 3 months, but within that we very often also have a carer-triggered review or a worker-triggered review [...] we probably very rarely get to our time-triggered review because we're working with the carer, we're seeing it as we go, we review as and when achievements and goals have been achieved.

Social work practitioners and carers identified that there is no review process in place for carer's assessments, and felt that this is needed along with a clearly defined and shared action plan. Reviewing and reflecting back on outcomes achieved may also enable workers and carers to be clearer on what has been achieved from a carer's assessment and what the benefits have been. Presently, all social work reviews are first and foremost formal, time triggered reviews, and are seen as a time-consuming process by practitioners and potentially by service users and carers. It may be beneficial to examine different models of review to better capture information about whether outcomes are achieved.

The impact of self-assessment compared to practitioner-facilitated assessment

The mode of contact or context in which the conversation takes place forms the third comparative element where the discussion focuses on self-assessment versus practitioner-facilitated assessment. These terms refer to particularly to social work processes where 'pure' self-assessment relies entirely on a document-tool, and takes place in the absence of conversation; whereas practitioner-facilitated assessment can involve both conversation and documents, however with varying degrees of emphasis on each.

Self-assessment

In the focus groups social work staff described using practitioner-facilitated assessment, self-assessment, and a mixture of methods (usually an initial conversation, followed by completion of the document by the carer). In relation to self-assessment, this was very clearly seen as a barrier by the carers in the social work focus group: 'I don't like forms, I like them to speak to me, because you can't ask forms things'. These views were reinforced by the evidence from the document analysis which found that that the tool is not flexible in enabling carers to record their own identified outcomes. One carer, who had completed a self-assessment, also found that the questions were difficult to answer without knowledge or discussion about what may be possible or relevant to her caring situation. The carer felt unsure as to what 'difference' a carer's assessment would make, and felt that 'nobody's come back and answered'.

Self-assessment was overall a minority experience with 8 self-assessments in total being completed in the 18 month period covered by the research project. A sample of 6 of these were analysed. The majority of the self-assessment forms had been sent out without widening the narrative text boxes (this needs to be done by the worker through the print settings), thus only giving one line for the carer to fill in, and implying that only a very small amount of information is being requested. The detail recorded in forms completed through self-assessment was very limited in comparison to those facilitated by a practitioner, and two of the forms only had tick boxes completed with no qualitative information, despite indicating areas as being issues. None of the self-assessments had any information entered under actions and agreements (although for the majority of these cases there was further information recorded in case notes).

Social work practitioners' view of pure self-assessment was that it was in general 'very bad practice'. However, they did see that combinations of methods could be appropriate for individual carers and stressed the importance of individualising the assessment process, as different approaches work for different individuals, and that professional skill and judgement is involved in making those decisions. For example, discussing the carer's assessment with the carer first, and then leaving it with them to complete: 'A few people I've sat with them and talked them through the form and they agreed this was beneficial. I've also gone back later on and filled in the form with the carer once they've looked it over and then retained it'. It was acknowledged that there are occasions where self-assessment would be the carer's preferred option, but these cases were felt to be exceptional:

> *I did have one particular carer who was a very private person, a very emotional person, and she wanted to fill it in herself, and that worked for her, so it really depends on the individual, their circumstances, their emotions.*

Although neither type of assessment has a formal review process in place, carers noted the absence of even a 'reply' in self-assessment as a key barrier, 'I didn't get any reply [...] I filled everything in and sent it back, but I've never had anything back to say, "we'll look into this or that" or "this is available" [...] nobody's come back and said, "oh, thanks very much, now we're going to do whatever", 'I just felt I didn't actually get any comeback, like yourself, nobody actually came back and said "you can do this, this and this". It seems that the lack of follow-up was felt more acutely by carers who completed self-assessment than those who had interacted with a worker in completing a practitioner facilitated assessment.

Practitioner-facilitated assessment

Practitioner-facilitated assessment was more prevalent with a total of 17 completed in the 18 month period, again six of these were sampled. Overall it was clear that all practitioner-facilitated assessments contained substantial detail of the caring role and presenting issues. Five out of the six of them also had completed actions and agreements sections. This would suggest that practitioner-facilitated assessments are more effective for gathering information, and agreeing actions, aside from the role of conversation discussed above.

For all practitioner-facilitated carer's assessments the conversation was conducted face-to-face. It was explained that the assessment could be completed in a single visit, but in practice practitioners found that multiple visits were often needed because there were often issues relating to the cared for person which needed to be addressed. It is also likely that where the carer's assessment is completed in a single visit that it is not the first contact with the carer, as it frequently comes after involving the carer in the community care assessment so a degree of rapport and understanding of the situation would already exist.

The two way nature of practitioner-facilitated assessment was particularly viewed as important. Social work carers who had experienced this felt this positive relationship with the practitioner was an enabler in identifying and achieving outcomes and additionally led to process outcomes:

> *He was absolutely perfect. He came into the house and sat with the patience of Job and went through everything. [...] these doors opened up with him.*

VOCAL staff conducted interventions through a range of modes, including face to face, on the telephone, and via email, and they expressed the view that a single conversation is not enough:

> *You're not going to get every bit of information straight away, there may be trust needing to be built up and also it might be the fact that they're identifying things during the third conversation that they can either trust you with or identify that you can help with, that they may not have identified at first.*

VOCAL carer's also described the phone contact as a 'lifeline', and valued it similarly to face to face conversations, though noting the different nature of the interaction:

> *Just speaking on the phone helps, you don't necessarily have to come out because that's travel time, although it is nice to see somebody face to face from time to time [...] you know someone, you can picture them.*

Profession and continuity of worker

The final comparative theme related to the importance of the worker's profession, and to the importance of having continuity of worker. The possible impact of having a worker within a statutory as compared to voluntary organisation is implicitly discussed under the first comparative theme; however, this additionally raises issues about continuity of worker. As previously outlined the Midlothian carer's assessment can be facilitated by one of three professions, and the potential impact of this was examined. There are a number of inconclusive findings relating to this theme.

Profession

There was much discussion during the social work practitioners' focus group about whether or not the profession of the worker affects the content of the assessment or its outcomes. It was felt that the profession of the worker, itself, does not affect the identification or achievement of outcomes with carers. Practitioners stated that CCAs, OTs and social workers are equally well qualified to complete the carer's assessment. Practitioners felt strongly that the key factor was continuity of worker rather than the profession. However in the 18 month period from which data was sampled for the document analysis, out of a total of 17 practitioner-facilitated assessments completed there were only 2 carer's assessments which had been facilitated by an OT, compared to 11 by social workers & 3 by a CCA. This data suggests that social workers are most likely to engage carers in the carer's assessment process, however further investigation would be required to draw conclusions on this as there may be other explanations. 2 carer's assessments were analysed from each profession but given the small sample of data to draw it was not possible to draw any conclusions about the impact of the profession of the worker on the content of the assessment or subsequent outcomes achieved. This may be an area indicated for future research in a larger scale document analysis.

At the time of the social work focus group being held a proposal had been made for carer's assessments to be 'tasked' to a CCA for completion. A task, unlike an allocation is a specific one-off visit to complete a short piece of work. All of the practitioners present including the CCAs themselves did not believe that this approach would be beneficial in achieving outcomes for carers and that a work request to a CCA meant that insufficient time would be spent on the carer's assessment. In addition to this as a single task it was identified that there is then no possibility of review or follow up 'I just think it's paying lip service to the carer'. It was also acknowledged that time is wasted in transferring the task to another worker as they would need to familiarise themselves with the background and wider situation, therefore although the profession of the worker was not seen as a factor, it has implications for continuity which was seen as important by practitioners.

Continuity

Continuity of worker was discussed as an important enabler, by both workers and carers, as it enables the building of a relationship with a worker and those feelings of being listened to, feeling understood and having trust in the worker. VOCAL carers all had the experience of working with one particular VOCAL worker (although two had also had involvement from other workers). All carers felt that continuity was positive and enabled them to build strong foundations upon which to achieve outcomes and prevented delays from having to retell information:

> *Continuity's very important and things like that, rather than starting again and telling your story, giving all the details, that bugs me.*

Continued involvement with VOCAL as an organisation was also talked about as a positive, as well as involvement with a single worker, carers felt they had the confidence that vocal would always be there to back them up 'even though I'm not needing to be in touch a lot at the moment it's a great help knowing that it's there.' VOCAL staff also felt that continuity was important in being able to discuss some of the more sensitive and emotional aspects of the caring role:

> *Changing relationship ones, that can be a more challenging conversation to have initially, I mean it's not a challenging conversation to have once you've got a relationship going with a carer [...] you would make sure you've got some kind of good understanding, trusting relationship with the carer to then delve into maybe the complexities of challenging relationships within the family.*

The value carers and staff place on continuity also raises issues about the handling of staff turn-over and allocation within VOCAL.

Social work practitioners also discussed continuity in some detail. It was generally felt that continuity was essential to relationship building and achieving positive outcomes. One worker illustrated this, commenting:

> *You need continuity and you need to be able to build up a professional relationship that the clients and carers are comfortable with. I think that's the way to get the best out of any kind of assessment.*
>
> The preference was strongly echoed by social work carers, noting the frustrations of lack of continuity:
>
> *So you're just getting to know somebody and they know you, you're not having to go through everything again. Then they're gone and you're having to start from scratch.*

Although social work staff felt strongly about continuity they also acknowledged that there might be specific cases which demanded separate allocations, for example if there were conflict between the carer and cared for. However, this was considered to be exceptional, and continuity was generally viewed as important for informing the depth and quality of the assessment. Professionals also thought that sending a different worker to complete the carer's assessment would not make the carer feel valued:

> *For me to go out to do a community care assessment, go through all that, talk at length, build up an understanding and then to turn around and say "oh by the way it's someone else who will be coming out to do the carer's assessment". I think it's going to add stress to the situation [...] how does that make the carer feel valued?*

Implications for policy and practice

The findings of this project have a number of implications for current practice within VOCAL and Midlothian Council, and implications for joint working between these and other agencies. The implications are further informed by the practitioner-researcher experience of undertaking joint research, and the fruitful discussions which have arisen from this. The findings may also be relevant to all services which have a responsibility to support carers and have an interest in outcomes focused approaches.

Implications for current and planned practice in Midlothian Council Community Care team

1. Focus on the carer: Carers reported finding it difficult to focus on themselves and in practice the approach of practitioners tends to focus on interventions directly for the cared for person which generally have an impact on the carer. There also appear to be internal processes and pathways which reinforce a focus on the cared for person. The message was that this reinforces the carer's belief that the assessment is not about them but about the cared for person and is possibly further linked to the belief by carers that it is their ability to care which is being assessed. It is therefore suggested that the focus needs to shift to the carer being at the centre of the carer's assessment and to take into account the wider implications of the caring role outside of services.

2. Focus on the conversation rather than the tool: Anecdotally the carer's assessment seems to be tool-focused, with the form being very visible to the worker and the carer. In contrast, the community care assessment was portrayed as more of a conversation/discussion which is then recorded into the tool afterwards. Social work practitioners should have the conversation for the carer's assessment in whatever way works best for the carer and should not feel constrained by the tool to ask or omit specific questions.

3. Support for conversation skills: The importance of the conversation 'toolbox' and the time, training and professional development involved in maintaining and refreshing this toolbox was heavily stressed by VOCAL. The benefits of this approach were also self evident through the research by the fact that all four

VOCAL carers described that the conversation itself achieved key outcomes. Social work practitioners recognised themselves as having this skill set but felt constrained by structures and process which did not value these skills. It was identified that investment is required at a both a managerial and practitioner level for example, through supervision structures, reading, training, etc to increase opportunities for practitioners to maintain and further develop these skills.

4. Flexible approach that fits the individual: While this research project clearly evidenced that the decision to stop offering self -assessments with the introduction of the new 'carer's conversation' is, in the majority of cases, a positive step. It equally highlighted the fact that one approach will not fit all and that individualisation is the key to identifying and achieving outcomes for carers. For example a face to face approach will not always be best for the carer and carers in the focus group mentioned the impact this can have on their limited availability of time. It is therefore suggested that decisions on how best to carry out a carer's conversation should be made jointly with the carer and that the possibility of using other methods of communication such as the telephone should be considered. This recommendation should also be considered alongside the evidence that a one-off conversation in many cases will be insufficient and the strong belief of social work practitioners that a task request will not do the carer's conversation justice.

5. Carer's assessment knowledge: It appeared that workers were not always confident in the benefit of a carer's assessment for the carer within the current system and this uncertainty was then mirrored by the carers. Conversation and clarification within the Council with practitioners as equal partners would be beneficial to explore themes such as 'why we do carer's assessments' and what are the potential 'benefits to carers' in addition to discussing what sort of work the practitioner should be able to do with the carer would be beneficial.

6. Clear action plan: Carers were unclear what outcomes had been achieved as a result of the carer's assessment, or what the benefit had been to them of engagement in the process. They identified that having a clear action plan, negotiated, between the carer and worker and then shared with the carer, would help. Workers also strongly felt that carers should have a copy of their completed carer's assessment, and that like community care assessments they should be asked to sign it to acknowledge it is a true representation of the conversation and any subsequent agreements. This step may also prove beneficial in reinforcing for carers that they have had a carer's assessment and would mean they have a copy of the action plan to refer to.

7. Review outcomes with the carer: It was further clear that the introduction of a review process could identify what outcomes had resulted from the carer's conversation, in addition to highlighting any new or ongoing issues. Learning could be taken from VOCAL's approach to reviews, which as opposed to being traditional all-encompassing and time triggered reviews (which is the case in current social work practice for community care assessment reviews) are used flexibly to identify outcomes at points which are most relevant and timely in the carer's situation. The review is a part of the conversation and is used to check out what has changed and what difference that has made to the carer. Gathering appropriate information through review would also enable Midlothian Community Care team to evidence the personal outcomes achieved with carers.

8. Organisational change: Workers clearly recognised and wanted to invest in the therapeutic benefit of the process of the assessment. They equally recognised the complex and competing demands and pressures on social work intervention and the fact that this resulted in limited time being invested in carer's in their own right. Space, encouragement and permission from management to take the necessary time to engage with carers and follow up strands that are related to the carer, but not directly to the cared for person are crucial to achieving positive outcomes for carers. Furthermore supervision and management support that focuses on putting skills into practice and discussing skills development and outcomes achieved, as opposed to a focus on throughput was viewed as necessary to promote a truly outcomes focused approach to working with carers.

9. Involving practitioners in developing practice and processes: It was evident during the focus group that social work practitioners were keen to work jointly with management to effect positive changes in practice but in order to do this they stressed that it was crucial that they have advanced knowledge and are involved in decisions about changes to practice.

10. Profession of the practitioner: Implications which can be drawn with regards to the impact of the profession of the practitioner on identifying and achieving outcomes are limited. This is due to the small sample of data available for the document analysis where it was only possible to analyse 2 completed carer's assessments for each professional group. It is possible that a larger scale document analysis would have identified some differences in approach and outcomes identified and achieved. The message from the both the practitioners and the carers' focus groups was that all professions are capable. What was felt to be more important was that the process was practitioner-facilitated and led by one informed and knowledgeable professional.

Implications for current and planned practice in VOCAL's outcomes focused approach

1. Focus on outcomes and strengths in documentation: Although the tool itself was flexible, and this is certainly a strength, and the conversations carers have with workers would appear to be outcome focused and build o the carer's strengths, this was not well reflected in the document analysis. The information examined in the document analysis also seemed, in general, to focus on key issues or problems, and information about barriers or enablers tended to be recorded retrospectively rather than prospectively. There was frequently little information on what outcomes the carer actually hoped to achieve, or the potential resources or enablers that the person had or needed to effect change in their own life, in line with a solution focused approach. Improvement in documentation would be another step towards becoming an outcomes focused organisation, and particularly important in the context of a transition to shared baselines, where the information recorded in a baseline will heavily influence the conversations that other workers have with carers. A recommendation would be for how the tool is used by workers to be considered further within VOCAL and to be included in any staff training or team discussions that may take place during the transition to using shared baselines.

2. Detail in baselines and reviews: At present, the information contained in the baseline and review documents is relatively minimal (it is likely that more detailed information exists in case notes). Consideration should be given as to how shared baselines should function, and what sort of information they should include, to enable different workers to share documentation - for example a worker may need to conduct an effective review conversation, based on the information recorded in a baseline recorded by a different worker. The sorts of information they are likely to need include what actions had been agreed and any resources or assets the carer had identified which could support them to achieve a positive outcome.

3. Process outcomes: Many of the outcomes reflected back by VOCAL carers were process outcomes: the impact of the conversation itself or their relationship with the worker, and the difference this had made to them as a carer or how they perceive their caring situation. However, this is not very well reflected in the documents that were analysed, which tended to cover more of the change outcomes which carers had achieved. This perhaps distorts the carer's view somewhat and it would also be useful for VOCAL as an organisation to be able to reflect how important those process outcomes can be to carers. It may be useful for workers to discuss how to cover process outcomes more explicitly with carers, and how to reflect them in the carer outcomes tool. However, it must also be acknowledged that any process outcomes are highly context specific, and are never as such 'achieved'. Process outcomes are constantly shifting and can be continuously worked towards.

4. Clear action plan: Carers were not clear on what specific actions had been agreed during their involvement with VOCAL, or what actions had contributed to the outcomes achieved. Equally, in the carer outcomes tool there was little information about how to address key issues, or, in some cases, how outcomes had been achieved. More explicit conversations between the carer and worker about what actions have been agreed, or how outcomes have actually been achieved would likely be an important learning experience for both the worker and carer. In line with solution focused techniques this reflection in a review may also leave the carer in a more resourceful and empowered state once the intervention ends. Additional information recorded in the outcomes tool about how carers are achieving outcomes may also lend additional detail to the information VOCAL currently collects, and ability to evaluate services.

5. Staff transitions and relationship with carers: Given the importance VOCAL carers placed on the quality of their relationship and communication with a worker, and the fact that outcomes were attributed to this, the concerns raised by some carers in the focus group should be considered. The impact of a worker leaving VOCAL was highlighted as an issue and potential barrier to accessing further support. Some carers seemed to interpret the nature of VOCAL's support as an ongoing relationship, rather than as something which was episodic with defined beginnings and ends, and this may have led to unattainable expectations. It may be useful for VOCAL to consider how it communicates the nature of the relationship with a worker and the episodic nature of support, both at an organisational level, and on a one-to-one level by individual staff. While the project highlights the value of continuity of worker for carers, the turnover of staff is a natural process for which carers could perhaps be better prepared.

6. Local resources and opportunities: Carers also highlighted that the presence of many carer training opportunities in Edinburgh was a barrier to Midlothian carers using this resource, due to the added time and costs of travel. Carers who had attending training courses in the past described how these had led to positive personal outcomes, particularly in some of the areas such as gaining in confidence, reducing feelings of guilt, and learning to take time to prioritise themselves. This is an issue which VOCAL are already aware of, and are taking steps to develop further training opportunities in the local area in the future, however this finding reinforces the value of these developments.

Joint implications

Some of the implications address how organisations might work together in their joint contribution to supporting carers in Midlothian.

1. Consistent message about carer's assessment: Lack of information and knowledge about the carer's assessment would seem to contribute to the number of declined assessments. All organisations play a role in informing carers about their right to an assessment and signposting or referring effectively. It is therefore important that there is a strong and consistent message from all local organisations, which informs carers about what they can expect from the process, and highlights the potential benefits to them. There have been a number of recent changes to the process for carer's assessment, and once this has been re-established it would seem timely to re-examine the information from Midlothian Council about carer's assessments.

2. Information giving: Both staff and carers felt that finding and giving information about services and resources (particularly local ones) was a challenge, yet knowledge and information were considered to be crucial enablers for the achievement of personal outcomes. Carers especially valued effective signposting from professionals to enable them to navigate the complex systems of health and social care with greater ease, but also felt this could be improved. Carers also suggested that information giving techniques could be improved, for example by revisiting information with someone once it has been given. These implications are relevant to all organisations, but it is likely that effective joint working and further development of information systems and provision to the public might be key enablers. The recent publication of Midlothian's Directory for Older People living in Midlothian, is an example of a resource which brings together a range of resources and services in the community (Midlothian Voluntary Action & Midlothian Council, 2013). It may be useful to examine ways to ensure this is widely accessible and build upon this across other client groups.

3. Continuity of worker within and between agencies: Continuity of worker was considered important by carers and workers alike, especially for the trust and rapport that this brings. Continuity is, however, a complex issue. It was identified that while having the same worker within social work for the carer and cared-for person may reduce the need for repetition it may also lead to increased focus on the cared for person, and be a barrier to shifting that focus to the carer. Workers also suggested that having specialised teams, or outsourcing carer's assessment to other agencies could be helpful, which would also sacrifice maintaining continuity of worker. Due to this conflicting information it was not possible to make any recommendations for continuity of worker between the cared for person and the carer, or within or between different agencies. Further investigation or discussion between stakeholders would be required to shed further light on this issue.

4. Joint working to support individual carers & shared language: At present, many carers do receive support from both agencies, and closer working between those workers might lead to improved continuity of support for carers. The benefits of existing joint working practices were discussed in the focus groups, and some workers suggested that things such as training and induction are existing enablers to developing joint working at an organisational level and between individual members of staff. These are pillars which could be built upon. Equally, the importance of having a shared language with carers was highlighted, and continuing to develop this shared language with carers and between organisations indicated the importance of developing carer engagement with all services.

5. Increasing accessibility of services: Carers described the 'big bolted doors' of social work, and that these could be difficult to open. However, carers also described how VOCAL linked them in to other organisations and services, and there was also some suggestion that voluntary organisations may seem less intimidating to carers who have concerns about approaching statutory services. Therefore, it would seem that further joint working between these and other organisations from the statutory and voluntary sectors could begin to break down some of these barriers. The practitioner-researchers are aware that the Community Care team have recently piloted a surgery model to increase its accessibility, and this is perhaps something which could be further built on with partner agencies.

Knowledge exchange

Following the completion of this project the next step is to share what has been found from the research. Target audiences for knowledge exchange include Midlothian Council and VOCAL practitioners and managers, and Midlothian carers. At an organisational level it is important to share this information in order to inform the work each organisation takes forward at a strategic level both individually and in joint working. Ultimately it is hoped that this will improve approaches to working with carers and, and lead to better outcomes. It is to share information across all levels of each organisation and with carers, as without support and investment from all sectors any efforts to carry forward any proposed recommendations are unlikely to be successful.

The first focus for information sharing will be at the PROP organised Knowledge Event which is being held in May 2013. We have invited the heads of services and relevant managers from both organisations. We also plan to present this information to the Midlothian Joint Carer's Strategic Planning Group and Carers Action Midlothian at their next meeting during March and April 2013.

At a grass roots level all of the carers and workers who participated in the focus groups were clear that they would like feedback on the results of their participation and we plan to send out the leafleted summary of the project with the offer of a copy of the complete document should people like to read it more in depth. For social work practitioners we will share the research through the 'Good Practice Forum' which is a quarterly event for practitioners to share experiences and practice examples. For VOCAL practitioners the research will be shared during a team meeting. We additionally aim to make available copies of the research summary leaflet through local resources including through information areas in Loanhead Social Work Centre and Vocal Midlothian Office.

Reflections

As a joint enterprise, bridging two organisations, their distinct processes, and the views of carers and practitioners on both, the project has resulted in multiple strands. However, it is felt that this complexity is also a strength, and it is hoped that it does justice to all those who participated.

The role of practitioner-researcher has also been multifaceted, presenting both challenges and opportunities for the workers, and it is hoped that this unique position may add further depth to the findings and implications for practice. The real and ever-changing landscape of practice has certainly affected the focus of the project as it has developed, as well as the transition of one practitioner researcher leaving and a new person coming on board. The process of joint working as practitioner-researchers has also been an enlightening and enjoyable one, and it is hoped that this might translate into continued effective joint working between our organisations in the future.

Reflection on the process of undertaking this project at an organisational level may also lead to further additional learning for how to support and maximise the benefit of practitioner-research to the organisations now and in the future.

Conclusions

This study brings together information from carers, workers, and the documentary context of two organisations, to examine the impact of different approaches to working with carers on the achievement of personal outcomes. Four comparative elements emerged through the analysis of the focus group data and documents. These themes look at the differing roles of voluntary and statutory organisations, the relationship between a focus on conversation and outcomes compared to a focus on paperwork and outputs, the impact of self versus practitioner-facilitated assessment, and the importance of the profession or continuity of the worker in identifying and achieving personal outcomes with carers.

Through these comparisons it has been possible to draw several conclusions and to determine steps which could be taken to improve the outcomes achieved with carers through carer's assessment and VOCAL's outcomes approach. Although flexibility is itself valuable, some key elements were apparent which workers and carers identified as enabling an outcome focussed approach. The value of conversational approaches, and that skilled outcomes focused conversation can itself lead to personal outcomes was a key finding and should instil confidence in practitioners in the value of their practice. Support for this approach, and a more explicit focus on carers at all levels of an organisation was also key to ensuring positive personal outcomes for carers. Clear processes, which include an action plan and an opportunity to review personal outcomes, as well as information about the process and potential benefits to carers can enhance the experience of carers, and support the achievement of personal outcomes. The value of information more generally to workers and carers was also supported by the findings. In addition to this, the benefits of existing joint working practices were highlighted, although the findings also identified further areas which all organisations could build on to better co-ordinate their support to carers.

There is inconclusive information about the impact of the profession of the worker, and the affect of continuity of worker which merits further consideration by the organisations concerned. This poses some dilemmas for practice, since while continuity was considered highly important it can be difficult to achieve. In the context of carer's assessment, continuity of worker may also need to be balanced against opportunities to increase the focus on the carer by having a different worker from the person they are caring for.

Some of the implications for practice are quite specific to the organisations in question, and to current developments. However the findings also go beyond the local context of support for older carers and carers of older people in Midlothian. Indeed, the practitioner-researchers feel that the findings are pertinent to outcomes focused approaches with all carers, and assessment methods more generally with a range of client groups. The experience and learning from this joint practitioner-research project has also been enlightening and it is hoped that it can illustrate the value of this form of research in effecting change which may be of benefit to people.

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Acknowledgements

Special acknowledgement to:

Grant Dugdale (previously of Midlothian Community Care team, and contributor to the project)

With thanks to:

All the carers and practitioners who participated in the focus groups

Kerry Kinnell (Loanhead Social Work Centre)
Emma Miller (PROP Mentor and Senior Research Fellow, University of Strathclyde)
Catherine-Rose Stocks-Rankin, the PROP team, and all our fellow practitioner-researchers

Appendix A - 1

Midlothian Council **Communities and Wellbeing Division**
Loanhead Social Services
4 Clerk Street
Loanhead
EH20 9DR

Tel:

Eibhlin McHugh
Acting Director Communities and Wellbeing

Midlothian

The Social Work Department has a duty to offer you an assessment of, and to take into account, your needs as a carer. The Carers Self-Assessment form gives you the chance to:
1. Inform Social Work about the work you do for the person you care for.
2. Say what services you need to support you in your caring role.
3. Look at what you need to remain in good health and have a good life of your own.

This information is important in order to provide an idea of how complex your situation is and gain a better understanding of the health of the person you care for. It also means that if you, the carer, are unable to provide care for any reason then appropriate help will be organised for the person you care for.

Any information you provide is treated confidentially. However, in order to access some types of support, information may be shared with relevant professionals and organisations.

You do not have to answer all the questions, but try to give as much information as you can.

These guidance notes cover every question in the assessment and are intended to give you an idea of what information is being asked for.

If you are having any difficulties, and would like someone to help you, there is support available at Loanhead Social Work Centre

Appendix A - 2

Carer Assessment - Carer

Carer's Details

Name

Current Address

Date of Birth

Home Telephone Number

First Language

Interpreter Required?

☐ Yes ☐ No

Cared For Person

Please see attached Guidance Notes for Carers when completing this Self-Assessment Form

Name of person(s) being cared for
Name

Address of person(s) being cared for (if different from above)

The relationship of carer to person(s) being cared for

What is the nature of the illness or disbility of person(s) being cared for

Has the cared for person had an Assessment of their needs?

☐ Yes ☐ No

Please give details

Caring Relationship

Length of time in caring role

Has your relationship changed?

O Yes O No

Can you describe how?

Carer's Other Commitments

Are caring issues affecting your ability to remain in employment?

O Yes O No

If Yes, can you describe the issues?

If not in paid employment, would the person be interested in finding out more about employment opportunities?

O Yes O No

If Yes, give details

Are you in education (e.g. college courses)

☐ Yes ☐ No

Please detail further

Are there any problems combining this with your caring tasks

☐ Yes ☐ No

If Yes, please detail

Do you have other family commitments?

☐ Yes ☐ No

If Yes, please detail

What is your family/partner's attitude to your caring responsibilities?

Carer's Health

Do you experience any health problems that affects your ability to provide care?

☐ Yes ☐ No

If Yes, please detail the issues and what you would like to happen to address these issues

Have you recently consulted GP/others for treatment?

☐ Yes ☐ No

If Yes, please detail

Name of GP/others consulted

Are you being woken during the night?

☐ Yes ☐ No

If Yes, please detail frequency

Do you feel under stress?

☐ Yes ☐ No

If Yes, what are the reasons for this

Have you sought help for this?

☐ Yes ☐ No

If Yes, please give detail

Are there any significant past or current events that could have an effect on caring role, e.g. bereavement?

☐ Yes ☐ No

If Yes, please detail

Caring Role

What do you do for the person you care for?

Are there any tasks you would prefer not to do, or need additional help with?

☐ Yes ☐ No

If Yes, please detail

Because of the behaviour/personality of the person being cared for are there any tasks that are a particular problem?

☐ Yes ☐ No

If Yes, please detail

Is there any other person/member of the family who provides direct help or shares the caring responsibility?

☐ Yes ☐ No

Does caring incur any cost for you or the person for whom you are caring?

☐ Yes ☐ No

If Yes, please detail

Do you feel able to continue your caring role?

○ Yes ○ No

Could you give an idea of how long you'll be able to continue in your caring role?

Social Life

Are you able to have outside interests, keep up contact with friends and family?

☐ Yes ☐ No

Please give further details

Would you like some time to yourself?

☐ Yes ☐ No

If Yes, what would enable this to happen?

Services Received

What services/help do you currently receive for you and the person you care for?

Service	Day	Time

Are you satisfied with the services/support you as a carer receive?

☐ Yes ☐ No

If No, please detail

Does the Carer feel satisfied with their involvement in the design of the Clients care?

O Yes O No

Do you or the person you care for have any needs that are not being met?

If Yes, please detail unmet needs

Who would help in an emergency (if no current service are in place)

Financial Situation

Has a benefits check been carried out?

☐ Yes ☐ No

Are you in receipt of any benefits in your own right?

☐ Yes ☐ No

If Yes, please specify

☐ Income Support ☐ Housing Benefit ☐ Carer's Allowance ☐ Disability Living Allowance ☐ Other

If Other, please specify

Legal Status

☐ Financial Guardianship ☐ Welfare Guardianship ☐ Corporate Appointeeship ☐ Power of Attorney

☐ Other (please specify)

Action & Agreement

Identified Action & Agreement

Issue	Action	Person /Agency Responsible	To be Actioned By

Note: a review of the Carers Assessment will be considered as part of the Client Community Care Plan Review

Signatures	
Signature of Carer	
Date	
Name of Worker/Care Manager	
Signature of Worker/Care Manager	
Name of Carer Advisor (if applicable)	
Signature of Carer Advisor (if applicable)	

Appendix A - 3

Carers Assessment - Guidance

Guidance

YOUR DETAILS
Your name, address and date of birth.

CARED-FOR PERSON
This is the person who you provide help and assistance to.

What is your relationship to the person you care for?
e.g.mother/ father/older sibling/ friend/ neighbour

Can you describe the main illness and/ or disabilities the person you care for has?
e.g.medical problems/ memory problems/ continence problems

Have they had an assessment of what activities they require help with?
e.g. washing/ dressing/ shopping/ taking medication/ walking

If they have, can you tell us who carried the assessment out and when this was done?

CARING RELATIONSHIP
This section is about finding out how long you have been caring for and how your relationship with the person you care for may have changed.

Length of Caring Relationship
The length of time does not need to be exact. Try to think of when you began **regularly** doing things such as food shopping/ looking-in/ assisting with laundry.

Changes in the Relationship
- How have things changed?
- Are they more dependant on you now than 1 year ago, for example?
- Is there more conflict and tension?
- How does the relationship affect your mood/feelings?

e.g. you can feel proud about providing support but, equally, feel frustrated at not being able to do things you need to

YOUR OTHER COMMITMENTS
It is important to recognise that you have other commitments, and ambitions, and that these can be affected by your caring role.

Employment
- If you are working, write down how many hours/days
- Try to describe any problems you may be experiencing to remain in employment

- If you have had to reduce your working hours or retire early because of the caring role, write that down too
- Have you considered returning to some form of work? e.g. paid or voluntary

Education
- If you are in education, write down that course/college and how many days a week you spend in education
- If you have had to reduce the time spent in education or to withdraw from a course because of the caring role then write that down too
- Would you like to enter or return to work

Problems
If you are experiencing problems with combining work or education with your caring role then tell us what the major problems are, for example:
- Is it lack of time and energy due to the caring situation?
- Is it lack of understanding by your employer/college or the person you care for?
- Lack of support?
- Is it due to the nature of the caring situation that causes difficulties?
e.g. continuous supervision to ensure the safety of the person you care for

Family Commitments
- Does your caring role mean you see less of your family than you would like?
- Is there a conflict between your family and caring commitments?

Your family/Partner's opinion
Your family/partner's view is important too. They may have noticed things you have not, and may see other changes that you have not.
If you are uncomfortable with this question then you do not have to comment

- Do they have any concerns about you and your health due to the level of caring you provide?
- Are they supportive of you in your caring role?
- Have they taken on activities such as housework/ cooking/ shopping, which you used to do?
- Have they noticed a change in routine? e.g. doing food shopping late at night
- Does your family/ partner have a clear understanding of your caring role?

CARERS HEALTH
If you are providing care for someone, it is sometimes difficult to have the time or energy to focus on your own health and well-being. However, this is important too because if you want to keep caring you need to be well enough to do so. Health not only includes physical health but also emotional health.

Physical health:
- problems with breathing, moving or walking
- heart problems

Emotional health:
- feeling low, unhappy
- anger, stress, anxiety
- frustration, resentment

Being well and healthy means you are better able to deal with stressful situations, and that can mean taking regular breaks, making sure you eat well, and exercise.

Own Health
- If you have any health problems please describe them
- If you have had any serious health problems in the past please write them down
- How do your health problems affect your caring resposibilities?

- Do you have any current health problems because of your caring?
e.g. back injury from lifting
- Do you have any other on-going health problems that may become worse over time?

What would help?
You may have identified areas/issues that are causing difficulties and/or stress.
What would you like to happen to make it less difficult/stressful?
e.g:
practical help/ time for yourself to attend appointment
someone to talk to/information

Treatment
- Have you seen a Doctor or Nurse recently for treatment?
- If you are receiving treatment or a course of treatment, how long is this for?
- Do you need to travel to a clinic or hospital?

Sleep Disturbance
If you are regularly not getting enough sleep it can affect your health, your mood and your ability to concentrate. If you are being woken tell us roughly:

- How often in a night? How many nights a week?
- What do you need to do for the person you care for when you are woken?
- How long can you be awake for?
- Is it difficult to get back to sleep?
- Do you wake early?

Stress
Caring situations can cause stress due to the extra responsibilities, demands on your time, and the physical strain.
Identifying areas that are causing particular problems is a start to try and ease or solve them. They can often be linked.

- Caring situation itself
- Personal/family relationships
- Financial
- Education/employment
- Domestic tasks

Tell us when you are most stressed and why
Have you sought help? Who have you contacted?

Events
Have there been any bereavements, accidents or relationship breakdown making your caring role more difficult?

CARING ROLE
What do you do for the person you care for?
Think what you do in the morning, afternoon and evening.
List the activities you do

Other things to include are:
- How much supervision is needed?
- Do you prompt/ encourage/ reassure?
- Additional jobs that the person you care for used to do
e.g. finances/ paying bills/ gardening/ housework/ cooking

Tasks you would like help with
Sometimes, it is uncomfortable, either for yourself or the person you care for, to carry out certain tasks because of whom you are caring for
e.g. assisting with washing and dressing, assisting them to the toilet

If you have an injury/ chronic illness/ arthritis it can be difficult to carry out practical tasks such as lifting, moving and even doing things like fastening buttons on clothes

Behaviour/ Personality of the person you care for
e.g. refusing medication/ wandering away when unsupervised/ going to appointments

Sharing of the Caring Responsibility
If there is someone who helps, please write down who they are and what they do to assist in caring
e.g. My brother, he washes and dresses our dad every second day

Extra Costs
e.g. heating on more often, washing machine used much more, reduction in working hours and income, buying new clothes or furniture

Continuing to Care
Not feeling able to continue your caring role is difficult and it is important to let us know so that we can support you and provide appropriate help
Can you describe any difficulties and what would need to occur to enable you to continue caring

SOCIAL LIFE
Interests/ Holidays/ Friends
- How often do you meet family/ friends? Would you like to see them more often?
- When was the last time you had a holiday?
- When do you socialise, is it with or without the person you care for?
- Would you like to socialise without the person you care for sometimes?

Time for yourself on your own
Have a think about **what you would like to do** if you had that time
How could things change so that could happen?
e.g. someone keeps the person you care for company for an afternoon/ family member takes the person out for the day/ weekend

SERVICES REQUIRED
What help do you and the person you care for receive?
e.g. home care/ cleaner/ District Nurse/ day care for the person you care for
support group/ carer training/ VOCAL

Are you satisfied with the support/ services you receive?
This covers both the services the person you care for receives, and the support you receive as a carer. Is there anything that needs to be improved?

Needs not being met
e.g. enough social contact/ encouraging independence/ education

Emergency Plan
Who would you contact if you became ill?
Would they be able to provide all the care you currently provide?

What could they not do?

FINANCIAL SITUATION
We need to ask about finances to ensure you have the benefits you may be entitled to and to ensure your income is the maximum it can be for your situation
If you receive Pension Credit/ Attendance Allowance/ Council Tax Exemption, **in your own right,** then please tick the 'Other' box and state what you receive.

LEGAL STATUS
Sometimes, you need special legal status to access and manage the finances and/ or welfare of the person you care for if they are unable to do so because of illness/disability.
- **Power of attorney (welfare):** you have legal status to make decisions relating to the welfare of the person you care for.
- **Power of attorney (continuing):** you have legal status to make decisions relating to the finances of the person you care for.
- **Appointeeship:** you are the named person responsible for accessing benefits and/or pension for the person you care for. This relates to the Department of Work and Pensions only.
- **Named Person (mental health):** Service Users (when well) can nominate someone to be their "Named person" to represent and safeguard their interests.

WHAT TO DO WITH YOUR CARERS ASSESSMENT
Thank you for taking the time to complete this self-assessment form.

Please send it to:
Loanhead Social Work Centre
4 Clerk Street
Loanhead
EH20 9DR

We will send a letter to confirm we have received it and what department to contact

Appendix B - 1

VOCAL Carer Outcomes Tool Guidance Notes – v1.6

1. Background

An outcome is the impact or end result of support and/or service(s) on a person's life. VOCAL has eight outcomes which it seeks to achieve with unpaid carers:

- Carers will report being better informed about issues linked to their caring role
- Carers will report improved confidence in their ability to shape services and support
- Carers will report improved confidence in managing their caring role
- Carers will report improved physical and mental wellbeing
- Carers will report improved confidence in their ability to deal with the changing relationships resulting from the caring role
- Carers will report improved social wellbeing
- Carers will report improved economic wellbeing
- Carers will report improved personal safety in relation to their caring role

In order to capture these outcomes VOCAL has developed the Carer Outcomes Tool. The following guidance details how the tool should be used and the key aims and principles underpinning its use. Further clarification on the eight outcomes detailed above can be found in appendix 1.

2. Key principles and aims

The aims of the tool are to allow:

- Staff to capture and evidence the difference the support offered makes to the carer, and to shape the support offered to that carer accordingly.
- Service teams to capture and evidence the outcomes of their service and to shape their service planning and delivery accordingly.
- VOCAL to capture and evidence the outcomes across the organisation, allowing it to shape both VOCAL's service planning and delivery and the planning and delivery of other providers.

In order to achieve these aims there are five key principles underpinning the use of the tool:

- **The focus is on outcomes** – the aim of the tool is to capture the impact on or change for the carer as a result of the support offered. In order to do this it is crucial to make the distinction between the 'outcome' (the impact on or change for the carer) and the 'output' what has been achieved as a result of the support offered eg. equipment installed, benefit awarded. For example the carer needs support to fill in a Carers' Allowance benefits form and as a result is awarded Carers' Allowance. The output is that the Carers' Allowance has been awarded but the outcome is the impact that has on the carer and this can only be established by getting feedback from the carer. For example the carer

may report feeling less stressed as a result of the additional income. It is the outcome as reported by the carer that the tool aims to capture and not the output. A detailed example is provided under 5. Casework Example.

- **Flexibility with consistency** - the tool is a means to an end and not an end in itself as such it should be flexible enough to be used in a number of ways but consistent enough to ensure that the information it captures is robust and useable.
- **Fundamental to our work** – the tool is a fundamental part of the work VOCAL undertakes with the carer. As stated above it will allow staff and VOCAL to shape the support to the carer in order to ensure the best outcomes for the carer. In order to achieve these outcomes the tool must be fully integrated into the way staff work with the carer.
- **The carer is in control** - where the carer is at baseline and review is their decision and this must be reflected in what is recorded by staff. If the staff member disagrees with the carer's assessment of where they are this can be recorded under comments (see 4. Comments, below).
- **Not a bureaucratic exercise** - the language of the tool must not bureaucratise the relationship with the carer. The flexibility of the tool should allow the interaction between staff and the carer to be based on effective listening and respect as before. Each interaction will be unique reflecting the unique dynamic between that individual member of staff and that individual carer. The tool should never get in the way of the conversation but rather help to facilitate, focus and capture it.

3. The Carer Outcomes Tool in practice

The tool consists of two main strands – the baseline and the review.

3.1 The baseline

3.1.1 When to use

a) The aim of the baseline is to firstly record the conversation staff have with the carer when they first make contact, and secondly to capture the ongoing issues for the carer through the time they are supported by VOCAL. For example during the first conversation with the carer it becomes clear that their lack of confidence in their skills and knowledge as a carer is an important issue. This would then be recorded as a baseline at that time. If a month later the carer identifies a new issue around their caring role and work life which is very important to them then this should be baselined at this point.

3.1.2 How to use

a) The tool allows staff and the carer to be flexible in the way they have their conversation eg. face to face, over telephone, in one meeting, over a number of meetings.

b) It aims to facilitate the conversation between the staff member and the carer eg. general opening question which allows the carer to identify the starting point.

c) As issues are identified through this conversation the tool brings a consistency to the way the issue is recorded, for example:

Issue = confidence in caring

Very important issue	**Important issue**	Small issue	Not an issue	Not discussed

d) In using the tool staff should always reflect back to the carer what they have understood are the key issues for them and how important an issue it is for them. This ensures that what is recorded is an accurate reflection of the carer's issues and needs.

e) The baseline will be recorded in the Outcomes Review Tool summary sheet (see appendix 2). The information recorded on the summary sheet will include:

- The issue identified by the carer eg. confidence in caring
- The importance of that issue to the carer eg. important issue
- The date the baseline was recorded
- Staff comments – for example where the issue is confidence in caring the comment included may give more detail on what staff have observed are the specific issues for the carer, such as 'feeling fearful of not coping now or in the future with the caring role'. The comments should also include any relevant facts or circumstances which aid understanding of the carer's situation, for example 'the carer has no other family members to assist them with the caring role' (see 4.)
- Date of the review
- Service identification number
- Whether or not comments should be included in reports

f) When the issues have been identified a clear set of actions for staff and the carer can be agreed. This will consist of what support VOCAL can offer and what the carer can do for themselves.

g) This activity will be recorded by staff either directly on to the database or on to the case record sheet.

h) The use of the baseline will be ongoing throughout the carer's contact with VOCAL. New issues, for example health and wellbeing, will be identified at different stages and it is crucial that they are recorded on the Outcomes Review Tool summary sheet as and when they are identified. The tool's flexibility will accommodate the changing nature of the carer's situation and issues while bringing consistency to the way they are recorded.

3.1.3 Key practice questions

The following is a checklist of key questions against which practice can be checked:

- Have the staff member and carer **agreed** what the issues are for the carer?
- Have the staff member and carer **agreed** what level of importance the issues have for the carer?
- Have the issues been fully recorded on the Outcomes Review Tool summary sheet (see list under 3.1.2 c) above).

- Have the staff member and carer **agreed** what support will be offered by VOCAL? What the carer will do?
- Have the agreed tasks and activities been recorded on the database or on the case record sheet?
- Has a date been recorded on electronic and paper diaries, and on the Outcomes Review Tool summary sheet for the review?

3.2 The review

3.2.1 When to use

a) The aim of the review is to capture the impact the support has made for the carer eg. increased confidence, better work/caring balance. The review should take place **no later than six months** after the original baseline was created.

3.2.2 How to use

a) Crucially the review asks the carer to focus on the difference to them (the outcome) – not on what they thought of the service, for example:

Issue = confidence in caring

Big improvement	**Small improvement**	No improvement	Worse
Not an issue		New issue = new baseline	

b) The review also allows any relevant facts or circumstances, which aid understanding of the outcomes reported by the carer, to be captured and recorded (see 4. Comments – below).

c) The review allows the carer to raise new issues as well as to re-baseline where they are with an already identified issue eg. confidence in caring continues to be a small issue for the carer. This needs to be recorded on the Outcomes Review Tool summary sheet as a new baseline and dated accordingly (see list under 3.1.2 c) above).

d) As before when the new issues or ongoing issues have been identified a clear set of actions for staff and the carer can be agreed. Again this activity will be recorded either directly on the database or on the case record sheets.

e) If a carer reports an improvement on an outcome that had not previously been discussed at baseline then the improvement should be recorded at review and a baseline recorded for the same date. For example the carer reports a 'big improvement' in 'health and wellbeing' on 30th June at review, this would be recorded at the review and a baseline created for 30th June for 'health and wellbeing'.

f) The review strand of the tool will be completed at a date agreed between the staff member and carer. It should be no later than 6 months from the completion of the first baseline with the carer.

g) The review will be recorded in the Outcomes Review Tool summary sheet (see appendix 2). The information recorded on the summary sheet will include:

    - The carer's assessment of where they are in relation to the issue(s) eg. big improvement, small improvement.
    - The date the review was recorded

- Staff comments
- Whether or not comments should be included in reports
- Whether or not a new baseline has been created for that issue.

3.2.3 Key practice questions

The following is a checklist of key questions against which practice can be checked:

- Have the staff member and carer **agreed** what the outcomes are for the carer? And if there is any disagreement has this been recorded under 'comments'?
- Have the outcomes been fully recorded on the Outcomes Review Tool summary – including any relevant facts or circumstances which aid understanding of the outcomes reported by the carer (see list under 3.1.2 e) above).
- Have the staff member and carer **agreed** if there are any new or ongoing issues for the carer. If so what are they and what level of importance do the issues have for the carer? These should be recorded on the Outcomes Review Tool summary sheet again referring to the information needed under 3.1.2. c) above.
- Have the staff member and carer **agreed** what support will be offered by VOCAL in relation to these issues? What the carer will do?
- Have the agreed tasks and activities been recorded on the database or the case record sheet?
- Has a date been recorded on electronic and paper diaries, and on the Outcomes Review Tool summary sheet for any further review?

4. Comments

As referred to above 'comments' are key pieces of information to be recorded at both baseline and review. The aim is to provide information which will add to the understanding of the carer's issues and the resulting outcomes.

4.1 Comments

The staff comments can serve two key purposes:

a) Providing additional information which aids understanding of the carer's situation and issues which are based on the observations of the staff member. For example where the issue for the carer is work comments could include 'carer seems very stressed trying to maintain carer/work balance' or 'carer's employer not understanding of the caring issues.' These comments clarify the nature of the issue and provide a clear focus for the support to be provided. At review if the carer reports that there has been a 'small improvement' in relation to their work comments might include 'the carer has reduced their working hours'. In another example in relation to health and wellbeing the carer may report feeling 'worse' and the comments may include 'short breaks currently not available.' However there will be occasions when the carer is not able to identify why the situation is better or worse and this should also be reflected in the comments.

b) Where there are any areas of disagreement between the member of staff and the carer. For example at review where the carer and member of staff may

take different views on the amount of improvement made by the carer. The staff comments can acknowledge this. For example 'carer feels that there has been no improvement but the review took place on a day when the carer was particularly stressed. There has been a small improvement overall.'

5. Casework Example

1. The caring situation and support offered
Mrs Jones cares for her husband with MS, over the last few months Mr Jones' condition has progressed significantly and he needs more assistance to get in and out of bed, to get dressed etc. Mrs Jones contacts VOCAL to ask for help as she is concerned that she may injure herself or her husband or both when she tries to help him with these activities. VOCAL assists her to contact an OT and arranges for there to be an assessment for Mr Jones and a carers' assessment for Mrs Jones. As a result of both assessments equipment is provided and Mrs Jones receives training on manual handling. Two months after the training has finished and the equipment has been installed VOCAL contacts Mrs Jones to ask how she is getting on. Mrs Jones reports that she is feeling a lot happier, and is confident to assist her husband in a way that feels safe for both of them. However she is less and less able to leave her husband on his own. As a result she is tired, less and less able to go out on her own and is considering having to give up her part-time job. She enjoys her work and does not want to give it up.

2. The outputs
The support offered by VOCAL staff resulted in two clear pieces of support for Mrs Jones:

a) new equipment was installed
b) she completed manual handling training.

These were the outputs from this piece of work with Mrs Jones.

3. The outcomes
As a result of the support offered to Mrs Jones she reported:

a) feeling more confident in assisting her husband.
b) feeling happier and less stressed.

These are the outcomes for Mrs Jones.

4. How would this look on the carer outcomes tool?
The two issues that Mrs Jones came to VOCAL with are:

a) lack of confidence in assisting her husband with getting in and out of bed, dressing etc.
b) concern that she may injure him, herself or both

4.1 Baseline
She sees both being of great importance so at baseline this would be reported as follows.

a) Confidence in caring

Very important issue	Important issue	Small issue	Not an issue	Not discussed

Comments: Carer is concerned that she is not able to assist her husband appropriately with manual handling, and that she may injure him, herself or both.

What support would help? Have agreed a referral to the OT for an assessment for Mr Jones, and for a carers' assessment for Mrs Jones. Also referred carer to training team for information about manual handling training.

b) Health and wellbeing

Very important issue	Important issue	Small issue	Not an issue	Not discussed

Comments: Carer is very concerned and as a result very stressed about possibility of injuring her husband or herself, and that she will not be able to support him.

What support would help? Have agreed a referral to the OT for an assessment for Mr Jones, and for a carers' assessment for Mrs Jones. Also referred carer to training team for information about manual handling training

4.2 Review

Two months later at review Mrs Jones reports:

a) feeling more confident in assisting her husband.
b) feeling happier and less stressed about this part of her caring role.
c) that she is more tired and isolated as she is unable to leave her husband for any significant length of time on his own.
d) that she is considering having to give up her part-time job.

This would be reported as follows:

a) Confidence in caring

Big improvement	Small improvement	No improvement	Worse
Not an issue		New issue = new baseline	

Any further action needed? Does this continue to be an issue?

Very important issue	Important issue	Small issue	**Not an issue**	Not discussed

b) Health and wellbeing

Big improvement	**Small improvement**	No improvement	Worse
Not an issue		New issue = new baseline	

Very important issue	**Important issue**	Small issue	Not an issue	Not discussed

Comments: Carer reports feeling tired and stressed as she is unable to leave her husband for any significant length of time.

What support would help? Agreed to look at options for respite/short breaks.

c) Work and caring role balance

Big improvement	Small improvement	No improvement	Worse
Not an issue		**New issue = new baseline**	

Any further action needed? Does this continue to be an issue?

Very important issue	Important issue	Small issue	Not an issue	Not discussed

Comments: Carer is considering giving up her job which is very important to her

What support would help? Agreed to look at options for alarm systems for her husband so that he can access support when the carer is at work

d) Social life and caring role balance

Big improvement	Small improvement	No improvement	Worse
Not an issue		**New issue = new baseline**	

Any further action needed? Does this continue to be an issue?

Very important issue	Important issue	Small issue	Not an issue	Not discussed

Comments: Carer feels increasingly isolated as a result of her inability to leave her husband for any length of time.

What support would help? Agreed to look at options for respite/short breaks. Also advised her of the support group run by MS Society. **Guidancenotes120423**

Appendix 1
VOCAL's outcomes – clarification and examples

The following guidance offers further clarification and some examples in relation to each of VOCAL's agreed outcomes.

- **Carers will report improved confidence in managing their caring role.**

The focus of this outcome is the carer's confidence in managing their caring role. This can include both practical and emotional aspects of the caring role. It is important with this outcome to distinguish between giving carers' information, skills and knowledge and the fact that the information, skills and knowledge leads to an increase in confidence, as this may not always be the case. The increase in confidence needs to be reported by the carer. Some examples would include:

- The carer feels that they are unsure about how to manage the person they care for's medication.
- The carer does not feel that they fully understand the condition of the person they care for and as a result lack confidence in how best to support the person.
- The carer is concerned about the future of the cared for person and does not know how to plan for that.

- **Carers will report improved physical and mental well-being.**

The focus of this outcome is on the health of the carer, both physical and mental. In particular it focuses on the impact that the caring role has on the health of the carer. Some examples would include:

- The carer feels extremely stressed by the amount of caring they are doing.
- The carer reports having back problems because of the lifting and handling they have to do as part of the caring role.
- The carer feels that they are unable to cope because they have not had a break from the caring role.

- **Carers will report improved confidence in their ability to shape services and support**

The focus of this outcome is on the confidence of the carer in their ability to shape or influence the services and support available to them. Again it is important to emphasise the issue of confidence for the carer in relation to this outcome. Some examples would include:

- The carer feels unhappy with the support package in place for the cared for person but does not feel confident to try and change it.
- The carer wants to increase or change the respite which is provided to them but does not feel able to do so.

- **Carers will report improved social wellbeing**

This outcome focuses on the social wellbeing of the carer. In particular it focuses on the impact that caring can have on their social wellbeing. Some examples would include:

- The carer feels socially isolated and does not get out to see friends and/or family.
- The carer feels that their confidence in interacting with people outside of the caring role has diminished.
- The carer feels that they are not able to have any leisure time or hobbies as a result of the caring role.

- **Carers will report improved confidence in their ability to deal with the changing relationships resulting from the caring role**

This outcome focuses on the carer's confidence in dealing with any changes to their relationships resulting from the caring role. This can be any relationship affected by the caring role. Some examples would include:

- The carer is not coping with the change in their relationship from wife to wife/carer and seeing their husband as someone who needs to be cared for. This can include dealing with feelings of anger, resentment and guilt.
- The carer is not able to set clear boundaries around their relationship with the person who has an addiction eg. lending money to the person which is used to buy alcohol/drugs.
- The carer feels their family has withdrawn from them and the person they care for and wants to encourage the family to visit and help.

- **Carers will report being better informed about issues linked to their caring role**

This outcomes focuses on the carer feeling better informed about issues linked to their caring role as a result of the support offered. Some examples would include:

- The carer wants to know more about the benefits available to them and the person they care for.
- The carer wants more information on the condition of the person they care for.
- The carer wants to understand how to deal with the medication for the person they care for.

- **Carers will report improved economic wellbeing**

This outcome focuses on the economic wellbeing of the carer. In particular it focuses on the impact that the caring role has on the carer's economic wellbeing. Some examples would include:

- The carer is thinking about reducing their working hours because they are struggling with working and being a carer.

- The carer is worried about their financial future and that of the person they are caring for, and wants to make plans around how they might manage in the future on their reduced income.

- The carer does not know what benefits they can access and how they might go about applying for them.

- **Carers will report improved personal safety in relation to their caring role**

  This outcome focuses on the personal safety of the carer. In particular it focuses on the impact of the caring role on the carer's personal safety. Some examples would include:

  - As a result of their condition, the cared for person is being aggressive and unpredictable in their behaviour.

  - The carer is being physically/mentally/emotionally abused by the person they are caring for.

Appendix B - 2

CAPTURING OUTCOMES – BASELINE

CARER NAME:_____

Address: _____

No review: ❑ why? _____

WORKER:_____

DATE: _____

SHORT TERM ❑
CASEWORK ❑

ENTERED ON DATABASE: _____

MORE INFORMED ABOUT CARING ROLE ❑

Not discussed: ❑ Review pending:

Very Important Issue	❑
Important Issue	❑
Small Issue	❑
Not an Issue	❑

COMMENTS:

Don't print: ❑

CONFIDENCE IN CARING

Not discussed:❑ Review pending: ❑

Very Important Issue	❑
Important Issue	❑
Small Issue	❑
Not an Issue	❑

COMMENTS:

Don't print: ❑

HEALTH AND WELL-BEING

Not discussed: ❑ Review pending: ❑

Very Important Issue	❑
Important Issue	❑
Small Issue	❑
Not an Issue	❑

COMMENTS:

Don't print: ❑

SOCIAL LIFE and CARING ROLE BALANCE

Not discussed: ❑ Review pending: ❑

Very Important Issue	❑
Important Issue	❑
Small Issue	❑
Not an Issue	❑

COMMENTS:

Don't print: ❑

CONFIDENCE dealing with changing relationship Not discussed: ❑ Review pending: ❑

Very Important Issue	❑
Important Issue	❑
Small Issue	❑
Not an Issue	❑

COMMENTS:

Don't print: ❑

CONFIDENCE IN ABILITY TO SHAPE SERVICES Not discussed: ❑ Review pending: ❑

Very Important Issue	❑
Important Issue	❑
Small Issue	❑
Not an Issue	❑

COMMENTS:

Don't print: ❑

PERSONAL SAFETY in relation to caring role Not discussed: ❑ Review pending: ❑

Very Important Issue	❑
Important Issue	❑
Small Issue	❑
Not an Issue	❑

COMMENTS:

Don't print: ❑

ECONOMIC WELLBEING Not discussed: ❑ Review pending: ❑

Very Important Issue	❑
Important Issue	❑
Small Issue	❑
Not an Issue	❑

COMMENTS:

Don't print: ❑

CAPTURING OUTCOMES – REVIEW

CARER NAME:_____

Address: _____

No review: ❑ why? _____

WORKER: _____

DATE: _____

END OF SHORT TERM ❑
END OF CASEWORK ❑

ENTERED ON DATABASE:_____

MORE INFORMED ABOUT CARING ROLE

Not discussed: ❑

Review date:	
Big improvement	❑
Small improvement	❑
No improvement	❑
Worse	❑
Not an issue	❑

COMMENTS:

Don't print: ❑

New baseline? Start new sheet

CONFIDENCE IN CARING

Not discussed: ❑

Review date:	
Big improvement	❑
Small improvement	❑
No improvement	❑
Worse	❑
Not an issue	❑

COMMENTS:

Don't print: ❑

New baseline? Start new sheet

HEALTH AND WELL-BEING

Not discussed: ❑

Review date:	
Big improvement	❑
Small improvement	❑
No improvement	❑
Worse	❑
Not an issue	❑

COMMENTS:

Don't print: ❑

New baseline? Start new sheet

SOCIAL LIFE and CARING ROLE BALANCE

Not discussed: ❑

Review date:	
Big improvement	❑
Small improvement	❑
No improvement	❑
Worse	❑
Not an issue	❑

COMMENTS:

Don't print: ❑

New baseline? Start new sheet

CONFIDENCE dealing with changing relationship

Not discussed: ❑

Review date:	
Big improvement	❑
Small improvement	❑
No improvement	❑
Worse	❑
Not an issue	❑

COMMENTS:

Don't print: ❑

New baseline? Start new sheet

CONFIDENCE IN ABILITY TO SHAPE SERVICES

Not discussed: ❑

Review date:	
Big improvement	❑
Small improvement	❑
No improvement	❑
Worse	❑
Not an issue	❑

COMMENTS:

Don't print: ❑

New baseline? Start new sheet

PERSONAL SAFETY in relation to caring role

Not discussed: ❑

Review date:	
Big improvement	❑
Small improvement	❑
No improvement	❑
Worse	❑
Not an issue	❑

COMMENTS:

Don't print: ❑

New baseline? Start new sheet

ECONOMIC WELLBEING

Not discussed: ❑

Review date:	
Big improvement	❑
Small improvement	❑
No improvement	❑
Worse	❑
Not an issue	❑

COMMENTS:

Don't print: ❑

New baseline? Start new sheet

Appendix C

Focus Group Schedule for VOCAL Midlothian Carer Support Workers

Carers Assessment and Outcomes Focussed Approaches to Working with Carers (Carers of Older People, and Older Carers)

This focus group is being held as a part of the Practitioner Research Project for Older People, which is being conducted jointly by VOCAL Midlothian and Midlothian Council. The project aims to aims to improve how organisations work with carers to identify and achieve personal outcomes.

We want to get the views of VOCAL's Carer Support Team about VOCAL's Carer Outcomes Approach, to develop an understanding of your experience of the approach and how you think it affects the outcomes achieved with carers.

This session should not last more than 1 ½ hours and at the end of the project you will be informed of the findings and recommendations of the research.

Can we start by asking you some questions about your participation in this focus group:

1) Can we check whether you have read the information sheet?
2) Do you have any questions about the project before we start?
3) Do you understand that any information you give will be treated confidentially and you will not be named in the final report or in any related publications?
4) Are you happy for me to audio record the discussion, with the understanding that only the researchers and the transcriber will have access to this recording?
5) Do you understand that you can change your mind about the information you have supplied to us any time until the project is finished in February 2013?
6) Are you happy to go ahead with this focus group?

Now we would like to ask you a bit more about your experience of working with VOCAL's outcomes-focussed approach in your work with carers.

Semi-structured questions, as actually asked during the focus group:

1. Do you feel that this approach enables the carer to identify personal outcomes?
2. Can you tell us about how you get the carers to identify the issues? What techniques help you to do that?
3. Does the approach enable you to take into account the wider situation, for example the caring situation, the views of the cared-for person, formal supports and formal services?
4. You mentioned, that the [initial] conversation can seem quite factual, but it kind of opens out into more than that, and I'm just wondering how that works, how you can go from something factual to something wider?

5. Do you feel the carers open up with the approach you take?
6. Do you think the relationship between VOCAL as an organisation and the carer is potentially different to the relationship with other organisations?
7. So, are these conversations always done face to face, or by telephone and face to face?
8. Do you notice any difference between phone contact and personal contact?
9. Could [you] tell us a bit about how the approach, does the approach help you and the carer identify a sense of direction, a sense of where you're going?
10. Do you find that the approach helps you and the carer to identify whether outcomes have actually been achieved?
11. Do you have a time frame for reviewing, or is it informal?
12. How you would describe the best way of doing that with the carer [reviewing], is it just ongoing conversation the whole time
13. What happens if new issues arise, as new issues possibly arise in the future, how does that work?
14. One of the things you have mentioned is the difference in the language that you use. I'm just wondering how that works, that difference between the language you use for what you're doing and how you present that to the carer.
15. Do you find the paperwork for the tool you use helpful?
16. It sounds like you see the tool as being a way of recording and it's simply for that purpose. But it sounds like you find it useful in more ways, you said things like refamiliarising yourself, tracking where things are going...?
17. It sounds like you see a distinction between the tool and the approach. We've talked a bit about the tool, but I was wondering how you define approach as opposed to the tool.
18. What helps you as practitioners to identify and achieve personal outcomes with the carers? I mean, what we're thinking in terms of training, supervision, guidelines, or other things within VOCAL.
19. What about achieving [outcomes]? Would you say that equally helps to identify and then to achieve the outcomes?
20. Is there anything else that you feel helps in your practice?
21. Are there barriers to your practice, barriers to identifying outcomes with your carers?

THANK YOU

Focus Group Schedule for VOCAL Midlothian Carers

Carers Assessment and Outcomes Focussed Approaches to Working with Carers (Carers of Older People, and Older Carers)

This focus group is being held as a part of the Practitioner Research Project for Older People, which is a joint project with Midlothian Council Adult Community Care Team and aims to improve the way both organisations work with carers. We want to get your views about your experience of VOCAL, and the difference this has made for you.

This session will last no more than 1 ½ hours.

Can we start by asking you some questions about your participation in this focus group:

1) Can we check whether you have read the information sheet?
2) Do you have any questions about the project before we start?
3) Do you understand that any information you give will be treated confidentially and you will not be named in the final report or in any related publications?
4) Are you happy for me to audio record the discussion, with the understanding that only the researchers and the transcriber will have access to this recording?
5) Do you understand that you can change your mind about the information you have supplied to us any time until the project is finished in February 2013?
6) Are you happy to go ahead with this focus group?

A. Introductions and highlight that carers don't need to disclose any specific personal details.

B. Summary of VOCAL's Approach and what is meant by 'Outcomes', using cake metaphor and comparison with services.

Now we would like to ask you a bit more about your experience of working with VOCAL's carer support workers.

Semi-structured questions, as actually asked during the focus group:

1. Maybe it would be good for you to start off by telling us about your experience of the carer support?
2. At what stage in that whole process did you get in touch with Vocal, or did they get in touch with you?
3. And was most of your contact, your 1:1 contact, was that by phone?
4. When you first contacted Vocal, what was your expectation of what the Carers Support Service was about?

5. So thinking about the role of X, she was one of the Carer Support Workers. What do you think was the purpose of that role?
6. Are you aware of any stages of your interaction with Vocal? Are you aware that there is a process that Vocal work through or has it just been good conversation and someone listening?
7. Did you feel there was a beginning, a middle, and an end? Was that important to you?
8. Did you feel that you were able to identify the outcomes, the things you wanted to achieve? Were you able to sit down with her and say "OK, these are the things that matter to me", do you remember pulling that sort of thing out of the conversation?
9. And did you feel through those conversations, was there a plan? Did you feel there was a plan in place to move things forward?
10. Through working with Vocal, what do you feel you achieved?
11. Do you think now, looking back on the conversations, have there been any changes to your life because of those conversations, any realisations, anything that's happened because of that?
12. So it sounds like quite a few of you have had long experiences of Vocal over the years. I was just wondering if it feels like individual episodes within that time or does it feel like one big thing?
13. At the end of those episodes [did you feel] you had a chance to kind of talk about what difference that had made and what had changed?
14. Have you had a conversation with X at any point discussing what you've achieved and the changes that have happened?
15. How did you know when the end of the episode was? Was it kind of controlled by yourself or did Vocal bring it to an end?
16. Are there any other really good things that you can think of with Vocal and with the Carer Support Workers?
17. Is there anything you think they could improve on? Was there anything that maybe didn't work as well, like with the approach?

THANK YOU

Your participation and input has been greatly appreciated, and the information you have given will be used as a part of a research project which aims to improve how organisations work with carers.

At the end of the project you will be informed of the findings and recommendations of the research. Please let me know whether or not you are happy to receive this information, and [illegible] it in a [illegible] format.

Focus Group Schedule for Midlothian Community Care Team Practitioners

Carers Assessment and Outcomes Focussed Approaches to Working with Carers (Carers of Older People, and Older Carers)

This focus group is being held as a part of the Practitioner Research Project for Older People, which is being conducted jointly by VOCAL Midlothian and Midlothian Council. The project aims to aims to improve how organisations work with carers to identify and achieve personal outcomes.

We want to get the views of Midlothian Council Practitioners about the carer's assessment, to develop an understanding of your experience of the approach and how you think it affects the outcomes achieved with carers.

This session should not last more than 1 ½ hours and at the end of the project you will be informed of the findings and recommendations of the research.

Can we start by asking you some questions about your participation in this focus group:

1) Can we check whether you have read the information sheet?
2) Do you have any questions about the project before we start?
3) Do you understand that any information you give will be treated confidentially and you will not be named in the final report or in any related publications?
4) Are you happy for me to audio record the discussion, with the understanding that only the researchers and the transcriber will have access to this recording?
5) Do you understand that you can change your mind about the information you have supplied to us any time until the project is finished in February 2013?
6) Are you happy to go ahead with this focus group?

Now we would like to ask you a bit more about your experience of using the carer's assessment in your work with carers.

Semi-structured questions, as actually asked during the focus group:

1. When offering a carer's assessment, did you offer to support the carer to complete the assessment or did you send a paper copy to them for them to complete it, and what influenced your decision?
2. In your experience have you found any carers to be uneasy or uncomfortable with the Assessment?
3. So, we're now moving to using a carer's conversation rather than a carer's assessment, do you think the new terminology changes the approach that you use?
4. Do you think that the profession of the person carrying out the carer's assessment makes a difference?

5. I was just wondering from the OTs, if you have any opinion about the profession of the person doing the carer's assessment?
6. Did the process enable the carers to identify personal outcomes?
7. So it sounds like you all have experience of identifying personal outcomes, I was just wondering how the process fits in with this?
8. I was just wondering if we could rewind X picked up on something about the paperwork and the process [does] the carer sees the paperwork?
9. Did the approach enable you to take into account the wider situation, for example the caring situation and views of the cared-for person, informal supports and formal services?
10. Are you able to take some information from the community care assessment when you're doing the carer's assessment?
11. Moving on to how you identify whether outcomes were achieved, how do you know that, how does that work?
12. [Does] anyone do a formal review of carer's assessment?
13. Do people feel that there's pressures from being a statutory agency, that's maybe presenting a barrier to some of the work you'd want to do with carers?
14. What is it about the process and the approach to working with a carer that helps you identify what outcomes the carer would like to achieve?
15. Thinking about the tool, how helpful would you say the old carer's assessment was, you know, sort of as a guide when you're looking at outcomes?
16. If someone was to call up and ask for a carer's assessment and their cared-for wasn't already allocated, I'm just wondering what would happen with that?
17. So, the introduction of the new tool, what happened with that?
18. We spoke a little bit earlier about things that could be a barrier to you identifying and achieving outcomes for carers, does anyone have anything to add about that?

THANK YOU

Focus Group Schedule for Midlothian Community Care Team Carers

Carers Assessment and Outcomes Focussed Approaches to Working with Carers (Carers of Older People, and Older Carers)

This focus group is being held as a part of the Practitioner Research Project for Older People, which is a joint project between Midlothian Council Adult Community Care Team and VOCAL. We aim to aims to improve how organisations work with carers.

We want to get your views about your experience of the carer's assessment and the difference this has made for you.

This session will last no more than 1 ½ hours.

Can we start by asking you some questions about your participation in this focus group:

1) Can we check whether you have read the information sheet?
2) Do you have any questions about the project before we start?
3) Do you understand that any information you give will be treated confidentially and you will not be named in the final report or in any related publications?
4) Are you happy for me to audio record the discussion, with the understanding that only the researchers and the transcriber will have access to this recording?
5) Do you understand that you can change your mind about the information you have supplied to us any time until the project is finished in February 2013?
6) Are you happy to go ahead with this focus group?

A. Introductions and highlight that carers don't need to disclose any specific personal details.

B. Summary of VOCAL's Approach and what is meant by 'Outcomes', using cake metaphor and comparison with services.

Now we would like to ask you a bit more about your experience of participating in a carer's assessment.

Semi-structured questions, as actually asked during the focus group:

1. With one you were very clearly aware that "this is a Carer's Assessment" and then with X you weren't so aware. What was the difference between the two for you, what effect was there?
2. They are trying to look more at: has the Carer's Assessment made a difference to those people, has it focussed on what matters to them?
3. Can I ask, how does that feel then, if you've taken the time to fill in this form and you've not had a response?
4. Even though you were filling in, it didn't feel as though it was separate?
5. Can I ask, when you did the Carer's Assessment, did somebody come to the house? And you filled it in together? And did that work for you then, coming to the house, did you feel that was a good way to do it? And better than sending you out the form to fill in?
6. Did he come out and fill in the form with you?
7. You said that it's a difficult door to open, the Social Work department. Is it a difficult door to approach?
8. Do you think, coming back to the process of the Carer's Assessment and that discussion with the Social Worker about being a carer and what's going to make a difference for you, do you think it makes any difference who the professional is who fills in that form? Do you think it needs to be a Social Worker or should be an Occupational Therapist, or....
9. There has been some talk about there being a different professional doing the Community Care Assessment, which is what the person you're caring for probably had, and a separate person for the Carer's Assessment with the carer. What would your views on that be?
10. Was it a Social Worker or OT or a Community Care Assistant who came to you about the Carer's Assessment?
11. What did you think the Carer's Assessment was for? If I just say the words Carer's Assessment, what are the kind of things that pop into your head?
12. Did it help you to identify the outcomes you wanted? Going through the process of this, did it help you have a concrete idea of what you wanted as the outcomes?
13. What do you think could make this more relevant to someone in your situation?
14. Did the process help you say things like "I want more time, I want to go to the gym", was there a space where you got to say that?
15. What was your experience of the Carer's Assessment process, did you get to put down what you wanted to achieve and did you manage to achieve that outcome?
16. You said something about X focussing on how to make your life easier. Do you think that's something you were able to discus and plan for?
17. And at the end were you able to discuss the difference it made to you?
18. Is there anything else you want to say about how this can be improved?
19. Did you get an opportunity to talk about it afterwards, did you have a formal review of the Carer's Assessment or an informal conversation with the worker? You know, to see if the outcomes have happened?
20. Do you think it would be helpful to come back and revisit it with the worker, what you'd said initially, what's happened since and how far along with achieving the outcomes you are?

21. Did you feel like you were treated as experts, did you feel like you were treated as kind of equal partners by the worker talking about your caring role and talking about that person?
22. Yes. So is there anything else, any questions about the research project or anything else you haven't had a chance to say that you really want us to know for the research?

THANK YOU

Your participation and input has been greatly appreciated, and the information you have given will be used as a part of a research project which aims to improve how organisations work with carers.

At the end of the project you will be informed of the findings and recommendations of the research. Please let me know whether or not you are happy to receive this information, and if you require it in a specific format.

Appendix D

Document Analysis Framework for Blank Tools and Guidance Notes

(Midlothian Carer's Assessment & VOCAL Carer Outcomes)

1. Outline the context of the document *(How does the tool and any accompanying guidelines function within the processes of the organisation (e.g. induction, training etc?))*
2. Are there guidelines for the tool, what do they include, and who are they aimed at?
3. At what point(s) is the tool designed to be used?
4. How is the tool designed to completed (i.e. by carer and worker together, by the carer alone etc.)?
5. How does the tool enable you to record the key issues identified?
6. What opportunity is there using the tool to record personal outcomes?
7. How flexible does the tool allow you to be in recording different personal outcome areas? (e.g. work, relationships, knowledge etc).
8. Does the tool allow you to record any enablers which could play a role in achieving personal outcomes (e.g. formal and informal supports, strengths and capacities etc.) If so give information.
9. Does the tool enable you to record any barriers and how these could be overcome? If so give information (e.g. deficits and problems).
10. Does the tool enable you to detail how these key issues/outcomes could be addressed/met? If so, give information.
11. Does the tool enable the worker and carer to agree when and how to review the key issues/outcomes.
12. Does the tool enable you to record whether or not outcomes have been achieved? If so give information.
13. Is the opportunity to record scale measurement data present? If so give information.
14. Is there opportunity using the tool to record narrative information? If so give information.
15. Does the tool allow you to record new and emerging issues/outcomes? If so give information.
16. Is there the opportunity to record difference of opinion? If so give information.

Document Analysis Framework for Completed Tools
(Midlothian Carer's Assessment & VOCAL Carer Outcomes)

1. At what point was the tool used?

2. How was the tool completed (i.e. by carer and worker together, by the carer alone etc.)?

3. Are the key issues identified? Please give information.

4. Are personal outcomes identified? Please give information.

5. Does the document record information about any enablers which *could* play a role in achieving personal outcomes? (e.g. formal and informal supports, strengths and capacities etc.)

6. Does the document record what any barriers might be to achieving personal outcomes? (e.g. deficits and problems)

7. Are there details about how these key issues/outcomes *could* be addressed/met?

8. Is there an agreement between the worker and carer on when and how to review the key issues/outcomes?

9. Is there evidence that the key issues/outcomes were reviewed? Please give information.

10. Does the review detail barriers and enablers which have affected the outcome? (e.g. examples of specific events, supports, personal resources or services)

Appendix E - 1

Code of practice for research in VOCAL

vocal
working *with* carers

1. Value Position

VOCAL acknowledges, respects and upholds:

- The rights of carers to determine their own involvement in any research programme;
- The need to ensure full confidentiality of carer data, and to observe any statutory duties in respect of this use or disclosure of carer data;
- The need to safeguard the integrity of the carer-worker relationship in the use of material;
- The recognition that VOCAL, as a public service agency, of our responsibility to contribute to research enquiry which seeks to broaden understanding of the environment of practice, the social and economic circumstances of carers;
- The responsibility of VOCAL to assist enquiry which seeks to evaluate the effectiveness of developed policies and procedures.

2. Research Project Protocol

VOCAL should satisfy itself regarding the credentials of the researchers/research agency. This may be particularly pertinent where the research is to be undertaken by individual students rather than a recognised agency. In such circumstances, academic references regarding the credibility of the researcher and a commitment of accepted professional standards should be sought

Questions of relevance of the proposed research should be addressed. VOCAL should seek to ensure that the subject of the research broadly accord with VOCAL's own priority policy and practice interests and, by implication, are of potential value to the work of VOCAL.

3. Intended Scope of Code

The Code of Practice should apply to all research involving VOCAL and undertaken by external agencies/agents, commissioned by an authority or secured by a research agency.

It should also cover research undertaken from within VOCAL itself through the means of its own research facilities or other authorised staff where its purpose is the evaluation of practice for a wider audience.

Such a code should not apply to VOCAL using data from their information systems for internal service management purposes. The creation and maintenance of management information systems are entirely within the control of VOCAL and, by their nature, fall out with the terms of reference of the code of research under consideration.

Inspections and audits carried out within VOCAL using research surveyor sampling methods should, in principle, be subject to technical scrutiny and comment on their design and can be considered within the terms of this code in respect of these matters.

4. Principles and Criteria

The following principles and criteria, if applied to research activity within VOCAL will ensure the professional conduct of the social research undertaken and, as such, should inform the commissioning process and the negotiating of access.

a) Research Subjects

i. A guarantee of confidentiality will be offered to the subjects of research. The only exception to this would arise where, in the course of research, information came to light pertaining to the wellbeing of the subject or third party, which requires to be conveyed by the researcher to the division e.g. where child abuse is identified.

ii. The researcher will take all practical steps possible to ensure the anonymity of participants in a research project. Data obtained for research purposes will be anonymised at the storage, analysis and presentation stages.

iii. The researcher must obtain informed consent from all those surveyed. Informed consent will only be deemed to have been given when the objectives, expectations, methodology, confidentiality, anonymity, and the required commitment of the individual have been fully explained and agreed.

iv. If subjects show signs of distress as a result of their participation in the research VOCAL will seek to offer the appropriate support as timeously as possible.

b) Implications for research protocol and resources

i. Consideration of the ethical issues arising from the purpose or conduct of the research should be accommodated within VOCAL's protocol and will be guided through the completion of appropriate checks on the ethical issues either via VOCAL (see Ethics Forms levels 1 and 2) or via the ethics procedures of the research agency carrying out the research.

ii. Practical issues relating to demands on staff and carer time and other resources required in the course of research access will also call for consideration.

c) Memorandum of agreement

Within a research project protocol, at the stage of approval, and prior to any research project commencing, a memorandum of agreement should be drawn up between VOCAL and the researcher, covering the terms of the research.

This should include

- ❑ Detailed research specification
- ❑ adherence to the code of practice timescales
- ❑ means of resolving disputes entry of disclaimers
- ❑ publication rights

d) Conduct of Research

i. All research originating inside or outside VOCAL must be conducted under the explicitly defined terms of a research specification agreed between the researcher and VOCAL.

ii. Although the exact form and content of research specifications will vary in relation to task requirements, they should contain all or most of the following elements:

- aim(s)
- objectives
- methodology to be applied
- reasoning behind the choice of methodology

- relevance of the study
- costs and source of funding
- conditions of confidentiality and anonymity awareness of
- the need for informed consent right of individuals to have their views fairly represented by the research
- audience to whom the survey is to be disseminated
- appropriate terms of the Data Protection Act means by which, and duration, of any proposed storage of data.

iii. The nature and extent of the consent given must be kept under constant review throughout the duration of the research project.

iv. For some research subjects it will be necessary to seek informed consent from a third party such as a carer or advocate. The principles outlined above will apply.

e) Dissemination of Research Findings

i. Final research reports should be disseminated to the audience defined by the research specification agreed by VOCAL. Any further widening or narrowing of the extent of dissemination should be negotiated between the researcher and VOCAL.

ii. Although it is recognised that in a few exceptional instances considerations of commercial or administrative confidentiality will be paramount, negotiations around the extent of dissemination should usually be informed and motivated by a desire to inform as wide an audience as possible.

iii. All research participants must be informed by the researcher why and how they were chosen to take part in the survey.

iv. Information received from participants, or from records, should not be shared with other parties in attributable form without the prior consent of the participants, or of the agency, referred to in the record.

Appendix E - 2

Code of practice for research in VOCAL

vocal
working *with* carers

Self-Audit Checklist for Level 1 Ethical Review

The audit is to be conducted by the **Principal Investigator**

- **Potential risks to participants and researchers**

1 Is it likely that the research will induce any psychological stress or discomfort? YES ☐ NO x
It is not considered likely that participation in the focus groups would induce any psychological stress or discomfort. However, it is possible that discussions in the focus groups could evoke feelings relating to the caring role, which may be difficult. Appropriate advice, information and support, as normally offered by VOCAL, would be available to any participants who wish to deal with any issues arising from the focus group discussions.

2 Does the research require any physically invasive or potentially physically harmful procedures?
YES ☐ NO x

3 Does the research involve sensitive topics, such as participants' sexual behaviour or illegal activities, their abuse or exploitation, or their mental health? YES ☐ NO x
The research questions themselves do not directly involve sensitive topics. However, the focus group discussions are semi-structured, so depending on the issues raised by the participants any discussion could potentially link into such topics (although the facilitators would not ask direct questions relating to such topics).

4 Is it likely that this research will lead to the disclosure of information about child abuse or neglect, or other information that would require the researchers to breach confidentiality conditions agreed with participants? YES ☐ NO x
It is not likely that this research would lead to the disclosure of information about child abuse or neglect. However it is a possibility that information could be disclosed leading to concerns about the protections of children or adults at risk. This disclosure would require confidentiality to be breached, in line with the policies of Midlothian Council and VOCAL.

5 Is it likely that participation in this research could adversely affect participants? YES ☐ NO x
Only to the extent as described in Q1 relating to psychological stress and discomfort, which is considered unlikely. Any participation in focus groups/interviews would be optional. Any participation in the project would not affect the service participants would otherwise receive from Midlothian Council or VOCAL, or for practitioner-participants their relationship as employees of their respective organisations. Analysis of previous carer assessments will be anonymised and not lead to any alteration in services received.

6 Is it likely that the research findings could be used in a way that would adversely affect participants or particular groups of people? YES ☐ NO x

7 Will the true purpose of the research be concealed from the participants? YES ☐ NO x

8 Is the research likely to involve any psychological or physical risks to the researcher, and/or research assistants, including those recruited locally? YES ☐ NO x

Normal health and safety/lone working policies would apply as the researchers ordinarily use in their respective work places, there is no additional risk relating to the research.

- **Participants**

9 Are any of the participants likely to:

be under 18 years of age?	YES ☐ NO x
be physically or mentally ill?	YES ☐ NO x
have a disability?	YES ☐ NO x
be members of a vulnerable or stigmatized minority?	YES ☐ NO x
be in a dependent relationship with the researchers?	YES ☐ NO x
have difficulty in reading and/or comprehending any printed material distributed as part of the research process?	YES ☐ NO x
be vulnerable in other ways?	YES ☐ NO x

These groups will not be targeted specifically to participate in the research project. However it is possible that participants may fall into the categories above, but only as would be representative of the normal population. Additionally, carers accessing either of our services may be experiencing negative emotional and/or physical affects as a result of caring. However, this will be taken into account in ensuring a supportive and sensitive environment for focus groups; and as is ordinarily available, advice, support, and information would be offered, if indicated.
The Researchers will not have worked directly with any of the carer-participants as either a Social Worker, or as a Carer Support Worker, participants will be drawn from the caseloads of the researchers' colleagues.

10 Will it be difficult to ascertain whether participants are vulnerable in any of the ways listed above (e.g. where participants are recruited via the internet)? YES ☐ NO x

The participants would already be in touch with the organisations, and information about possible vulnerability may have been identified as a part of internal processes. The VOCAL carer support team will be consulted prior to the recruitment of participants, and carers may not be invited to the group if it is deemed potentially detrimental to their physical or mental health and wellbeing.

11 Will participants receive any financial or other material benefits because of participation, beyond standard practice for research in your field? YES ☐ NO x

Refreshments will be provided in the focus groups. Transport and replacement care costs will be paid if required to enable participants to attend the focus group.

- **Confidentiality and handling of data**

12 Will the research require the collection of personal information about individuals (including via other organisations such as schools or employers) without their direct consent?

YES ☐ NO x

No additional data will be collected. The data required for document analysis already exists within the organisations, and is subject to the usual internal policies for confidentiality and data protection.

13 Will individual responses be attributed or will participants be identifiable, without the direct consent of participants? YES ☐ NO x

Data will be anonymised prior to publication. If identifiable information needs to be shared across the organisations (e.g. for Midlothian Council Social Worker to view identifiable information about VOCAL service users) written consent would need to be obtained from the persons concerned. At present the methodology is designed so that this information would not be shared.

14 Will datafiles/audio/video tapes, etc. be retained after the completion of the study (or beyond a reasonable time period for publication of the results of the study)? YES ☐ NO x

No data collected will be retained beyond a reasonable time period for publication of the results of the study.

15 Will the data be made available for secondary use, without obtaining the consent of participants?

YES ☐ NO x

- **Informed consent**

16 Will it be difficult to obtain direct consent from participants? YES ☐ NO x

- **Conflict of interest**

A conflict of interest would arise in cases where the researcher might be "compromising research objectivity or independence in return for financial or non-financial benefit for him/herself or for a relative or friend." Conflict of interest may also include cases where the source of funding raises ethical issues, either because of concerns about the moral standing or activities of the funder, or concerns about the funder's motivation for commissioning the research and the uses to which the research might be put.

The responsibility for avoiding a conflict of interest, in the first instance, lies with the individual, and potential conflicts of interest should always be disclosed to the organisation. Failure to disclose a conflict of interest may result in VOCAL withdrawing from the research programme.

17 Does your research involve a conflict of interest as outlined above? YES ☐ NO x

- **Overall assessment**

If all the answers are NO, the self audit has been conducted and confirms the ABSENCE OF REASONABLY FORESEEABLE ETHICAL RISKS. The following text should be emailed to the relevant person in VOCAL, as set out below:
"I confirm that I have carried out the School Ethics self-audit in relation to [my / name of researcher] proposed research project [name of project and funding body] and that no reasonably foreseeable ethical risks have been identified."

If one or more answers are YES, risks have been identified and a level 2 audit is required. Please see VOCAL Code of Practice for Research – Ethics forms level 2.

Appendix F

MIDLOTHIAN COUNCIL

COMMUNITY CARE
CHILDREN AND FAMILIES
CRIMINAL JUSTICE

CODE OF PRACTICE FOR RESEARCH IN SOCIAL WORK

This Policy is Authorised by:	Eibhlin McHugh
This Policy was issued on:	31 October 2012
This Policy supersedes:	None
This Policy was circulated to:	All SW Staff
Date of circulation:	31 October 2012
Contact within Communities and Wellbeing for Further Information:	Nina Lomas
Review Date (Maximum of 2 Years from Issue):	31 October 2014

Midlothian Council
Community Care, Children and Families and Criminal Justice

Document Control Information

Revision	Date	Revision Description
Version 1.0	31 October 2012	First Publication

Midlothian Council
Community Care, Children and Families and Criminal Justice

Midlothian Council
Community Care, Children and Families and Criminal Justice

Code of Practice for Research in Social Work in Midlothian

1. Value Position

- Respect for the rights of service users/carers to determine their own involvement in any research programme;
- The need to ensure full confidentiality of service user data, and to observe any statutory duties in respect of this use or disclosure of service user data;
- The need to safeguard the integrity of the service user-worker relationship in the use of material;
- the recognition by the department, as a public service agency, of their responsibility to contribute to research enquiry which seeks to broaden understanding of the environment of social work practice, the social and economic circumstances of service users, and the factors determining the social behaviours with which social work practice is engaged;
- The responsibility of local authority Social Work departments to assist enquiry which seeks to evaluate the effectiveness of developed policies and procedures.

2. Research Project Protocol

Social Work should satisfy itself regarding the credentials of the researchers/research agency. This may be particularly pertinent where the research is to be undertaken by individual students rather than a recognised agency. In such circumstances, academic references regarding the credibility of the researcher and a commitment of accepted professional standards should be sought

Questions of relevance of the proposed research should be addressed. Social Work should seek to ensure that the subjects of the research broadly accord with the department's own priority policy and practice interests and, by implication, are of potential value to the work of the department.

All proposed research within Social Work must be submitted to DMT for approval.

3. Intended Scope of Code

The Code of Practice should apply to all research involving Midlothian Social Work and undertaken by external agencies/agents, commissioned by an authority or secured by a research agency.

It should also cover research undertaken from within Midlothian Social Work itself through the means of its own research facilities or other authorised staff where its purpose is the evaluation of social work practice for a wider audience.

Such a code should not apply to the department using data from their information systems for internal service management purposes. The creation and maintenance of management information systems are entirely within the control of the department and, by their nature; fall out with the terms of reference of the Code of Research under consideration.

Inspections and audits carried out within departments using research surveyor sampling methods should, in principle, be subject to technical scrutiny and comment on their design and can be considered within the terms of this Code in respect of these matters.

4. Principles and Criteria

The following principles and criteria, if applied to research activity within Midlothian Social Work, will ensure the professional conduct of the social research undertaken and, as such, should inform the commissioning process and the negotiating of access.

5. Research Subjects

(i) A guarantee of confidentiality will be offered to the subjects of research. The only exception to this would arise where, in the course of research, information came to light pertaining to the wellbeing of the subject or third party, which requires to be conveyed by the researcher to the department e.g. where child abuse is identified.

(ii) The researcher will take all practical steps possible to ensure the anonymity of participants in a research project. Data obtained for research purposes will be anonymised at the storage, analysis and presentation stages.

(iii) The researcher must obtain informed consent from all those surveyed. Informed consent will only be deemed to have been given when the objectives, expectations, methodology, confidentiality, anonymity, and the required commitment of the individual have been fully explained and agreed.

Consideration of the ethical issues arising from the purpose or conduct of the research should be accommodated within the department's protocol.

Practical issues relating to demands on staff and service user time and other departmental resources required in the course of research access will also call for consideration.

6. Memorandum of Agreement

Within a research project protocol, at the stage of approval and prior to any research project commencing, a Memorandum of Agreement should be drawn up between the department and the researcher, covering the terms of the research.

The Memorandum of Agreement should include:

- detailed research specification
- adherence to the Code of Practice timescales
- means of resolving disputes entry of disclaimers
- publication rights

7. Conduct of Research

(i) All research originating inside or outside Midlothian Social Work must be conducted under the explicitly defined terms of a research specification agreed between the researcher and the department.

(ii) Although the exact form and content of research specifications will vary in relation to task requirements, they should contain all or most of the following elements:

1. aim(s)
2. objectives
3. methodology to be applied
4. reasoning behind the choice of methodology
5. relevance of the study
6. costs and source of funding
7. conditions of confidentiality and anonymity
8. the need for informed consent
9. right of individuals to have their views fairly represented by the research
10. audience to whom the survey is to be disseminated
11. appropriate terms of the Data Protection Act means by which, and duration, of any proposed storage of data.

(iii) The nature and extent of the consent given must be kept under constant review throughout the duration of the research project.

(iv) For some research subjects, it will be necessary to seek informed consent from a third party, such as a carer or advocate. The principles outlined above will apply.

8. Dissemination of Research Findings

(i) Final research reports should be disseminated to the audience defined by the research specification agreed by Midlothian Social Work. Any further widening or narrowing of the extent of dissemination should be negotiated between the researcher and Midlothian Social Work.

ii) Although it is recognised that in a few exceptional instances considerations of commercial or administrative confidentiality will be paramount, negotiations around the extent of dissemination should usually be informed and motivated by a desire to inform as wide an audience as possible.

(iii) All research participants must be informed by the researcher why and how they were chosen to take part in the survey.

(iv) Information received from participants, or from records, should not be shared with other parties in attributable form without the prior consent of the participants, or of the agency, referred to in the record.