Understanding outcomes and impact

DAY CENTRE RESOURCES HUB - SECTION 4

These resources are for older people's day centres and organisations who may work with them. They aim to support day centre sustainability by improving knowledge about them, supporting their operation and encouraging joint working.

NIHR | Applied Research Collaboration South London

KING'S College LONDON

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About this document

This document forms part of the Day Centre Resources Hub which can be found at https://arc-sl.nihr.ac.uk/day-centre-resources-hub. These resources are for older people's day centres and organisations who might work with them. They aim to support day centre sustainability by raising awareness and improving knowledge about them, supporting their operation, and encouraging joint working.

People who might be interested are those whose roles involve planning, funding, evaluating and referring or signposting to day centres. They might be people working in community organisations or considering partnership working with day centres. Others might work or volunteer in day centres or support other stakeholders, research service provision, or be carers of people who attend day centres.

This Resources Hub contains seven sections.

Each section is available as a downloadable Adobe Acrobat document. Alternatively, you can download one document that includes all seven sections. There are also Word or Excel templates that can be downloaded and used locally.

Documents can be printed in black and white by selecting 'printer properties' and 'print in grayscale'.

Each section is a compilation of useful material. We hope people will dip in to find specific resources relevant to their work and appropriate to their needs. A broad range of day centre stakeholders were involved in developing these resources. They address priority support needs identified by day centres and their stakeholders in various roles. They were created because a survey found that day centres felt unsupported and under-prepared for current and future environments. Day centre providers, professional decision-makers and community groups felt there needed to be more supportive and informative resources, and they had an appetite for joint working.

- About this Resources Hub
- Why research matters
- Research evidence on day centres for older people
- **Understanding outcomes and measuring impact**
- A guide to marketing communications
- Workforce: staff and volunteer recruitment
- Case studies and inspiration

This work was funded by the National Institute for Health and Care Research Applied Research Collaboration (NIHR ARC) South London, which brings together researchers, health and social care practitioners, and local people under different themes. It focuses on 'applied' research designed to solve practical problems faced by local people and their health and social care services. This work falls within the Social Care theme, which aims to support the sustainability of social care services.

People who 'road-tested' the Day Centre Resources Hub said:

My overall reflection is that this is the type of resource I wish I had when I first started commissioning day services 7 years ago. I can see this being like a 'one stop shop' resource that collates examples of what good looks like and valuable hints and tips that can be considered by professionals from different sectors, whether it's policy makers, commissioners, or providers.
Commissioner

I found the resources really helpful and have already shared some with my team.
Assistant Locality Team Manager (adult social care social work team)

I found it very useful and I am sure that it will be used to enhance understanding and joint working.
Senior Social Worker

I would direct "commissioners" or those looking at local health and social care spending to see these pages and find the evidence to inform their plans for local services.
GP

The website is well structured and offers detailed information. The presentation is clean and easy to read. The content is right to the point on the topics. I particularly like the links to research and marketing.
South Croydon Day Centre for the Retired Co-ordinator

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Table of content

Understanding outcomes and measuring impact

This document explains what is meant by ‘outcomes’, or ‘impact’, and discusses the collection of data in English day centres. It sets out how and for whom day centre related outcomes data may useful and introduces different types of outcomes data. It summarises some challenges involved in gathering and making use of outcomes data, and things to bear in mind when doing so. Finally, it lists some ways to gather different kinds of data and gives examples.

1. A brief introduction to ‘outcomes data’

Outcomes data show the impact of an activity (e.g. impact of attending a day centre on wellbeing). The terms "outcome(s) data" and "impact" are sometimes used interchangeably. Outcomes are not the same as outputs which refer to measurable results (e.g. numbers of day centre places filled).

Outcome, or impact, data are any data (information) that evidence what happens (benefits and changes) as a result of a particular input, service or intervention – in this case the day centre. Outcomes/impact may include changes and benefits for individuals, changes for organisations or systems (e.g. NHS, social care), communities, or financial changes, for example. These changes may be positive (good), negative (unwanted), inconsequential (neutral) or may be completely unexpected. Outcomes data may reflect potential, slow and small progress, or maintenance (i.e. delaying deterioration). Or they can focus on the ‘here and now’, for example, people being happy and having a good day rather than on achieving set goals. They may aim to discover whether people got what they hoped for from attending the day centre that day and what was missing if they didn't.

Data can be quantitative (involving numbers) or qualitative (rich, informative text). Both are useful in different ways. Sections 4 and 5 explain these types of data further.

Data may be collected by regular monitoring or in evaluations. Monitoring may be undertaken at set times, for example, before starting to attend a day centre, one month after starting to attend, 3 months later, 6 months later and after a year. Regular monitoring shows long-term impact on individuals. Evaluations may take place during a project that is unfolding to inform its future and further development. Or they may take place after an event to discover what has been learnt. One-off measurement of outcomes for individuals can also take place.

> **Outcomes can be:**
>
> **‘hard’** - obvious and very likely quantifiable, for example, number of GP appointments attended
>
> **‘soft’** - for example, feelings of wellbeing, quality of life or safety
>
> **‘maintenance’** - aiming to *retain* a certain level of quality of life, for example, rather than *changing* it
>
> **‘process’** - about the way a service is delivered and experienced
>
> **‘change’** – about any changes experienced due to the service.

2. Are outcomes data routinely gathered in English day centres?

No standardised ways of gathering outcomes data about day centres are in place in England. This is the case even in other countries where there are day service umbrella bodies, for example the United States of America.

Experts in the United States (US) have called for the development of a uniform set of outcomes measures for use in US day services [1]. One reason for this is to help the leverage of additional funding streams. As in England, US day services are varied, having developed in a piecemeal and inconsistent way, and they may lack resources. Unlike English day centres, US day services are part of the health care system’s home and community services, they cater for larger numbers (average 58 per day) [2] and, as some are social and some address their attenders' medical or physical needs, staff bodies often include social workers, nurses and physiotherapists. Measures proposed, therefore, may not all necessarily be suitable for English day centres, although some have been included here.

In England, some commissioners want a better, more systematic way of gathering data across directly commissioned services (for example, a framework). However, because of the lack of systematised outcomes data collection, individual commissioners and providers need to develop their own local approach. Without a strong, systemised evidence base, local authority (LA) and NHS commissioners struggle to justify continuing to fund or to expand services.

Challenges involved in gathering and making use of outcomes data are discussed in section 6.

3. What are outcomes data useful for?

Within a day centre context, outcomes data can serve various purposes and may be of interest to many people in different roles, including people who take decisions related to day centres.

They may be useful for:

- Tracking individual progress
- Showing (evidencing) usefulness/impact for funding-related decision-makers
- Informing staff who are new or new in their role within LA or NHS services
- Making links between services and policy goals
- Evidencing impact for people who make referrals or who signpost to day centres
- Raising awareness of how day centres can support people
- For service improvement
- Supporting recruitment and retention of staff and volunteers
- Informing topic-based local initiatives
- Demonstrating value for money
- Supporting care plan reviews and enabling people to know more about the service.

Tracking individual progress

Outcomes data can track the progress of individuals who attend the day centre. People may wish to see how they've progressed since starting to attend their day centre (especially if feeling tired or having 'a wobble' about going). Carers may appreciate knowing how their relative/friend is doing, too.

Showing (evidencing) usefulness/impact for funding-related decision-makers

Outcomes data can show (evidence) the usefulness (or impact) of the day centre to its users for funders, commissioners and others who make service-related decisions. Outcomes data can be helpful for funding applications/tender bids and service monitoring. They can inform service reviews. They can also contribute to economic evaluations or social value/social return on investment exercises. Business analysts who can help construct strong justification for commissioning decisions are less common in LAs now, and, therefore, easy-to-use data/evidence is appreciated.

Informing staff who are new or new in their role within LA or NHS services

Outcomes data inform new staff and staff moving roles within LA and NHS services where there is high turnover, reorganisations and resulting changing roles are common. Background information will be necessary for new or re-assigned staff and is particularly important within an environment that encourages joint commissioning.

Making links between services and policy goals

Outcomes data can also help map service impact across to current policy goals, thus furthering the understanding of day centres' relevance to policy. Policy goals include ensuring good quality of life for people with care and support needs, delaying or reducing the need for care and support, ensuring people have a positive experience of care and support, safeguarding adults whose circumstances make them vulnerable and protecting them from avoidable harm. Some contracts may specify policy-related outcomes for service providers to aim for.

Evidencing impact for people who make referrals or who signpost to day centres

Outcomes data can evidence the usefulness (impact) of the day centre to social care and NHS professionals and others who may consider making referrals, or signposting, to day centres (e.g. social workers, occupational therapists, social prescribing link workers, information and advice services). Any referrals made should be appropriate, and outcomes data may help with this.

Raising awareness of *how* day centres can support people

Demonstrating how day centres make a difference to those who attend them supports marketing of the service to potential service users and to the general public. This is especially important because day centres will increasingly need to make their services attractive (marketable) to people who will pay for services themselves or their families. These 'self-funders' include people who do not meet a local authority's criteria for services but who have other needs which could be met by a day centre (e.g. functional mental health needs such as depression). These people and their carers will need to understand exactly what they would get for their money. This will be even more important for services not subsidised by contracts and which, therefore, may make higher charges to users. The Resources Hub includes a **section on marketing communications**.

For service improvement

Outcomes data can support day centre providers to self-audit and undertake service improvement.

Supporting recruitment and retention of staff and volunteers

Monitoring staff and volunteers' feelings/role satisfaction/views may improve staff/volunteer retention as it helps identify where changes need to be made. Publicising satisfaction data may also help market a day centre as a good place to work or volunteer.

Recruitment and retention in social care are often problematic [3]. Volunteering at a day centre is not only an opportunity to help others and can also be beneficial to volunteers' health and wellbeing, especially if they are older themselves [4].

Informing topic-based local initiatives

Localities may wish to address particular problems that have been identified, such as high levels of loneliness. Outcomes data can inform themed briefings for staff or local strategies – such as how to reduce loneliness locally.

Demonstrating value for money

Outcomes data may also help demonstrate value for money (economic evaluation).

Supporting care plan reviews and enabling people to know more about the service

A participant in this research explained how central registration of outcomes data for individuals on statutory databases used by other professionals, for example, can support reviews of an individual's overall care and support package. At the same time, data support other staff within a directorate to better understand the service and raise the profile of the day centre.

4. What are qualitative data (rich information)?

Qualitative data are ‘rich’ information. They help to gain a better understanding of people’s perspectives, views, experiences or emotions, the ‘whys’ and ‘hows’. They are detailed feedback (or descriptions). They are usually provided in response to open questions (i.e. ones that do not require yes/no or a 1-5 scaled response answer). They may also be provided not on request (e.g. compliments or complaints). Qualitative data are individual and, therefore, subjective.

Gaining such insights and understanding can help a provider better understand their users (or staff/volunteers) which can help improve service provision (and recruitment and retention). Data can be practically useful for:

- informing, for example, development or direction of services, for understanding what goes well and what goes less well, or for understanding satisfaction with various aspects of service provision or working/volunteering at a day centre
- helping (potential) funders, commissioners, decision-makers and other supporters (e.g. local businesses, ‘Friends of’ groups) to understand the service offer better and its value
- helping the wider public and potential future users know more about what a ‘day centre’ is
- providing evidence that service users have been consulted about, for example, organised activities, meals, service developments.

Qualitative data can be collected in various ways - in surveys, in conversation, by email, or in group discussions, for example. They may be collected alongside quantitative data, for example in a survey that asks people to rate how happy they were with x, and which also asks what they particularly liked about x.

It is crucial to record and process the data collected so that they are of practical use. They can be collated and reported in different ways – narratively (in text), as case studies, or a mix that includes descriptive statistics (e.g. percentages). Short reports can be useful for internal purposes, as records, and for funders or marketing (e.g. on a website). Short reports can also be circulated to service users, carers or 'Friends of', and to motivate staff/volunteers.

Individual case studies (e.g. short overview of the person and the benefits they have experienced as a result of using the service, a 'story') can also be written up and used for this purpose. Information about ways to do this appear in section 7 of this document. The **Most Significant Change approach** uses a person's own words to explain the most important change they have experienced as a result of using a service and why this change is important to them, and **Twelve principles for effective personal outcomes-focused recording** are suggested by Social Care Wales.

Some examples of how qualitative data can be presented are shown below.

Examples of ways to present qualitative data

People reported enjoying the meals and valued eating in company. It was important to them that the meals were served to everybody at one table at the same time. Their suggestions for improvement included….

Most people reported enjoying the organised activities. Although most attenders enjoyed bingo – saying it was fun, engaging and mentally taxing – a small number did not.

Most carers reported that their relative seemed happier after attending the day centre, which also helps their own wellbeing. Some carers made some suggestions about x.

Staff satisfaction was influenced by x.

The volunteering survey found that an important factor contributing to people choosing to stay was x. This was because y. All volunteers said volunteering at the day centre improved their wellbeing and was satisfying.

Case study of an individual that demonstrates the value of a service to that person.

Case study demonstrating the 'added value' of a service (what is provided in addition to what is expected or contracted for), for example:

- staff making a GP appointment for someone they suspect may have a urinary tract infection, or liaising with the District Nurse so that someone can have their insulin injection/bandages changed at the day centre instead of waiting at home and missing the companionship they enjoy at the day centre
- how the provider promotes staff wellbeing
- someone taking some flowers from their garden into the day centre for others to enjoy gave the person purpose in life and made them feel like they have actively contributed to this community.

Some things to bear in mind when planning to gather qualitative data:

- Permission may need to be gained to report individual 'stories' (case studies) on websites, social media or in funding bids.
- Although it may be time-consuming to organise, collate and summarise qualitative data, this is usually time well-spent.

The **Institute for Research and Innovation in Social Services (IRISS) developed a guide for individuals and organisations collecting and using, or planning to collect and use, personal outcomes data** (i.e. information gathered from people supported by health and social services and their unpaid carers about what's important to them in their lives and the ways in which they would like to be supported).

It has three sections. Part one discusses why qualitative data is important and what it can help achieve. Part two covers the practical steps involved in the process (collecting, recording and analysing data, ensuring credibility, and reporting findings). This section contains key messages, reflections from case studies and exercises that can be used with groups to encourage discussion, consideration and debate. Part three presents case study examples developed by people using qualitative data about outcomes for the first time.

Miller, M and Daly, E (2013) *Understanding and measuring outcomes: the role of qualitative data*. Institute for Research and Innovation in Social Services (IRISS).

The National Institute for Health and Care Research (NIHR) Applied Research Collaboration, Kent, Surrey and Sussex (ARC KSS) developed CAVEAT (The Community And Voluntary Organisation EvaluAtion Toolkit) which is a free resource designed to help Voluntary, Community and Social Enterprise (VCSE) organisations demonstrate their impact by helping organisations to describe, measure and report key information. The toolkit can be used by charities, community, voluntary and social enterprise organisations, and faith groups. Funding bodies or service commissioners may find the toolkit useful for identifying outcomes for quality monitoring. The Knowledge Base contains useful information, guidance, video clips, documents and webpage links for users to access. Users must register their details (free of charge) before being able to access CAVEAT.

5. What are quantitative data and standardised questionnaires / scales / tools?

Quantitative data relate to numbers; they are countable and measurable. These data help us to understand matters concerning quantity (how much, many or often?) or people's characteristics. Data can be objective (e.g. how many days someone attends the day centre, how many times has someone been absent) or subjective (e.g. how much did you enjoy x on a scale of 1-5?). People often refer to this type of evidence as 'hard' (rather than 'soft' which is a term often used to describe qualitative data).

Some examples of objective data include overall attendance levels; how often people attend; do people return after their first attendance; how many people do not return; numbers of carers staying in paid work; the personal or demographic details of those who attend collected in a standardised way (ethnicity, date of birth, health conditions etc).

Such data may be presented statistically (using descriptive statistics). For example, x% of people reported enjoying Y; x% of carers reported that Y; x% of volunteers said Z; x% of people reported improved quality of life since starting to attend their day centre. Presenting them alongside qualitative data gives a broader picture of the service and its outcomes/impact.

Quantitative data can also be gathered about individuals' experiences (subjective data). 'Standardised' questionnaires (i.e. validated scales, tools or measures) may be used to do this. These are questionnaires developed to measure a certain thing in a specific group of people. If a questionnaire (tool, scale or measure) has been 'validated', it has been tested to check how well it measures what it is intended to measure. This will have involved using it with a representative group of people and checking that the results did actually represent what they are supposed to measure (i.e. were valid) and if the results could be reproduced when used again (i.e. were reliable). Because standardised questionnaires have been carefully tested, they usually have questions with pre-determined wording and structured answer options. Some questionnaires are objective (e.g. health status) and some are subjective (e.g. perspective on feelings of wellbeing or how/if a service has helped someone). Some questionnaires are very short (e.g. five questions) and some are longer (e.g. 20 questions). Their length does not necessarily indicate how long they may take to use; some are quick, and some are not. Many standardised questionnaires are free to use. Some require registration (i.e. informing their issuer that they are being used, with whom and in what context). Some require payment. Many tools that are likely to be useful in day centres are available free of charge. Some of these appear in section 7 of this document.

Collecting data in a standardised, systematic way like this can be helpful for reporting - both about individuals and about the whole service user group – because it means that the resulting scores are comparable and standard across the group.

As with qualitative data, **it is crucial to record and process the data collected so that it is of practical use**. Standardised questionnaires are usually accompanied by guidance on their use, scoring and interpreting the results. You do not necessarily need to be 'an expert' to use these questionnaires.

Traditionally, 'hard' data, like those resulting from standardised questionnaires, have not been collected by day centres about their clients. In the current environment, in which evidence-based commissioning is encouraged, it may become increasingly important to consider this option. Gathering such standardised evidential data may contribute towards day centres beginning to be considered more as health and wellbeing 'interventions' and be taken more seriously. This is particularly important as LAs are continuously under pressure to save money and justify spending, and social prescribing is becoming increasingly widespread in primary care.

In summary, standardised questionnaires can be useful for:

- monitoring individual outcomes and experiences – at one point or at several points over time (e.g. when starting to attend a day centre, one month later, 3 months later, 6 months later and after a year). Scores may indicate individual improvement (i.e. the service has made a positive impact) or maintenance (i.e. that deterioration has been delayed).

- feeding into care plan reviews - as evidence of outcomes/impact for older people attending day centre (and their carers, if also using tools with them).

- enabling a person to see how far they've progressed since starting to attend their day centre. This may be useful for people who may be feeling tired and need encouragement to go to a day centre or are having 'a wobble' about going.

- carers may also appreciate knowing how the person they care for is progressing.

- reporting about whole groups (e.g. all the older people attending a day centre) – as averages, for example. Such data may be reported to funders (and other decision-makers) or included in funding applications. 'Hard' evidence, like the scores resulting from standardised questionnaires (validated tools), are often very appealing to people working in the NHS.

6. Challenges involved in gathering and making use of outcomes data, and things to bear in mind

Background knowledge, expertise and time are significant barriers to gathering and using outcomes data. Measuring outcomes can be complex and involves time and resources.

Individual outcomes can cover a very broad span. For example, safety is an outcome (feeling safe, lack of falls, being out of a risky situation), as is improved wellbeing; feeling significant as a person is an outcome; and enjoying companionship is an outcome.

It is important to remember that service or organisational outcomes, are the sum of the individual outcomes as a group, but these outcomes may also be linked with use of other services, such as additional home care, respite, GP appointments, hospital bed use or care home placements.

Many questions need consideration and decisions must be made *before* gathering outcomes data. For instance:

- What is the purpose of gathering these data?
- Is there in-house expertise on how to measure outcomes?
- Which outcomes should be measured and how should this be undertaken?
- How difficult/easy and time-consuming will it be to gather these data?
- Is staff training necessary?
- When should data be gathered – how often, after what period and during which part of a day centre day?
- Are there staffing implications?
- Should the exercise be undertaken in a private area?
- Is the person willing to provide data about their own outcomes?
- How will data be interpreted and presented?
- Will data be reported on an individual basis or for groups of people? How should data be stored?

When gathering outcomes data (whether qualitative or quantitative), it is also important to bear in mind that:

- brevity is key: the method should not be burdensome for any party involved, but some people are happy to fill in longer forms. People can be asked if they are happy to do so.

- frailty can also be a barrier to collecting data: people may have too much going on in their lives and may not wish to add another exercise.

- some conditions, for example dementia, are progressive and can mean that collecting reliable outcomes data is challenging. Carers may need to be involved in a respectful way. The best way to gain consent to complete surveys will need to be considered.

- sensory loss may mean considering additional things. Tips on administering questionnaires with people with sensory loss appear on pages 30-31 of Campaign to End Loneliness' *Measuring your impact on loneliness in later life* (also see section 7 of this document).

- the process should be stress and anxiety free, especially for people living with dementia, and undertaken in a way that minimises discomfort about what's going on for them and realisation of their loss of skills etc.

- timing is important:
  i) getting to know a person, building a rapport and letting them settle before asking lots of questions can lead to fuller responses
  ii) some people do not mind being asked questions at first contact, but others may not wish to share personal feelings before having developed a relationship with staff/volunteers
  iii) some people function better at certain times of day
  iv) outcomes for people with cognitive limitations (e.g. memory loss) may need to be measured 'in the moment' rather than a long while after an event.

- carers' responsibilities may mean some are reluctant to respond to requests.

- when surveying staff/volunteers or older people attending a day centre across an organisation that provides various services, surveys may like to include some separate questions for each service to enable reporting of findings by service.

- if data are collected across several day centres, it is useful to be able to separate data for each service.

- if any standardised questionnaires are being used, guidance on their use and interpretation is available (see below).

- outcomes data gathered should be put to use somehow: it is counterproductive to collect data from individuals (using any method) and then file it away in its original form without processing it somehow.

- becoming more digitally literate is a target for some (e.g. local authorities), so being stretched by the use of digital outcomes monitoring data can be a good thing.
- permission may need to be gained to report individual 'stories' (case studies) on websites, social media or in funding bids.
- although it may be time-consuming to organise, collate and summarise qualitative data, this is usually time well-spent.

Some advice is provided in Campaign to End Loneliness' Measuring your impact on loneliness in later life (pages 22-29). This covers how to introduce a questionnaire (useful more generally although specifically about loneliness), encouraging staff and volunteers to use a questionnaire, at what points and how regularly a questionnaire might be used, how to choose people to use a questionnaire with ('the sample'), getting consent, asking open questions and making sure enough information is gathered about the people it is used with.

7. Some ‘tools’ (questionnaires) or approaches to gathering data that could be used by day centres

This section gives an overview and links to further information about tools, questionnaires or approaches that may be useful for day centres to consider using when monitoring or gathering evidence about outcomes.

Introducing tools, questionnaires and approaches

This section introduces and gives some background to tools, questionnaires or approaches that may be useful for day centres to consider using when monitoring or gathering evidence about outcomes. Clicking on links will take readers directly to further information in the next sub-section. All tools are free of charge to use unless otherwise stated.

Practical suggestions are made for recording individual outcomes in Social Care Wales’ **12 principles for effective outcomes-focused recording**.

Thinking about giving examples of how involvement with a day centre (attending, volunteering, being a carer) has improved people’s lives, **how to write ‘stories’ to communicate outcomes** that have resulted in change is explained, building on the Most Significant Change technique.

Social care service-related quality of life can be measured by the **Adult Social Care Outcomes Toolkit (ASCOT)**. ASCOT is a set of questionnaires specifically designed to measure aspects of quality of life that specific social care services may impact upon. They cover a broad range of aspects of quality of life that are relevant and important to people who use social care and their carers (e.g. social relationships, control over daily life, feeling significant, feeling safe, time to yourself, feeling supported). As well as helping service providers understand client experiences, these questionnaires support care planning and quality monitoring and are useful for demonstrating service impact. Other tools to measure outcomes include:

- **ICECAP-O (ICEpop CAPability measure for Older people)** which is free of charge and measures older people’s capability-wellbeing in 5 areas (attachment, security, role, enjoyment and control).
- **Outcomes Stars**, a popular but charged-for tool that is more suited to support key work with individuals.
- Health Improvement Network’s (HIN) straightforward **tools to measure outcomes for people with dementia** in a range of support settings (including community groups).

ASCOT and ICECAP-O have been recommended for use in economic evaluations [5].

Measuring staff time needed to support older people attending a day centre is another useful approach to evidencing individual changing needs and for organisational planning purposes. A day centre manager developed a 'time tool' to do this.

Social care is expected to be person-centred. Different understandings of what 'person-centredness' means make monitoring and reporting it difficult. A review of definitions concluded that understanding the person, engagement in decision-making and promoting the care relationship are central to service person-centredness [6]. To ‘measure’ how person-centred a day centre service is from the perspective of the older people who attend it, two tools may be useful:

- **PERCCI – the Person-centred Community Care Inventory** – a questionnaire with 12 questions about how people feel they are treated, to what extent they are involved in decisions about their care and how well the service addresses individual needs and preferences.

- **Making it Real** includes a set of "I" statements covering various aspects of a person's experiences, designed for broader use within and outside social care.

Loneliness is one aspect of wellbeing that day services may help to reduce. Measuring loneliness is important because feeling lonely can be accompanied by worsening physical and mental health[i]. Recognising that persistent loneliness can harm health, the **Government published a strategy for tackling loneliness in 2018 and has continued its work in this area**. Loneliness can be measured (at different points in time) to discover whether attending a day centre has reduced feelings of loneliness. Several questionnaires do this. They are short and useful for different purposes:

- The **Campaign To End Loneliness Measurement Tool** aims to measure the change that happens as a result of an intervention (e.g. day centre attendance), with a focus on how people’s scores change over time. This questionnaire is based on the idea that loneliness is felt when there is a mismatch between the social contact a person has and the social contact they want. Because it was co-designed with older people and service providers, it uses language that is non-intrusive and unlikely to cause any embarrassment or distress and, therefore, may be the most appropriate questionnaire for use in day centres.

- The **loneliness measure recommended in the Government's Loneliness Strategy** is a 4 question scale (including 3 questions from UCLA scale and an additional question) that is widely used and suitable for gathering data that may be compared with data about other services or service user groups.

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[i] See a) Campaign To End Loneliness’ page about research https://www.campaigntoendloneliness.org/the-facts-on-loneliness/; b) What Works Centre for Wellbeing in its report A brief guide to measuring loneliness (2019); c) Hol Holt-Lunstad J, Smith TB, Baker M, Harris T, Stephenson D. Loneliness and social isolation as risk factors for mortality: a meta-analytic review. Perspectives on Psychological Science. 2015 Mar;10(2):227-37. https:/doi.org/10.1177/1745691614568352.

- The **de Jong-Gierveld scale** is also widely used.
- Further information about these three tools can be found in Campaign to End Loneliness' guide **Measuring your impact on loneliness in later life** (2015) and What Works Centre for Wellbeing's **A brief guide to measuring loneliness**.

Certain health measures may be of particular interest to people working in health, for example commissioners, occupational therapists, physiotherapists, or GPs.

- The **Timed Up and Go Test (TUG)** is a good indicator of balance and, therefore, **falls risk**, and may be helpful in determining levels of staff support needed in day centres.
- Changes in individual wellbeing could be measured as an indicator of service impact and may be helpful for monitoring purposes. The **Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) (or the Warwick Edinburgh Mental Wellbeing Scale (WEMWBS))** are recommended by the What Works Centre for Wellbeing.
- The **SF-12 or SF-36 health outcomes questionnaires** measure quality of life and functional health and wellbeing from a person's own perspective. They may be better for providing an overall profile of a day centre's service users. However, the latest versions (SF-12v2 or SF36v2) are subject to licence.
- The **Assessment of Quality of Life (AQoL)** measures health-related quality of life in four domains: Independent Living, Relationships, Mental Health and Senses. It may be helpful for profiling older people attending a day centre, as a group, and for evidencing impact (even in a single domain, such as Relationships).

Making records of healthcare service use, suggested by US day service experts [1], may also form part of an approach to evidencing day centre attendance outcomes.

Matters concerning staffing may also form part of a day centre's impact. Staff recruitment and retention are known to be challenging in social care. Day centres may wish to **monitor their staff's job satisfaction**.

While **this resource does not cover Social Return on Investment (SROI)**, readers may wish to read an example of an exercise undertaken on a Peer Support Network for people with dementia signposted here.

Tools, questionnaires or approaches: further information

In this section, further information is given about tools, questionnaires and approaches introduced in the previous section. Hyperlinks to these and further supporting information are provided, and information about use outlined.

Twelve principles for effective personal outcomes-focused recording.

Social Care Wales suggests principles for meaningful and effective outcomes monitoring and provides guidance and practice examples of personal outcomes-focused recording for each of the principles (e.g. case records, reflections).

Friend not foe: supporting meaningful outcomes focused recording in social care in Wales (36 pages) (2022) (see page 10).

Using 'stories' to convey change outcomes

The 'Most Significant Change' technique involves a person (e.g. day centre attender, volunteer) reporting, in their own words, the most significant change that has happened to them as a result of something (e.g. attending or volunteering at the day centre). The 'story' covers the most significant change they have experienced, what happened/where/what or who was involved/when, why it is significant for you/what difference it has made to the person's life, and why this difference it has made for the person is so important.

Detailed guidance and examples: **The 'Most Significant Change' (MSC) Technique. A Guide to Its Use** (2005) by Rick Davies and Jess Dart

Examples appear in ***Magic Moments in adult service provision* (numbers 1,6, 7, 20, 33 and 40 are about day services)** developed by Swansea University and Swansea Council in 2016.

More detailed examples of stories that have been written are available in section 8 of this document (see **Evidencing impact using individual stories written using the Most Significant Change approach: Knit one, purl one, see my confidence grow My wife – big difference)**. See also **Joan's story** in Case studies and inspiration on the Resources Hub.

Social care-related quality of life questionnaire: Adult Social Care Outcomes Toolkit (ASCOT) – for older people attending day centres and their carers

The **Adult Social Care Outcomes Toolkit** is a set of standardised questionnaires specifically designed to measure aspects of quality of life affected by social care services – to understand client experiences, for care planning and quality monitoring. Instead of focusing only on physical or psychological health, ASCOT includes broader aspects of quality of life (e.g. social relationships, control over daily life, feeling significant, feeling safe) that are relevant and important to people who use social care and their carers. These are called 'domains'. Questionnaires can be used to monitor individual progress, demonstrate the impact of a service across a group of people, and for economic evaluations of services (i.e. cost effectiveness) if unit cost data are available. Scores/results can be shown visually using a spider chart. There are several versions which include questionnaires to be read out to older people/carers (i.e. 'administered in an interview') and questionnaires to be completed by older people attending a day centre or carers themselves:

- **ASCOT INT4** (23 questions for service users), **ASCOT Carer INT4** (21 questions) and **ASCOT-ER (OP)** are designed to be read out in an 'interview'. **ASCOT-ER (OP) is a revised version of ASCOT INT4 which is aimed specifically at older people with or without memory problems.** These versions discover how much the service has impacted on someone. As well as overall benefit, they are helpful for identifying which are the areas (domains) in which people feel they have benefited the most and the least, so can also inform service improvement initiatives. Questionnaires include explanatory notes for the person reading them out and prompts they can use. These versions measure the *current* quality of life and '*expected'* quality of life (i.e. how the person perceives their quality of life would be in the absence of the service). The difference between these scores is the "gain", or the impact of the service on that person's quality of life (expressed numerically). Because of this structure, service users/carers must be able to imagine hypothetical situations. A benefit is that it only needs to be used once to measure service impact. ('ASCOT INT4 four-level interview tool', 'Carer INT4 four-level interview tool or family/friend (unpaid) carers', 'ASCOT Easy Read (Older People)')
- **ASCOT SCT4** (8 questions for service users) and **ASCOT Carer SCT4** (7 questions) can be completed by older people attending a day centre or carers themselves. It can be used once or repeated to monitor change. These versions are currently used in local authority service user surveys. ('ASCOT SCT4 four-level self-completion tool', 'Carer SCT4 four-level self-completion tool or family/friend (unpaid) carers')

ASCOT questionnaires are free of charge by not-for-profit organisations or if to be used for the benefit of the public (e.g. a LA using these for quality monitoring or service improvement). For-profit organisations are required to pay a fee. All will need to complete a registration form (explaining planned use) and agree to Terms and Conditions of use before a license is granted and the questionnaire and guidance for its used provided. Guidance documents include how to calculate scores manually. Data entry tools (i.e. Excel spreadsheets set up to do automatic calculations of scores and graphs – one for each questionnaire) cost £50 and can be downloaded from the website (cost at May 2024).

A 13 minute **video explains how providers can use the ASCOT tools in a 'circle of care' interview.**

Katharine Orellana shared her experiences of using ASCOT (INT4 and INT4 Carers) in day centres for older people in a talk at an ASCOT 10th Anniversary webinar series (October 2022). See **https://www.youtube.com/watch?v=SUDgp1q16Tw** (from minute 21).

An ASCOT care work-related quality-of-life questionnaire is under development (at the time of writing). Day centre staff wellbeing is likely to impact on the quality of service provided, and on outcomes for service users. Therefore, understanding the aspects of quality of life most affected by their work is important. See **www.pssru.ac.uk/ascotforstaff/homepage**.

ICECAP-O (ICEpop CAPability measure for Older people)

The ICECAP-O measures older people's wellbeing in 5 dimensions: Attachment (love and friendship), Security (thinking about the future without concern), Role (doing things that make you feel valued), Enjoyment (enjoyment and pleasure), Control (being independent). The questionnaire is short and easy to complete. Registration is straightforward.

Using ICECAP-O is free for non-commercial users, but users must sign a licensing agreement with the University of Bristol in which they agree not to change the wording of the measure. Scoring coding is provided on the website using STATA and SPSS statistical software. An Excel scoring spreadsheet is available upon request after registration.

The **registration form, questionnaire and scoring system codes** are downloadable from the ICECAP-O web page.

Outcomes Star

The **Outcomes Star** is a charged-for standardised tool in the shape of a star, each leg of which represents different levels of progress towards an outcome area. It is a keywork tool that increases awareness and informs action planning/interventions. Many versions are available including the Older Person's Star (covering Staying as well as you can, Keeping in touch, Feeling positive, Being treated with dignity, Looking after yourself, Feeling safe, and Managing money and personal administration) and the Carers Star (covering Health, The caring role, Managing at home, Time for yourself, How you feel, Finances, and Work). Paper or online versions are available.

An annual licence and training for each staff member using an Outcomes Star is required. Supportive resources are available (action plans, guidance, flashcards etc). Costs start at £250 per annual licence for all published versions, the online version and supportive resources; additional licences cost £40 per person. Training starts at £960 (costs at May 2024).

Measuring outcomes for people with dementia

The Health Improvement Network (HIN) developed a set of easy **tools to measure outcomes for people with dementia** in a range of support settings (including community groups) which may be useful in demonstrating the value of day services to people with dementia (see page 15).

Time Tool spreadsheet to monitor staff time needed to support older people attending a day centre

The Time Tool is a spreadsheet used by a day centre to monitor the frequency of certain occurrences and staff time needed to intervene. This has enabled better understandings of changing needs and was also valuable for self-audit as staff could learn from each other about how best or most efficiently to support clients. It is straightforward and calculations are made automatically behind the scenes. Detailed information about the areas of support monitored, how to use it and its benefits appears **at the end of this document**. The tool is downloadable from the Resources Hub in the **Understanding outcomes and impact section**.

Person-centred related quality of life experience questionnaire: Person-Centred Community Care Inventory (PERCCI)

PERCCI (pronounced ‘percy’) a short (12 questions), straightforward standardised questionnaire that measures quality of care experiences (e.g. if people feel they are treated with kindness, respect and compassion, are involved in decisions about their care, if care is personalised and responsive to their needs and preferences). It was co-designed with people with lived experience of care services and is based on evidence.

It can also help to demonstrate whether the service/provider is well-led (how it promotes a person-centred culture, if it has a process for continuous quality improvement, if it gathers and acts upon people’s experiences of care or if it uses evidence-based processes within the service).

The questionnaire can be downloaded from the website; people wishing to download the questionnaire are asked for their details, how they heard about it and if they are willing to be contacted about their experience of using PERCCI.

Scoring is explained on the PERCCI website. An Excel spreadsheet for entering and storing scores is available on request. Each response is scored 0, 1, 2 or 3 (0 for 'rarely or never' and 3 for 'always') and scores for all 12 questions are added together. Individual scores range from 0-36. Scores can be compared between people (e.g. to identify those with particularly low scores) or for the same people over time (e.g. to see if care experiences are improving).

An **infographic summarises PERCCI**.

Read more about how it was developed in a **presentation given to the Day Centre Research Forum in June 2020**.

Making it Real

Making it Real is a framework built around 6 themes that reflect important parts of personalised care and support. It is for use in and beyond social care services (i.e. in housing, residential care, hospitals, public services) therefore, not all themes may be relevant to day centres. It was co-produced by Think Local Act Personal with input from a range of organisations and individuals.

Each theme has a set of “I” statements about how support is experienced by an individual (e.g. I have considerate support delivered by competent people; I am supported to make decisions by people who see things from my point of view, with concern for what matters to me, my wellbeing and health) and related “We” statements that cover the provider’s perspective of what needs to be in place for the “I” statements to happen (e.g. We don’t make assumptions about what people can or cannot do and don’t limit or restrict people’s options).

Campaign to End Loneliness Measurement Tool

A three-question standardised questionnaire that is useful for service providers wanting a short questionnaire that uses positive and sensitively worded language (i.e. written in language which is non-intrusive and unlikely to cause any embarrassment or distress) and is easy to use. It was co-designed with older people and service providers. It is based on the idea that loneliness is felt when there is a mismatch between the social contact a person has and the social contact they want. **Guidance** covers the questionnaire itself and scoring system (pages 11-13), how to introduce it, encouraging staff and volunteers to use it, at what points and how regularly a questionnaire to measure loneliness might be used, how to choose people to use it with (sample), getting consent, asking the questions themselves and making sure enough information is gathered about the people it is used with (see pages 22-29).

National Loneliness Measure (UCLA Loneliness Scale)

The UCLA is the standardised loneliness questionnaire recommended in the Government strategy. It has three questions and is helpful for service providers wanting a short tool that uses a simple scoring system. Although these questions do not mention 'loneliness', they are worded negatively. The Government strategy recommends adding a fourth question that uses the word ‘loneliness’. This approach is widely used and, therefore, enables the comparison of data between different types of services or service user groups.

Details and scoring information can be found in **Campaign to End Loneliness’ Measuring Your Impact on Loneliness in Later Life** (see page 17-19), in **What Works for Wellbeing’s Brief Guide to Measuring Loneliness** (see page 10-11), on the **ONS web page**, and on **What Works for Wellbeing’s pages on National Loneliness Measures on its ‘Measure Bank’**.

De Jong Giervald Loneliness Scale

A six-question standardised questionnaire developed for researchers. It distinguishes social loneliness (when the number of friendships or relationships someone has is smaller than desired) and emotional loneliness (when someone is missing intimacy from their relationships, friendships or acquaintances) and gives an overall measure of loneliness. Although it does not mention 'loneliness', questions are worded negatively. Details and scoring information can be found in **Campaign to End Loneliness' Measuring Your Impact on Loneliness in Later Life** (see page 14-16), and on **What Works for Wellbeing's pages on National Loneliness Measures on its 'Measure Bank'**.

Timed Up and Go (TUG) Test

The Timed Up and Go Test [7] is a standardised test that assesses mobility, balance, walking ability and falls risk. If repeated at intervals, this test can monitor change; it may be useful, for example, before and after specific programmes of exercise, for example. It may also indicate levels of staff support that a person may need at their day centre (e.g. going to the toilet or moving between activities). The test is simple, quick and requires no special equipment or training; a person is asked to rise from a standard chair, walk to a marker 3 metres (10 feet) away, turn, walk back, and sit down again. They do this while wearing their usual footwear and using their usual mobility equipment, if any (e.g. walking stick, walking frame).

Different approaches are taken to scoring (i.e. being at risk of falling starts at 12 seconds for some, 13.5 seconds for some, or 20 seconds for others). The UK Chartered Institute for Physiotherapy defines a person being at risk of falls if the test takes 15 seconds or more.

The Chartered Institute for Physiotherapy has produced a **video that demonstrates the test**.

Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) and Warwick Edinburgh Mental Wellbeing Scale (WEMWBS)

The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) is a standardised self-completion questionnaire developed to measure mental wellbeing in the general population and evaluate projects, programmes and policies which aim to improve mental wellbeing. Both ask positively worded questions about feelings and thoughts over the previous 2 weeks. Each has a choice of 5 response categories. The WEMBWS has 14 questions and the SWEMWBS has 7 questions.

Both scales are recommended by the What Works Centre for Wellbeing, with further details in its 'Measures Bank': **WEMWBS** and **SWEMWBS**. **Scoring and interpretation guidance is provided**. The full (and rather complex) **user guide** covers both questionnaires. **Frequently Asked Questions** provide additional useful information about its use. The only drawback to this questionnaire is that it has not been validated for use with people aged 75 and older.

Both scales are free to use (non-commercial use) but users must register for a license.

SF-12 or SF-36 health outcomes

The SF-12 and SF-36 are standardised questionnaires that measure quality of life and functional health and wellbeing from a person's own perspective. They cover physical functioning, bodily pain, limitations due to physical health problems and personal/emotional problems, emotional wellbeing, social functioning, energy/fatigue, general health perceptions, and a perceived change in health. They have 12 and 36 questions respectively.

These questionnaires may help day centres to present information about the health and wellbeing characteristics of older people using their service (as a group of service users) rather than to evidence outcomes and impact (i.e. background information to outcomes/impact data gathered in another way).

Use of the original (outdated) version of SF-36 is subject to a few **Terms & Conditions**, including crediting its development at RAND as part of the Medical Outcomes Study. The **questionnaire (blank printable form; can also be completed online and printed) and scoring instructions (see Table 1-steps 1&2) are downloadable** from RAND's website.

Use of the most up-to-date versions (SF-12v2 or SF36v2) require a license (3-page form more suited to academic research than local monitoring of service users' characteristics). See **further information about these and the licences required.**

AQoL (Assessment of Quality of Life)

Several versions of the AQoL standardised questionnaire measure health-related quality of life. The shortest is **AQoL-4D** which has 12 questions covering four domains: Independent Living (self-care, household tasks, mobility), Relationships (friendships, isolation, family role), Mental Health (sleeping, worrying, pain) and Senses (seeing, hearing, communication).

The AQoL may be useful for presenting health information about older people attending a day centre (as a group of service users as background information to outcomes/impact data gathered in another way) as well as a means of evidencing outcomes and impact. A single score is calculated, or the score for each domain may be reported separately (e.g. Relationships) and the measure repeated at intervals to evidence any change.

Scoring assigned to each question differs according to whether the questionnaire is being used as a 'psychometric' measure (i.e. to get scores on health-related quality of life that can be used as a single score or separately by domain) or as a 'utility' measure (i.e. to be used in economic evaluations). Psychometric scores are more straightforward (e.g. 1-5 for each of 5 answer options). Utility scores are 'preference weighted' (i.e. reflect preferences more accurately than unweighted scores).

The **analysis spreadsheet to calculate Psychometric (unweighted) scores** is downloadable (see Step 1). A **Zip Folder of SPSS and STATA documents to calculate Utility scores is downloadable from the web**. Use is free, but users must **register**. Registration means that technical support can be provided.

Healthcare use records

In their call for the development of a set of uniform set of outcomes measures to be used in US day services, Anderson and colleagues [1] reported that simple records of healthcare use have been recommended as useful for evidencing impact. For example, records may include numbers of hospital admissions, numbers of Accident and Emergency visits, numbers of prescribed medications, or numbers of GP consultations or NHS professional home visits.

Monitoring job satisfaction

What Works Centre for Wellbeing has developed a Workplace wellbeing question bank. One measure is of job satisfaction in terms of worker wellbeing. Seven response options range from 'Completely dissatisfied' to 'Completely satisfied'. The **question and response options** can be found on the Measures Bank.

As a single question, it is easy to interpret.

A longer, 10-question version, the **Worker wellbeing snapshot survey** is also available.

Social Return on Investment (SROI)

SROI aims to measure the wider (social and environmental as well as economic) value of a service (or organisation). It uses financial calculations to indicate the ratio of input cost to wider value created (e.g. for every pound spent, the service achieved a return of £x in social value). The scope of this resource for day centres and their stakeholders does not include SROI, but readers may wish to read an example of an **SROI study undertaken by the Health Improvement Network on Peer Support for People with Dementia**.

8. Some local examples

Study participants have shared some examples developed locally and given permission for these to be downloaded and edited to suit local circumstances.

- A short event evaluation form that uses smiley faces and open questions
- A short evaluation form of a project, event or workshop
- A telephone survey carried out by keyworkers at Central Hill Day Service (London Borough of Lambeth) with carers of older people using the service to collect their opinions and preferences (includes instructions for keyworkers)
- Evidencing impact: Two examples of individual stories written using the Most Significant Change approach: *Knit one, purl one, see my confidence grow* and *My wife – big difference.*

Short event evaluation form that uses smiley faces

[downloadable in Word format]

[Name of organisation]
[Event e.g. workshops]

ADDRESS

	NAME		OVER 50	
	DATE		SEX	

1. MARK HOW THE PARTICIPANT FEELS ABOUT THE [EVENT] 1=LOW, 10=HIGH:

D

1	2	3	4	5	6	7	8	9	10

2. Did the workshops improve your health and wellbeing?

3. If yes how?

4. BENEFIT OF WORKSHOP IN GENERAL?

Short event/project/workshop evaluation form

[downloadable in Word format]

[Name of organisation and project/event]

LOCATION:

NAME: **SEX:** **DATE:** **OVER 50**

please tick one box - yes, no, or not sure		**YES**	**NO**	**NOT SURE**
Was this workshop an enjoyable experience?				
Did the workshop help you overcome lockdown?				
Did coming to the workshop reduce isolation?				
Did you find people in the workshop friendly?				
Did the workshop make you feel part of the community?				
Did you feel included in the activities?				

Did workshop improve your health and wellbeing?			

If yes, how did is improve your health and wellbeing

DID YOU EXPERIENCE ANY OF THE 5 STEPS TO WELLBEING? Please tick: **A. Connect B. Being active C. Learning D. Give to others E. Mindfulness**

Any particular benefits that the workshop provided for you?

Telephone survey carried out by day centre keyworkers with carers of older people using the service (Central Hill Day Service, London Borough of Lambeth)

[downloadable in Word format]

Collecting carers opinions and preferences

INSTRUCTIONS FOR KEYWORKERS

Please call the carers of the people you keywork. All the information needs to be returned to [manager] by [date].

Have a quick friendly chat to put the person at ease. Ask them if this is a good time to have a quick chat with them – **you will tell them you need about 15 minutes of their time and have 5 key questions for them. Tell them this is in confidence and totally anonymous, so please do be frank.**

There are 2 questions about their preferences which obviously we do need to identify them for.

Tell them You may have responded to our last survey. (The questions are the same). If you did, I will take you straight to your preferences

If **no**, they are too busy with something else, ask them when a good time is to call them and try to keep this time.

If **yes,** they are free, go on to say the following:

Thank you. Your input is important to us.

As you know we have been able to open in August 2020 and remain open throughout this last lock down.

We want to make sure we are getting things right and need your opinions and preferences.

Q1. Before Covid-19: Please rate the quality of contact you received from [name of day centre].

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Disappointing					Exceptional

If disappointing, please ask them for a comment

Q2. During Covid-19 lockdowns: Please rate the quality of contact you are receiving from Central Hill.

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
Disappointing					Exceptional

If disappointing, please ask them for a comment

Q3. Please rate the quality of contact you receive from [name of day centre].

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Disappointing Exceptional

If disappointing, please ask them for a comment

Q4. Please rate how confident you are in your loved one coming to [name of day centre]

☐ 1	☐ 2	☐ 3	☐ 4	☐ 5
Feel unsure	OK	Happy	Totally happy	More than happy

If unsure, please ask them for a comment

Q5. Please rate your overall satisfaction with the service we offer.

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Disappointing Exceptional

If disappointing, please ask them for a comment

Preference 1. How often do you wish to be contacted about (Name of their loved one here)

Just delete the ones they do not choose before you send it to me

1. At the end of the day
2. Once a week
3. Once a fortnight
4. Only if there is an issue

Preference 2

We want to set up a way to pay for lunches which does not include collecting cash.

We want to start a TOKEN system where you pay for a set number of lunches up front. Your tokens will only be used if your loved one attends and has lunch.

We cannot accept cash for the tokens, and we cannot take a credit card.

Are you able to pay be cheque?

Y N

If you do not have a cheque book, can you order one from your bank?

Y N

Can someone send a cheque in on your behalf, and you pay them?

Y N

Evidencing impact using individual stories written using the Most Significant Change approach: Knit one, purl one, see my confidence grow My wife – big difference

The 'Most Significant Change' technique involves a person (e.g. day centre attender, volunteer) reporting, in their own words, the most significant change that has happened to them as a result of something (e.g. attending or volunteering at the day centre). The 'story' covers the most significant change they have experienced, what happened/where/what or who was involved/when, why it is significant for you/what difference it has made to the person's life, and why this difference it has made for the person is so important.

Detailed guidance and examples can be found in **The 'Most Significant Change' (MSC) Technique. A Guide to Its Use** (2005) by Rick Davies and Jess Dart

Examples appear in **Magic Moments in adult service provision (numbers 1,6, 7, 20, 33 and 40 are about day services)** developed by Swansea University and Swansea Council in 2016.

Below are two detailed examples of stories. Permission has been given for these to be used to training and development purposes.

Knit one, purl one, see my confidence grow

Background to my story

I am an older person who attend a 'knit and natter' group in a local library in South Pembrokeshire every Tuesday

What changes have happened

- My confidence has increased
- I walk to the library instead of taking the car
- I really look forward to the weekly sessions, the chatter, tea and biscuits
- I love to share patterns, ideas and skills
- My knitting has improved
- I am helping others by knitting '**chip shop baby**' sweaters and hats

Which of these changes are most significant to me?

Regaining my confidence and courage. It took a lot of courage for me to join the group. I felt I may be seen as stupid if I couldn't knit what the group were all knitting. I hadn't knitted for 15 years as my children and grandchildren didn't need anything knitted. I was nervous – could I fit in?

What it was like before

I have always relied on my husband's company since we retired. I think I was getting to feel that I couldn't do things on my own anymore. I was apprehensive about going out on my own. I didn't think people would have anything to say to me.

What it is like now

The 'knit and natter' sessions allow me time for myself. They have increased my confidence and I love knitting once more. I have something to look forward to! I am also looking out for ideas to share with the group. I also share what I have been doing with my family. Last weekend, when my son called, we were watching a TV programme on Africa and as he moved closer to the TV, I asked him why? He said "I am looking for the 'chip shop baby' jumper you knitted" We all laughed!

What happened to make the changes come about

The volunteer who leads the knitting sessions allows us to be ourselves and the sessions are very much about enjoying our time together. She suggests things for us to knit, so we can choose what to do. I have found my long-lost knitting skills and now really look forward to our Tuesday morning get-togethers over a cup of tea and a biscuit.

I have also shared my concerns about my recent bout of pneumonia. Before, I was worried that the doctor had said that my lungs had been affected by the condition, but my fellow knitters have reassured me. I am not so worried now.

My wife - big difference

Background:

Arthur and his family are involved in the work of ACE Ely Caerau, an asset-based community development organisation based in Cardiff. They co-ordinate a range of projects, one of which is a community shop. Arthur's wife became involved in the shop.

What changed

"My life has completely changed. For 25 years I've been by myself even though I was in a partnership. My wife wouldn't go out. I was like a carer. I cooked and did the shopping, now she is able to come with me."

What it was like before

"We used to go out at 2.00 in the morning, down to the Knap or to Porthcawl. She would run along the beach and into the sea. She would then get out, get dried and dressed and we would go home. If there was nobody around, then she was fine. We would go shopping at 2.00 in the morning, as soon as it started filling up she was gone. We went to Tesco one day at 1.00 in the morning, she sent me off for something, when I came back she had left the trolley and had gone. She had the money and everything. I had to get the assistant to help look for her, but she wasn't there. I headed home and found her there with my two daughters. I then had to go back to the shop and pay for the shopping. She couldn't even answer the door."

What caused the change

"My daughter had the idea of the community shop and took mum along to see the room. It was a really small room. She needed someone to run it. Mum took to the idea straight away, she was in her element because it was like being in a cupboard. She wanted pictures up on the wall. One day a lady came in and asked to buy the pictures but she said "You can't, that's my window". She now runs the shop 4 days a week."

What it was like after

"For me the most significant change was my wife, big difference, it's been hard. I'm from a big family, my niece got married but she couldn't come. My family were asking why. Fantastic, unbelievable, she is a different person. They run a knitting club now, they run the Retreat group on a Thursday, she goes out with the women, gets on a mini bus and goes, goes out for meals. It's unbelievable, I've got time for my garden and my dogs. I don't worry now. I still cook and shop but she can come with me now and we can go during the day, she isn't stuck in the house anymore. We get on like a house on fire. She is phenomenal."

Why this is the most significant change:

"I got my relationship with my wife back."

Introduction of an Excel ‘Time Tool’ to monitor time needed by staff to support people and to prompt reflection about support techniques

An Excel ‘Time Tool’ to monitor time requirements for individuals’ and whole-group support needs was developed by the manager of a local authority (LA) day centre for people with dementia.

The manager of a local authority day centre for people with dementia, Esther Wiskerke, developed a spreadsheet to monitor the frequency of certain occurrences (e.g. individual behavioural, mobility or personal care related support needs), and the staff time needed to support people at these times. The Time Tool aimed to help monitor a person’s changing needs for support and overall group needs. It was also useful for sharing expertise between staff and for self-audit. The tool was intended as a positive monitoring exercise - to support staff, improve personalised support and support care plan reviews.

Rough timings were entered into the tool retrospectively in whole group staff meetings. Each client was discussed in turn. How long was spent supporting them (to do different things)? Was the day centre still appropriate for them? The staff team then reflected on support timing differences and learnt from each other how best and most efficiently to support clients in certain situations. For example: if one staff member said it took them five minutes to support a certain person to use the toilet, and another commented that it took them 20 minutes, discussion would follow about what method each had used. Care plans were sometimes amended accordingly.

Background

Although day centre clients are part of a group, they can expect a certain level of individual input from staff during their day at the centre. Some people will need exclusive individual support with some tasks to ensure that they are not at risk of harming themselves or others. The Time Tool addresses this.

The following were measured: time taken by certain ‘events’, the number of times these would happen (frequency), staff time taken in intervening (minutes) and numbers of staff needed to intervene. These would lead to a number and time that could be logged to review progress. Support needs were divided into categories, such as mobility and nutrition. Frequency and length of staff intervention time for certain ‘events’ were noted based on clients’ behaviours and needs, and the number of intervention minutes totalled. This enabled progress monitoring /intervention needed at individual level.

Examples

Behaviour: If, in the beginning, before a client had settled in, they needed help to feel calm, measures of this would be recorded on the behaviour category. For instance, 10 times, 2 and a half minutes each time, two staff (25 minutes per staff member, 50 minutes in total). Over time, once they had settled in, this might reduce significantly.

Personal care: Somebody not needing help to use the toilet would have no measure recorded on the tool. With time, they might need to be signposted to the toilets or need prompting or help with handwashing. Later, they may need to be discouraged from putting inappropriate things into the toilet. Eventually, full personal care assistance may be necessary (e.g. incontinence pad changes).

Mobility: A client may ask where they need to go and be able to go there without assistance. If they are at risk of falls, or require supervision or assistance to move around, then these would be examples of increased staff intervention.

Nutrition: If a client can eat and drink independently, even with modified diet or equipment such as a non-spill cup, they would not have any measures recorded on the Tool. If clients need prompting to drink enough, assistance with eating, or supervision to ensure they do not take food from others, then time measurements reflecting the need to provide one to one support would be included in the Tool.

Outcomes of using the Time Tool

- **Benefits for clients:** Better understanding of changing needs and the time and methods necessary to support them. Staff sharing tips may lead to improved personalised support. Regular reviews of needs, sometimes leading to care plan changes, would ensure their needs are recognised, met and accounted for. More focus on actual practical support time needed means that clients would not be excluded from the service on specific individual criteria, such as whether they are able to weight-bear.
- **Benefits for relatives**: Provides non-judgemental evidence supporting decisions about whether the service continues to be appropriate for individual clients. Providing non-emotive descriptions of time intensity required to support their relative can be less painful for carers to hear than details of ‘inappropriate’ behaviours (e.g. undressing, faeces-smearing). It may be helpful for carers to be given clear explanations of Time Tool evidence, and how it was arrived at. This could help illustrate how their family member has been treated as an individual and not compared with other clients and may alleviate any concerns they may have.
- **Benefits for staff**: Staff felt that identifying specific individual support challenges helped them feel validated because the challenges they faced on a daily basis were evidenced. The tool was also useful for service self-audit – e.g. team meetings identified how much time staff spent supporting people with the same tasks – shared tips etc. Reflective discussions at meetings were reportedly experienced as refreshing.
- **Benefits for manager/service**: Gaining clarity on the complex behavioural and psychological symptoms as clients’ dementia progresses and the effect this has on pressure felt by staff and on staffing levels. Additional way to review care plans and monitor clients’ needs.

Notes on use of the Time Tool

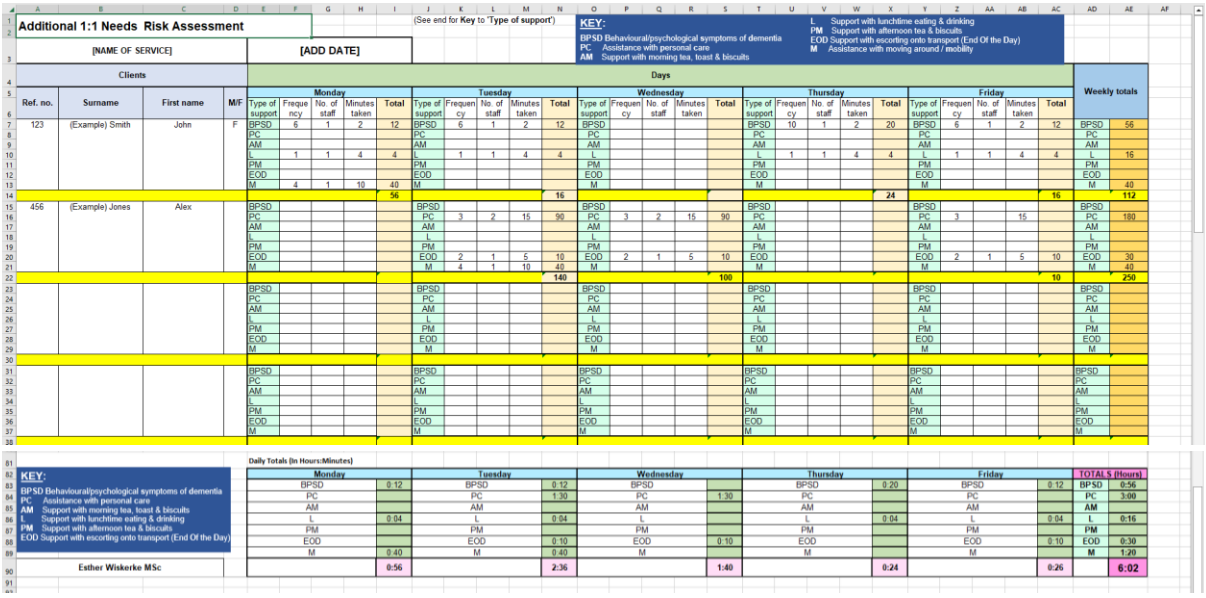
The Time Tool is intended to be used at intervals, to monitor a person's support needs. For example, every month or 6 weeks. Staff groups would then discuss individual support needs and any differences across time.

Two example lines have been completed to demonstrate how to input. A screenshot appears at the foot of this page.

- Spreadsheet users input to white cells only (name, m/f, frequency of support, number of staff needed and minutes taken).
- Figures in coloured cells are calculated automatically.
- Figures in the final daily totals section are calculated automatically (minutes of support in each category and in total).
- One row is provided for each area of support required.
- The key to areas being monitored appears at the top and bottom:

BPSD	**B**ehavioural/**p**sychological **s**ymptoms of **d**ementia
PC	Assistance with **p**ersonal **c**are
AM	Support with morning (**am**) tea, toast & biscuits
L	Support with **l**unchtime eating & drinking
PM	Support with afternoon (**pm**) tea & biscuits
EOD	Support with escorting onto transport (**E**nd **O**f the **D**ay)
M	Assistance with **m**oving around / **m**obility

Below is a screenshot of the Time Tool which can be downloaded as an Excel spreadsheet from the **Understanding outcomes and impact section of the Resources Hub**.



Additional 1:1 Needs Risk Assessment

(See end for **Key** to 'Type of support')

KEY:
BPSD Behavioural/psychological symptoms of dementia
PC Assistance with personal care
AM Support with morning tea, toast & biscuits
L Support with lunchtime eating & drinking
PM Support with afternoon tea & biscuits
EOD Support with escorting onto transport (End Of the Day)
M Assistance with moving around / mobility

[NAME OF SERVICE]

[ADD DATE]

Clients				Days																										
				Monday					Tuesday					Wednesday					Thursday					Friday					Weekly totals	
Ref. no.	Surname	First name	M/F	Type of support	Frequency	No. of staff	Minutes taken	Total	Type of support	Frequency	No. of staff	Minutes taken	Total	Type of support	Frequency	No. of staff	Minutes taken	Total	Type of support	Frequency	No. of staff	Minutes taken	Total	Type of support	Frequency	No. of staff	Minutes taken	Total		
123	(Example) Smith	John	F	BPSD	6	1	2	12	BPSD	6	1	2	12	BPSD					BPSD	10	1	2	20	BPSD	6	1	2	12	BPSD	56
				PC					PC					PC					PC					PC					PC	
				AM					AM					AM					AM					AM					AM	
				L	1	1	4	4	L	1	1	4	4	L					L	1	1	4	4	L	1	1	4	4	L	16
				PM					PM					PM					PM					PM					PM	
				EOD					EOD					EOD					EOD					EOD					EOD	
				M	4	1	10	40	M					M					M					M					M	40
								56					16										24					16		112
456	(Example) Jones	Alex		BPSD					BPSD					BPSD					BPSD					BPSD					BPSD	
				PC					PC	3	2	15	90	PC	3	2	15	90	PC					PC	3		15		PC	180
				AM					AM					AM					AM					AM					AM	
				L					L					L					L					L					L	
				PM					PM					PM					PM					PM					PM	
				EOD					EOD	2	1	5	10	EOD	2	1	5	10	EOD					EOD	2	1	5	10	EOD	30
				M					M	4	1	10	40	M					M					M					M	40
													140					100										10		250
				BPSD					BPSD					BPSD					BPSD					BPSD					BPSD	
				PC					PC					PC					PC					PC					PC	
				AM					AM					AM					AM					AM					AM	
				L					L					L					L					L					L	
				PM					PM					PM					PM					PM					PM	
				EOD					EOD					EOD					EOD					EOD					EOD	
				M					M					M					M					M					M	
				BPSD					BPSD					BPSD					BPSD					BPSD					BPSD	
				PC					PC					PC					PC					PC					PC	
				AM					AM					AM					AM					AM					AM	
				L					L					L					L					L					L	
				PM					PM					PM					PM					PM					PM	
				EOD					EOD					EOD					EOD					EOD					EOD	
				M					M					M					M					M					M	

Daily Totals (In Hours:Minutes)

Monday		Tuesday		Wednesday		Thursday		Friday		TOTALS (Hours)	
BPSD	0:12	BPSD	0:12	BPSD		BPSD	0:20	BPSD	0:12	BPSD	0:56
PC		PC	1:30	PC	1:30	PC		PC		PC	3:00
AM		AM		AM		AM		AM		AM	
L	0:04	L	0:04	L		L	0:04	L	0:04	L	0:16
PM		PM		PM		PM		PM		PM	
EOD		EOD	0:10	EOD	0:10	EOD		EOD	0:10	EOD	0:30
M	0:40	M	0:40	M		M		M		M	1:20
	0:56		2:36		1:40		0:24		0:26		6:02

KEY:
BPSD Behavioural/psychological symptoms of dementia
PC Assistance with personal care
AM Support with morning tea, toast & biscuits
L Support with lunchtime eating & drinking
PM Support with afternoon tea & biscuits
EOD Support with escorting onto transport (End Of the Day)

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