

Angus Health and Community Care Partnership

National Outcomes for Community Care Pathfinder

Interim Report

April 2008

Version 1.0



Contents

Executive Summary	4
1 Introduction	6
1.1 Background to the Pathfinder	6
1.2 An Overview of the Angus Pathfinder	8
2 Progress to Date.....	12
2.1 Testing and Technical Evaluation of OC2 Measure	12
2.2 Evaluation of the UDSET in Different Care Settings	13
2.3 Assessment of Tools for Modelling the Balance of Care	13
2.4 Assessment of IoRN to Measure Dependency in Home Care Setting.....	13
2.5 Review of Data Issues and Reporting Requirements.....	14
2.6 Integration with Community Planning Arrangements	14
2.7 Organisational Development	15
2.8 Review of Financial and Governance Arrangements	16
2.9 Implementation of National Information Standards	19
2.10 Mapping of Service Developments and Initiatives.....	20
3 Evaluation of the National Outcome Measures	23
3.1 Overview and General Issues.....	23
3.2 Measure 1: OC5.....	28
3.3 Measure 2: OC7(1) and (2).....	30
3.4 Measure 3: OC9	31
3.5 Measure 4: PR1a	32
3.6 Measure 5: PR1b	34
3.7 Measure 6: OC8a	35
3.8 Measure 7: OC8b	38
3.9 Measure 8: OC3	39
3.10 Measure 9: IP1	40
3.11 Measure 10: OP6 (related to HEAT 4.01K measure).....	41
3.12 Measure 11: OP8 (1) and (2).....	42
3.13 Measure 12: OP5a (SPI ASW 1a)	43
3.14 Measure 13: OP5b (SPI ASW 1a)	44
3.15 Measure 14: OP7a (related to HEAT 4.08K measure).....	45
3.16 Measure 15: OP7b (HEAT 4.02K measure).....	46
3.17 Measure 16: OC2	47
4 The Measures as a Suite	49
4.1 Interactions between the Measures	49
4.2 Alternative Measures.....	49
4.3 Additional Measures	50
5 Next Steps: Pathfinder Phase 3.....	52
5.1 Completion of Tasks outstanding from Phase 2.....	52
5.2 Development of a Balance of Care and Commissioning Model	52
5.3 Development and Testing of Alternative / Additional Measures	53

5.4	Adaptation of Outcomes Framework for other Care Groups	53
5.5	Development of Ability / Assessment Summary Scale	53
5.6	Development and Delivery of an Organisational Development Plan for the Angus Partnership	53
5.7	Development and Delivery of a Shared Learning Programme	54
Appendix 1 Revised Angus Community Planning Partnership Governance Structures for Health and Community Care		55

Executive Summary

This report sets out progress to date in delivering the objectives of the Angus Pathfinder.

While the objectives of the Pathfinder have not changed, the new relationship between Scottish Government and Local Government set out in the Concordat in November 2007, and the subsequent development of the Angus Single Outcome Agreement (SOA), have shifted the emphasis within the Pathfinder Programme. The National Outcomes for Community Care Framework will no longer be a requirement on local partnerships, and the ending of ring-fencing of key budgets for local authorities removes one of the constraints on effective partnership working which the Pathfinder was originally intended to address.

Within this new policy context the Pathfinder's role remains to develop the outcomes approach, both within the context of performance management and service delivery, and to demonstrate the benefits of this approach in driving improvements in joint working and commissioning.

The scope of the Pathfinder was also extended to include the delivery of the Telecare Development Programme in view of the close connections between the two projects.

The Pathfinder Project Initiation Document (PID) set out 11 success criteria for the project (see section 1.2.3). Three of those have been delivered, namely:

- Assessment of the proposed national outcomes
- Development of reporting arrangements within community planning
- Mapping existing governance and funding arrangements

An in depth assessment of the 16 proposed outcome measures has been completed and is presented in detail in section 3 of this report. The assessment found that 6 measures were fit for purpose subject to some technical refinements, 3 were fit for purpose but required to be balanced with additional measures, and that 7 required substantial additional work or should be replaced by alternative measures.

Reporting arrangements for community care have been embedded in the draft Angus SOA which has been developed as a partnership agreement to underpin Community Planning.

Associates from the Joint Improvement team have reviewed our existing governance and financial arrangements and made recommendations for future work in this area. Their report is included in full in section 2.8.

Significant progress has also been made in relation to the remaining success criteria. A number of additional or alternative measures have been identified and developed to ensure that the suite of measures represents a balanced framework for performance reporting and management. Service users and carers have been actively involved in the development and assessment of the User Defined Service Evaluation Tool (UDSET) and will continue to be involved in the development and assessment of the outcome measures. Initial work is almost complete in indentifying appropriate tools and systems to capture and report on the outcome measures. In particular, existing single shared assessment tools have been reviewed against the draft National Information Standards, the UDSET has been piloted in different care settings, and an evaluation of the suitability of the IoRN scale to enable reporting on one of the proposed measures.

The work of the Pathfinder is being delivered through 12 workstreams (see section 1.2.2). Interim reports on the main workstreams will be completed in June 2008, including reports on the piloting of the UDSET, evaluation of the IoRN, and progress in developing a local balance of care model. A number of workstreams have identified further work which needs to be carried out in order to deliver the Pathfinder Objectives. These are detailed in section 2.

In addition, the Project Board have agreed the following work priorities for the next phase of the Pathfinder:

- Development and testing of alternative and additional outcome measures
- Adaptation of the outcomes framework to cover other care groups
- Development of an ability / dependency or assessment summary scale
- Development of an organisational development plan for the Angus Partnership
- Development of a shared learning programme

In summary, the Pathfinder has made steady progress in delivering its objectives to date and is on target to complete its work in early 2009.

1 Introduction

1.1 Background to the Pathfinder

The development of the Angus Pathfinder project has taken place in the context of rapid policy development and political change, in particular the election of a new Scottish Government in May 2007 and the advent of the Concordat between Scottish Government and Local Authorities in November 2007.

The Pathfinder has also had to take account of local political change, major restructuring within the local authority, and the commencement of a redesign of community medicine and rehabilitation service across the county.

At the same time the Pathfinder has been developing against the backdrop of the first multi-agency inspection of older people's services (which covered the NHS Tayside area), and a Best Value Review of older people's services within the Angus Partnership.

It is not surprising that the shape and purpose of the Pathfinder has changed and developed, and that it continues to be work in progress.

However, the project retains a clear vision: to develop an outcome focused approach to service delivery and performance management that delivers better outcomes for people with community care needs.

1.1.1 *Proposed Local Outcome Agreement*

In October 2006, the Angus Partnership was approached by the then Scottish Executive with a view to developing a pathfinder project to explore the benefits of Local Outcome Agreements in community care, building on the approach already adopted by the Treasury with local authorities in England.

The key driver for this initiative was the Scottish Executive's Reform Agenda, which sought to engage local authorities and other public bodies more directly in the delivery of the Executive's national priorities, and to achieve greater efficiency in the delivery of those outcomes.

Alongside this it was envisaged that Local Outcome Agreements would reduce the level of reporting required from local authorities and their partners, and would provide a performance framework which would enable the removal of ring-fencing of relevant funding streams and the removal of barriers to developing flexible governance arrangements.

Discussions initially focused on the development of an outcome agreement covering community care services to older people. It was recognised by all parties that the delivery of a shift in the balance of care from institutional settings to care at home or in community settings potentially involved a loss of economies of scale. One of the key objectives of the proposed Local Outcome Agreement was to establish how removal of ring-fencing and more flexible governance and joint service delivery arrangements could enable partnerships to deliver efficiencies through economies of integration.

It was proposed that the Angus Pathfinder would develop and test an Outcomes Framework which would underpin the Local Outcome Agreement, and explore opportunities for achieving service improvements and efficiencies through greater integration across organisational and professional boundaries, including more flexible governance and funding arrangements.

1.1.2 *National Outcomes Framework for Community Care*

Alongside the Reform Agenda, the other major driver behind the Pathfinder was the development by the Joint Future Unit of an outcomes focused performance management framework for community care to replace the JPIAF.

Following extensive consultation with stakeholders, the draft outcomes framework was launched in April 2008 with a view to phased implementation by 2008-09. The intention was that all partnerships would be required to use the National Framework of 4 outcomes and 16 measures to report their performance, enabling benchmarking and performance comparisons nationally.

In view of this development the focus of the Angus Pathfinder shifted from the development of an outcomes framework to the evaluation of the national framework and piloting its implementation locally.

Additionally, six other partnerships were invited by the Joint Future Unit to become Early Implementer Sites and to test and evaluate specific aspects of the national framework and its impact on commissioning and performance management within partnerships.

The Angus Pathfinder retained the Reform Agenda objectives of exploring opportunities for improved services and efficiencies of delivery through removal of budgetary ring-fencing and barriers to flexible governance.

1.1.3 *Impact of the Budget Spending Review and Concordat*

In November 2007 the Scottish Government set out its first Budget Spending Review, which set out radical proposals for an outcomes focused performance management framework throughout all levels of Government.

The Concordat between Scottish Government and Local Government, unveiled at the same time, established a framework for Single Outcome Agreements with local authorities, removing ring-fencing from the majority of funding streams and giving local authorities freedom to reflect local priorities within the national outcomes framework.

The consequence of these developments for the Pathfinder has been far reaching. The National Outcomes Framework for Community Care, which had been intended to be a requirement on local partnerships will now be voluntary. Although a single community care outcome indicator has now been included in the menu of local outcome indicators, local authorities are not obliged to report community care outcomes at all if they so wish, and are not required to use the 16 measures which form part of the National Framework for Community Care.

The Pathfinder no longer has a role in making the case for the removal of ring-fencing of relevant local authority budgets as these have already been merged under the Concordat.

However, the development of Single Outcome Agreements is a process and the removal of ring-fencing brings new challenges for Partnerships in making the case for resources, for which they will now need to compete, within the wider priorities of local authorities. While Community Planning Partnerships will be expected to adopt an outcomes focused approach in line with local authorities, other partners, notably NHS Scotland, will continue to operate with very different governance and funding arrangements from those now enjoyed by councils.

The context has changed, but the challenge for the Pathfinder remains the same: to develop an outcomes approach to performance management within the partnership context, to identify how partnerships and individual partners will need to develop and

adapt to embrace and realise the benefits of the outcomes approach, and to demonstrate how an outcomes focus can deliver better more efficient delivery of services and real benefits for service users and their carers.

1.2 An Overview of the Angus Pathfinder

1.2.1 *Project Initiation and Management*

In initiating the Pathfinder, it was decided to adopt a robust project management approach, using the Prince 2 methodology.

The Pathfinder is jointly sponsored by the Scottish Government Partnership Improvement and Outcomes Divisions and the Angus Healthy, Safe and Caring Communities Partnership, which performs the functions of a health and community care partnership within the Angus Community Planning Partnership structures.

The Partnership appointed a Project Board to oversee the Pathfinder, chaired by the Community Planning Manager, and including:

- General Manager of the Angus Community Health Partnership
- Director of Neighbourhood Services
- Director of Social Work and Health
- Representative from the Scottish Government Partnership Improvement and Outcomes Division
- Representative from the Scottish Government Public Sector Reform Group.

A Project Team was also established to support the Board, and a full-time Project Manager appointed to oversee the day to day management of the Pathfinder.

A Project Initiation Document (PID) was drawn up and approved by the sponsors in October 2007. The PID, which is a working document, sets out the objectives of the project, the key deliverables, and how delivery will be structured, managed and evaluated.

1.2.2 *Project Objectives and Workstreams*

The PID set out the following broad objectives for the Pathfinder:

- 1 To design, develop, and deliver existing and emerging outcomes focussed performance management frameworks in a manner that is practicable and achieves positive results for the development of the outcomes framework at a national level and for Angus
- 2 To inform the National Outcomes Performance Framework for Joint Future
- 3 To share information and experiences gained through this pathfinder programme with other stakeholders across Scotland, including co- operation with early implementer sites.
- 4 To provide an opportunity to develop and test the outcomes based framework within a context that will enable ;
 - a) The development and testing of qualitative measures and targets
 - b) Connections to the wider health, housing and social care activities

- c) Eventual assessment of the framework for use with other community care groups
 - d) Connections to the wider community planning arrangements to assess opportunities to broaden the approach across all public services
 - e) Development of proposals to improve the infrastructure in order to make it more conducive to joined up working at both a local and national level– e.g. alignment of funding streams, reducing the level of performance reporting, rationalisation of accountability etc.
- 5 Through the pathfinder project, inform the wider public sector reform, and joint future developments
 - 6 Inform future strategy for other client / patient groups
 - 7 Inform potential for future joint management and governance arrangements to maximise arrangements for planning and delivery of services with an outcomes focussed approach
 - 8 Ensure evaluation of benefits realisation compared with the status quo
 - 9 Ensure wider stakeholder involvement
 - 10 Review and ensure integration of framework with existing information systems
 - 11 Identify possible further work beyond March 2008

To deliver on these objectives, 11 workstreams were established, each with clear objectives, deliverables, and workplans.

Subsequently a twelfth workstream was added to incorporate oversight of the Telecare Development Programme within Angus, and to develop opportunities within the Telecare Programme to test aspects of the outcomes approach. Although managed within the Pathfinder and contributing to it, the Telecare Programme is the subject of separate reporting arrangements.

The following table lists the workstreams, their objectives, and key deliverables.

Work Stream	Objectives	Key Deliverables
1. Requirements / definitions of OC2 – emergency admissions without assessment	Urgently review the ability to meet the requirements of this from information and definition perspective taking account SMR process and acute specialty definition.	<ul style="list-style-type: none"> • Report produced outlining options for data retrieval and evaluation of measure • Resource implications identified
2.(a) User satisfaction and involvement 2.(b) Carer satisfaction and involvement	<p>2 (a) Review any existing user satisfaction tools and test out the UDSET tool developed by the Joint Improvement Team to meet the requirements of OC5, 7 and 9 as contained within the current national outcome measures.</p> <p>2(b) Review exiting carer assessment tools to ensure compliance with the ARCG National Standards when published, in particular new Angus carers self assessment tool. Review and evaluate any carer satisfaction tools and test out the UDSET tool developed by the Joint Improvement Team to meet the requirements of OC3 and OC7.</p>	<ul style="list-style-type: none"> • Tools developed and tested – re measures for users • Tools developed and tested – re measures for carers • Report on evaluation of measures (with involvement of users and carers) produced • Links with community planning identified • Links with service improvements agreed

Work Stream	Objectives	Key Deliverables
3. Balance of Care issues	<p>Review current performance information in order to meet the requirements of IP1.</p> <p>Develop a balance of care model that takes account of the key social, health and housing elements and that reflects current local needs and priorities and is able to be adapted to changing demographics.</p>	<ul style="list-style-type: none"> • Evaluation of available tools for 'whole systems modelling' • Evaluation of measure IP1 • Identification of barriers and opportunities to 'shifting the balance of care' • Report produced outlining recommendations for service improvements
4. Data capture, aggregating, reporting frameworks inc LITS,SSA	Mapping of exiting data requirements relevant to the pathfinder project across health, social work and housing.	<ul style="list-style-type: none"> • Mapping of national reporting requirements • Report produced outlining recommendations for streamlining reporting burden
5. Dependency measures / tools etc	Review and evaluate the use of dependency measures and tools e.g. the IORN and identify opportunity for use in supporting the measurement and analysis of key outcomes for older people.	<ul style="list-style-type: none"> • Evaluation of available tools for measuring dependency • Report produced outlining recommendations for future application of tools
6. Community planning Arrangements	To look at the future role and links with Community Planning in supporting /leading outcomes approach.	<ul style="list-style-type: none"> • Set of measures developed to meet community planning priorities • Reporting arrangements established
7. Organisational Development requirements	<p>Develop systems to cascade learning from the Pathfinder Project to other care groups.</p> <p>Operationalise learning from pathfinder project.</p>	NOT YET COMMENCED
8. Evaluation	Apply an evaluation framework to measure the success of the pathfinder project.	<ul style="list-style-type: none"> • Appropriate evaluation framework identified • Initial, mid and final stage evaluation report completed
9. Financial and Governance Arrangements	To map current funding and governance arrangements across community care services and identify barriers to, and opportunities for improvement.	<ul style="list-style-type: none"> • Mapping of current arrangements • Report produced outlining barriers/ opportunities
10. National and Local Standards for Assessment and Care Management	Review current assessment and care management standards and assess effectiveness of current reporting arrangements to meet forthcoming national standards.	<ul style="list-style-type: none"> • Evaluation of current tools and processes against national standards • Tools and processes revised to meet national standards • Report outlining barriers/ opportunities for application across partner agencies
11. Current and Planned Services Developments and Initiatives	Map current and planned service development and initiatives across the partnership and identify potential contribution to achieving better outcomes.	<ul style="list-style-type: none"> • Mapping of current initiatives and key drivers • Report produced outlining barriers/ opportunities for service improvements
12. Angus Telecare Development Programme	Develop and deliver identified telecare projects, incorporating where possible testing of outcome measures, and developing ongoing monitoring systems to support outcomes based performance management	<ul style="list-style-type: none"> • Delivery of 6 projects identified in programme design documents • Testing of outcome measures within projects • Development of performance monitoring framework

1.2.3 Success Criteria

On the basis objectives set out in the PID, the Project Board agreed the following specific success criteria:

- 1 Completion of an assessment of proposed National Outcomes
- 2 Identification of a suite of outcome measure which are 'fit for purpose'
- 3 Active involvement of users and carers in the development and assessment of outcome measures
- 4 Identification of appropriate tools, processes and systems to capture and report on the outcome measures
- 5 Development of reporting arrangements on the outcome measures within the Angus Community Planning structure
- 6 Mapping of current national reporting requirements
- 7 Mapping of existing funding streams and governance arrangements
- 8 Identification of barriers (national and local) to effective outcomes-based performance management
- 9 Recommendations made to improve infrastructure (national and local) to improve outcomes for people using services
- 10 Identification of areas of good practice and learning within the Angus Partnership
- 11 Production of a Final Report on the Pathfinder Project

This interim report contains our assessment for the proposed national outcome measures, the mapping of current funding and governance arrangements within the Partnership, and the integration of the National Outcomes within the Angus Community Planning structure and the development of the Angus Single Outcome Agreement. As such it is intended to deliver on Success Criteria 1, 5, and 7.

The report also contains a summary of substantive progress towards meeting Success Criteria 2, 3, 4, 6, and 8.

2 Progress to Date

This section gives a progress report on each of the active workstreams, with the exception of Workstream 12 (Telecare) and Workstream 8 which covers the evaluation of the Pathfinder Project.

The Project Board selected the OCG Gateway Process to evaluate the delivery of the Pathfinder. A stage 0 review was signed off in January 2008 and a further stage 0 review will be carried out following approval of this interim report by the Pathfinder sponsors.

2.1 Testing and Technical Evaluation of OC2 Measure

Workstream 1 has focused on preparing the way for reporting on the OC2 measure for 2007-08.

There have been two main dimensions to this:

- Reaching a common understanding of what constitutes a “health and social care” assessment in the local context
- Identifying and resolving data definitions and data compatibility issues to ensure records can be accurately cross-matched between Health and Social Work IT systems

Reaching agreement on these issues has required extensive consultation Medicine for the Elderly Consultants, Older People’s Services, Community Hospitals and Palliative Care Service Management Team, and Angus CHP Managers, as well as NHS Tayside Information Services and ISD.

One problem encountered was that community hospital beds in Angus are not designated or used in a way which readily fitted the requirements for this measure. We have now reached agreement with NHS Tayside on the profile and classification for beds in Angus for the purposes of this measure. The NHS Tayside code set will be used to define and describe emergency admissions.

A sample set of Social Work and Health CareFirst records have been provided to NHS Tayside Information Services to test the compatibility of the data fields. We are awaiting the results of this work.

There has been considerable discussion locally about what assessments should be counted for the purposes of this measure. As part of workstream 10, a review of all assessment tools has been undertaken and it is apparent there is still a lack of consistency of approach with some assessment processes which makes it difficult to evaluate whether they would constitute a “health and community care” assessment. Further work is also required to identify how assessments undertaken by District Nurses, and recorded on the Octagon system, can be extracted and cross-referenced with the ISD data.

We have therefore agreed that only assessments that conform to Single Shared Assessment principles included in the measure in 2007-08 in Angus.

We are now awaiting delivery of the dataset from ISD. Cross-referencing will have to be carried out manually.

2.2 Evaluation of the UDSET in Different Care Settings

Work has been taken forward locally to test out a number of different tools, based on the UDSET, to record the self-defined assessment by service users and carers of the outcomes delivered by their care packages. A total of 70 users and carers have been involved to date throughout this process. A range of staff from across the Community Partnership has carried out this work including care and case managers, psychiatric nursing staff, with input from the Angus Carers Association.

In addition, Outcome Focused Assessments have now been carried out in respect of significant numbers of users and carers using the UDSET approach. As part of the Digital Stories Agenda, discussions are taking place with the Joint Improvement Team regarding filming a story of user/ carer experience of Intermediate Care services in Angus.

To date, feedback on the use of the various tools has been largely positive from service users, carers and staff. From this, a number of themes can be identified:

- A training framework will be required in order to roll out this agenda across the wider Partnership
- There is a need to link to the new national standards in order to ensure that any tool is compliant with these standards.
- There are a number of issues around the use of terminology. These include the need for very clear definitions of the key indicators, the potential for capacity issues to hamper the collection of information, and the continuing unnecessary use of “professional jargon” by different staff groups.
- The new methodologies could contribute to establishing the national care management framework as part of the reviewing/monitoring process.

A final theme, which has been identified from a service user and carer perspective, is the importance of their relationship with the professional staff member, with particular regard to such personal concepts as congruence, empathy and acceptance.

A full report on the outcome of the pilots will be completed in June.

2.3 Assessment of Tools for Modelling the Balance of Care

Workstream 3 has been focused on the evaluation of tools to enable partnerships to model the resource implications of different balance of care models against the background of demographic change.

We are currently in the final stages of populating and evaluating the JIT Capacity for Change tool, and hope to have completed this by the end of April 2008. A report on our experience of using the tool and our evaluation of its usefulness in informing service planning and commissioning will be produced later in the year.

2.4 Assessment of IoRN to Measure Dependency in Home Care Setting

The original objective of workstream 5 was to review and evaluate the use of a range of dependency measures currently being applied in community care settings both nationally and locally. At an early stage in this activity it was agreed that the workstream should concentrate on one specific measure: *Indicator of Relative Need (IoRN)*. The rationale for this was that there was already local knowledge within Tayside around the application of IoRN, and that other than some limited local use of SHRUGS and SCRUGS in relation to NHS in-patient groups, there was a paucity of alternative measures in use.

The IoRN has not at this point in time been formally introduced to Single Shared Assessment activity in Angus although there are plans to do so this year. Some activity has been undertaken in respect of assessing dependency levels of clients within Local Authority residential care, but the measure is not in common use in Angus. The groups of staff who are currently generating assessments through the eCare application have the facility in the system to generate IoRN scores. These, however, represent a minority of staff.

The activity within the workstream contains two separate strands. The first strand seeks to test out the application of IoRN across a range of clinical/operational areas (community care clients, NHS in-patients, and residents in Independent care homes) and asks questions around ease of use, accuracy and usefulness and added value to the assessment process. It also seeks to map consistency between IORN dependency scores and wider conclusions from the assessment process.

The second strand examines a sample of thirty clients assessed in mid 2007 to whom IoRN scores have retrospectively been applied on the basis of the assessments. The intention is to examine correlations between IoRN scores and actual care packages put in place following assessment. The exercise also traces the progress of the thirty clients to present day and examines actual outcomes for these clients.

The present status of the workstream is that data is currently being collected and on the basis of an analysis of this data, a report will be submitted to the Pathfinder Project Group for its April meeting. The report will contain recommendations for the application and roll out of IoRN across Angus based on what has been learned locally and from discussion with colleagues in other Partnerships.

2.5 Review of Data Issues and Reporting Requirements

One of the initial objectives of the Pathfinder was to map existing statistical and performance management reporting arrangements, and to identify ways in which these could be rationalised. Information is currently being collected from partner agencies and recommendations for rationalisation will be included in a final report on this workstream in due course.

2.6 Integration with Community Planning Arrangements

Angus has a well established community planning structure in which the partnership arrangements for community care are firmly embedded (see Appendix 1). The task of workstream 6 has been to ensure that the community care outcomes and supporting measures were incorporated within the Community Planning Partnership's strategic planning documents and reporting processes.

Initial work was completed in October 2007 to align the outcomes and measures to the priorities and outcome areas of the Angus Community Plan 2007-2012. However, this work was overtaken with the announcement of the Concordat, and the requirement that Angus Council develop a Single Outcome Agreement (SOA).

Angus Council took the decision that the SOA should be developed from the outset within the context of the Community Plan and jointly with community planning partners. Extensive work was done between December 2007 and March 2008 to develop an SOA that reflected both the Community Plan and Angus Council's corporate priorities. Members of the Project Team and Project Board, supported by the partnership's Joint Strategic Support Unit, were directly involved in the development of the SOA and in ensuring that the Outcomes Framework for Community Care was reflected in the draft document.

It was unfortunate that the single community care indicator was not included in the Improvement Service menu of local indicators until late in February 2008. As a result it was too late to incorporate it into the draft SOA at this stage, and those community care outcome measures which have been incorporated have been aligned to other indicators within the framework of national and local indicators.

The draft Angus SOA which has now been submitted to the Scottish Government includes 8 of the 16 measures but does not explicitly refer to the four national outcomes for community care, or to the single community care indicator. The selection of measures reflects the evaluation of the suite of measures undertaken by the Pathfinder, detailed in section 3 of this report.

The Angus SOA will be further refined and finalised over the next three months, and work will continue to develop a more extensive SOA for the Angus Community Planning Partnership over the next year. This workstream of the Pathfinder will continue to ensure that the developing outcomes framework for community care is robustly and coherently reflected within the outcomes agreements for Angus, and within local performance management processes.

2.7 Organisational Development

The output from the Pathfinder to date, as reflected in this report, raises a number of issues for the Angus Partnership and for individual partners in adopting and embedding an outcomes approach, and in developing staff capacity and commitment to outcomes focused service delivery.

The Project Team have been involved in piloting the JIT "Popit" performance management self-assessment tool, and all key partnership service managers and planning and performance staff are completing the tool as part of their preparation for a Partnership Development Day in May 2008. The event will focus on the impact of the Angus Single Outcome Agreement and the changes that the partnership will need to ensure it can deliver on the national outcomes for community care.

Representatives from the Scottish Leadership Foundation and NHS Tayside Modernisation Department will be present at the event to assist partners to begin the process of developing an organisational development plan for the Partnership.

The Partnership has already made significant progress in responding to the emerging need for a more flexible workforce to deliver outcomes focused services and achieve a real shift in the balance of care, in an integrated way.

The Angus Community Planning Partnership has established a Workforce Planning Group, chaired by the General Manager of the Community Health Partnership. The role of the group is to develop an action plan for developing a care workforce to meet demographic changes, particularly the growth in the proportion of older people in the Angus population.

The group is focusing on reviewing the workforce needs arising from the service plans for older people and children's services. The group will also consider the impact of the Best Value Review of Services for Older People when it is completed in May 2008, and the current review of Community Medicine and Rehabilitation Services in Angus, which will enable a clear approach to modelling future services and a new care role within that context.

The group has begun a review of the projected numbers of care staff and the collation information about the care role for the future. To date the group has considered a paper outlining the possible creation of a new generic home carer post, including the job remit of such a post. There are still a number of issues to be addressed as regards

the administration of medication, the future registration of care staff, and the best way to pilot the new post, before a pilot is approved.

The group has also recognised the need to promote public sector work as a positive destination for young people, and is developing a stall for school careers evenings. The group is also considering how best to extend the Health and Social Care Academy to engage with people who wish to return to work, especially those who are at some distance from the labour market and may need support to return to employment.

A briefing bulletin on the work of the Pathfinder and the outcomes approach has been distributed to frontline staff. As part of the ongoing communications plan and organisational development work of the Pathfinder, a series of meetings with service managers, first line managers, and supervisory staff will be held over the next few months to ensure they are fully engaged in the development and delivery of the outcomes approach.

2.8 Review of Financial and Governance Arrangements

Workstream 9 is being taken forward on behalf of the Partnership by JIT Associates, David Pigott and Stan Smith. Their interim report is reproduced below. The recommendations from the report have been agreed by the Project Board and are being carried forward in the next phase of this workstream.

2.8.1 Background

This workstream is designed to map current funding and governance arrangements across community care services and identify barriers to, and opportunities for improvement.

Information on this subject was primarily gathered through discussions which took place on 21 November and 17th December 2007 involving:

- David Pigott, JIT Associate
- Stan Smith, JIT Associate
- David Cooke, Finance, CHP
- Elaine Hughes, Finance, Social Work
- Catriona Ferrier, Housing

Lorraine Young, Senior Manager Social Work and Health and David Archibald, Principle Corporate Planning Officer, Angus Chief Executive's Dept, both also members of the Project team, helpfully attended the second meeting.

The conclusions drawn reflect separate discussions held by the authors following these meetings including discussions on 11 January 2008 with:

- Tim Armstrong, Senior Manager (Strategic Development and Adult Care)
- Robert Peat, Director of Social Work and Health
- Keith Whitefield, Project Manager
- Susan Wilson, General Manager, Angus CHP

2.8.2 Discussion

Within Angus there is already an open sharing of information in relation to Community Care budgets across Health and Local Authority. Currently budgets are aligned but not pooled. While budgetary information is available across health and social care it is not related or tied to activity. At one point there were regular meetings when budget information was shared by housing, social work and health.

These joint meetings (attended by finance staff) did not develop beyond information sharing and so have not been continued following the establishment of joint groups for each of the care groups as well as other crosscutting groups (see Appendix 1).

These four Joint Management and Commissioning Groups include one relating to Older Peoples services. They are accountable groups with responsibility for planning, financial and delivery matters in relation to the care group and report to the General Manager of the CHP and the Director of Social Work who in turn feed in to community planning structures. These arrangements have only very recently been introduced and therefore should be seen as work in progress rather than fully established elements within the system. Finance officers in Health and Social Work share care group support across each service.

Some progress has been made in improving flexibility at an operational level across organisational structures so, for example within joint teams' health staff can commit Local Authority resources. This has been achieved by health providing Angus Council with a letter of comfort. A more formal scheme of delegation is under development in relation to social work services but no work has been undertaken in a health service context.

Consideration was also given to the potential future arrangements in relation to Extended Integrated Community Teams through a recent workshop and this will be the subject of further work going forward.

Another service area which illustrates a commitment to minimise the impact of organisational boundaries and governance arrangements is in relation to the operation of the joint OT Store. The storeman is a council employee but both health and local authority staff can commit resources. However operational arrangements and rules can be inhibitors so, for example the two organisations take different approaches to stock management and the current IT system and processes are not helpful.

Within the circumstances which currently prevail in Angus there are a number of issues which limit the degree of partnership between health and local authority.

The potential for an effective Joint Team arrangement is constrained by governance, professional and financial issues.

For example the timing of local authority budget setting and debate has traditionally been at significant variance with health where financial information and budget setting come considerably later than in the Local Authority. However the timing of budget preparation for the coming financial year is happening within the same timeframe and this has proved very helpful in providing the opportunity to explore the potential to achieve efficiencies across the health and social care system and consider the service implications of potential budget constraints in a whole system context. It is unclear at this stage whether it will be possible to co-ordinate the timing of budget preparation in future years.

The CHP also receives some of its monies "with strings" from NHS Tayside which significantly limits the potential for local decision making. In terms of creating a pooled budget in Angus one potential mechanism for playing in health resources would be to divide the money coming from NHS Tayside in to Core and Development/Clinical Priorities thereby allowing local decision making over the core element alongside the local authority contribution to the pooled budget. This would not include the substantial GMS and medical budgets.

Similar structural difficulties arise in relation to planning where in a health context significant resource and significance is attached to board wide strategies e.g. NHS Tayside Older Peoples Strategy. Consideration needs to be given to the formal

linkage and relationship between this work and that going on at a local level in the four Care Groups.

The ring fencing of budgets is something which traditionally happens within the local authority and health systems. Examples identified included:

Health –Delayed Discharge, Blood Borne Viruses

Local Authority – Quality of Life, Mental Health Specific Grant, Social Work Training, Supporting People

Decisions by the Scottish Government are likely to lead to significant changes with the ring fence removed in relation to Social Work Training, Supporting people and Delayed Discharge with the latter seeing money channelled through the local authority rather than health. Angus Council have already decided that Supporting People budgets should be located with the social work service. Angus Council will need to make decisions on the utilisation of these budgets but there is a recognition that this needs to be examined recognising the wider context of the health and social care and community planning partnerships.

Another significant potential area of difficulty in relation to a pooled budget (as opposed to the current position of aligned budgets) is where either or both financial systems wish to impose savings or efficiency targets and the possible difficulty in doing this over time.

The pooled budget would also include a significant amount of resource transfer (£1.6M in relation to Older Peoples services in Angus). Although local reporting arrangements on resource transfer are less resource intensive than previously it still seems anachronistic that this area is ring fenced and subject to annual reporting and accounting across organisations when looked at in the context of the national drive to remove ring fencing and minimise reporting requirements. The current arrangements are also a source of some discord between health and social care because there is no annual uplift for inflation within the transferred amount.

This is an area (i.e. the reporting requirements) which would merit consideration / discussion at a national level.

2.8.3 Summary

There is evidence of a high level of commitment to greater integration in the management, planning and delivery of community care services in Angus but only very limited progress has been made in relation to the management of financial matters and the articulation of clear governance arrangements in relation to health and social care. To change this would require a fundamental commitment by Angus Council and NHS Tayside as well as the social work and housing services because it would require adjustments to corporate systems and approaches as well as service delivery and planning. Up to this point change in relation to financial management and governance has been at the margins. There would need to be clearly identifiable benefits for both organisations and service users to encourage a shift to the current approach.

If it were considered that there would be benefit locally in examining this in greater detail then there are a number of elements which would need to be explored. These would include:

Vision – is there a shared view about the destination (and the benefits it would bring) in relation to more integrated financial and governance arrangements in Angus?

To date the approach has been one of pragmatic development to achieve better outcomes for service users and this focus on outcomes is one which is likely to continue with developments in relation to finance and governance following improvement opportunities rather than an end in itself. At the present time there seems to be clear local support for greater integration but progress may be faster and more systematic if there is greater clarity about the desired destination. Any exploration of this needs to include NHS Tayside, Angus Council and the wider community planning partnership and take account of the local and national political context.

Culture – there is a strong sense of partnership in Angus but this does seem to be constrained by organisational boundaries and separate accountabilities.

Structures – the recently introduced Care Group structures do seem to provide a potentially powerful vehicle for more effective integrated working and could provide a useful focus for developmental activity in relation to planning and finance. However further work is required to clarify the respective roles and relationships of/with NHS Tayside and the wider community planning partnership.

Systems – at the present time systems are insufficiently integrated. Some of these cannot be resolved at a local level e.g. timing of budget discussions, while others are more open to local improvement. The current work in relation to outcomes would provide a useful vehicle for the development of an effective and integrated performance system. Similarly further work in relation to delegated authority and stronger linkage between budgets and activity is work which could be progressed locally.

2.8.4 Conclusion and Areas for Potential Further Consideration and Action

The building blocks for more integrated financial and governance arrangements are in place. Current practical inhibitors to greater integration seem mainly around structures and systems but this may mask the need to undertake further work in articulating what is meant by greater integration and importantly the perceived benefits for the organisations involved in relation to service planning and delivery and ultimately service users/patients.

The Extended Local Partnership Agreement has not been reviewed in the recent past and there would be benefit in undertaking this to ensure that it remains fit for purpose and reflects appropriately the current local and national position. There would be benefits in undertaking this work alongside a review of different models in place elsewhere in Scotland (and possibly England) with a view to identifying “what works” and considering the potential relevance of alternative models (or aspects of them) within an Angus context.

2.9 Implementation of National Information Standards

The remit of workstream 10 is to ensure compliance with the new “National Minimum Information Standards for all Adults in Scotland for Assessment, Shared Care and Support Plan, Review and Carers Assessment and Support” across the Angus partnership. The draft National Minimum Information Standards were issued for consultation in Dec 2007 with responses invited by 29th Feb 2008 and expands on the current National Minimum Information Standards for Single Shared Assessment with which the Tayside Adult Assessment Tool is compliant. The consultation document was circulated widely across the Angus Partnership and 2 specific meetings were arranged in February with key stakeholders to discuss and contribute to the Angus response.

The key points within the Angus response were that we supported the principal of having national standards however standards alone will not necessarily improve the

quality of assessments and will only contribute minimally to the outcomes agenda. We recommended that there is a need to invest in practitioner training in order that the standards are applied consistently across all staff groups and agencies. We also recommended a minimum of 1 year be allowed to achieve compliance.

As part of the CareFirst6 implementation project the draft standards were referred to in the development of a core referral data set. Further work will have to be undertaken once the standards are published to ensure that the wider data set for assessment, care planning and review are also compliant with the national standards.

Once the standards have been published an analysis of tools currently in use across all adult services in terms of compliance status will need to take place. An action plan will need to be produced in order to prioritise work in relation to revising current tools to meet minimum standards.

The Pathfinder is represented on the Assessment Review Co-ordinating Group, and will contribute to the analysis of the responses to the consultation and to the finalising of the national standards.

2.10 Mapping of Service Developments and Initiatives

The work of the Angus Pathfinder is taking place in a context of rapid policy and organisational change. A feature of this change is the complex and changing landscape of initiatives, service redesigns, and strategies which impact on the work of partners and the partnership as a whole. The National Outcomes Framework for Community Care, and the development of an Angus Single Outcome Agreement in line with the Concordat, are only two amongst a web of policy and service developments and initiatives which are impacting on the Angus Partnership.

Workstream 11 has attempted to map these developments, and to identify the linkages and dependencies. The purpose of this exercise is to enable the partnership to ensure links between the initiatives are maintained and that the maximum benefit can be derived from each without conflicting with or undermining other key activities.

Within Angus, a Best Value Review of services for older people is nearing completion. Although primarily focused on Social Work and Health and Housing services, the review covers areas of partnership working including joint services and initiatives, and the interface between acute and community based services. The review has also included the development of an Older Persons Housing Strategy.

Alongside this Angus CHP are in the early stages of undertaking a major redesign of community medicine and rehabilitation services. The redesign project is exploring a "hospital at home" approach including the development of a mobile MIU service and mobile diagnostics, along with the development of an integrated out of hours service.

At a Tayside level, NHS Tayside and the three Tayside local authorities are in the process of implementing the recommendations from the Multi-Agency Inspection of Services for Older People which took place in 2006. The main element of the action plan to impact on Angus will be the development of a Tayside Older Persons Strategy by NHS Tayside.

NHS Tayside has also commenced a major project on Shifting the Balance of Care, which is likely to result in a shift in the balance of resources from acute to primary care to support more local delivery of services.

At the same time a number of key service areas are undergoing development which will impact on, or will be shaped by, the Pathfinder. These include the ongoing development of Angus Intermediate Care and the development of the enablement / re-enablement model, the expansion of respite services including respite at home,

developing care pathways for long-term conditions, and the Telecare Development Programme.

Finally, major redesigns of neurological rehabilitation services and services for people with learning disabilities will also have a significant impact on the partnership's delivery of services for older people.

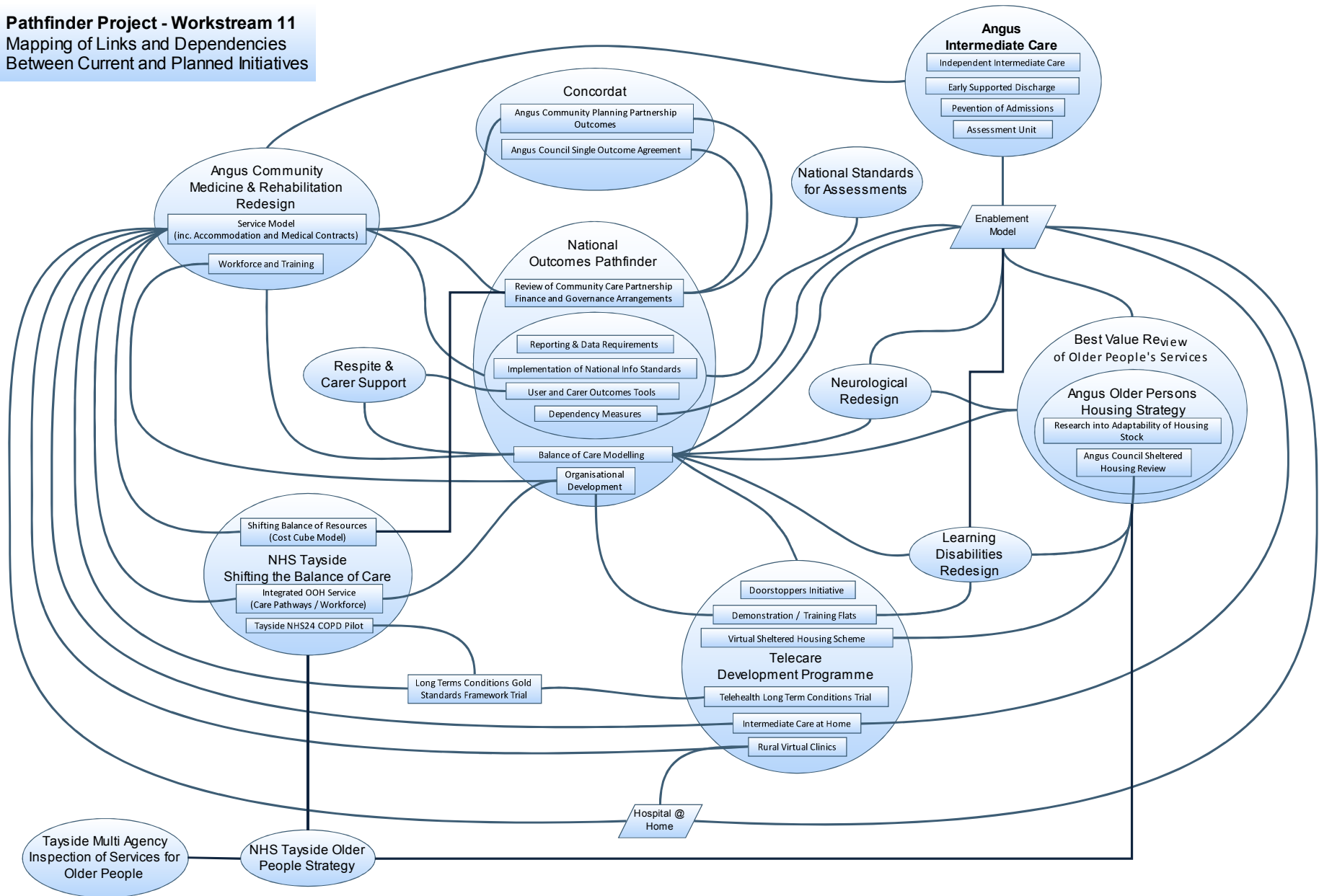
A number of issues have emerged during the mapping exercise. Firstly, the governance arrangements for many of these initiatives are unclear, or sit outside the established partnership governance structures. This has meant some duplication of effort and some developments being pursued within partner agencies which potentially conflict with the partnership's strategic objectives or with existing joint services.

Secondly, lack of joined up policy making at Scottish Government level has resulted in partners being encouraged or required to pursue initiatives or policy agendas which do not fit together well and which can undermine rather than support the capacity for partners to work effectively together. The failure to make the essential connection between the National Outcomes Framework for Community Care and Single Outcome Agreements during the development of the Concordat is an example of this.

The diagram below shows the complex inter-relationship of initiatives within which the Angus Partnership is currently operating. It also gives a flavour of the challenge the Pathfinder faces in developing an outcomes focused performance management framework that is fit for purpose and will enable the Partnership to assess the effectiveness of the emerging service models in delivering better outcomes for individuals.

A more detailed report on this workstream will be produced once analysis of the linkages is complete.

Pathfinder Project - Workstream 11
Mapping of Links and Dependencies
Between Current and Planned Initiatives



3 Evaluation of the National Outcome Measures

3.1 Overview and General Issues

3.1.1 *Data Collection Issues*

The capacity to record and aggregate data for OC3, 5, 7, and 9 is dependent on the integration of the UDSET, or a similar tool, into the current assessment, care planning, and review process, and specifically into the electronic SSA systems. Work is nearing completion to ensure that capacity is built into the e-Care and Care First systems used locally.

However, the successful delivery by the Transformational Technologies Division of a technical solution to data sharing between disparate systems is critical to enabling a number of the outcomes measures to be populated. There is concern that funding for ongoing development at national level and for the local Data Sharing Partnerships is under threat and this essential work is likely to remain uncompleted. In Angus we are particularly concerned that the delivery of the data sharing solution takes full cognisance of the existing investment made by 17 out of the 32 local authorities in the deployment of the OLM Care First system.

Partnerships are also at different stages in rolling out electronic recording of assessments, care plans, and reviews. This will impact on a number of measures where manual matching and collation of data will be necessary. This will not be sustainable as it is extremely resource intensive. It may be necessary for some of the measures to be reported as an estimate based on a sample in the first instance, as is proposed for measure 12 (OC2).

3.1.2 *Principles of the Outcomes Approach*

The key principle of the outcomes approach is that the focus should be on the outcome for the individual not on the method by which it is achieved, e.g. through the delivery of direct community care services. This principle underpins the Concordat and the National Outcomes Framework and should be reflected in the choice of measures.

3.1.3 *Consistency Between Measures*

Measures which are also HEAT targets, and which are reported as rates are expressed as rates per 100,000 population. By contrast OC5a and OC5b are expressed as rates per 1000 population.

We recommend that a consistent scale of 100,000 population is used across all relevant measures.

3.1.4 *Additional Levels of Analysis*

The Design Authority identified a number of additional characteristics to be included in data reporting to enable more detailed analysis. These were:

- Age
- Ethnicity
- Gender
- Care group (service user measures)
- Carer Group (carer measures)
- Acute specialties (emergency admissions measures)

The care group variable is of particular importance in interpreting the results of the outcome measures. However, it is essential that multiple care groups can be recorded, e.g. a service user may be over 65 and have both physical and learning disabilities.

As the draft national standards are adopted for assessment, care planning and review, the opportunity will arise to enable variables to be included.

The content of a care package, and the mix of informal and formal care, is partly determined by the nature of the service user's normal accommodation setting, their household context, and the structure of their informal care network.

We would recommend that the drill down hierarchy is extended to include the following housing related variables:

- Accommodation type
- Dwelling type
- Tenure

Inclusion of these variables will enable analysis of the inter-relationship between the outcomes and different housing contexts (e.g. the correlation of the sense of safety, the number of multiple admissions due to falls or domestic injuries, and the accommodation context).

We would also recommend the inclusion of the following variables for service users:

- Lives alone (Yes/No)
- Informal carers (Yes/No)
- Number of informal carers

These data items are included in the draft national standards for all assessments and therefore should, in time, be reportable for all community care service users. These variables will enable analysis of the degree to which outcomes are affected by the degree of social isolation of service users and the availability of informal care and support. For example, low levels of personal care and intensive care at home in a local authority area may be due to a lower proportion of service users living alone and a higher proportion of service users with extensive informal networks of care.

It is also recommended that the Postcode of service users is also collected as part of the data collection process. While this is not relevant to national reporting of the outcomes, it is important in identifying potential "hot spot" localities within the local authority area, or localities in which there may be issues of inequity of service provision.

3.1.5 Targets

We have included an assessment of any issues for target setting in the evaluation of individual measures, and in some cases have made tentative suggestions about realistic targets.

However, for measures which do not currently have targets, these should not be introduced until the a comprehensive baseline study has been conducted and the results analysed.

More generally, while we recognise the value of national target setting, it is important within the context of SOAs that local partnerships have the freedom to set local targets appropriate to the specific circumstances and policy context in their locality.

3.1.6 Summary of Conclusions

The table below summarises the conclusions of our evaluation of the individual outcomes.

Measure Number	Unique Reference	Brief Description	Fit for Purpose	Change to Formula Required	Data Collection Issues	Alternative Measure(s) Required	Additional Measure(s) Required	Main Issues
1	OC5	Feeling Safe	No	No	Yes	Yes	Yes	Different aspects of safety need to be measured separately Methodological issues with data capture
2	OC7	Feeling Involved	Yes	No	Yes	No	Yes	Carer partnership in service user care package needs to be measured separately Methodological issues with data capture
3	OC9	Social Interaction	Yes	Yes	Yes	No	No	Methodological issues with data capture
4	PR1a	National Standards – Users	No	Yes	Yes	No	No	Standards need extended to include quality standards Fails to capture assessment outwith definition Formula requires revision
5	PR1b	National Standards – Carers	Yes (Qualified)	Yes	Yes	No	No	Standards need extended to include quality standards Formula requires revision Need for GP carer register to be made universal
6	OC8a	Intensive Care at Home	No	No	Yes	Yes	Yes	Measure is arbitrary and inconsistent with national policy on personalisation Serious definitional issues – misrepresents local service configuration decisions Measure is a disincentive to delivery of enablement / rehabilitation services
7	OC8b	Personal Care at Home	No	No	No	No	Yes	Measure is arbitrary and inconsistent with national policy on personalisation Serious definitional issues – misrepresents local service configuration decisions Measure is a disincentive to delivery of enablement / rehabilitation services
8	OC3	Carer feels Supported	Yes (Qualified)	Yes	Yes	No	Yes	Carer partnership in service user care package needs to be measured separately Formula requires revision Need for GP carer register to be made universal

Measure Number	Unique Reference	Brief Description	Fit for Purpose	Change to Formula Required	Data Collection Issues	Alternative Measure(s) Required	Additional Measure(s) Required	Main Issues
9	IP1	Shift in Resources	N/A	N/A	N/A	N/A	N/A	Concern that measure is likely to focus on standardised activity costs which will not reflect enablement / personalisation Concern that measure will focus on transfer from acute to primary within health
10	OP6	Delayed Discharge	No	Yes	No	Yes	No	No longer measure – effectively a standard
11	OP8	Reviews within timescale	Yes	Yes	Yes	No	No	Formula requires revision
12	OP5a	Time from Referral to Assessment	Yes	No	Yes	No	No	None
13	OP5b	Time from Assessment to Service	No	No	Yes	Yes	No	Serious definitional issues Cannot reflect phased care-plans, care-plans where only the carer receives support, or care plans which only put in place provisions for emergency situations Will require recording of multiple timescales for different elements
14	OP7a	Occupied Bed Days	Yes	No	No	No	Yes	Needs to be balanced by other measures
15	OP7b	Multiple Admissions	Yes	No	No	No	No	Needs to be balanced by other measures
16	OC2	Multiple Admissions / No Assessment	Yes (Qualified)	No	No	No	Yes	Needs to be balanced by other measures

3.2 Measure 1: OC5

Percentage of users of community care services feeling safe

3.2.1 *Fitness for Purpose*

The Design Authority's rationale for this measure was:

- 1 To identify those who are vulnerable and at risk
- 2 To provide a safe and secure living environment for users
- 3 To empower, enable and respect people

Angus, along with a number of other "early implementer" local partnerships, is testing the UDSET tool as a mechanism for collecting data for this measure. The tool provides for both a "free text" record of the service user's self defined evaluation of the community care services they receive, and for a summary score under various headings which can be aggregated for groups of service users. This includes the service user's evaluation of the contribution of the service to their feeling of safety.

In evaluating this measure it is important to distinguish between the qualitative data which can be derived, and the summary scores used in the measure. Analysis of the qualitative data is likely to be very useful in identifying individuals who are vulnerable or at risk, and enable assessment of the effectiveness of services in achieving objectives 2 and 3.

However, the measure itself, derived from the summary scores, will not meet the three objectives.

There are at least three dimensions of the impact of care services on service users feeling of safety, and which contribute to an overall objective improvement in safety for the service user.

- **The service is safely delivered** – the service is reliable, staff treat the service user with respect, staff have the skills and training to provide care safely and professionally, the service is managed to prevent intimidation or abuse by staff (or by other service users in "group" services such as day care), the service is delivered in a socially inclusive, non-stigmatizing manner.
- **The service delivers safety** – the service improves the physical safety of the service user, e.g. through aids and adaptations, alarm systems, safety controls, assistance with or undertaking of potentially hazardous tasks such as cooking.
- **The service builds service user's capacity** – the service builds the service user's confidence and skills to assess and manage risk, deal with hazards and protect themselves from sources of harm.

These broadly correspond to the Design Authority's objectives. However, although the UDSET includes questions on stigma / discrimination and respect, as well as feeling safe, it does not enable distinctions to be drawn between these three dimensions.

A service user may, for example, feel the services they receive have contributed to their feeling safe because the staff are friendly, responsive, and treat them with respect. However, the services themselves may be failing to contribute to important aspects of the service user's physical safety, and may be being delivered in a way

which promotes dependence and does not empower the service user to cope with situations of risk.

In its current form, the single measure of “feeling safe” will not enable identification of a service which is failing to perform in one of these dimensions if service users consider it is performing well in the others.

We consider this measure is a key component in a balanced suite of measures. However, we do not believe this measure is fit for purpose in its present form.

We recommend that further work is done in refining the measure to separately evaluate whether service users feel the service is delivered safely, and secondly whether the service improves their safety and capacity to manage risk.

3.2.2 Formula and Data Collection

The proposed formula is:

Number of people who report the services they receive contribute to their feeling of safety / the number of people responding to the survey.

Data for the measure could be collected in two ways; either as an integral part of the review process, or as a separate survey.

Both methods have their advantages and disadvantages. Integration with the review process would be consistent with the draft national standards and would ensure that, as the standards require reviews to be conducted at least every 12 months, the measure should be reported for all service users. However, there is a risk of bias if the review is undertaken by a member of staff who has been directly involved in the delivery of the services under review. This approach would also require significant resources in terms of the additional time to complete the UDSET and for data analysis, particularly of the qualitative data.

A sample survey approach, perhaps carried out independently of care providers or managers, may avoid bias arising from the professional / client relationship and would reduce the extent of resources required for collection and analysis. However, there is a danger of bias in sample selection and the risk that only those service users with either very strong negative or positive views on the services they received would reply.

It is recommended that the UDSET be further developed as an integrated part of the review process, but that further research is undertaken to establish how this may be achieved while minimising the risk of bias arising from the professional / client relationship.

Finally, while for the purposes of aggregation and reporting, the measure needs to yield a logical score (yes or no), we believe there would be benefits in developing a scalar summary measure for use at an individual level. For example, where a service user is receiving services to enable recovery after an incident where the individual's sense of safety was compromised (e.g. a fall, burglary, loss of a partner), a scalar approach would enable the improvements in the service user's sense of safety and capacity to manage risk to be measured through time.

These comments apply equally to Measures 2, 3, and 8.

3.2.3 Targets

Service users can be very sensitive to changes in the delivery of services which, though they may be intended to bring positive benefits to service users and represent an improvement in quality, can give rise to uncertainty and anxiety for

service users until they become accustomed to those changes. Other extraneous factors, such as reports of elder abuse appearing in the press around the time of the service user's review, may lead service users to express concerns regarding safety which are not grounded in their experience of the service. Though these, and similar factors, are typically short term in their impact they are likely to result in relatively large fluctuations in this measure which do not reflect a "real" increase or decrease in the underlying safety and sense of safety of service users.

The target for this measure should be 80% or over, with banded ranges of 20% below that in the first instance. Over the first year of reporting partnerships should be asked to monitor and analyse local variations on a monthly basis as reviews are carried out to establish a baseline for the sensitivity of this measure, and the 80% target and 20% banding further refined in the light of the findings.

3.3 Measure 2: OC7(1) and (2)

Percentage of users of community care services satisfied with involvement in their health and social care packages

Percentage of carers satisfied with involvement in their health and social care package

3.3.1 *Fitness for Purpose*

The Design Authority's intended goals for this indicator were to promote:

- 1 influence over the type and quality of services being provided, including real choice over the care environment
- 2 partnership with users/carers
- 3 person centred services
- 4 independence and self management
- 5 increased confidence for users
- 6 good quality services

We are currently trialling the UDSET as a method for collecting this data. At this stage we are confident that we can collect data to inform this measure in such a way that it reflects service user's satisfaction in relation to these six domains.

In relation to carers, a distinction needs to be made between their satisfaction with involvement with health and social care packages provided to them following assessment of their needs as carers, and their involvement in the health and social care package for the person for whom they care.

It is important to be able to measure whether carers, as service users themselves, are satisfied with their involvement with their own support package, and we are confident that this can be effectively done using the UDSET. In this respect we believe the measure is fit for purpose.

It is also important to measure the extent to which carers are engaged in partnership in the design and delivery of the cared for person's care package. This partnership is critical for both carers and service users, and is not adequately reflected in Measure 8. In its current form the UDSET for Carers is focused on partnership with the service providing support to the carer, not in respect of the partnership with the service providing support to the cared for person.

An additional measure should be introduced to complement both this measure and Measure 8 to focus on partnership with carers in the design and delivery of the service user's care package (see section 4.3.1).

3.3.2 Formula and Data Collection

See comments on Measure 1 above.

3.3.3 Targets

A realistic initial target for this measure is 90%. This should be reviewed after the first year of reporting.

3.4 Measure 3: OC9

Percentage of users of community care services reporting satisfaction with the opportunities provided for meaningful social interaction

3.4.1 Fitness for Purpose

This measure arose from the recognition that social activities, social contact and meaningful day opportunities make a vital contribution to the wellbeing of individuals.

The goals of the measure were to:

- 1 Provide a key indicator of social inclusion
- 2 To build participation in the community
- 3 To build self worth and esteem
- 4 To help users be more economically active

This measure is intended to capture a complex set of inter-related elements of wellbeing and social inclusion. The measure is inevitably "broad brush" in its approach. The weakness of this approach is that it will not enable assessment at a partnership level of the effectiveness of services in respect of particular dimensions of social inclusion such as volunteering, digital inclusion, participation in healthy exercise activities, etc. This data may be recorded in some detail in narrative form using the UDSET or similar tool, but if not measured separately, will require complex and time consuming methods to collate and analyse. That said, the broad scope of this measure means that it is able to capture positive social inclusion outcomes in a way which respects the diverse priorities, aspirations, personal preferences, and cultural context of service users.

While evaluation of the UDSET is not yet complete, we are reasonably confident that the tool has the flexibility to be used to capture data to inform this measure effectively. There is merit in developing the tool locally as a means for analysing the degree to which service users have been enabled towards more specific areas of social inclusion. The current tool picks out a number of broad areas (largely reflecting the goals for this measure listed above), to which a simple scale can be added to enable aggregation of these more specific dimensions. While it is important not to over-complicate the tool or to make the review too onerous to service users and staff, there is merit in local partnerships adapting the tool in this way to enable this measure to be drilled down to more specific social inclusion issues identified as priorities by community planning partners, e.g. digital inclusion.

This measure is fit for purpose (subject to the issues noted below).

3.4.2 **Formula and Data Collection**

The proposed formula is:

Number of people satisfied / number of people provided with opportunities for social interaction

The measure is intended to test whether those who are assessed as needing assistance to engage / re-engage with opportunities for social interaction receive those opportunities to their satisfaction. As currently worded, the measure would exclude people who were assessed as needing assistance in this area but where no assistance was provided.

The denominator could be amended to the “*number of people responding to the survey who had previously been assessed as requiring assistance with opportunities for social interaction*”. Although there will be a proportion of service users who are not assessed as requiring this assistance, it is important to make sure that services are not delivered in a way which hinders the service users engagement with these opportunities (e.g. as a result of the timing of services, stigma associated with staff visiting the home in marked vehicles, etc). This will be captured by extending the denominator to include all service users.

It is recommended that the formula should be the same as for Measure 2: “*number of people satisfied / number of people who responded*”.

See comments on Measure 1 above.

3.4.3 **Targets**

A realistic initial target for this measure is 90%. This should be reviewed after the first year of reporting.

3.5 **Measure 4: PR1a**

Percentage of user assessments completed in accordance with agreed national standards

3.5.1 **Fitness for Purpose**

The purpose of this measure was:

- 1 To ensure that assessments are carried out effectively and consistently, so that users' care needs are properly identified
- 2 To engage users in health improvement and prevention programmes
- 3 To improve self management and get the appropriate support and care

Both the current and draft national standards are primarily focused on data standards (the specifications and coding of core data fields) and information standards (the range and scope of the issues to be covered in tools for assessment, care planning and review).

Guidance on single shared assessment provides a framework of the values, principles and objectives which underpin consistent person centred assessment. There are currently no nationally agreed quality standards or a quality assurance framework for ensuring assessments meet the three goals of this measure.

National quality standards and a national quality assurance framework should be developed as a matter of urgency to provide a benchmark against which assessments could be judged to meet the three objectives of this measure.

The measure is of value as it will act as a driver towards consistency in data and information collection in single shared assessments, enabling improved “shareability”.

However, there remain significant definitional issues which need to be resolved before this measure could be considered fit for purpose.

3.5.2 Formula and Definition

The proposed formula is:

Number of user assessments carried out according to national standards / total number of user assessments required (based on total number of users)

In some cases the outcome of an assessment is that the person is assessed as having no community care needs, or that these can be adequately met by informal carers provided the carers receive appropriate support. The current formula would exclude such cases as the assessed individuals would not become service users following assessment. We believe it is important that these assessments are recorded and that they are also carried out in compliance with the national standards. It is recommended that the qualifying statement “(based on total number of users)” is removed from the formula, and the denominator amended to read “*total number of user assessments / reviews carried out within the period plus reviews due within the period which were not carried out*”.

There is also a real danger that the proposed formula will miss exactly those cases where inadequate assessments are currently being made. For example, Measure 16 is focused on ensuring that a full assessment of need is carried out for people with two or more emergency admissions in a year. Where these individuals have been diagnosed as having one or more long-term conditions they should be receiving a regular assessment or review by their GP. These assessments are typically clinically focused and do not constitute assessments of both health and social care needs, although these are precisely the individuals for whom a comprehensive assessment is likely to be most beneficial.

The criteria for determining which assessments should be included in the measure are unclear. In the absence of clear criteria different partnerships are likely to adopt differing approaches, resulting in measures which are not comparable. It also opens up the potential for “gaming” by restricting the measure locally to only those assessments carried out using tools which are fully compliant with the standards.

This measure should act as a driver to extend the range of situations where individuals who may have unmet community care needs are offered a comprehensive assessment consistent with the principles of single shared assessment, rather than narrowly focused assessments, for example, clinically focused assessments in relation to people with diagnosed long-term conditions.

For these reasons this measure is not considered fit for purpose in its current form.

Further work is required to identify suitable criteria for deciding which assessments should fall within the scope of the measure.

3.5.3 Data Collection

Where assessments are recorded electronically, it should be a relatively easy process for partnerships to develop audit reports to check compliance. Where

assessments which are recorded manually, compliance can only realistically be based on extrapolation from a sample audit.

There are particular difficulties where assessments are being recorded on systems which have been designed and commissioned for other purposes without reference to the national standards for assessment / care management (e.g. Community Nursing and GP electronic record systems), and where the local partnership does not have sufficient control over system development to ensure technical compliance and systematic compliance audit processes.

3.5.4 Targets

It is not possible to suggest how targets might be set until the definitional issues discussed above are resolved. If the scope of this measure is as comprehensive as is being suggested then the target level will need to be set fairly low in the first instance. If the scope is restricted to assessments specifically designated by partnerships as part of the SSA process it would be reasonable to set the target level at or close to 100% at this stage.

Once quality standards are introduced it may be necessary to review the target as it will take some time to establish and embed quality assurance mechanisms within partnerships, and ensure all assessment staff are trained to these standards.

3.6 Measure 5: PR1b

Percentage of carers assessments completed in accordance with agreed national standards.

3.6.1 Fitness for Purpose

The purpose of this measure was:

- 1 To ensure assessments are being carried out effectively and consistently, so that carers' support needs are properly identified
- 2 To engage carers in health improvement and prevention programmes
- 3 Improve self management and get the appropriate support and care

The new draft national standards set out information standards for carer assessment for the first time. As responsibility for carer assessment lies with the local authority it should be fairly easy to ensure that all assessment are compliant with the standards.

We would, however, reiterate the urgency for the development of quality standards and a quality assurance framework to cover the assessment, care planning, and review process.

In the absence of quality standards the measure will not achieve the intended purpose. It will go some way to ensuring consistency and its qualified use within the suite of measures at this stage is recommended.

3.6.2 Formula and Data Collection

The proposed formula is:

Number of carer assessments carried out according to the national standards / total number of carers who accepted the offer of an assessment.

It is of concern that the numerator and denominator are not aligned, and the formula is not consistent with that used for service user assessments / reviews. The

measure applies to all assessments and reviews within the sample period, but the denominator relates to the number of persons receiving an assessment or review. Different partnerships may give different priority to monitoring and responding to carer support needs, and the emphasis they place on an enablement approach. This is likely to lead to significant variations in the number of carers receiving an assessment and at least one review within the period, or previously assessed carers receiving more than one review. Socio-economic and demographic factors (including the average age of carers in a locality) may also influence the regularity with which carers support plans are reviewed. It is even possible that, where a partnership places emphasis on providing intensive short term enablement support to service users and their carers involving much more regular reviews, the reported measure may be over 100%.

It is recommended that, for consistency, the denominator should be amended to the *“total number of assessments / reviews carried out within the period plus the number of reviews due within the period which were not carried out”*.

Two further issues are worth noting about the scope of this measure. Firstly, As acknowledged in the Design Authority’s proposed formula, some carers decline the offer of an assessment. This may be a useful indicator at a local level of the degree to which carer support services are publicised, of waiting lists for these services, and of the lack of public understanding of the benefits of carer assessments. The adoption of an additional measure is not being proposed, however partnerships should be encouraged to monitor refusal levels as a proportion of those who are offered carer assessments.

We would note that the measure only covers those carers known to Social Work and who accept the offer of an assessment. The inclusion of carer identification as an enhanced service within the new GMS contract has been a valuable development. This should be rolled out over time as a core service backed by a standard referral protocol to ensure the benefits of assessment and support services can be extended to the many carers who remain unknown to Social Work and Health services.

No potential issues have been identified with the collection of data for this measure beyond the need to incorporate compliant functionality to record the assessments within existing electronic systems.

3.6.3 Targets

Given the clearly defined scope of this measure it is reasonable to set the target at or close to 100% at this stage. As with the previous measure, it may be necessary to review the target once quality standards are introduced.

3.7 Measure 6: OC8a

Percentage of older people aged 65+ with intensive care needs receiving services at home (proxy)

3.7.1 Fitness for Purpose

The expressed aim of this measure is to:

Promotes greater numbers of people with high levels of need to be supported to live at 'home' – allowing retention of more independence

Although this measure has been in use for some time as part of the JPIAF, there are concerns that the current definition of intensive care needs – a package of 10 hours or more – is not only unsatisfactory but results in a perverse disincentive to promote independence through enablement.

There are three fundamental flaws with the measure as currently framed.

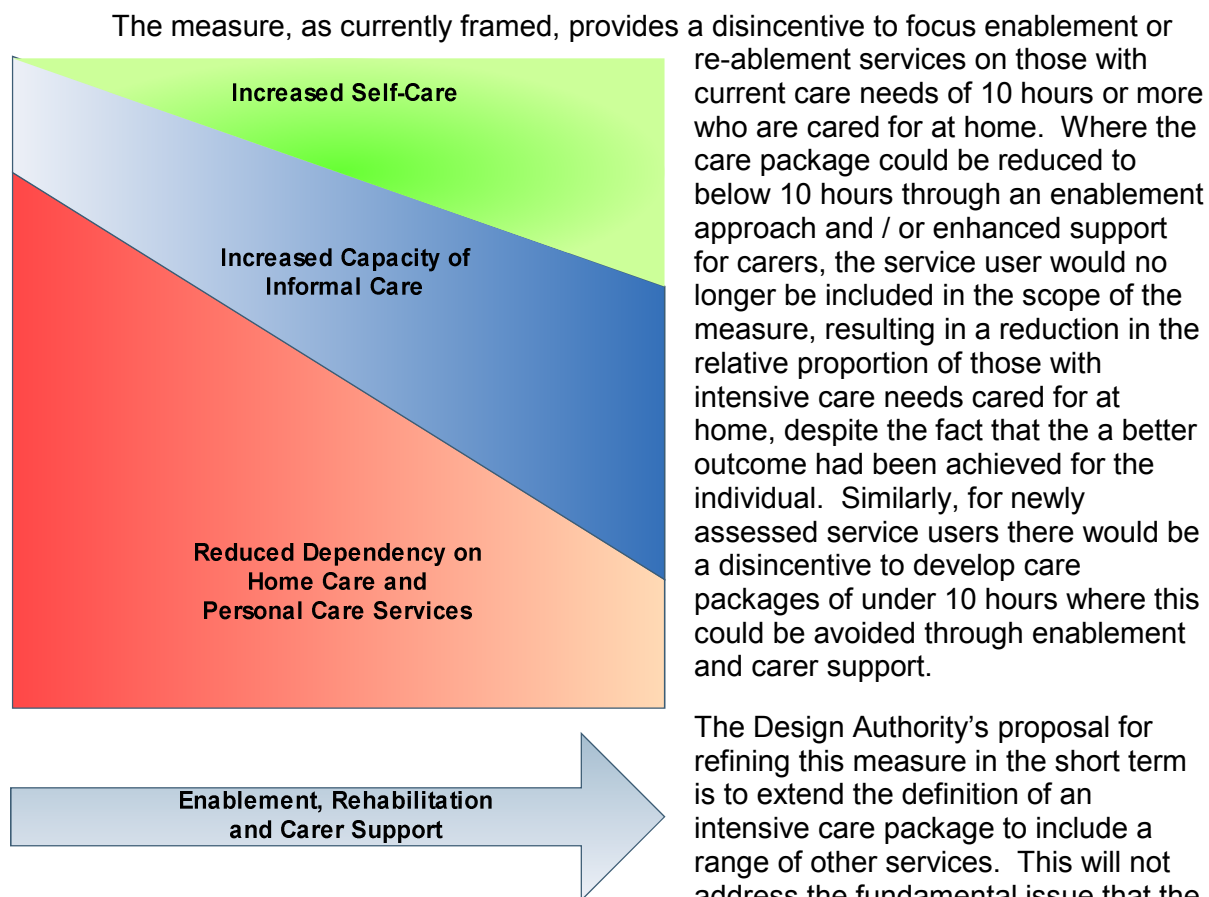
The definition is based on the assumption that there is a direct correlation between the outcome of an assessment and the care package which follows from it. This is not the case. Two people may be assessed as being unable to manage independently in the same functional areas, and as having the same issues of vulnerability. The particular combination of support from informal carers, adaptability of the living environment, and the capacity of the service user to develop new skills and coping strategies, may result in very different formal packages of care. Using a defined package of care as the criterion will exclude many people with high care needs from being reflected in the measure, particularly as those cared for in their own homes are more likely to have a significant proportion of their needs met by informal carers than those in residential care.

Secondly, the express purpose of the measure is to encourage partnerships to enable more people with high care needs to remain in their own homes in a safe and sustainable way with the maximum independence achievable. To achieve this partnerships need to develop flexible and creative individual solutions, and as a result there is no simple correlation between the proportion of service users with high care needs supported at home and the shift of resources to the community required to achieve this.

Tension arises from the desire for a proxy measure for the shift in resources to the community. However, levels of service activity are an output not an outcome. For this purpose the measure is an output measure, reporting a volume of 10hr+ home care packages delivered in the community as a proportion of the total spend on 10hr+ packages of care. The measure cannot function as both an outcome and an output measure.

Thirdly, the measure is framed around a static model of care where a service user is assessed as needing a care package of "x" hours, and this is delivered either in their home or in a residential setting. This is not consistent with national policy which is directed towards increasing independence, enablement and rehabilitation, and supporting the role of informal carers.

The four outcomes for community care which underpin the National Outcomes Framework focus on improving the independence, inclusion, and health and wellbeing status of people with community care needs. This means enabling people to maximise their independence and becoming less dependent on formal care through services which develop the capacity for self care and supporting carers to more effectively sustain and develop their caring role.



measure should focus on needs and the outcome of being supported at home rather than on a specified package of care, even if this is selected from a broader menu than home care alone.

The Design Authority's longer term recommendation is that the criterion for including a service user in the scope of the measure be changed to one based on their IoRN score. A more objective definition which is based on an assessment of vulnerability rather than on levels of service provision required (which is dependent on the particular configuration of services within a partnership) would be welcome. Further work needs to be done to evaluate whether the IoRN is comprehensive enough for use in this context, and this work is being carried out as one of the Pathfinder workstreams.

The shift from a quantity of service to a relative vulnerability definition of "intensive care needs" does not address the fundamental problem identified with this measure, namely, that it is a disincentive to the deployment of an enablement / re-ablement approach.

The current measure is therefore not fit for purpose and should not be included in the set.

The design authority has proposed that this measure should ultimately be *"percentage of adults with higher level of community care needs living in their own home"*. The deployment of this measure clearly depends on the universal use of an agreed measure of community care needs, whether this is IoRN or an alternative scale. This is a much more appropriate measure as it does not focus on the delivery of a service or the level of that service, and will not be a disincentive to strategies which maximise the contribution of informal carers.

In the interim we recommend that the focus of the measure is reversed, and an alternative measure developed to record the relative numbers of older people with care needs of whatever level, cared for in institutional settings (see section 4.2.1).

A second measure should be developed explicitly to measure the extent to which the partnership is effective in delivering enablement and re-enablement of service users (see section 4.3.2).

3.7.2 Data Collection Issues

If this measure is retained in its current form data is readily available through the existing H1 home care statistical return.

3.7.3 Targets

The SR2004 target of a 30% increase in this measure requires to be reached in 2008. This is not a meaningful target and there are no recommendations on future targets should the measure be retained.

3.8 Measure 7: OC8b

Percentage of older people aged 65+ receiving personal care at home (proxy Balance of Care)

3.8.1 Fitness for Purpose

The following goals for this measure were identified by the Design Authority:

- 1 To promote a shift in resources (measured initially in activity terms) from hospital to community and home care
- 2 To ensure provision of services closer to home
- 3 To ensure improved and equitable access to community care

This measure is less problematic than Measure 6 as it focuses on a narrow range of services which reflect well defined community care needs. The recent Audit Scotland report on Free Personal Care identified that there was still a lack of clarity in relation to food preparation and other aspects of the current legislation and guidance. It would be helpful if these were resolved at national level, as recommended by Audit Scotland, before this measure is rolled out. If this is not possible the definition could be amended to exclude service users whose only personal care service is the provision or preparation of meals (this is likely to be a relatively small proportion of the total).

Local variation in service configuration and definition is also less likely to impact on this measure as it is not based on the provision of a set number of hours of service but on the provision of any level of personal care.

This measure, in its current form, presents the same disincentive as Measure 6 to focus services on re-enabling service users to manage aspects of personal care or to support carers to undertake those tasks where appropriate. A recent pilot project in Angus demonstrated that in relation to personal care tasks in particular, intensive short-term enablement intervention can dramatically reduce the number of hours of care required by many service users previously receiving, or assessed as requiring, personal care.

This measure is a more meaningful measure than Measure 6; it does however suffer from the same fatal weaknesses and is therefore not fit for purpose in its current form.

If it is felt that a measure of community based activity is still required it is recommended that this measure is used in preference to Measure 6, but only if it is balanced against a complementary measure which demonstrates the partnership is at the same time delivering effective enablement or re-ablement of service users (see section 4.3.2).

3.8.2 Formula and Data Collection

In its current form, data is readily available to populate this measure from the statutory Free Personal Care quarterly returns.

3.8.3 Targets

There are no recommendations on targets should this measure be retained in its current form.

3.9 Measure 8: OC3

Percentage of carers who feel supported and capable to continue in their role as a carer.

3.9.1 Fitness for Purpose

The intention of this measure is to:

- 1 Address concerns about the health impacts of caring
- 2 Focus on carer well-being
- 3 Promote working in partnership with carers

The original focus of this measure was on the impact of the caring role on the health and wellbeing of carers, as expressed in the first two goals of this measure. As noted under Measure 2, while the degree to which carers feel engaged in partnership in the design and delivery of the cared for person's care package may have an impact on the carer's health and wellbeing, this should be measured separately (see section 4.3). The third intended goal of this measure should be deleted.

The UDSET for carers includes a number of questions aimed at eliciting evidence from carers to inform this measure. The context of these questions is the contribution of the services received by the carer as part of their support package to their health and wellbeing and capacity to sustain the caring role. This is not the same as measuring the carer's health and wellbeing as such, which is a key driver behind this measure.

The concern is that although a carer may feel their care package has supported them to continue their caring role and has contributed an improvement in their health and wellbeing, their general state of health may still remain poor with support and care needs which remain unaddressed. Based on the UDSET the measure would report a positive outcome for the carer where an objective assessment of their health and wellbeing would not.

The recommendation of the Design Authority was that a general health questionnaire should be used to inform this outcome. While the UDSET does cover the four areas identified in the detailed definition for this measure, it is focused on the contribution of services received to the carers current "health status" and is not detailed enough to give an objective picture of their general wellbeing.

This measure is fit for purpose (subject to the technical issues discussed below) and can be effectively informed by the UDSET for carers tool, so long as it is clear that it is purely focused on whether the carer feels supported by their care package and capable of continuing their caring role.

It is recommended that this measure is supplemented by the use of a suitable validated tool to measure the general mental and emotional wellbeing of the carer, such as the Warwick-Edinburgh Wellbeing scale (see section 4.3). This would enable partnerships to demonstrate a contribution towards the Scottish Government National Indicator 15 for a group which is known to be particularly vulnerable to mental and emotional stress.

3.9.2 Formula and Data Collection

The proposed formula is:

Number of carers determined as “healthy” during an assessment or review / Number of carers registered on GP register

The numerator reflects the original aim of this measure and not the revised measure. As indicated above, the mental and emotional wellbeing of carers should be measured separately from questions related to the impact of services they receive on their capacity to continue as carers. The numerator should therefore be amended to the “*number of carers who feel supported and capable to continue their role as carers*”.

The denominator for this measure needs to be consistent with the denominator for Measures 1, 2, and our proposed revised denominator for Measure 3. As the UDSET tool is likely to be deployed as part of carer assessment and review process, this measure should report the proportion of those carer assessments and reviews in which the carer reports feeling supported and able to continue as a carer. The denominator should therefore be amended to the “*number of carers who responded*”.

There is value in seeking to include the widest number of carers within the scope of this measure. However, as the GP register of carers is an optional extended service within the GMS contract it is not universal in its coverage and there is no protocol in place to ensure that carer identified by GPs are cross reference with carers known to Social Work or voluntary Carer Support Centres. There would be significant benefits if the GP Register for Carers were to be rolled out as a core service within the GMS, supported by a robust referral protocol and data sharing agreement. Unless and until this is achieved there is no reliable way to include carers who have not had a statutory carer’s assessment within this measure.

3.9.3 Targets

It is not possible to set a target for this measure until baseline data has been collected and analysed.

3.10 Measure 9: IP1

Shift in Balance of Care from “Institutional” to “Home Based” Care

3.10.1 Purpose and Future Development

The goals for this measure are:

- 1 To promote a shift in resources from hospital to community care
- 2 To support the development of services at home or closer to home
- 3 To support improved and equitable access to community care

The importance of the “Shifting the Balance of Care” agenda within the NHS from acute to community based care and from reactive treatment to anticipatory care is recognised. There is concern that this agenda is focused on a medical model of wellbeing and is primarily aimed at securing improved clinical outcomes.

The difficulties in quantifying this shift are demonstrated by the difficulty in determining what constitutes an “intensive home care” package. The further from the acute sector the balance of care is shifted, the less it is possible to identify units of activity of specific types which can be mapped against a reduction in bed days, “avoidable” admissions, ambulance costs, etc.

A more social model of community care might, for example, suggest investment in local transport, enhanced access to leisure and recreational services, and in support for carer mutual support networks and carer training programmes. The adoption of an enablement model may result in a shifting of resources to investment in telecare, intensive short term interventions for people with low care needs, and investment to support the development of mainstream “homes for life”.

A suitable measure cannot be developed independently of partnerships developing a whole systems model of the balance of care appropriate to their population. While a measure of the shifting of resources from acute to primary care would be a welcome contribution to the overall shift in the balance of care, a more sophisticated approach will be required to measure the shift in the balance of care within the wider health and social care context to deliver better outcomes for people in their own homes.

Further work is required to develop tools and guidance to enable local partnerships to develop whole systems modelling of the balance of care appropriate to their populations, and to develop a range of possible measures which will enable partnerships to monitor the shift of resources locally to align with the balance of care model they develop.

3.11 Measure 10: OP6 (related to HEAT 4.01K measure)

Number of patients waiting more than six weeks to be discharged into a more appropriate care setting

3.11.1 Fitness for Purpose

The goals of this measure are to:

- 1 Reduce the number and length of stays in hospital that are longer than clinically necessary
- 2 Provide a clear indicator of effectiveness of joint working

This measure is similar to an existing HEAT measure which already has a target for 2008 of zero. As such it is no longer a measure but a standard. Monitoring of non-compliance with the standard will still take place through HEAT, and partnerships

should already have in place measures to ensure that the standard can be consistently met.

As the measure no longer indicates a direction of travel it does not meet either of the goals and is no longer fit for purpose.

If a delayed discharge measure is to be retained it is recommended that an alternative measure is developed to report the average delay before discharge (see Section 4.2.2).

3.12 Measure 11: OP8 (1) and (2)

Percentage of service user care plan reviews carried out within agreed timescale
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Percentage of carer care plan reviews carried out within agreed timescale

3.12.1 *Fitness for Purpose*

The Design Authority identified the following goals for this measure:

- 1 To ensure care packages are regularly reviewed to ensure they continue to appropriately meet the health and social care needs of users and carers
- 2 To promote a focus on prevention and to promote well being
- 3 To ensure people at risk are identified and their changing needs for health and community care can be tracked

The draft national standards will introduce a maximum timescale between reviews, and from the completion of a care plan to the first review, of 1 year. The draft standards also include required fields for recording the intended agreed review dates within the care plan and each review which will enable compliance to be monitored.

This measure will contribute to, but will not on its own meet, the objectives set out by the Design Authority. It needs to be seen as part of a sub-set of the measures (along with Measures 1 to 5 and 8), which will only fully meet these three goals once quality standards are in place.

The measure does provide a critical driver towards consistency in reviewing care plans and therefore, subject to the technical issues covered below, this measure is fit for purpose.

3.12.2 *Formula and Data Collection*

The proposed formula is:

Number of care plans reviewed in agreed time scale / Total number of care plans

The denominator assumes that care plan reviews will be carried out at or near the maximum timescale of 1 year, set down in the draft standards. Partnerships will adopt different approaches to the regularity of reviews, depending on the balance of care model they adopt. It is possible that in partnerships where a high proportion of care plans are reviewed more regularly the result from this measure may exceed 100%.

It is recommended that the denominator is amended to “*total number of care plans falling due for review within the period*”.

The capacity to report on this measure will depend on the extent to which care plans and reviews are recorded electronically and will, in any case, depend on the local implementation of the new national standards when they are agreed.

3.12.3 Targets

Ultimately the target for this measure should be 100%. This will not be realistic until implementation of the new national standards, comprehensive adoption of electronic recording of care plans and reviews, and implementation of e-Care to facilitate data sharing where different agencies are involved at different stages of the assessment / care planning / review process.

3.13 Measure 12: OP5a (SPI ASW 1a)

Number of people waiting more than targeted time from referral to completion of assessment per 1,000 population

3.13.1 Fitness for Purpose

Taken together with Measure 13, the purpose of this measure was to:

- 1 Provide an indicator of the accessibility and responsiveness of services
- 2 Foster reduced waiting times
- 3 Promote more rapid access and delivery of services that effectively meet the assessed needs of users

This is a well focused measure which, taken alongside Measures 4 and 5 (compliance with national standards), will deliver the three goals above. Subject to the technical issues discussed below, this measure is considered fit for purpose.

3.13.2 Formula and Data Collection

The scale chosen for this measure should be consistent with other rate measures in the suite. The adoption of a rate per 100,000 population throughout is recommended.

As assessments may be commenced in one agency and completed in another, the capacity to report on this measure is dependent on delivery by the Transformational Technologies Division of a functional software tool to enable reliable data sharing between disparate information systems. Furthermore, only a minority of assessments are currently recorded electronically and the proportion varies significantly between partnerships. Until all assessments are recorded electronically it will not be logistically feasible to report on this measure, except by estimation from a sample.

3.13.3 Targets

Targets should be set following an analytic study of current waiting times.

3.14 Measure 13: OP5b (SPI ASW 1a)

Number of people waiting more than targeted time from the delivery of community care services following an assessment per 1,000 population

3.14.1 *Fitness for Purpose*

Taken together with Measure 12, the purpose of this measure was to:

- 1 Provide an indicator of the accessibility and responsiveness of services
- 2 Foster reduced waiting times
- 3 Promote more rapid access and delivery of services that effectively meet the assessed needs of users

The measure is based on the assumption that the outcome of a care plan will be the delivery of a defined package of care as soon as possible thereafter. In practice elements of a care plan may be sequential – home care and occupational therapy might be deployed for a period as part of a rehabilitation service with the intention of providing equipment and adaptations at a later stage once the level of long-term recovery is ascertained; a care plan may put in place a package of service which can be deployed in an emergency (e.g. if the carer falls ill), but otherwise services may be focused on supporting the carer rather than the service user; it may be that the appropriate in some cases to delay implementing a care package which is required as a result of a future change in the circumstances of the primary carer (e.g. a resident adult carer who is planning to leave to get married).

It was also noted during the Design Authority's consultation on the measures that the timescale for delivery of major adaptations is dependent on external factors such as planning permission and the labour time required to construct more complex adaptations.

The Design Authority proposed limiting the scope of this measure to four potential elements of care packages:

- Equipment
- Adaptations
- Home Care (specifically personal care or support)
- Specialist Services

It is of concern that there is considerable variation within these categories as to the timescale for delivery. For example, delivery of simple equipment such as walking frames and removable bath aids can be achieved very quickly, while the provision of specialist wheelchairs or the installation of stair lifts will be affected by the technical complexity and the capacity of specialist contractors.

Account also needs to be taken of different approaches taken by partnerships in prioritising access to services. It is consistent with the principles of the Concordat that local partnerships should be free to develop strategies which target resources to those clients who can best benefit from those services or who would be most at risk without them.

There is also concern that the results of the measure may significantly misrepresent overall performance. For example, there may be particular local difficulties over a period of time in delivering a simple piece of equipment such as removable toilet

aids. In every other respect the partnership may be providing services well within target, and may be compensating for the delay in toilet aid provision by providing additional hours of personal care. However, as it stands, the measure would record all service users who did not receive their toilet aid within the target, even although their needs were temporarily being met in another way and delivery of all other services had been within the target.

While the principle that partnerships need to demonstrate they are responding quickly and effectively to the assessed needs of service users and carers is endorsed, this measure as it stands is too complex and not sufficiently flexible to accommodate local strategies for targeted personalised services.

This measure is not considered to be fit for purpose, and it is regrettable that this measure has been selected by Audit Scotland as a statutory performance indicator for 2008-09 in advance of these complex issues being resolved.

The development of a robust alternative to this measure form a key task in phase 3 of the Pathfinder is recommended.

3.14.2 Formula and Data Collection

The scale chosen for this measure should be consistent with other rate measures in the suite. It is recommended that there is a rate per 100,000 population throughout.

If the measure is retained in its current form, separate targets will need to be set for each of the component elements of the service areas identified. This will also require electronic systems for recording care planning and service provision to be adapted to record the timing of initial delivery of services in additional detail.

The capacity to report on this measure is also dependent on delivery by the Transformational Technologies Division of a functional software tool to enable reliable data sharing between disparate information systems. Furthermore, only a minority of care plans are currently recorded electronically and the proportion varies significantly between partnerships. Until all care plans are recorded electronically it will not be logistically feasible to report on this measure, except by estimation from a sample.

3.14.3 Targets

Targets should be set on the basis of the results of a comprehensive analytic study.

3.15 Measure 14: OP7a (related to HEAT 4.08K measure)

Number of emergency bed days in acute specialities for older people aged 65+ per 1,000 population

3.15.1 Fitness for Purpose

The intended purpose of this measure is to:

- 1 Promote action to both reduce emergency admissions and average length of stay
- 2 Encourage provision of non-hospital forms of care often through services that are delivered closer to home
- 3 Focus on improving the delivery of treatment and planning for discharge

On its own the measure addresses only the first goal listed above. As noted in the consultation process, this measure needs to be cross referenced with evidence that any reduction in bed days is resulting in poorer clinical outcomes for patients, for

example, an increase in multiple admissions, increased mortality in the three months following discharge, or the proportion of patients discharged requiring long-term intensive care packages either at home or in residential care.

The inclusion of Measures 6 and 15 will go some way to providing a check that this is not the case, and in ensuring the third goal for this measure is not compromised. A quality audit process should be developed to ensure treatment standards and clinical outcomes are not compromised.

The development of an additional measure to identify the volume of emergencies which are managed through the delivery of care in the home or in community based non-acute settings is recommended. The development of this measure should be a key task in phase 3 of the Pathfinder.

This measure is considered to be fit for purpose.

3.15.2 Formula and Data Collection

The adoption of a rate measure rather than an absolute number is welcomed. In addition to allowing better comparison between areas with very different populations, there is concern that account needs to be taken of the differing rates of growth in the 65+ population and the different levels and patterns of morbidity in this age group in different partnership areas.

Successful deployment of this measure will depend on ISD make the necessary adjustments to HEAT data to identify and correctly re-aggregate on the basis of a patients "area of usual residence".

3.15.3 Targets

The current HEAT target is not appropriate for the same reasons as above. In order to take account of differing rates of growth and patterns and levels of morbidity, it would be more appropriate to set a target expressed as a percentage reduction in the rate of bed days per 100,000 population.

3.16 Measure 15: OP7b (HEAT 4.02K measure)

Number of older people aged 65+ admitted for any reason two or more times in a year as an emergency to acute specialities per 1,000 population

3.16.1 Fitness for Purpose

The Design Authority's rationale for this measure is that it:

- 1 Fosters a reduction in acute emergency admissions and multiple admissions
- 2 Encourages provision of non-hospital forms of care, often through services that are provided closer to home
- 3 Encourages case-finding and assessment of people at risk of multiple admissions in order to provide, where necessary, anticipatory focussed health and social care in the community

On its own this measure does not meet the three goals set by the design authority, but needs to be cross referenced with evidence that a reduction in multiple admissions represents improvements in the management of long-term conditions or the identification, assessment, and delivery of appropriate care to people who are otherwise vulnerable to multiple admission.

Measure 16 may assist in this: however, it is recommended that the development of an additional measure to identify the volume of emergencies which are managed through the delivery of care in the home or in community based non-acute settings is considered. The development of this measure should be a key task in phase 3 of the Pathfinder.

That said, we consider the measure fit for purpose.

3.16.2 Formula and Data Collection

The adoption of a rate measure rather than an absolute number is welcomed. In addition to allowing better comparison between areas with very different populations, there is concern that account needs to be taken of the differing rates of growth in the 65+ population and the different levels and patterns of morbidity in this age group in different partnership areas.

Successful deployment of this measure will depend on ISD make the necessary adjustments to HEAT data to identify and correctly re-aggregate on the basis of a patients "area of usual residence".

3.16.3 Targets

The current HEAT target is not appropriate for the same reasons as above. In order to take account of differing rates of growth and patterns and levels of morbidity, it would be more appropriate to set a target expressed as a percentage reduction in the number of patients admitted ... per 100,000 population.

3.17 Measure 16: OC2

Number of older people aged 65+ admitted for any reason two or more times in a year as an emergency to acute specialities who have not had a community care assessment per 1,000 population

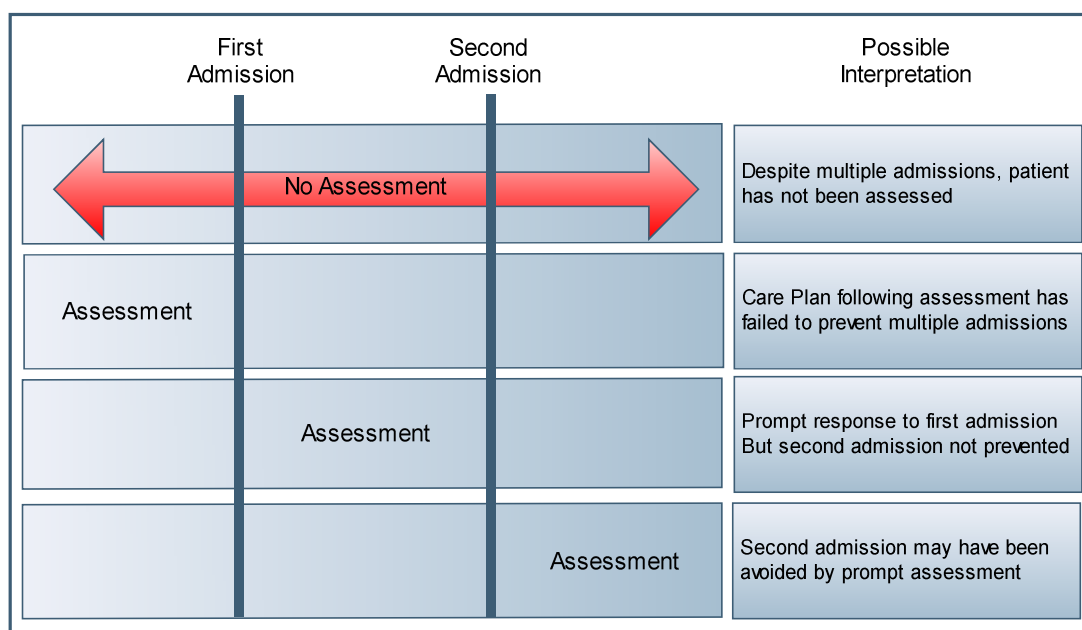
3.17.1 Fitness for Purpose

The intended purpose of this measure is to:

- 1 Focus on anticipatory care management
- 2 Focus on prevention and early intervention to promote well being of users of community care services
- 3 Focus on preventing unnecessary emergency admissions by devising appropriate care pathways for those being identified as 'at risk of admission'

While the purpose of this measure is welcome, it is felt that on its own, it will tell not us a great deal. Holistic assessment is a essential first step in planning and delivering effective preventative or anticipatory care, and it is reasonable to focus attention on cases of multiple admissions where an assessment has not been carried out.

It is equally important to highlight those cases where multiple admissions have occurred despite an assessment having been carried out, as it may indicate that there are quality issues with the assessment / care planning process, that the care pathways are poorly developed, or that services are not effective.



There are only four assessment outcomes for people with two or more admissions, and each may indicate weaknesses in the partnerships assessment, care planning, and condition management arrangements.

This measure will focus on the least acceptable of these outcomes, where people are “slipping through the net”. We believe that, for this more limited objective, the measure is fit for purpose (subject to the technical issues covered below).

It is equally important to track what impact assessment has had on those who have had an assessment, especially where they have gone on to have 2 or more emergency admissions.

This can be achieved through the development of additional measures derived from the SPARRA 2 dataset. SPARRA 2 data currently covers the 65+ population and provides a real-time analysis of the probable risk of admission / re-admission based on previous patterns of admissions. The SPARRA 2 data is intended to assist GPs and CHPs to target resources to those most likely to benefit from anticipatory care, integrated care pathways, or even care / case management.

Two additional measures: one tracking those patients who have not had a health and social care assessment within 3 months of being identified as high risk by SPARRA 2, and the other tracking patients who have 2 admissions within one year of being identified by SPARRA 2 (see section 4.3.3) should be developed.

3.17.2 **Formula and Data Collection**

In the first instance, populating this outcome will only be possible by manual correlation NHS and Social Work data. The successful delivery by the Transformational Technologies Division of a technical solution to data sharing between disparate systems is critical to enabling this population of this measure to be sustainable in the long-term.

3.17.3 **Targets**

The target for this measure should be set only once a full year’s baseline data has been analysed.

4 The Measures as a Suite

4.1 Interactions between the Measures

One of the key success criteria of the Pathfinder was to develop suite of outcomes measures which is “fit for purpose”.

As will be clear from the evaluation of the 16 measures above, a suite of measures needs to be capable of capturing the unintended consequences of improvement in each of the main dimensions of the balance of care.

The critical importance of mapping the interactions between potential measures can be illustrated by the following examples.

One objective is the increase in the number of people with intensive care needs receiving an intensive care package at home. However, provision of intensive care at home needs to be achieved in such a way that it does not undermine the role of a resident carer (e.g. making them feel useless and bypassed), and potentially damaging a key supportive relationship. A balancing measure needs to be in place to check that this is not happening.

It is important that the assessment / care planning process is timely and carried out to consistent standards, and that access to services is also timely. However, measures of the assessment / care planning and service delivery processes need to be balanced against measures which evidence that these processes lead to the delivery of appropriate, anticipatory, enabling, and rehabilitation focused care.

It is important to reduce the delay in discharge from hospital. However, this needs to be balanced by measures which demonstrate that discharges are not being made too early, or to settings which are not individually appropriate, resulting in readmission or less successful rehabilitation than might have been achieved had the discharge been delayed for an additional period.

To be an effective tool in performance management, the suite needs to be comprehensive and internally consistent enough to take account of the different approaches taken by partnerships in meeting local needs.

The process of mapping these inter-relationships to ensure that the suite is not “lopsided” is in progress. This task will be completed as part of phase 3 of the Pathfinder, but a number of alternative and additional measures have already been identified which will contribute to the completeness and internal consistency of the suite.

4.2 Alternative Measures

4.2.1 Alternative Measure 6

The following measure is proposed:

The number of people aged 65+ with community care needs provided with long term care within a care home or NHS continuing care setting as a rate per 100,000 population

The measure would include only those with a package commissioned by the local partnership, whether or not the placement was within the partnership area, and would exclude service users receiving intermediate or respite care with the expectation of returning to a mainstream, sheltered or supported housing setting.

4.2.2 Alternative Measure 10

The following measure is proposed:

The average (median) delay before discharge to a more appropriate care setting for those delayed 1 day or more beyond the planned discharge date.

This data is already recorded and should be possible to obtain through ISD. The revised measure would be more likely to act as a driver for continuous improvement in performance. It is recommended that the median is adopted as it is less prone to skewing as a result of single complex cases where the period of delay is disproportionately high.

It is recommended that the revised measure is reported quarterly for all patients actually discharge in that quarter. This will avoid the potential for gaming with the existing target where partnerships can deploy resources to reduce the number of delayed discharges on census days well below their typical level.

It is possible that this measure will not be sensitive enough to capture “sluggishness” in the system within some local partnerships and it is recommended that a baseline study is undertaken to identify local variations.

4.3 Additional Measures

4.3.1 Additional Measure 2a

Percentage of carers satisfied with involvement in the development and delivery of the health and social care package of the person for whom they provide care

This measure would demonstrate the degree to which carers felt they were genuinely recognised as full partners in planning the package of care for the person for whom they care, and their role within that package of care.

The UDSET could be revised to include an additional question, or questions, which would elicit the views of carers on this aspect of the care planning process.

4.3.2 Additional Measure 6a

The proportion of service users whose dependency score has reduced within the period

One of repeated themes in within the outcomes framework is that assessments, and the care plans and services which flow from them, should be anticipatory, enabling, and rehabilitation focused. We believe a measure of this sort is essential to demonstrate that partnerships are delivering services outcomes which meet these expectations. However, the measure relies on the development of a suitable scoring system for recording dependency levels.

The outcomes framework was developed with a view to measuring partnership performance in improving outcomes in the aggregate. It is also important to have a clear understanding of how effective interventions are for individual service users in improving, rather than merely maintaining, their health, wellbeing, social inclusion, and independence.

As part of the Pathfinder we are evaluating whether the IoRN is sufficiently comprehensive to serve this purpose, given its original purpose as a predictor of relative resource use. Alternative approaches which might be more adapted to support and evidence the impact of a rehabilitation and enablement focused approach are also being explored.

Angus Council has been involved in developing a goal orientated approach in relation to housing support, using a simple scale to record levels of independence at assessment on a range of vectors (effectively a summary of the assessment), and providing a basis for goal setting and recording progress toward independence. This “Change Matrix” approach built on work by the City of Edinburgh Council in relation to homelessness, which was also reflected in a similar approach adopted by the National Supporting People Steering Group.

A similar methodology, through the development of an ability scale, as an element in the wider development of an enablement approach in community care is in the early stages of development. This work, and the existing “change matrix” for housing support, may provide a basis of a scoring system which, once validated, could be used to populate this measure.

The measure is expressed in terms of dependency as this is perhaps more easily understood in relation to the four national outcomes. However, it could equally be expressed in terms of ability.

4.3.3 Additional Measures 16a and 16b

The following measures are recommended as additional to, or replacements for, Measure 16: OC2.

Measure 16a

% of SPARRA 2 identified patients with >50% risk of admission / re-admission who have not had an assessment of their health and social care needs within 1 month of initial identification

The SPARRA 2 dataset provides “real-time” analysis of the risk of admission / re-admission for GP registered patients based on previous patterns of emergency admission. The aim of this dataset is to help GPs and CHPs to target resources at those most at risk, an most likely to benefit from a comprehensive assessment of need and the provision of an integrated health and social care plan, most particularly those who suffer from multiple or complex long-term conditions.

This measure evidences whether that information is being used effectively by triggering a health and social care assessment of those at highest risk of emergency admission. It is therefore a good indicator of the partnership’s commitment to anticipatory care and a joint approach to long-term conditions management.

There are data sharing issues which would need to be resolved before individualised data could be made available for matching against records of assessment. The use of this data in this way does not fundamentally differ from the proposed use of the dataset for OC2.

Measure 16b

% of SPARRA 2 identified patients with >50% risk of admission / re-admission at previous index date, who have had two or more emergency admissions within 1 year

This measure complements the previous measure, focusing on the effectiveness of the partnerships response to the needs of patients at high risk of admission / re-admission.

There should be no data sharing difficulties with this measure as the cross-referencing of SPARRA 2 data with admissions could be undertaken by ISD without individualised data being released to partnerships.

5 Next Steps: Pathfinder Phase 3

Phase 1 of the Pathfinder focused on development of the PID and the establishing of the workstreams and project plan. Phase 2 has seen significant progress in delivering the projects objectives, with completion of the evaluation of the 16 measures, completion of the first phase of work in workstreams 6, 9, and 11, and workstreams 3 and 5 are on track to complete the initial phase of their work by May 2008.

This section outlines the key priorities for Phase 3 of the Pathfinder.

5.1 Completion of Tasks outstanding from Phase 2

The following tasks will be completed by the end of May 2008:

- Workstream 2 – Completion of the UDSET pilots, and production of an interim report on the results and lessons learnt, including an assessment of issues related to the implementation of the tool including resource implications and requirements for staff training and written guidance. The report will also identify further work on refining the tool, integration with assessment / care planning / review process, and systems development issues, to be taken forward in Phase 3 of the Pathfinder.
- Workstream 5 – An interim report on the assessment of the suitability of IoRN as a dependency indicator to support Measure 6 and its potential use in the development of measures to record the impact of anticipatory, enablement, and rehabilitation focused services. The report will include set out recommendations for further work on Including report on UDSET trials, implementation of national standards (once published) including systems development, to be taken forward in Phase 3 of the Pathfinder.
- Workstream 3 – Complete an evaluation of “Capacity to Change” as a tool for assisting partnerships to model the existing balance of care, the balance of care the partnership considers appropriate locally, and the resource and commissioning changes required to achieve the shift to the desired balance of care.

5.2 Development of a Balance of Care and Commissioning Model

As part of our evaluation of the “Capacity to Change” tool we will contribute to wider work by the Early Implementers Network to further develop and realign the tool to support outcomes focused commissioning.

At the same time we intend to build capacity locally to develop whole a dynamic whole systems approach to modelling the balance of care and the development of care pathways.

We intend to:

- Commission training for 10 health social work and housing planning staff I the use of systems dynamics modelling techniques using I-Think software package
- Develop of a “balance of care” model for Angus covering older people and specified long term conditions
- Developing a balance of care model to inform the learning disabilities redesign

- Support evaluation of options for service configuration as part of the Angus Community Medicine and Rehabilitation Redesign Project.

5.3 Development and Testing of Alternative / Additional Measures

As indicated above, we plan to complete evaluation of the suite of measures as a whole, mapping interactions within the suite and in relation to other existing or additional measure.

In the light of this work, and the evaluation of the 16 measures contained in this report, we will develop a revised and augmented suite of measures which is adaptable to different local balance of care strategies.

5.4 Adaptation of Outcomes Framework for other Care Groups

One of the key tasks of the Pathfinder is to explore how the outcomes approach can be extended to cover other care groups. We propose to start by focusing on identifying how the suite of measures needs to be adapted for services to people with learning disabilities, and how this approach might support the ongoing service redesign for this care group. We also hope to develop appropriate frameworks for adult mental health and physical disabilities care groups.

It is recognised that there are significant overlaps between these care groups, and our ultimate vision is to develop a single suite of measures which is able to provide a comprehensive performance management framework for all community care groups.

5.5 Development of Ability / Assessment Summary Scale

We will continue evaluation of different approaches to capturing and recording summary data at each stage of the assessment / care planning and review process representing the relative dependency / ability of a service user on a range of key vectors of ability.

Specifically we will:

- Assess options for further development of the IoRN scale, including contributing to the development of IoRN 2
- Further develop the Angus Ability Tool in the context of a rollout of an enablement model across older people's services
- Explore how the model of the Angus "Change Matrix" for housing support can be integrated into a comprehensive scalar ability tool for all community care groups
- Identify the systems developments and resource requirements to implement the tool
- Assess the potential value of the tool in supporting individual enablement and in supporting outcomes focused performance management

5.6 Development and Delivery of an Organisational Development Plan for the Angus Partnership

The Angus Partnership is committed to embedding an outcomes focus in all aspects of its activity, not just in the management and reporting of performance. We recognise that this will have wide-ranging implications for governance, commissioning, service design and delivery, for workforce development, and for professional practice.

We intend to develop a joint organisational development strategy to engage staff across all the partners in a process of cultural and structural change.

As a first step we intend to revise the Angus Extended Local Partnership Agreement to ensure the governance arrangements, and the framework for joint commissioning and management of services, are aligned to deliver the 4 community care outcomes.

We will also explore ways of delivering better services and outcomes for service users through the development of para-professional and multi-disciplinary posts and the re-alignment of existing staff roles.

5.7 Development and Delivery of a Shared Learning Programme

We intend to develop a shared learning programme, in consultation with neighbouring local authorities, NHS Tayside and the Scottish Government Partnership Improvement and Outcomes Division, to share what we have learned in developing and implementing the outcomes approach.

Appendix 1

Revised Angus Community Planning Partnership Governance Structures for Health and Community Care

