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We've Got To Talk About Outcomes

**Using the Talking Points Outcomes
Frameworks in Evaluation:
Limitations, Principles and
Practicalities**

**The Personal Outcomes
& Quality Measures Project**

About This Series

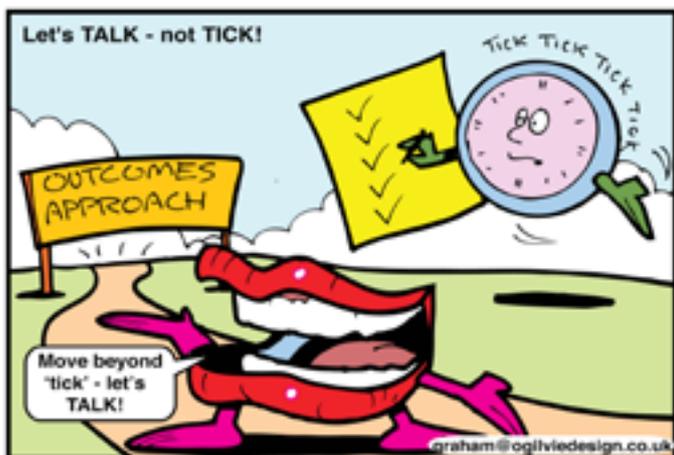
"We've Got to Talk about Outcomes" is a series of insights developed by the Personal Outcomes and Quality Measures project, hosted by the Health and Social Care Alliance Scotland. Focusing on the outcomes important to people who use care services offers real potential to realise person-centred and enabling objectives, but at the same time challenges several tenets of healthcare quality measurement. This short project set out to determine whether and how a personal outcomes approach could be embedded within several diverse healthcare services supporting people living with one or more long term conditions. This series of insights summarises the key project learning.

The series takes its title from the *Review of the Talking Points Personal Outcomes Approach*¹ that was carried out in 2012 by Professor Alison Petch, Institute of Research and Innovation in Social Services (IRISS).

There has been an excessive emphasis on questionnaires, checklists and tick boxes in recent years². In contrast, supporting people to achieve personal outcomes requires genuine dialogue between those accessing and providing services and reasserts the importance of supportive relationships.

However, there are other reasons why **we've got to talk about outcomes**. Several issues need to be discussed and resolved if future decisions about the design and delivery of care and support for people living with long term conditions are to be not only driven by evidence of 'what works', but are also responsive to what matters to individuals who use health and social care services and respect the principles of 'co-production'.

This series of insights hopes to contribute to that discussion and will inform the focus on personal outcomes within the *People Powered Health and Wellbeing* programme that is being led by the ALLIANCE.



The title is a bit of a play on words, referring primarily to the central role of conversation within a Personal Outcomes Approach.

The **"We've Got to Talk about Outcomes"** series:

1. Reconciling PROMS and Personal Outcomes
2. A Question of Purpose: Implementing a Personal Outcomes Approach in Different Healthcare Settings
3. Talking the Same Language: Translating a Personal Outcomes Approach into Support for Self Management
4. Rethinking Enablement: The Enabling Potential of Outcomes Focused Working
5. **Using the Talking Points Outcomes Frameworks for Evaluation: Limitations, Principles and Practicalities**

About This Insight

Previous insights in this series have described Project efforts to support the adoption of a Personal Outcomes Approach in different healthcare contexts, highlighting the capacity of such an approach to fulfil the purposes of engagement, improvement, planning and performance measurement.

This final insight in the series now turns its attention to applications of the evidence-based *Talking Points Outcomes Frameworks* for the express purpose of **Evaluation**.

When positioning “Talking Points” in the context of evaluation, it is essential that the important distinction between the *Talking Points Personal Outcomes Approach* and all that entails, and the narrower use of the *Talking Points Outcomes Frameworks* as a basis for service impact evaluation does not become blurred.

The insight begins by establishing that evidence-based outcomes frameworks *can* be used for the purpose of evaluation, but that different issues are encountered depending upon whether the evaluation is embedded in routine practice, or conducted at arms-length.

Recognising the importance of learning from experience on the ground, the insight



examines in detail the limitations of more embedded applications of the *Talking Points Outcomes Frameworks* with a purely evaluative intent by sharing the experience of one healthcare service from different perspectives.

It then describes the application of the *Talking Points Outcomes Frameworks* for the purpose of more arms-length evaluation, such as required of the crop of new service models and projects that are emerging in response to the need to radically rethink the care system. It calls to attention a set of principles that can guide such applications to respect the ‘ethos’ of outcomes focused working, together with the practicalities of adhering to these principles when faced with different reporting demands and delivery constraints.

Key Points

- Evidence-based outcomes frameworks *can* be used for the express purpose of evaluation, but different issues are encountered depending upon whether the evaluation is embedded in routine practice, or conducted at arms-length.
- When outcomes focused evaluation was embedded in practice in one healthcare setting:
 - The Evaluation Tool provided summary evidence of the extent to which the service was supporting people to achieve the high level outcome types identified in the Tool
 - Qualitative data analysis also uncovered contributory factors and the interactions between different types of outcome, with important implications for practice and service provision
 - Caution is required when making assumptions about what is relevant and should be evaluated based on limited understandings of why the service exists (e.g. keeping people out of hospital) or what the service thinks it does best (e.g. promoting confidence in managing a condition) and that may not relate to the priorities in people's support provision or lives
 - In particular, 'morale' and 'process outcomes' (which concern the impact resulting directly from the way that support is provided) and had been purposefully removed from the Evaluation Tool and were therefore absent from high level outcome scores, but 'resurfaced' through the analysis of qualitative data, reaffirming their importance
 - Ultimately, the limitations of focusing on service impact only, as documented in the Talking Points Practical Guide⁴, were reaffirmed
- As a result of then moving towards a Personal Outcomes Approach, practitioners identified:
 - The direct link between improved practitioner conversational and listening skills and improvements in the wellbeing of people previously classed as "resistant to change"
 - Connecting with people's lives and learning to take a 'step back' approach to risk enablement reduces practitioner stress and enhances job satisfaction
 - The far greater importance of the conversation compared to the recording tool
 - The need to consider proportionality of recording to meet data uses other than assessment and support planning, and the value of involving the whole team when refining recording practices
- When using evidence-based outcomes frameworks as the basis for arms-length evaluations:
 - A set of principles can help to establish an evaluative approach that is consistent with the 'ethos' of outcomes focused working and co-production
 - Adhering to these principles in practice however raises a number of challenges

Part 1: Introduction

Context

In recent years there has been a shift within UK policy and practice away from the inputs, processes and outputs of health and social care systems towards the **outcome** of this activity - the difference they are helping to make to the lives of people who use services and their carers.

A radical rethink of the care system is currently taking place in response to demographic and societal changes, and the ongoing financial pressures. This rethink requires a more preventative agenda and increased partnership working, with an enhanced role for individuals, families, communities, the third and independent sectors. A host of new service models and support initiatives have emerged, particularly in response to the need to reshape care and support for older people. The requirement to demonstrate impact in terms of outcomes for the people supported is now almost universal across new and existing forms of provision, with an increasing reliance upon self-evaluation.

At the same time, established health and social care services and new models of support are increasingly expected to demonstrate commitment to active and meaningful participation by the people supported. Engaging with people in decisions about their care and support, and their values, as well as involving them as partners in care or self-care is recognised by research and policy as key to maximising health and wellbeing. It is also essential if care and support is to be legitimate and properly respectful of the people using services, consistent with a human rights based approach³.

A Personal Outcomes Approach

A Personal Outcomes Approach addresses both of these concerns. It embeds a focus on “personal outcomes” (or what matters to the person) within individual assessment, support planning and review processes. Personal outcomes data can also be aggregated to inform various forms and levels of decision making. A Personal Outcomes Approach can therefore fulfil the following purposes:

- **Engagement:** to address practice, policy and ethical imperatives at the heart of public sector reform and a human rights-based approach to health and social care
- **Improvement:** to learn what we can do to make services work better or to innovate
- **Planning:** to understand the issues that are arising for people using services and to predict and provide the types of supports that will be needed in the future
- **Performance:** to understand what is and is not working and what represents best value

The Talking Points Personal Outcomes Approach

*The Talking Points Personal Outcomes Approach*⁴ is now being used by health and social care partnerships across Scotland, a growing number of NHS services and numerous and diverse providers of community care services, including many in the third and independent sectors. A full account of the *Approach* is provided in the Practical Guide⁴ developed by Emma Miller and Ailsa Cook, but in brief:

- The approach is underpinned by 3 evidence based frameworks of high level outcome types

- Practitioners engage with individuals to identify their personal outcomes at the outset
- Support is shaped to work towards personal outcomes in a way that actively recognises people's own capabilities, resilience and existing social support networks
- The continued relevance of and progress made towards achieving personal outcomes is later reviewed and support reshaped accordingly
- Recorded outcomes information is aggregated to inform different levels of decision making

The approach is therefore concerned first with engagement and then shaping care in a responsive and enabling way, with evidence of progress towards achieving outcomes generated as a by-product.

Positioning "Talking Points" as an Evaluation Tool: The Focus on Impact Measurement

Although the *Talking Points Personal Outcomes Approach* is concerned with ensuring that people are supported in ways that are not only effective, but crucially are also responsive and enabling, it is its capacity to provide evidence (including 'counts') of outcomes for individuals at service or organisational level that has caught the eye of those concerned with measuring impact. As a result, "Talking Points" has sometimes been positioned as an "Evaluation Tool", despite the insistence of the researchers who developed it that it is an "approach" and not an "evaluation tool".

Using the Talking Points Frameworks as a Basis for Evaluation

Each of the 3 frameworks that underpin the *Talking Points Personal Outcomes Approach* offers the potential to support flexible and structured applications, and the case *can* be made for uses with individuals and groups. In fact, the researchers who developed the *Approach* were originally commissioned by the Joint Improvement Team (JIT) to produce a tool to evaluate the outcomes of partnership working for individuals - a tool that later became known as the User Defined Service Evaluation Toolkit (UDSET)⁵. The UDSET has been used in a number of service settings.

The *Talking Points Outcomes Frameworks* therefore *can* be used for the specific purpose of evaluation, but quite different considerations arise depending on the type of evaluation:

Arms-Length, Independent Evaluation:

The application of the frameworks can be perfectly valid, particularly in the case of independent or more arms-lengths evaluations, such as required of the crop of new service models and projects that are emerging in response to the need to radically rethink the care system. This use can also be enhanced by ensuring that the limitations are understood and adhering to a few key principles. Examples include the evaluation of the Perth and Kinross Healthy Communities Collaborative⁸ and the evaluation of the Change Fund Community Capacity Building Programme in Fife.

Drawing upon these and other examples, a discussion of the principles and practicalities of using the “Talking Points Frameworks” for the purpose of arms-length evaluation is provided in **Part 3**.

Embedded Evaluation

When outcomes focused evaluation is embedded in routine practice, evidence of service impact in terms of outcomes for individuals can be derived, but a number of significant limitations are encountered. These limitations are summarised within *the Talking Points Practical Guide*⁴, but centre on concerns about a failure to recognise the contribution of the individual, missed opportunities for genuine co-production and distorting effects on practice.

Blurring Boundaries and Learning from Experience on the Ground

A key concern resulting from the positioning of “Talking Points” as an “evaluation tool” is that the important distinction between the *Talking Points Personal Outcomes Approach*, and all that entails, and the narrower use of the *Talking Points Outcomes Frameworks* as a basis for service evaluation has at times become blurred.

Due to the emphasis on quality measurement in NHS settings, *Talking Points Outcomes Frameworks* have been used as the basis for more embedded evaluations by some healthcare services, with substantial implications for practice. Important learning messages can be shared from such on the ground experiences.

An extended case study is shared in **Part 2** in an attempt to further clarify the differences between ‘evaluation tool’ and ‘personal outcomes approach’.

Part 2 - CASE STUDY: The IMPACT Team’s Learning Journey

Background

The IMPACT (IMProved Anticipatory Care and Treatment) team is a nurse led service that was established in 2008 to improve the quality of life for people with long term conditions through support for self management and to offer support to their carers. There is also a strong emphasis on reducing preventable hospital admissions.

The team was first introduced to the idea of working in a more outcomes focused way in 2008.

At that time the User Defined Service Evaluation Toolkit (UDSET)⁵ was still in circulation and served to support services to evaluate the outcomes being achieved for individuals. Towards the end of 2008, the limitations of the UDSET had become clear to its developers and it was recognised that what was required was an approach to focusing on outcomes for individuals that started with assessment. This became known as the Talking Points Personal Outcomes Approach. The IMPACT team was then introduced to “Talking Points”, but the need to evaluate their service remained

a priority and the potential significance of “a personal outcomes approach” for everyday practice was overlooked.

The team has since received training and facilitation from the Thistle Foundation to enhance its capacity to support ‘self management’ in the broadest sense. This training includes a strong focus on **engaging** with people about their personal outcomes.

In addition, in 2012 the ALLIANCE, through the Personal Outcomes and Quality Measures Project, and in partnership with the Thistle Foundation, linked with the IMPACT team. This input served to support the team to develop **recording** practices and to think about **using outcomes information**. As part of this work, there was an opportunity to access data that the team had collected using the original UDSET-based Evaluation Tool. This opportunity served to establish what could be

learned from outcomes data gathered for purely evaluative purposes, and also to gain insights into the limitations of engaging with people about service impact in the course of everyday care encounters.

About this Case Study

This case study is provided to illustrate the differences between “evaluating the outcomes the service achieves for individuals” and “adopting a personal outcomes approach”. To ensure that the implications for the 3 practice components of **engaging, recording** and **using outcomes information** are understood, it includes reflective accounts from 2 perspectives:

1. This Quality Measurement & Improvement Advisor
2. The Advanced Nurse Practitioner

“Prioritising Practice”: The Quality Measurement & Improvement Advisor’s Perspective

Karen Barrie

I first met the IMPACT team back in 2009 when I was asked to help them to make digital stories featuring some of the people they were supporting. The team had been introduced to “Talking Points” and as far as I was aware, they had grasped the concept of “personal outcomes.” My role was to capture some stories as more personalised evidence in support of a personal outcomes approach.

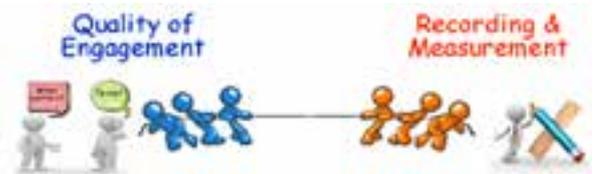


A ‘personal’ outcome is a particular and individualised instance of any given high level outcome type, expressed in a way that is meaningful and important to the person. For instance, for one person the outcome category “feeling safe” could address a social concern about noisy and boisterous neighbours, for another an emotional concern about facing an uncertain future in the face of a progressive illness without fear.

I do remember a discussion regarding one story; a nurse expressed concern that the lady in question hadn't mentioned having access to emergency antibiotics in her story. I responded to the effect: "oh, but that wasn't important to her, that's your outcome". I didn't think too much about it at the time, and it was only recently that I discovered that recording that particular story had been a bit of a learning point for the team.

I was then reintroduced to the team in 2012 as part of the Personal Outcomes and Quality Measures project. Throughout this project, I've worked closely with the Thistle Foundation and IMPACT was one of the teams that they were supporting. The partnership with Ross Grieves and Lindsay Graham from Thistle worked really well because, as a non-practitioner myself, I've always been very clear about boundaries. Although I've been fortunate enough to gain lots of experience in listening to and supporting people to share their stories about their care experiences and lived experiences, that's all that's been expected of me. I don't have to listen to people while changing the dressing on a leg ulcer, or knowing that I've only got another week to get someone back on their feet or I'll have to discharge, or having the threat of a three line whip hanging over me should the person happen to be readmitted to hospital. Practitioners have very real accountabilities and face daily pressures that I can never hope to fully understand. I'm not equipped to advise or support a practitioner with engagement practices, but with personal outcomes work, you do have to look at **engagement, recording and use of information**. The Thistle practitioners and facilitators have been supporting people with very

complex conditions and situations to enjoy their lives for many years. They are also highly skilled in supporting other practitioners to develop conversational and listening skills, and also to support 'self management' in the very broadest understanding of the term.



I've worked in health informatics, quality measurement and improvement for decades now, so I do understand the potential of good quality information, quantitative and qualitative. I'm therefore very happy to support people to get the best of out their data, which in turn means considering recording practices. Here I'm always mindful of the words of my colleague, Emma Miller, that recording and measuring shouldn't ever undermine conversations with people.

I was delighted when I heard that Thistle was supporting IMPACT. It was three years since I'd last met them and I assumed they'd have some rich personal outcomes data. I was interested to see if the outcomes they were supporting people to achieve were fully covered by the Taking Points categories, and what particular forms they took. I was curious to see if there were any additional outcome types specific to 'people being supported to self manage', as opposed to 'people using services'. The timing was perfect; the team had completed their outcomes focused reviews, but hadn't had a chance to look at the data yet. They were working flat out, so they were

very happy to let me loose. In return, I planned to develop a very simple and practical coding tool and then support the team to make best use of the text comments that were being recorded in the future.

However, when I spoke to Thistle and the team a bit more, I discovered that they had realised that the documentation that they were using needed a complete overhaul. It was still based on the old UDSET tool, but 'tweaked' to reflect the aims of the team. A quick glance at the documentation was enough to establish that they had been using it purely for service evaluation. The review form was even called the IMPACT Evaluation Tool.

Now the UDSET had its limitations, but the outcome categories within it were based on robust evidence of the things that are important to people using health and social care services. The changes that IMPACT had made to the Tool included the removal of what we call 'process outcomes', such as 'being listened to' or 'treated with respect'. They had also introduced a couple of service-specific outcomes relating to 'understanding and being confident in managing your condition' - the things the service should be good at. There were also a few amendments to some of the 'Change' outcomes, such as replacing 'confidence and morale' with 'confidence', and 'skills' with 'daily living skills'. A final question had been added about 'admissions to hospital' since receiving the service, alongside a counterfactual question about the number of admissions the person believed had been avoided since having support from the team. These modifications were hugely insightful in themselves, indicating that the service had made assumptions about what was important and should therefore be measured based on their

understandings of why the service existed and what it is good at, and at the same time removing import 'human' outcomes based on relationships and self-worth.

The Evaluation form question wording and data entries confirmed that personal outcomes were not being identified at the outset and instead improvements in high level outcome types were being measured. But I still saw this as a great learning opportunity. I knew

from discussions with the team that they did now understand personal outcomes and had been supported by Thistle to develop sophisticated communication and listening skills. The stories they were coming back with from everyday practice were terrific. I wanted to learn more about the limitations that the documentation had placed on their practice. I also wanted to discover more about the types of outcomes that people were and, as importantly, were not being supported with, and why. There was also the potential to feed the learning into the development of new documentation that would fit with the way the team was now practising. For me, this meant working closely with Ross from Thistle and Kirsty, the IMPACT team leader, and then leaving them to take things back and forward with the rest of the team.

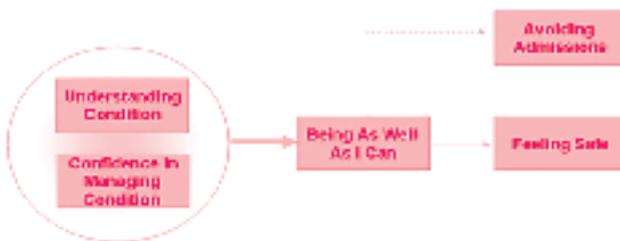
I produced an Evaluation Report too - largely something for the team to look back on, but



also a source of some useful insights - and not just about the limitations of focusing on service impact. The Evaluation Report details the results of the analysis of 48 *Evaluation Tool* questionnaires that were completed during the latter half of 2012 and I've included 2 extracts below:

Evaluation Report Extract 1: Insights from the Evaluation Data

The largest improvements were reported for the Change Outcomes '*Managing Symptoms*' (45) and '*Confidence*' (45), followed by the closely related service-specific outcomes '*Confidence Managing your Condition*' (39) and '*Understanding your Condition*' (36). The pattern of high level outcome results was consistent with the findings from previous years. The overall impression formed was of an effective service that succeeds in achieving improvements in outcome types directly related to long term condition management, resulting in people '*Staying as Well as You Can*'.



In some cases these changes also translated into improvements in '*Feeling safe*' and perceptions of '*Avoiding admissions to hospital*', but this '*conversion*' was by no means universal and depended on what else was going on in the person's life, and whether or not the person had

disengaged with life. This observation has some important implications when it comes to drawing conclusions from the admissions data.

The qualitative analysis provided a bit more insight into the high level patterns between outcome types, with a number of contributory factors emerging for each outcome type, which were often interconnected. Family inputs, relationships and other social factors were also found to have a profound impact upon people's outcomes, both positively and negatively. *Living with / seeing family* and *having good neighbours* were particularly important, while *having bad neighbours, loss of loved ones, lack of understanding by family members* and *being alone* were very detrimental. The contribution of family and other supports was most obviously associated with *Seeing People*, but also exerted a strong and direct influence on *Having Things to Do*, and more implicitly on *Feeling Safe*, with a particular concern being the carer's ongoing ability to cope. The significant contribution of family and social support systems therefore reinforced the importance of the IMPACT team's role in working with and supporting unpaid carers.

The acquisition of '*skills*' other than those associated with daily living, together with improvements in '*morale*' also emerged from the data. These *Talking Points* outcome types had been removed during the adaptation of the *Evaluation Tool* and therefore were not reflected in the high level summary scores. The finding that they were '*reintroduced*' via people's conversational responses reaffirmed their importance.

Of particular importance, the analysis also resurfaced '*process*' outcomes such as '*being*

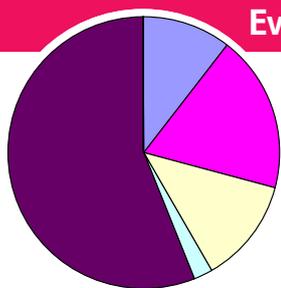
listened to', 'treated with respect' and indeed 'respecting the nurses'. The importance of interpersonal contact and supportive relationships with the nurses were key themes throughout the analysis, in particular *being checked upon, not feeling abandoned, feeling able to phone with any concerns, no matter how trivial and seeing the same person*. Defining the contributions that practitioners play, including listening, supporting and encouraging people is validating and very important for team morale, particularly when working with people with progressive conditions.

The analysis also uncovered some outcome types that were indicative of 'enablement,' such as

greater *self-awareness, trying new things, being more proactive, feeling more positive about life and coping better with things myself*. The enabling potential of outcomes focused working is often lost where there is an emphasis on demonstrating impact. However, the practitioners were involved in the ongoing care and support of the people accessing the service and had forged strong and supportive relationships with them. While the documentation being used at baseline and review did not in itself support enabling practice, or highlight this through summary scores, qualitative data analysis uncovered evidence that enablement was happening through ongoing care and support.

Alongside these insights, significant limitations were encountered as a result of asking questions very explicitly about service impact. These were apparent throughout the analysis and are perhaps best illustrated by considering some of the report findings. Below I've extracted the part of the report that considered the outcome type '*Seeing People*':

Evaluation Report Extract 2: Limitations of Questions Focusing on Service Impact



OUTCOME TYPE	Improvement				(Or Issue Type)		
	Big	Small	None	Worse	Not an Issue	New Issue	Not Discussed
Seeing People	5	9	6	1	27	0	0

Question: Do you feel that the support you have received means that you see the right amount of people now? [Note: *This question wording differs from that used in the UDSET*]

The question wording is interesting in itself. As with the choice of outcome types included, the

focus on attributing any change to the service reduces the opportunity for engaging with the person about what is going on in their lives more broadly, or what the steps the person may have been taking. This sits as odds with the principles of 'co-production'. It can also be awkward for practitioners.

Findings: *Seeing People* was not identified as an issue by more than half of the interviewees (27)

OUTCOME TYPE: SEEING PEOPLE						
Theme	Factor	Big Imp	Small Imp	No Imp	Worse	Not An Issue
Staff / carer contacts	Seeing the nurses	4	3			
	Seeing people at the Day hospital		1			
	Carer increase		1			1
	Reduced carer input				1*	
New contacts	Making new friends	1				
New abilities	Pacing / able to go out and see people		1			
Family / neighbours	Increased family inputs		1			
	See family / neighbours regularly		4	2		15
	Death of partner				1*	
N/S	No reason given			2		9
	Don't want to see any more people					2
Unable to see people	Would like to go out but nobody...			1		
	Unable to manage stairs			1		

* Same person

Of the 5 people who identified big improvements, only one had made “*new contacts*” following a house move, with the remaining 4 attributing this change to ‘*seeing the nurses*’.

Similarly, reasons for small improvements were again most often attributed to increased staff contacts, primarily from the nurses, and also attending the day hospital. One person attributed a small improvement to the development of “*better pacing skills*” and being “*able to go out more*”, while another attributed “*increased help from my family*” to nursing team intervention.

Two people who reported no improvement expressed disappointment at being unable to see more people, one the result of a continued

“*inability to manage the stairs*” following physiotherapy, the other having “*nobody to take me out*”. In addition, one person felt things had got worse and now saw less people as a result of the “*death of my husband and reduced carer input*”. However, no ‘further actions’ were identified in any of these 3 instances.

Discussion: The analysis reaffirmed the central importance of family and existing networks. The lack of any recorded action in response to the emotive issues of social disconnectedness, loneliness and loss, as identified in the 3 instances above, suggested difficulties encountered by practitioners when discussing issues that they were, at the time, not always adequately equipped to address. Engaging with this dimension of quality

of life has not traditionally been part of their remit. *'Seeing people'* was an issue for nearly half of the people being supported by the team, but only 3 people experienced improvements that were not attributable to increased contact with care staff. This finding was significant as there is often no one else involved in the ongoing care of the people supported by the team to take such issues forward.

The finding that many people *"enjoyed the visits from the nurses"* was consistent with previous observations regarding the importance of the

relationships developed. However, the high-level improvement scores create a false impression, at odds with the full meaning of this outcome type. Moreover, for people who are socially isolated, this also risks creating dependency and compounding loneliness, should the service later be withdrawn.

Overall, the contribution that team was making to *'seeing people'* was limited and the evaluative purpose of the review encounter resulted in missed opportunities to fully engage with this issue.

I should emphasise that the team is now confident in taking a personal outcomes approach and understands how this fits with service expectations, their roles and accountabilities, and of course, the priorities of the people they support. The ways in which they might contribute to broader and relatively neglected aspects of quality of life such as *'seeing people'* and *'dealing with stigma and discrimination'* are being worked through. This journey has been facilitated through skilled and sustained support from Thistle. The practitioners have themselves recognised the direct link between enhancing their conversational and listening skills and the impact on people who had previously been reluctant to engage with the service as a result of connecting with their lives, and that's huge.

Of course, the team need to be able to record and use the personal outcomes data, not only to develop, implement and review outcomes focused care plans, but also to fulfil other reporting requirements.

In parallel, we've worked to develop a revised set of care assessment, planning and review documentation, combining clinical assessment. This makes explicit provision for recognising the different contributions towards achieving outcomes. There is a clear focus on people's strengths, resilience and social support networks.



When it comes to recording, proportionality as always is critical. There is some summary *'scoring'* to aid quantitative reporting, as they do still need to be able to monitor progress and demonstrate impact. But it's understood that the real value lies in the comments; understanding what's contributing to different outcomes, why certain outcome types are proving trickier to support, and the interplay between outcome types. There's still some work to do to develop pragmatic ways of realising this value, and the qualitative data workshops now being developed and piloted by the JIT are an ideal way to take this forward.

Supporting guidance and a new service-specific set of outcome 'prompts' have also been developed, mainly for use by new or seconded staff and placement students. It's essential that all such tools are treated as a small but integrated part of broader practice development efforts. The prompts are consistent with the principles of support for

self management in the very broadest sense and, importantly, use language that's emerged directly from practice. [This process is described in more detail in the 3rd Insight in this series]. My take home message is: Recording and measuring tools need to reflect, protect and support practices and values, not undermine them. Engagement takes priority.

"Just One Small Slice of the Pie" - The Advanced Practitioner's Perspective

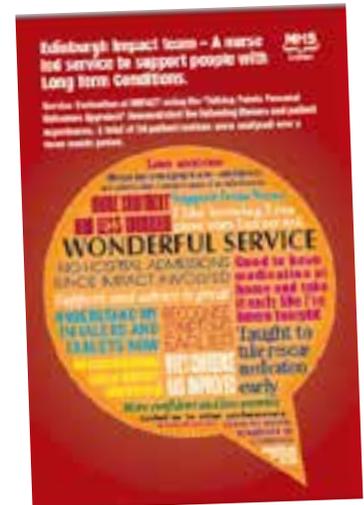
Kirsty McBeth

Our journey into outcomes started with the introduction of UDSET in 2008 as a service evaluation tool. The intention was to evaluate our service using these outcome types that were known to be important to people, but we seemed to miss the point of personal outcomes completely. UDSET then changed to Talking Points, but from our perspective it was still in place as a service evaluation tool.

We focused on the tool and how to use it. We struggled to find the right questions to use with people to fill in the categories, such as 'do you feel safe at home? I think we mostly used closed questions and this felt cumbersome and awkward. Many of the outcome categories didn't seem relevant and were not filled in.

The result was poor staff engagement. It was seen as a tick box exercise that got in the way of

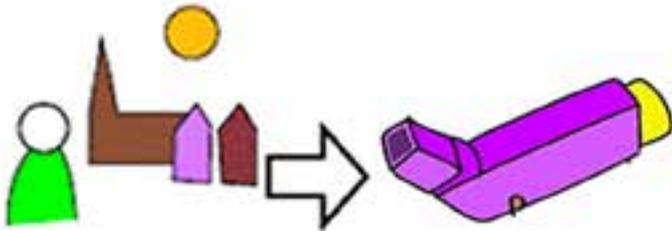
engagement. It was something else we had to do. We didn't see the value. The training we received focused on the tool and its background, rather than on the approach or the sort of skills required. However, initial evaluation indicated that people did feel more supported in managing their conditions, as shown in the poster, so we chugged along with it for a while.



Then came the first light bulb moment when we began to look at patient stories as another



way of supporting evaluation and we got help from the Digital Story project that the JIT was running in parallel with Talking Points. We then discovered that the storytellers were coming out with things that didn't relate to condition management at all - if asked the right questions.



For instance, what mattered to one lady was being a fun granny rather than one you had to be quiet for, her faith and getting back to church, and having her hair done and a bit of make over so she felt more able to do that. She didn't say that she wanted to take her inhaler or know more about her condition. We then realised that by using her medications correctly and managing her condition better, this lady would improve and we would be working towards her personal outcomes, such as getting back to church. Engagement



towards self management improved after that, but on reflection we were thinking of personal outcomes as a means to our ends, rather than the heart of the matter.

At that point the team expanded and Advanced Practitioners were given lead areas to develop, including personal outcomes and self management. We started looking at ways to support the team in working with people who had complex situations or were disengaged with or disinterested in life and how to engage with them towards self management. That was the second light bulb moment.

Some team members had training with the Thistle Foundation and they began to focus on the therapeutic approach and finding out what was important to people as a starting point. The training was very participatory and pragmatic, with lots of practice. We were invited to bring 'live' cases to role play – especially those that we were struggling with - and there was lots of time for reflection and discussion. As a result, the team members began to realise that they were getting better at supporting people to identify personal outcomes, although ironically this wasn't why they had gone on the training. The team felt their conversational skills improved and they became much better at listening to what people were really saying. Then the third light bulb moment when we began to see the benefits of doing this. People who had previously not made any changes and had very complex chronic problems were beginning to engage in a better way and we were connecting with their lives.



Practice Example:

An example of this in practice came from one of my colleagues – and concerns a gentleman with multiple conditions who was referred to the service for assessment. When the nurse asked what was important for him, this took him aback as he was so used to being told how to manage his conditions and what medication to take. However, he said that he wanted to go to Australia to see his family and the nurse asked ‘so what’s stopping you?’ She didn’t take a negative view.

He identified that his health wasn’t good enough and the nurse asked ‘how would you know when you were well enough?’ He replied, ‘well I would be coughing less and have less swollen ankles’. The nurse took a step back approach and asked ‘what is it going to take for you to do this?’ and they then worked together to identify what strategies were needed.

At the next visit he announced he had booked his flight!! The nurse was slightly alarmed and anxious that perhaps she had encouraged him too much, and began to wonder what would happen if he became unwell and if this was too risky. But again she took a step back approach and together they planned contingency if he became unwell on his trip, including advice, where needed, about rescue medication and insulin control. He had a great time and sent us a postcard, which we’ve kept.



You know, the terminology can be so confusing for staff and it keeps changing. We are jargoned out: outcomes focused, self management, solutions focused, assets based - when really it is all very simple and they all fit together with the person in the centre. It is all about having good conversations – it is not about tools. Tools can get in the way of a good conversation if introduced too soon. Our learning showed that we needed to learn about personal outcomes and to have better conversations and listen more before we thought about a tool.

I guess what we have done is stop focusing on proving what we do as a service and instead worked on improving engagement. The whole team has now ‘bought into outcomes’. The conversation has become integral to the clinical assessment too and we try to combine these. We start with a conversation and find out about the person and what their hopes are and what is important for them from the first meeting. Sometimes we don’t take our nurses bags on the first visit. That would have been unthinkable before. And of course there’s our ‘sparkle box’. That’s a quick and easy way to collate and share what’s working, and “a pretty good measure” of continued staff engagement.

Of course, we also needed to redesign the documentation we were using to be able to record and measure progress towards personal

outcomes. The issues we needed to address were identified very clearly through the analysis of data recorded with the old tool, which the ALLIANCE undertook. Then the ALLIANCE and Thistle worked together to help us think about how we could capture things in a way that would support people first and foremost, but would also make it easier to understand, improve our practice and service, and yes measure, without interfering with engagement. And we've worked on that involving the whole team. It's been a process of continual reflection and learning.

We still need to demonstrate our effectiveness. We can use the Talking Points outcome categories to do this in summary, and we now really understand the added value of the text comments. And we also use 'harder data' such as admission histories, SPARRA scores, case load sizes etc. However, our focus now is not just to 'measure outcomes', but firstly to identify what matters to the people using our service and to support them to achieve that.



The new paperwork captures evidence of progress towards these outcomes and importantly, what it is that people are doing themselves to get there alongside our clinical involvement. Our job

is still to keep people out of hospital, but there is no point in doing that if we don't improve their quality of life. Often it's about supporting people to manage their lives. That's a big change for us.

Managing their condition is just one small slice of the pie.

The people we work with feel listened to, supported, included and valued. And they are more likely to listen to us - if that's required. The difference for the team is the same - we feel supported, valued, included and listened to. We also feel the pressure is off, not having to fix everything for everyone all of the time. We have a different perception. Seeing people's strengths has allowed us to 'step back'. Hopefully that will lead to relief from burn out. It's also more enjoyable and rewarding.

The ongoing support from Thistle and from the ALLIANCE has been essential in helping us embed the new learning about outcomes into practice. It kept it high on the team's agenda and we had permission to reflect, discuss our practice and support each other. And having the time to do this - support from managers and their acceptance that change was slow but effective.

We've had a lot of support, but in turn we have been able to share our learning with colleagues, medical staff, other professionals and students, and we now plan to involve the wider generic district nursing service. These conversational and listening skills are fully transferable. I do appreciate the pressures on other services. We have the luxury of a bit more time and there is no task as such, but I believe it is possible to modify this approach and improve our conversations - at all levels.

PART 3: Using The Talking Points Outcomes Frameworks as the Basis For Evaluation

The previous case study highlighted the limitations of a focus on proving service impact, and the benefits that practitioners themselves identify when they are able to connect more fully with people's lives. There will be of course be situations where the adoption of a Personal Outcomes Approach is not feasible or appropriate, particularly in the case of retrospective evaluations.

In addition to the User Defined Evaluation Toolkit (UDSET) described previously, the user and carer interview schedules developed as part of the original research that informed "Talking Points" are also available on the Joint Improvement Team website.⁵

These tools were published in 2007 and served to understand the difference that health and social care services make to the outcomes for people using services and carers. While they still hold where the focus is firmly on 'service impact', thinking and practice have moved on since they were developed, as the enabling, preventative and therapeutic benefits of outcomes focused working have become apparent and the concept of 'co-production' has become more firmly established.

More recently, outcomes focused evaluations have been carried out in different settings that have tried to counter some of the issues

encountered when using outcomes frameworks for evaluation by incorporating a set of interconnected principles, adapted from the *Philosophy and Principles* guidance developed in support of the *Talking Points Personal Outcomes Approach*⁶.

Principles

It is essential that all approaches, including our approaches to "evaluation" and "measurement", reflect, protect and support the principles and values that motivate the desired change⁷.

A set of interconnected principles that can be used to guide evaluations in a way that respects the 'ethos' of a personal outcomes approach is set out in **Box 1** below:

Box 1: Principles Underpinning Personal Outcomes Oriented Evaluation

- Individualised, Holistic and Values-Based Understanding of Outcomes
- Evidence-Based Approach
- Founded Upon Conversations and Relationships
- Co-production
- Strong Improvement Orientation

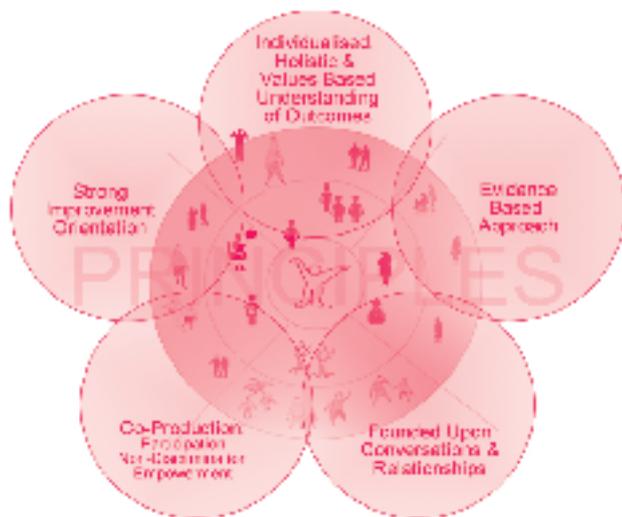


Figure 1 - Principles for Outcomes Focused Evaluation Consistent with the Ethos of "Talking Points"

1. Individualised, Holistic and Values-Based Understanding of Outcomes

Talking Points understands personal outcomes as “what matters to the person”. A personal outcome gives expression to values and aspirations in life in a way that is meaningful to the individual.

2. Evidence-Based Approach

The *Talking Points Personal Outcomes Approach* is underpinned by 3 evidence based frameworks of outcome types important to people who use services, unpaid carers and people living in care homes.

The frameworks have a strong conceptual basis. Each framework provides a flexible core for thinking about what matters to people in the context of their whole lives.

3. Founded Upon Conversations and Relationships

The *Talking Points Personal Outcomes Approach* advocates a flexible approach to communication, requiring the conversational elicitation of outcomes information and the prioritisation of relationship building over data gathering.

4. Co-Production

Co-production in part relates to the understanding of outcomes above, including the extent to which people have been involved in determining and achieving their own outcomes, building upon the skills, knowledge and experiences of individuals and communities. It encompasses the principle of non-discrimination and also relates to the formation of reciprocal relationships described above. It entails doing things with not to or for people, who act as catalysts for change.

5. Strong Improvement Orientation

There is a strong emphasis within the *Talking Points Outcomes Approach* on the difference between using information for improvement or judgement purposes, with the approach conducive to the former. This orientation is consistent with the idea of a learning organisation.

Practicalities of Implementing the Principles in an Evaluative Context

Individualised, Holistic and Values-Based Understanding of Outcomes

The understanding of “personal” outcomes differs from an understanding of outcomes that is restricted to only those outcome types that the service or support aspires to deliver or has decided are most important. A personal outcome may take the form of an individual expression of a service or project outcome for individuals, and often will, but this should not be assumed. It is also important to understand the many different forms that high level outcome types can take.

In addition, it is critical that the outcomes are important to the person. Restricting evaluation questions to address a restricted set of outcome types presumed to be important for the person misses the opportunity to identify other unanticipated outcomes, which may become incorporated into future service models. Equally, it is important to identify any unanticipated negative outcomes. This suggests a line of inquiry of the type described opposite:

“While the Talking Points outcome categories, plus the 2 additional categories of outcome identified as pertinent to the focus of the Collaborative informed our exploration, we did not ask individuals specifically about these outcomes. Instead, we asked in more general terms about what was important to the person (or people in a group situation), any benefits from being involved and anything they would like to change”.

Healthy Communities Collaborative Evaluation Report (Miller & Barrie, 2010)⁸

When faced with pressures to demonstrate the anticipated outcomes for individuals using a service, it can be difficult to remember “whose outcomes matter”, which in an evaluative context can result in filtering information in efforts to identify supportive data. Tensions can also unfold during the execution of a project, as illustrated in the extract below:

The project was fully committed to its model of community support as it had seen some of the quite profound outcomes that could be achieved. But there was a risk of confusing *project outcomes* with *personal outcomes*. The project was so intent on looking at the difference the community supports could make and the numbers of people being supported in that way that there was, at times, a danger of overlooking other outcomes that were very important to people.

During one shared learning session, a practitioner told a story whereby a community support provider had been all set to accompany an older man to a local activity that he was interested in. But then the man's daughter found out about it and said that she used to love watching her dad doing that activity and was sure she could change her work arrangements to go along with him. While failing to achieve intended project outcomes, this was recognised as a great outcome for the man and his daughter.

Project Resource: Personal Outcomes for Older People Project Review (Barrie, 2013)

Evidence-Based Approach

The Talking Points outcomes frameworks can help evaluators to think about the types of outcomes that *might* be enabled. It also provides a structure for organising outcomes data and reporting in a language that is understood by people using services and that is used in a growing number of settings.

Although developed to reflect the outcomes of services delivered in partnership between health and social care that are important to people using all health and social care services, the frameworks also encompass outcomes that are important to people in the context of their whole lives, thus maximising their applicability.

However, the applicability of the various outcome types should not be assumed. There are different frameworks for people living in care homes, adults using services who live in the community, and for unpaid carers. In some settings, specific forms of outcome types may come to dominate, such as the psychological and emotional dimensions of 'feeling safe', notably 'hope' within mental health recovery. It is important to use both the evidence based framework and the wider evidence base to inform evaluations as illustrated opposite:

Using the Talking Points Outcomes Framework for People Using Services

The Talking Points Outcomes Framework informed our approach because of the good match between the outcome categories within the framework and the principles of building community capacity and social capital underpinning the Collaborative, such as improved confidence and skills, wellbeing and inclusion.

However, we also took the view that these outcome types might not be entirely relevant to all of the people we were going to be talking to, or indeed to the Collaborative way of working. Collaborative team members, although by definition older people, do not fit the traditional description of 'service user' in most cases. Rather, they are individuals who live in their communities and, while perhaps in contact with services at a low level or intermittently, are largely leading independent lives.

Moreover, the Collaborative ethos is built around individuals being actively involved in health and wellbeing promoting activity, and supporting others to similarly be involved. The concept of volunteering is integral. Therefore we needed a concept which allowed for this aspect. We returned to the original research from SPRU at the University of York, from which Talking Points is derived, and selected the outcome '**making a contribution**'.

Additionally, given that the Collaborative has a focus on poverty as one of the key themes, we needed an outcome which captured this and again returned to SPRU to incorporate the outcome '**financial wellbeing**'.

Healthy Communities Collaborative Evaluation Report
(Miller & Barrie, 2010)⁸

Another important consideration is the strong conceptual underpinnings of Talking Points. Very often outcomes focused evaluations are concerned exclusively with change. However, the Talking Points Outcomes Frameworks comprises 3 broad categories of outcomes and it is important to pay attention to each type. In particular, in the case of people who use services, quality of life (or maintenance) and 'process' outcomes are included:

Quality of life outcomes: For older people or people living with progressive conditions, *maintaining* the things that give their life meaning and purpose is vital and can help to delay deterioration and dependency, and result in profound preventive effects. The inclusion of 'maintenance outcomes' will be important in the case of evaluations in support of a more preventative agenda. Likewise, for people with learning or profound physical disabilities, often these outcome categories pertain to things they are striving to achieve for the first time.

Process outcomes: These outcome types relate to the direct impact of way that care or support is provided. Very often outcome measures such as Patient Reported Outcome Measures purposefully exclude these dimensions, as conceptually they intend to separate the difference made to aspects of (health related) quality of life (or impact) from the way that care and support is provided. It is believed that these aspects are more akin to 'patient experience' or 'service satisfaction'. However, "Talking Points" recognises that affects such as 'feeling listened to', 'having a say' and 'being respected' are important outcomes in their own right, having intrinsic as well as instrumental value.

This is an important distinction and again has a strong conceptual basis. Talking Points is concerned with people's whole lives, not just those aspects that are 'health-related' in a narrow sense and therefore include considerations of personal and relational identity. While some process outcomes are in part the result of the way that support is organised, most are relational in nature, thereby reaffirming the importance of supportive relationships.

From an evaluative perspective, this inclusion is important at a time when commentators have highlighted a 'profound malaise in care professionalism'⁷ amid concerns that concepts such as shared decision making are being 'reduced to task-oriented information exchanges' that 'undermine important qualities such as discretion, intuition and humanity'⁷. It is therefore vital to know whether or not such process outcome types are being achieved.

Founded Upon Conversations and Relationships

This principle relates closely with the improvement orientation and favours

conversational elicitation of outcomes data and qualitative data analysis. The limitations of a reliance on professionally devised questionnaires are discussed in detail in the 1st insight in this series, but primarily concern the lack of meaningfulness of questions for respondents. Findings from the original research upon which Talking Points is based found that people could

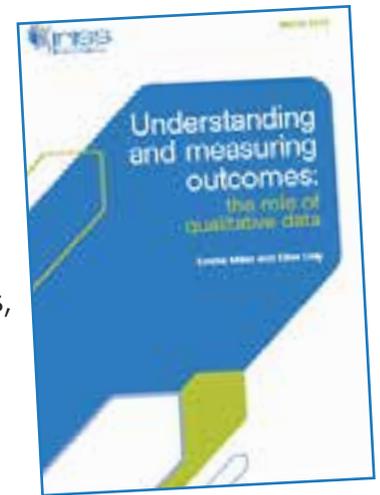


not talk about outcomes in a close ended way.¹⁰ In addition, the development of a trusting relationship between interviewee and interviewer does not simply counter concerns about bias, in that the interviewee may feel obliged to give the responses the interviewer wants to hear, but is hugely beneficial in its own right and can be of therapeutic value. This can be achieved even in a one-off encounter, if the conversation is approached as an opportunity to support the individual to reflect and give shape to their experiences, rather than purely as a data collection exercise.

It is first essential that the person conducting the interview has a clear understanding of outcomes. In addition, it requires skills in interviewing and qualitative data analysis, which are often limited in service settings and many organisations have struggled with the management and analysis of outcomes

data. Guidance including several examples from practice has been developed by IRISS⁹ and a pragmatic training module is being piloted by the JIT to try to address this deficit.

It is likely to take time to build practitioner confidence and this will be particularly the case where asking outcomes based questions directly contravenes previous practice⁹. This is illustrated in an example taken from the Qualitative Data Guidance, as referenced above:



Wearing a Different Hat, Lesley Smart

“Being a practitioner does give you some advantages because you know the system but on the whole being inside the system you are researching can make it more difficult to be objective. You learn defences that help you to work within the constraints of the system. You also have a tendency to be loyal to your profession. When I listened to the recording of my first interview, it struck me that I had approached it as a practitioner. I realised the challenge was to set aside my normal role as a practitioner and the approach I would usually take. I had to make a conscious decision to go in with a different hat on, the researcher’s hat”.

Qualitative Data Guidance, IRISS [2013]⁹

Co-Production

Co-production promotes and recognises the contribution of everyone involved in achieving personal outcomes, not least the individuals themselves. It is interested in the interplay between aspects of services and all other contributory factors. Commissioners and funders invariably want to know the difference that a particular programme, service or intervention has made. While there have been some developments at system level suggesting that the concept of Contribution Analysis¹¹ may be more appropriate in understanding the way in which outcomes are achieved, the concept is less evident at project level. However, as the concept of co-production itself becomes more widespread, this situation will have to change.

Co-production suggests a line of inquiry that seeks to involve people at individual and collective levels, not only in sharing their experiences, but in

effecting change. The embedded principle of non-discrimination requires taking appropriate steps to include people with communication difficulties, learning or cognitive disabilities.

Strong Improvement Orientation

In addition to favouring the conversational elicitation of qualitative data, an improvement orientation suggests an evaluative approach that is interpretative and explanatory. Qualitative data on *what is going on for people* and how services and supports impact is essential.¹⁰

This orientation fits well with theory-based approaches to evaluation, which seek to understand not only if something works but why, for whom, under what circumstances, and what would make it even better. Although increasingly associated with approaches such as logic modelling that set out the outcomes that an initiative is seeking to achieve at the outset, theory-based evaluation can be used retrospectively.

Unlike judgment driven approaches to evaluation, and consistent with the principle of co-production above, there is less concern with attribution. Judgement oriented approaches suggest that a ‘proper’ analysis requires a counterfactual - what would have happened without the intervention. Outside of the world of clinical trials, this is seldom feasible and other approaches have developed to establish a counterfactual, including the growing use of counterfactual questions. These take the form “if not for our service or project, what would have happened to you”. Their use can be problematic for conceptual and ethical reasons, risks creating or reinforcing service dependency, and sits at odds with enabling approaches.

Conclusion

This insight has considered the application of the evidence-based outcomes frameworks that underpin "Talking Points" for the purpose of evaluation, making clear the distinction between these narrower applications and the adoption of a Personal Outcomes Approach.

Different issues are encountered depending upon whether evaluation is embedded in routine practice, or conducted at arms-length.

By considering an extended case study of the embedded application of the *Talking Points Outcomes Framework* for purely evaluative purposes in one healthcare setting, important insights were secured. While outcomes data collected through the Evaluation Tool generated some useful and important insights, the limitations of focusing on service impact only, as documented in the *Talking*

*Points Practical Guide*⁴, were reaffirmed.

Specifically, the evaluation highlighted the need for caution when making assumptions about what it is about service provision that is relevant and therefore should be evaluated based on limited understandings of why the service exists (e.g. introducing outcomes about prevented hospital admissions) or what the service thinks it does best (e.g. introducing outcome types concerned with confidence in managing a condition). Moreover, these outcome types were privileged over those concerning supportive relationships and inner life. Talking Points 'process outcomes' that relate to the way in which care and support is provided and improvements in 'morale' were removed from the Evaluation Tool during its development, and thus omitted from the summary outcome scores routinely measured. The full significance of this became apparent following qualitative data analysis, resulting in the resurfacing of 'process outcomes', together

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with improvements in 'morale' and 'self-esteem'. The importance of developing supportive relationships with practitioners was a central theme within the qualitative data, yet not reflected within the service's choice of high level reporting outcomes. Given that the service aims to enable people to self manage and that there is now strong evidence¹² that enablement cannot be achieved without empathy, arguably these outcome types should take centre stage on any quality dashboard.

As a result of then moving towards a Personal Outcomes Approach, practitioners themselves identified a direct link between enhancing their conversational and listening skills and the impact for people who had previously not engaged and had seen little improvement. This was attributed to connecting with people's lives, rather than focusing on the 'small slice of the pie' that is the long term health condition. Practitioners also reiterated the assertion that is now familiar in personal outcomes

work, namely that "the conversation is far more important than the recording tool".

Inevitably there will be situations when a personal outcomes approach is not feasible or appropriate, particularly when conducting retrospective evaluations of pilots and projects. Here a set of basic principles is offered that can help to maintain an evaluation 'ethos' that is consistent with the philosophy of a personal outcomes approach. For now, adhering to those principles when faced with pressures to demonstrate and attribute impact by service will be challenging. However, a future of 'co-production' suggests that such challenges will have to be overcome.

Ultimately, it is essential that all approaches, particularly our approaches to "evaluation" and "measurement", reflect, protect and support the values that motivate the desired change⁷.

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