ABSTRACT
Policy and practice documents are increasingly adopting a focus on outcomes. This article seeks to clarify what is meant by the term ‘outcome’, the outcomes that have been highlighted in key policy documents, and the extent to which they reflect the outcomes prioritised by service users. The discussion will draw on the early stages of a DoH-funded project exploring the effectiveness of health and social care partnerships from the perspectives of service users.

KEYWORDS: SERVICE AND USER-BASED OUTCOMES; HEALTH AND SOCIAL CARE PARTNERSHIPS; USER-DEFINED EFFECTIVENESS

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Introduction
Recent policy documents from both the Department of Health and the Scottish Executive have been characterised by an emphasis on outcomes. The Green Paper Independence, Well-being and Choice (DoH, 2005), for example, proposes clear outcomes for social care ‘derived from what people have told us they want’ (p10), while in Scotland Better Outcomes for Older People (Scottish Executive, 2004) is perhaps the most detailed strategy arguing for an outcome focus. The outcomes highlighted by the Green Paper, for example, are improved health, improved quality of life, making a positive contribution, exercise of choice and control, freedom from discrimination or harassment, economic well-being and personal dignity. This policy focus is in turn being endorsed in practice by an emphasis on the development of outcome-based performance criteria, for example the Joint Performance and Information Assessment Framework (JPIAF) of the Scottish Executive.

This attention to outcomes is both welcome and long overdue. Indeed, it is difficult to know how progress towards policy objectives can be evaluated adequately without the evidence of effectiveness provided by the identification of outcomes. Equally important can be to determine whether unintended outcomes are emerging as a result of specific policy or practice initiatives. It is important that this recent commitment to an outcome agenda is not distracted by semantic debate about the nature of outcomes, but it is vital that debates are grounded in a clear understanding of the concept of outcomes. A number of distinctions have emerged over the years which should clarify rather than confuse, and these will
be discussed in the following section. This will provide the prelude to an examination of the extent to which the promotion of policies for partnership working, in particular between health and social care, has been articulated in terms of outcomes. Where an outcome focus can be discerned, the extent to which the outcomes highlighted are those that are prioritised by service users will be explored.

Outcome typologies

Units such as the Personal Social Services Research Unit (PSSRU) and the Social Work Research Centre (SWRC), together with the DoH-funded Outcomes of Social Care research programme (OSCA), have been wrestling with the debates on outcomes for some years, and it is useful to distil the legacy of these debates. SWRC, for example, was funded by the Economic and Social Research Council and the Scottish Executive to undertake work ‘aimed specifically at developing ways of establishing and measuring outcomes’, while the specification for the 1995 DoH research brief included the following passage.

*The main thrust of our development programme is to focus more on outcomes rather than processes. Much of the attention in the early years of implementing the reforms has, necessarily, been on the mechanics of community care. But although there are still areas where systems and processes need to be further improved, it is time to remind ourselves of the overarching objective of community care: improving the quality of life of users and carers. This must involve empowering users and carers.*

(Original emphasis)

The SWRC work (Cheetham et al, 1992) made an important distinction between service-based and user-based outcomes. The former relate to outcomes at the level of the service, the latter to the impact at individual level. It may be that at service level there is a desire to examine the detail of the way in which support is being delivered – in the current context, for example, the fit between the design that may have been put forward for partnership working and the actual mechanics of its operation. Alternatively (or additionally), the spotlight may be on the impact that a specific service design is having on the individuals who are receiving it, for example those for whom a partnership initiative has been developed.

At each level, three specific varieties of outcome were identified: service-based outcomes embrace basic service measures such as response times or care package elements; outcomes measured by the achievement of objectives, for example enhanced collaboration through a reduction in the number of duplicate visits; and quality of care indicators, relating for example to aspects of privacy or choice or independence within any provision. At user level, the three forms are standardised validated measurement scales (for example the General Health Questionnaire or the Philadelphia Geriatric Morale Scale), quality of life – the subjective experience by the individual of the quality of care provision – and user satisfaction.

Similar work by PSSRU framed the distinction between service level and user level as intermediate and final outcomes. Intermediate outcomes again focus on measures of performance, service or activity, final outcomes on changes in individual well-being. The revision of this framing by SWRC was to avoid any necessary assumption of a progression from intermediate to final, and recognition of the validity of solely service-based evaluation. ‘Intermediate’, perhaps unnecessarily, suggests transience and a somewhat lower status; it also implies a logical sequence of service delivery and final outcomes which may be unwarranted. Nonetheless, the current emphasis on exploring policy impact on individual users is perhaps an argument which favours the PSSRU terminology, not least for the implied link between changes in service delivery and improved quality of life for individuals. This has been summarised by Knapp (1984), who categorises intermediate outcomes as:
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indicators of performance, service or activity rather than indicators of effect, influence or impact,

while final outcomes address:

changes in individual well-being compared with the levels of well-being in the absence of a caring intervention (pp31–2).

There may, however, be some areas where distinctions are less readily drawn. For example, is ‘improved school attendance’ service- or user-based? Is ‘early diagnosis of dementia’ intermediate or final? It is not intended that these typologies are definitive, but rather that they are heuristic devices designed to assist understanding and to ensure that the outcome agenda is advanced.

Discussion of outcomes does, however, inevitably raise questions of attribution. To what extent can the assumption be made that the outcomes identified, whether at individual or service level, are a product of the activity under scrutiny? To relate the point again to the context of this article, is it partnership working that has produced the observed outcomes, or might they have occurred as the result of other extraneous activity? Very often, in the context of partnership working in health and social care, the traditional experimental method is not practically attainable. It is necessary, therefore, to rely on what would be traditionally termed ‘most likely’ explanations or, in more contemporary terminology, ‘theories of change’ in order to relate process activity to outcome (Sullivan et al., 2002). The onus to specify such theories at the outset should assist in teasing out not only causal chains, but also interactions across the whole system. Health and social care systems are complex, open systems, and what is being sought is a flexible approach that can embrace this complexity yet still say something of value (Barnes et al., 2003).

The DoH OSCA programme confirmed the importance of an emphasis on outcomes, and generated work appraising a range of social care situations. A linked sequence of projects under the DoH-funded Outcomes research programme at the Social Policy Research Unit, York (SPRU) is of particular significance, both for its emphasis on identification of the outcomes salient to service users and carers themselves (Qureshi, 2001), and for the promotion of evaluation based on these outcomes to be incorporated into routine practice (Nicholas et al., 2003). Three types of outcome have been identified in this work – maintenance, change and process.

Initial work with older people on identifying the outcomes important to them has been extended to identify similarities and differences in the outcomes identified by other user groups (Harris et al., 2005). For example, adults of working age with physical or sensory impairment prioritised a range of outcomes associated with four key areas: autonomy, personal comfort, economic participation and social participation. The current work at Glasgow on developing a user-defined partnership effectiveness tool under the Modernising Adult Social Care (MASC) initiative is seeking to build on the user outcomes identified by SPRU.

**Partnership**

The aim in linking the literature and empirical evidence on outcomes to the policy priority of partnership working is two-fold. First, the intent is to explore the extent to which repeated calls for enhanced partnership working have specified the outcomes that it is intended to achieve. Associated with this is how far, where outcomes are cited, there is a link to any evidence. Second, if outcomes from partnership working can be identified, there is an interest in whether or not they are user-defined outcomes. The review of partnership working by the Audit Commission (1998) emphasised the importance of this perspective at an early stage in the partnership drive.

… the point of forming a partnership is to improve performance, and this should principally be measured through the eyes of service users, citizens and other stakeholders (p32).
Initially, and for many intrinsically, partnership working is an attractive proposition. Conceptually, however, it soon becomes evident that partnership is ‘a slippery concept’ (Audit Commission, 1998), one characterised by ‘methodological anarchy and definitional chaos’ (Ling, 2000 p82). More specifically:

Partnership has the advantage – in terms of political rhetoric, at least – of being relatively non-specific. While this lack of specificity may be a source of concern to policy analysts, it has some distinctive political benefits. Like ‘community’, partnership is a word of obvious virtue (what sensible person would choose conflict over collaboration?). It is unspecific about the dimensions, axes or composition of particular ‘partnerships’; partnerships can exist between sectors, between organisations, between government departments, between central and local government, between local government and local communities, and between state and citizen (at least) (Clarke & Glendinning, 2002 p33).

A particular temptation, widespread in the literature, is to blur the distinction between partnership and integration. While the variety of activities can be located on a spectrum ranging from limited collaboration on specific issues to full integration in the form of pooled resources and a single set of objectives, a useful strategy in the current context is to consider the process of working between health and social care as partnership working, while integration is the desired achievement; partnership is the process, and service integration is the intended outcome. It is important to acknowledge, however, that partnership working does not necessarily guarantee the delivery of integrated care (Woods, 2001).

Pinning down the essence of partnership working can be difficult; equally elusive is the evidence base. Although it tends to be assumed that partnership working must be the preferred option for effective service delivery, the available evidence is less certain (El Ansari et al, 2001).

Brown et al (2003), for example, in a case study in Wiltshire, casts doubt on whether integrated health and social care teams were any more effective in supporting older people than a more traditional model. The conclusions also from the evaluation of the joint health and social care trust in Somerset (Peck et al, 2002) were less than a ringing endorsement for partnership working.

**Partnership policies**

Nonetheless, examination of the specific policy documents that have promoted partnership working between health and social care reveals the extent to which such documents have assumed partnership working is beneficial and asserted benefits in a generalised form which are rarely expressed as specific outcomes. It could be argued that there has been both a presumption of an evidence base and a frequent failure to identify target outcomes.

Throughout the nineties there was growing emphasis on the perceived value of a co-ordinated approach to service specification and development, and, in particular, promotion of joint commissioning for mental health and learning disability services (DoH, 1995, 1997). With the election of a new government and its declared intent to demolish the ‘Berlin Wall’ between health and social care services (Hiscock & Pearson, 1999), the current major phase of development was ushered in by the DoH discussion paper of 1998, *Partnership in Action*. The key elements sought for the health and social care sectors are highlighted in Table 1, opposite.

This in turn led in England to the 1999 *Health Act* which sought to advance partnership working through the removal of structural barriers under what have been termed the Health Act flexibilities – pooled budgets, lead commissioning and integrated provision. At the same time, additional resources were made available, including a £647m Partnership Grant under the Social Services Modernisation Fund to ‘foster partnerships between health and social services in promoting
Table 1: OUTCOME SPECIFICATION IN POLICY DOCUMENTS

<table>
<thead>
<tr>
<th>Policy</th>
<th>Service focus</th>
<th>User outcomes</th>
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| **Partnership in Action (DoH, 1998)** – clarification of the purpose of partnership | Clarification of the purpose of partnership  
Recognition and resolution of areas of conflict  
Agreement on a shared approach to partnership  
Development of strong leadership  
Continuous adaptation to learn from experience  
Incentives to reward effective-cross boundary working |                                                                                     |
| **National Service Framework for Mental Health (DoH, 1999)** | Seven standards  
Specification of outcome indicators under nine headings for severe mental illness | Indicator 9 = ‘service user-assessed health-related quality of life’                   |
| **National Service Framework for Older People (DoH, 2001)** | Eight standards, with specific targets (milestones) – use of HAFs ‘to ensure an integrated approach to service provision’ | Person-centred care  
Health and independence                                                                  |
| **Valuing People (DoH, 2001)**                  | National objectives  
Learning Disability Partnership Boards  
Development Fund contingent on pooled funds under HAFs | Better life chances  
More choice and control  
Support for carers  
Improved health                                                                       |
| **Framework for Mental Health Services (Scottish Executive, 1997)** | Development of a joint approach to the planning, commissioning and provision of integrated mental health services |                                                                                     |
| **The Same as You? (Scottish Executive, 2000)** | Framework for integrated support for people with learning disabilities, with people to be valued, consulted and seen as individuals | More say  
Greater control  
Central to decision-making  
Increased range of opportunities  
Greater inclusion                                                             |
| **Better Outcomes for Older People – Framework for Joint Services for Older People (Scottish Executive, 2004)** | Mainstreaming of joint services for older people based on three key principles – person-centred care, an outcome focus and whole-system working | Independent living  
Person-centred services  
Safe communities  
Removal of health inequalities (BME)                                             |
| **Joint Performance Information and Assessment Framework (JPIAF) (Scottish Executive, 2003)** | A range of performance indicators (n=8) designed to assess local performance of joint services | Seeking to ‘develop more outcome-focused indicators’                                  |
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independence’. The 2001 Health and Social Care Act can be seen as further strengthening the partnership imperative, with its provision for enforcing the use of flexibilities if health and social care in an area are not adequately working together.

It is of note that the national evaluation of the first notifications for use of the Section 31 partnership flexibilities (Hudson et al., 2001) highlighted the challenges inherent in identifying and attributing outcomes to initiatives of this type.

It is often difficult to detect the impact of new service initiatives on the quality of life or well-being of users, even where the service change or intervention is uniform and closely specified. Even where changes in users’ experiences can be detected, it may be difficult to establish clear causal relationships, given the difficulties of controlling for other variables within rapidly changing social and service environments. (p6)

Acknowledging this complexity, the evaluation adopted the tenets of pluralistic evaluation and sought outcome measures relevant to different stakeholders’ definitions of success. Asked (open-ended) to identify three desired outcomes for their partnership in using the flexibilities, the most frequently cited responses were ‘joined-up organisation’, ‘efficient resource use’, ‘user outcomes’ and ‘partnership general relations’.

At the same time as this drive for partnership working, a range of key policy directives for specific user groups was emerging (Table 1). It is instructive to explore both the extent to which they are built on partnership working and the extent to which specific outcomes for users were anticipated. Valuing People, for example, put the development of learning disability partnerships at the heart of its strategy. The eight standards of the National Service Framework for Older People (DoH, 2001) are characterised by unusually detailed specification of the evidence base from which they have been constructed, and specific targets (milestones) are set which can be equated with service-based outcomes. Perhaps less explicit are the specific outcomes for the individual expected from each standard, although it could be argued that at least some of them are implicit in the prescribed action.

In addition, the standards of the NSF are being linked to both the NHS and the PSS Performance Assessment Frameworks. These are starting to shift towards the inclusion of user-based outcome measures, including the first composite outcome measure for older people in the form of the index of Healthy Life Expectancy. Agencies are also being required to conduct annual surveys of users’ and carers’ experiences of the services they have received. However, the NSF acknowledges that linking outcomes to service change such as partnership working is not unproblematic.

It can take longer to demonstrate changes in outcomes as a result of service improvement and, as long as input and process changes are known from the research literature to improve health and well-being, and/or the experience of care, measures of these can provide interim surrogate indicators. Input and process indicators can assess early local progress. The focus should be on those where a clear relationship with outcome has been demonstrated. (p122)

In Scotland, in the wake of the Report of the Joint Future Group (Scottish Executive, 2000), a Framework for Joint Services for Older People was issued for consultation in July 2004 with the title Better Outcomes for Older People. In the current context, this appears to marry the dual focus on partnership working (found also in the NHS Scotland document Partnership for Care and the creation of community health partnerships) and on the identification of outcomes. As with the other policy documents already highlighted, there is an unqualified assertion that 'joint services can deliver better outcomes for individuals and their carers' (p17), 'seamless services and a continuum of care are essential for improved outcomes' (p19), indeed that:
Implementation of Joint Future, e.g. joint management and joint resourcing of community care services, and single shared assessment, [which] are improving outcomes for older people (p16).

At the same time, the policy document recognises that to date there has been more focus on structures and processes than on outcomes.

The focus on the Joint Future Agenda needs now to be on achieving better outcomes for people and their carers. Joint structures and processes are well embedded and it is now necessary to use them to achieve better results. (p30)

Four ‘over-arching’ national outcomes for service users and carers have been agreed: more people supported at home, reduced hospital admissions, improved quality of care, and better support and involvement of carers.

In this form these outcomes are fairly general. Moreover, several are expressed at the service level rather than in terms specific to the individual. Thus a focus on hospital discharge and the speed of transfers represent service outcomes without necessarily an examination of the consequences for the individual. Likewise, faster access to services is an important service-level outcome, but its impact on the individual also needs to be monitored.

There is, however, in this document a more serious attempt to introduce systematic evaluation of the extent to which the specified outcomes are being achieved. Local partnerships will be required to set local improvement targets which will reflect continuous improvement towards the local achievement of the national outcomes and the extent to which additional outcomes specified locally have been achieved. Action 4 of the Framework is prescribed as follows.

When reviewing or designing services, local partnerships should develop joint services that deliver improved outcomes for individuals and their carers. These outcomes should have been agreed by the local partnerships with people who use services and their carers. These will assist in the achievement of Local Improvement Targets. (p7)

The more general conclusion to be drawn from Table 1 is the lack of focus on specific user-defined outcomes. The JPIAF indicators, for example, are very much service- and process-driven, while from the NSF for Older People there is some embryonic inclusion of user-based outcome measures in the NHS and PSS PAFs. Dowling and colleagues (2004) have confirmed that the emphasis to date in discussion of partnership working has been very much more on the process of the working relationship than on the impact on outcomes for service users or carers. They argue that the emergence of outcome measures relating to process should not detract from (final) user-focused outcomes, with the various evaluation tools developed to date, for example the Nuffield Institute Partnership Assessment Tool (Hardy et al, 2000), favouring only the mechanics of the working process. Dowling and colleagues conducted a literature review designed to identify evidence of successful outcomes for service users and carers resulting from partnership working between health and social care since 1997. Thirty-six relevant papers were identified. Of these, however, all but five focused on what were seen as process rather than outcome issues.

User-defined outcomes

It would appear that there is a strong imperative to explore the outcomes delivered by partnerships to service users. The initial phase of the project Users and Carers Define Effective Partnerships, funded by the DoH under the MASC initiative, has sought to build on the outcomes already identified in the SPRU studies as important to users and carers. Conducted in partnership with three user-researcher organisations, Central England People First, Older People Researching Social Issues (OPRSI) and SURE (Service User Research Enterprise), the aim of the
The salience of the SPRU outcomes was in the main confirmed, although respondents were uncomfortable with the outcomes referring to being personally clean and comfortable and having a clean and hygienic home. However, there were some important additions, and in particular some important distinctions between the three groups. Those with learning disabilities focused on maintenance outcomes (defined by SPRU as maintaining aspects of quality of life such as comfort, safety, access to company and activity, control over one’s life) and on process outcomes (for example, service users feeling treated as a person, valued and respected and with privacy and confidentiality maintained). Independence and reliability (turning up on time and delivering to plan) were identified as additional outcomes. None of the change outcomes identified by SPRU as expectations from service provision was highlighted. Key words which emerged were choice, respect, control and trust.

For older people the bulk of responses concerned maintenance outcomes. Security and safety were key themes, together with social contact and having control over daily life and routines. Change outcomes that were valued included improving the ability to get out and reducing symptoms. Of particular importance as a process outcome was being treated as someone with a right to services, with full provision of information.

Individuals with mental health problems were looking for social contact, for an absence of stigma, for employment and for safety, including housing. Process outcomes they desired were feeling valued and being treated with respect, having ready access to services and being enabled to make a contribution. Focus group participants rarely mentioned outcomes from the third category of outcome identified by SPRU, change outcomes. Therefore change outcomes were addressed through an open question about the difference services have made to users’ lives.

Overall, there were more similarities than differences between groups, with in total five maintenance and four process outcomes. The position is summarised in Table 2, below.

<table>
<thead>
<tr>
<th>Table 2: KEY USER-DEFINED OUTCOMES</th>
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<tr>
<td><strong>Maintenance</strong></td>
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<tr>
<td>• Safety</td>
</tr>
<tr>
<td>• Having things to do</td>
</tr>
<tr>
<td>• Social contact</td>
</tr>
<tr>
<td>• Staying as well as you can be</td>
</tr>
<tr>
<td>• Living where you want</td>
</tr>
<tr>
<td>• Living life as you want</td>
</tr>
<tr>
<td>• Dealing with stigma (mental</td>
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<td>health service users only)</td>
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</tbody>
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These key outcomes have provided the basis for the development of the partnership effectiveness tool. The aim is to produce an interview tool which can be used by agencies and others for rapid appraisal of whether a partnership initiative appears to be delivering or enhancing the outcomes that users have cited as important. Practical considerations have led to the development of two distinct interview schedules, one for use with older people and mental health
service users, and a slightly simplified version for use with people with learning disabilities. The only outcome which did not apply across the three groups was dealing with stigma, as identified in the mental health focus group. This outcome has been added to the mental health service evaluation tool. Interviews with 300 users from 15 health and social care partnerships are currently under way, and we will report in due course on the fit between desired and actual outcomes.

Conclusion
The drive for partnership working has become a familiar feature of much recent policy, yet despite increasingly detailed evidence of the outcomes desired by service users, the extent to which partnership policies are framed in terms of achieving these outcomes is still tentative. With the announcement in July of a joint White Paper designed to deliver integrated health and social care systems and of a ‘joined-up national improvement strategy for adult social care’, the opportunity must be seized to ensure that these initiatives are not only outcome-led but also designed to deliver the outcomes that users have defined as priorities.

References
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