COMMUNITY CARE OUTCOMES FRAMEWORK – FINAL DEFINITIONS 2008

OUTCOMES FRAMEWORK FOR COMMUNITY CARE 2009/10

National Outcomes

Improved health	Improved well-being
Improved social inclusion	Improved independence and responsibility

Performance measures and targets

Themes	Code	Measure	Type	Data Source / Status	E/N
Satisfaction	S1	% of community care service users feeling safe.	Outcome	Data drawn from NMIS	N
	S2	% of users and carers satisfied with their involvement in the design of care package.	Outcome	Data drawn from NMIS	N
	S3	% of users satisfied with opportunities for social interaction.	Outcome	Data drawn from NMIS	N
Faster access	A1	No. of patients waiting in short stay settings, or for more than 6 weeks elsewhere for discharge to appropriate setting.	Output	HEAT Standard	E
	A2	No. of people waiting longer than target for assessment, per 000 population.	Output	Pending Implementation of Lord Sutherland's Review of Free Personal Care	
	A3	No. of people waiting longer than target time for service, per 000 population.	Output	Pending Implementation of Lord Sutherland's Review of Free Personal Care	
Support for carers	C1	% of carers who feel supported and capable to continue in their role as a carer.	Outcome	Data drawn from NMIS	N
Quality of assessment and care planning	Q1	% of user assessments completed to national standard.	Process	Data drawn from NMIS and local systems	N
	Q2	% of carers' assessments completed to national standard.	Process	Data drawn from NMIS and local systems	N
	Q3	% of care plans reviewed within agreed timescale.	Output	Data drawn from NMIS	N
Identifying those at risk	R1	No. of emergency bed days in acute specialties for people 65+, per 100,000 pop.	Outcome	HEAT target (T12)	E
	R2	No. of people 65+ admitted as an emergency twice or more to acute specialties, per 100, 000 pop.	Outcome	National indicator reported in Scotland Performs	E
	R3	Percentage of people 65+ admitted twice or more as an emergency who have not had an assessment.	Output	Measure administered through ISD	E
Moving services closer to users patients	BC1	Shift in balance of care from institutional to 'home based' care.	Input	No overarching measure	
	BC2	% of people 65+ with intensive needs receiving care at home.	Input/ Outcome	Measure administered through ASD	E & N
	BC3	% of people 65+ receiving personal care at home.	Output (proxy)	Measure administered through ASD	E

Measures: 6 (7) outcomes 7 output 2 process 2 (1) input

- NMIS is National Minimum standards for assessment, shared care and support plans and review (July 2008)
- HEAT is the NHS Scotland suite of measures and targets on which NHS Boards base their annual Local Delivery Plans
- ISD is the Information Services Division of NHS Scotland
- ASD is the Analytical Services Division of Scottish Government
- E – Existing measure
- N – Measure defined in this document

2. Purpose

This document presents the final definitions of a subset of the measures forming the Community Care Outcomes Framework, for use in 2008/09 and beyond.

For the first time in Scotland, the Community Care Outcomes Framework helps partnerships to understand their performance at a strategic level in improving outcomes for people who use community care services or support, and their carers.

It also allows partnerships to share this information with other partnerships in Scotland and compare performance directly on the basis of consistent, clear information.

This definitions document springs from 2 years of work across Scotland by a network of people using community care services, carers, researchers, practitioners, managers and planners to develop an outcomes approach to the delivery and management of community care services and support.

It presents a one page definition for each measure, designed for use by officers in health and social care systems who are responsible for collating data and creating reports on community care performance.

It also summarises the context for the performance framework, and the reasoning that the network has used in arriving at each of the definitions.

The Concordat between Scottish Government and Scottish Local Authorities (November 2007) indicates that there will be a streamlining of performance reporting by Local Authorities to the Government. A fundamental principle underpinning the whole of the Community Care Outcomes Framework is that where there are pre-existing measures which are still fit for purpose or the best available proxy, these will remain unchanged. There are 5 such measures in the suite for 2008/09.

The Community Care Outcomes Framework is designed to promote a strategic understanding of performance in improving outcomes for people who use community care services or support, and their carers. For that reason it is deliberately pitched at a high level of data aggregation. Local partnerships may wish to ensure that they can understand the building blocks that make up the overall performance figure for anyone of the measures in their local area. Depending on the measure, it may be useful to be able to drill down by the following groupings:

- Care group
- Geographical area/teams
- Age
- Gender
- Minority groups

Disaggregating data and monitoring performance at this level may also assist in complying with equalities legislation.

3. Setting the performance framework in the context of frontline working – the key role of assessment, care plans and review

Assessment, care planning and review lie at the heart of identifying and improving outcomes for people using community care or support and their carers. The Community Care Outcomes Framework offers a means of understanding how a local system is doing in improving outcomes for people overall. But the biggest impact day to day will come from putting outcomes for people at the heart of assessment, care plans and review. At the time of writing, 14 partnerships are using UDSET in Scotland.

We are piloting and promoting the User Defined Service Evaluation Toolkit (UDSET) approach to support frontline staff in shifting their focus onto outcomes and quality of life.

The new National Minimum Information Standards (Assessment, Care Plans, & Review for people using services and for carers) were published in July 2008 and will be a powerful lever in promoting the outcomes approach. Data standards are built in so that 7 of the "new" measures in the National Community Care Outcomes Framework can be captured as a by-product of each assessment, care plan and review. The table on page 1 identifies these 7 measures.

The national e-care programme will ensure that all partnerships have the capacity to share assessment, care planning and review data electronically by 2009/10. In order to make use of this capacity, local partnerships will need to specify their electronic tools so that data can be captured according to the new National Minimum Information Standards, and aggregated to produce reports against the Community Care Outcomes Framework.

We have made sure that the Community Care Outcomes Framework is aligned with the National Minimum Information Standards and UDSET so that where systems adopt the information standards they will capture data for related measures in the outcomes framework as data standards. This will mean that the data can be compared with that from other partnerships – which should in turn help partnerships to understand and judge their own performance alongside others'.

Satisfaction Measures - Rationale

A number of measures in the Community Care Outcomes Framework aim to measure the experience of people using services or support, or their carers, directly. The purpose of this approach is to place user and carer experiences at the centre of performance management, planning, commissioning and service improvement.

The choice of these satisfaction measures is primarily based on findings and research tools developed during the course of a two-year research project which looked at the outcomes most important to users of services delivered in partnership between health and social care. This research (Petch et al, 2007) was based at the University of Glasgow and established two frameworks of the outcomes that are important to service users and their carers.

These frameworks were adapted from a ten-year programme of research on service user and carer outcomes at the University of York. The research team at the University of Glasgow adapted the University of York outcomes framework for service users, in collaboration with three user research organisations, to ensure that it reflected the priorities of a broad range of community care service users, and used accessible language. The revised framework was then tested out in interviews with 230 service users across the UK. The framework and related review tool were also piloted in Orkney.

Table 1. Outcomes Important to Service Users

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

The University of York outcomes framework for carers was adapted in collaboration with carers' representatives in Scotland to ensure it reflects those issues most important to carers. This framework was tested in two pilot sites in Scotland, Orkney and East Renfrewshire.

Table 2. Outcomes Important to Carers

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

4. The 6 themes

The Community Care Outcomes Framework was initially generated by a representative group of 60 stakeholders and refined through a virtual consultation involving 5,600 people and organisations. 7 Early Implementer Partnerships then tested various elements of the Framework, facilitating further refinement in the light of experience. The suite of 16 measures fall into 6 key themes, as follows:

- **Satisfaction** – amongst people using services or support, and carers
- **Access** – getting the right service or support at the right time
- **Support for carers** to continue their caring role
- **Quality of assessment, care planning and review**
- Identifying and supporting those at **risk of admission to hospital**
- **Shifting the balance of care** to support more people at home for longer, promoting self-care rather than reliance on professionals, and providing necessary services and support closer to people's own homes.

The history of performance management at a national level in Scotland has been one of focussing on a small number of measures as key priorities. The approach underpinning the Community Care Outcomes Framework is one of understanding the performance of the local health and care system in the round; the interactions between the measures across the suite mean that it is essential that it is balanced across the range of themes, and not narrowed down on one or two measures. Put another way, it is likely that a local system that looks only at measures in some of the 6 key themes will tend to throw the system out of balance and experience deterioration in the areas that are not measured. This is wholly in line with the National Performance Framework approach which looks to balance improvement across 5 strategic objectives and 15 national outcomes.

5. The suite of measures: sub-set for use in 2008/09

Final definitions have now been agreed for 13 of the suite of 16 measures. Where partnerships implement the National Minimum Information Standards, and have the capacity to share data generated from those assessments, care plans and reviews electronically, they will be able to use all 13 of these measures in 2009/10. The table at page 1 identifies these measures.

Two further measures are dependent on the implementation of the Review of Free Personal and Nursing Care carried out by Lord Sutherland. This will begin in April 2009 and negotiations are currently continuing as to its precise nature. We will develop measures to fit with the product of that work once it is available.

6. Using the framework

Ten local areas committed to the use of the full Community Care Outcomes Framework in their Single Outcome Agreements for 2008/09. A small number of partnerships have begun to collect data to populate the 13 definitions during 2008/09, with some mid-year reports now emerging. More partnerships have told us that they expect to have their first data by the end of March 2009.

The Midlothian Partnership is leading a piece of work to develop and support a benchmarking network using the Community Care Outcomes Framework, building on work done by the Community Care Outcomes Framework Early Implementer Partnerships and learning from the successful Scottish Housing Best Value Network. An invitation to join this will be issued soon.

The Community Care Outcomes Framework is for local partnerships to use as they see fit. The Framework is designed to help partnerships to understand their performance at a strategic level in improving outcomes for people who use community care services or support, and their carers. The Partnership Improvement and Outcomes Division within the Scottish Government is keen to offer any support that may be useful in this regard, including direct local involvement, and/or signposting to other interested partnerships for peer support. Please contact us if this would be useful to you. In the first instance please contact: Colin Blyth – colin.blyth@scotland.gsi.gov.uk, Tel No: 0131 244 3744

7. The measures - in detail

Theme: Satisfaction

S1 - PERCENTAGE OF PEOPLE WHO USE COMMUNITY CARE SERVICES OR SUPPORT WHO FEEL SAFE

This first measure has prompted more debate than any other in the Community Care Outcomes Framework suite. The majority view is as follows:

Research (see above, p.3-5) shows that feeling safe is a major concern for people who use community care services or support.

That concern is not necessarily expressed in relation to services. What people say is important to them is the overall feeling of being safe – or not.

Although community care partnerships are not solely responsible for ensuring safety, they should recognise any concerns people raise with them, and facilitate improvements both internally and by engaging with community planning partners e.g. Police, Building Design, political representatives, Environmental services, etc.

So the National Minimum Information Standards propose a data standard which captures the answer to the question “Do you feel safe?” (Standards for assessment, p.20, Standards for Review, p. 41). Where someone does not feel safe, this will be explored according to the four key themes which were identified in the research, covering both physical and emotional safety.

The data standard will generate a yes or no answer which will be gathered as part of the Community Care Outcomes Framework measure. If someone says they do not feel safe, the subsequent discussion in the assessment / review will directly inform the plan for shared care or support. If the experience of the plan for shared care and support addresses the person’s concerns about feeling safe, they will say that they feel safe when asked about this at the subsequent review. Data gathered in this way will therefore generate:

- A measure across the whole partnership for all client groups which will give an indication of success in delivering this outcome which is directly comparable with measurement in other partnerships
- Detailed information at individual level, which can be interrogated locally at client group or geographical area level, to begin to uncover a detailed picture of the partnership’s performance locally.

The purpose of this measure is therefore:

- to empower, enable and respect people by listening to their key concerns
- to identify those vulnerable and at risk
- to promote actions which will ensure a safe and secure living environment and services for people using community care services or support

S1 - PERCENTAGE OF PEOPLE WHO USE COMMUNITY CARE SERVICES OR SUPPORT WHO FEEL SAFE

<table>
<tr><td>RATIONALE</td><td colspan="4">Research with people who use community care services (Petch et al, 2007) shows that their perception of their own safety is a key concern. So it is important to understand this aspect of people's experience.</td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">All assessments & reviews of people who use community care services or support carried out in accordance with National Minimum Information Standards (NHS, social care, housing and other staff)</td></tr>
<tr><td>FORMULA (Numerator / Denominator)</td><td colspan="4">Number of people reporting that they feel safe at review / Number of people whose care and support plan was reviewed.
Supplementary measure: number of people reporting that they feel safe at assessment/number of people assessed.
Both numerator and denominator would refer to the same time period eg. the previous year. Each individual would be counted only once using the latest recorded information.</td></tr>
<tr><td>UNIT</td><td colspan="4">Percentage</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="4">Continuous – as required – with annual counts.</td></tr>
<tr><td>DRILL DOWN HIERARCHY</td><td colspan="4">It may be useful to be able to drill down by the following groupings:
Care group; Geographical area/teams; Age; Gender; Minority Groups</td></tr>
<tr><td>COLLECTION YEAR</td><td>08/09</td><td>No <i>(limited pilots)</i></td><td>09/10</td><td>Yes (Baseline)</td></tr>
<tr><td>NATIONAL MINIMUM INFORMATION STANDARDS</td><td colspan="4">Cross References: Assessment – page 20
Review – page 41
The National Minimum Information Standards outline four particular areas of concern (safe at home, in the community, when using services, and emotionally safe) and it may be useful to record and analyse against each of these. This will allow practitioners to consider possible actions to increase safety and make it more likely that this measure actively contributes to driving up performance against this particular outcome.</td></tr>
<tr><td>RELATED DATA</td><td colspan="4">▪ Existing research evidence about client experience in Scotland, the rest of the UK and elsewhere (SPRU, University of Glasgow)
▪ Work that SWIA does to measure user and carer perceptions of safety in preparation for inspections
▪ Relevant pilots to test UDSET in North Lanarkshire, Glasgow (2007/08/09)</td></tr>
<tr><td>TARGETS</td><td colspan="4">▪ Target setting is purely a matter for local partnerships
▪ Performance is likely to vary across and within partnerships. However a continuous improvement approach would suggest setting challenging performance improvement targets for a partnership based on the baseline, and performance in relevant benchmark partnerships.</td></tr>
</table>

S2a - PERCENTAGE OF PEOPLE WHO USE COMMUNITY CARE SERVICES OR SUPPORT SATISFIED WITH INVOLVEMENT IN DESIGN OF THEIR HEALTH AND SOCIAL CARE PACKAGES

S2b - PERCENTAGE OF CARERS OF PEOPLE WHO USE COMMUNITY CARE SERVICES OR SUPPORT SATISFIED WITH INVOLVEMENT IN DESIGN OF THEIR HEALTH AND SOCIAL CARE PACKAGES

The second of the satisfaction measures concerns a range of the key concerns identified through research with people using community care services or support, including:

- Real choice and control of good quality services or support, which are responsive to individual needs and preferences.
- Self-directed support wherever possible and appropriate
- Services that support people to make their own decisions, and give advice as and when required.
- Independence and choice by supporting people to continue to live in their own environment if they wish, providing a robust network of support to make this an effective option.

Involvement in this context covers not only being asked but also having those views taken into account in the decision-making process. But it does not mean the ultimate decision will necessarily be the one the user wants.

So the National Minimum Information Standards propose a data standard which captures the answer to the question “Does the person feel satisfied with their involvement in the design of their care?”. Where someone does not feel satisfied, this will be explored by the assessor/reviewer.

If someone says they do not feel they have been appropriately involved, the subsequent discussion in the assessment / review will directly inform the plan for shared care or support at practitioner level. Once the Care Plan is agreed the person will be asked (again) if they are satisfied with their involvement in the design of the plan for Shared Care and Support. The data standard will generate a yes or no answer which will be gathered as part of the Community Care Outcomes Framework measure.

Data gathered in this way will therefore generate:

- A measure across the whole partnership for all client groups which will give an indication of success in delivering this outcome which is directly comparable with measurement in other partnerships
- Detailed information at individual level, which can be interrogated locally at client group or geographical area level, to begin to uncover a detailed picture of the partnership’s performance locally.

Carers also identified the importance of a number of factors which are reflected in this measure, including:

- Being valued/respected and expertise recognised
- Having a say in services/support
- Services/support being flexible and responsive to changing needs
- Positive/meaningful relationship with practitioners
- Having a life of their own
- Choices in caring, including the limits of caring
- Feeling informed/ skilled/equipped
- Partnership with services

For these reasons this measure is also defined with respect to carers with the intention that a score for the measure in relation to carers be collected and reported separately from that for people using services or support.

Performance against this measure will be reported as two numbers; one the % of users who feel satisfied (S2a) and the other the % of carers who feel satisfied (S2b).

There is a real concern that the methodology of capturing satisfaction data within the context of a community care assessment or service review may lead to skewed results, because the person using services or support may feel pressurised in to saying that they feel more satisfied than they actually are. It is suggested that the positive impact on the content and nature of assessment and review will outweigh this concern. However, triangulation of summarised responses through independent survey (SWIA, Patient Experience Programme, and other bespoke local activities) will be of value in understanding any overall skewing and amending aggregated results accordingly.

<table>
<tr><th colspan="5">S2a - PERCENTAGE OF PEOPLE WHO USE COMMUNITY CARE SERVICES OR SUPPORT SATISFIED WITH INVOLVEMENT IN DESIGN OF THEIR HEALTH AND SOCIAL CARE PACKAGES</th></tr>
<tr><td>RATIONALE</td><td colspan="4">Research with people who use community care services and carers (Petch et al, 2007) shows that the degree to which they are listened to and have control over their own lives is very important. So it is important to understand this aspect of people’s experience.</td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">All care plans & reviews of people who use community care services or support carried out in accordance with National Minimum Information Standards (NHS, social care, housing and other staff)
This information should be collected at the ‘care plan’ and ‘review’ stages.</td></tr>
<tr><td>FORMULA (Numerator / Denominator)</td><td colspan="4">• All shared care and support plans agreed or reviewed where the person feels satisfied with their involvement / All care plans agreed or reviewed
Both numerator and denominator would refer to the same time period eg. the previous year.</td></tr>
<tr><td>UNIT</td><td colspan="4">Percentage</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="4">Continuous – as required – with annual counts.</td></tr>
<tr><td>DRILL DOWN HIERARCHY</td><td colspan="4">It may be useful to be able to drill down by the following groupings:
Care group; Geographical area/teams; Age; Gender; Minority Groups</td></tr>
<tr><td>NATIONAL MINIMUM INFORMATION STANDARDS</td><td colspan="4">Cross References:
Shared Care & Support Plan – page 36
Review – page 42 Carers Assessment and support – page 52</td></tr>
<tr><td>COLLECTION YEAR</td><td>08/09</td><td>No <i>(limited pilots)</i></td><td>09/10</td><td>Yes (Baseline)</td></tr>
<tr><td>RELATED DATA</td><td colspan="4">▪ Existing research evidence about client experience in Scotland, the rest of the UK and elsewhere (SPRU, University of Glasgow)
▪ Work that SWIA does to measure user and carer satisfaction with involvement in preparation for inspections
▪ Relevant pilots to test UDSET (2007/08/09)</td></tr>
<tr><td>TARGETS</td><td colspan="4">▪ Target setting is purely a matter for local partnerships
▪ Performance is likely to vary across and within partnerships. However a continuous improvement approach would suggest setting challenging performance improvement targets for a partnership based on the baseline, and performance in relevant benchmark partnerships.</td></tr>
</table>

S2b - PERCENTAGE OF CARERS OF PEOPLE WHO USE COMMUNITY CARE SERVICES OR SUPPORT SATISFIED WITH INVOLVEMENT IN DESIGN OF THEIR HEALTH AND SOCIAL CARE PACKAGES

RATIONALE	Research with people who use community care services and carers (Petch et al, 2007) shows that the degree to which they are listened to and have control over their own lives is very important. So it is important to understand this aspect of people's experience.			
DATA SOURCE	All carer assessments and support plans carried out in accordance with National Minimum Information Standards (NHS, social care, housing and other staff)			
FORMULA (Numerator / Denominator)	• Number of carers feeling satisfied with involvement in design of their support package / Number of carers assessment and support plans agreed or reviewed. Both numerator and denominator would refer to the same time period e.g. the previous year.			
UNIT	Percentage			
MEASUREMENT PERIOD	Continuous – as required – with annual counts.			
DRILL DOWN HIERARCHY	It may be useful to be able to drill down by the following groupings: Care group; Geographical area/teams; Age; Gender; Minority Groups			
NATIONAL MINIMUM INFORMATION STANDARDS	Cross References: Carers Assessment and support – page 52			
COLLECTION YEAR	**08/09**	No (limited pilots)	**09/10**	Yes (Baseline)
RELATED DATA	▪ Existing research evidence about client experience in Scotland, the rest of the UK and elsewhere (SPRU, University of Glasgow) ▪ Work that SWIA does to measure user and carer satisfaction with involvement in preparation for inspections ▪ Relevant pilots to test UDSET (2007/08/09)			
TARGETS	▪ Target setting is purely a matter for local partnerships ▪ Performance is likely to vary across and within partnerships. However a continuous improvement approach would suggest setting challenging performance improvement targets for a partnership based on the baseline, and performance in relevant benchmark partnerships.			

S3 - PERCENTAGE OF USERS OF COMMUNITY CARE SERVICES REPORTING SATISFACTION WITH THE OPPORTUNITIES PROVIDED FOR MEANINGFUL SOCIAL INTERACTION

The third of the satisfaction measures reflects another key concern identified through research with people using community care services or support, including:

- social activities, social contact and meaningful day opportunities contribute vitally to the wellbeing of individuals
- key indicator of social inclusion
- builds participation in the community
- builds self worth and esteem
- to help people who use services to be more economically active.

Although care services are not solely responsible for providing opportunities for social interaction, they should facilitate these arrangements by engaging with community planning partners e.g. Adult Education, Department of Work & Pensions, local employers, Scottish Enterprise, Sport & Recreation, voluntary sector, etc.

So the National Minimum Information Standards propose a data standard which captures the answer to the question “Is the person satisfied with the opportunities available for social interaction?”. Where someone does not feel satisfied, this will be explored by the assessor/reviewer, and the subsequent discussion in the assessment / review will directly inform the plan for shared care or support. If the experience of the plan for shared care and support addresses the person’s concerns about social interaction, they will say that they are satisfied when asked about this at the review stage.

The data standard will generate a yes or no answer which will be gathered as part of the Community Care Outcomes Framework measure.

Data gathered in this way will therefore generate:

- A measure across the whole partnership for all client groups, which will give an indication of success in delivering this outcome, which is directly comparable with measurement in other partnerships.
- Detailed information at individual level, which can be interrogated locally at client group or geographical area level, to begin to uncover a detailed picture of the partnership’s performance locally.

There is a real concern that the methodology of capturing satisfaction data within the context of a community care assessment or service review may lead to skewed results, because the person using services or support may feel pressurised in to saying that they feel more satisfied than they actually are. It is suggested that the positive impact on the content and nature of assessment and review will outweigh this concern. However, triangulation of summarised responses through independent survey (SWIA, Patient Experience Programme, and other bespoke local activities) will be of value in understanding any overall skewing and amending aggregated results accordingly.

<table>
<tr><th colspan="5">S3 - PERCENTAGE OF USERS OF COMMUNITY CARE SERVICES REPORTING SATISFACTION WITH THE OPPORTUNITIES FOR MEANINGFUL SOCIAL INTERACTION</th></tr>
<tr><td>RATIONALE</td><td colspan="4">Research with people who use community care services and carers (Petch et al, 2007) shows that social interaction contributes vitally to the wellbeing of individuals. So it is important to understand this aspect of people's experience.</td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">All assessments and reviews of people who use community care services or support carried out in accordance with National Minimum Information Standards (NHS, social care, housing and other staff)</td></tr>
<tr><td>FORMULA (Numerator / Denominator)</td><td colspan="4">▪ Number of people using services or support feeling satisfied with opportunities for meaningful social interaction at review/ Number of people whose care and support plan was reviewed.
Supplementary measure: number of people reporting that they feel satisfied with opportunities for meaningful social interaction at assessment / number of people assessed.
Both numerator and denominator would refer to the same time period eg. the previous year. Each individual would be counted only once using the latest recorded information.</td></tr>
<tr><td>UNIT</td><td colspan="4">Percentage</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="4">Continuous – as required – with annual counts.</td></tr>
<tr><td>DRILL DOWN HIERARCHY</td><td colspan="4">It may be useful to be able to drill down by the following groupings:
Care group; Geographical area/teams; Age; Gender; Minority Groups</td></tr>
<tr><td>COLLECTION YEAR</td><td>08/09</td><td>No <i>(limited pilots)</i></td><td>09/10</td><td>Yes (Baseline)</td></tr>
<tr><td>NATIONAL MINIMUM INFORMATION STANDARDS</td><td colspan="4">Cross References:
Assessment – page 27
Review – page 41</td></tr>
<tr><td>RELATED DATA</td><td colspan="4">▪ Existing research evidence about client experience in Scotland, the rest of the UK and elsewhere (SPRU, University of Glasgow)
▪ Work that SWIA does to measure user and carer satisfaction in preparation for inspections
▪ Relevant pilots to test UDSET (2007/08/09)
▪ Capturing this information at assessment (in addition to review) may be useful at a local level to inform future decision-making and for analysing trends</td></tr>
<tr><td>TARGETS</td><td colspan="4">▪ Target setting is purely a matter for local partnerships
▪ Performance is likely to vary across and within partnerships. However a continuous improvement approach would suggest setting challenging performance improvement targets for a partnership based on the baseline, and performance in relevant benchmark partnerships.</td></tr>
</table>

Theme: Faster Access

A1a - NUMBER OF PATIENTS IN SHORT STAY SETTINGS IN HOSPITAL WAITING TO BE DISCHARGED INTO A MORE APPROPRIATE CARE SETTING

A1b - NUMBER OF PATIENTS WAITING MORE THAN SIX WEEKS ELSEWHERE IN HOSPITAL TO BE DISCHARGED INTO A MORE APPROPRIATE CARE SETTING

Patients delayed in hospital once their treatment is complete are known to be vulnerable to a number of negative effects, not least reduced independence and increased risk of infection (Cornes 2007). The importance of providing the right community care services or support at the right time, and thus minimising such delays was recognised in the development of the Community Care Outcomes Framework.

These 2 measures are now well established across Scotland, having formed targets within the NHS HEAT suite until 2007/08. Performance against both measures was reduced to zero by April 2008 and keeping numbers at this level is now a standard for NHS Boards working with local councils. This can only be delivered through effective partnership working.

Delayed discharges have been recorded and reported in Scotland since 2001 according to national standard definitions and data recording criteria. Further information is available on the ISD website.

Drill down hierarchy - partnerships may want to go further and target specific client groups who due to the complexities involved are currently outwith the zero standards. Partnerships may also want to consider setting local targets to reduce the numbers of bed days lost to delayed discharges.

A1a - NUMBER OF PATIENTS IN SHORT STAY WAITING BE DISCHARGED FROM HOSPITAL INTO A MORE APPROPRIATE CARE SETTING

A1b - NUMBER OF PATIENTS WAITING MORE THAN SIX WEEKS ELSEWHERE IN HOSPITAL TO BE DISCHARGED INTO A MORE APPROPRIATE CARE SETTING

<table>
<tr><td>RATIONALE</td><td colspan="4">Research (Cornes, 2007) demonstrates that once treatment and rehabilitation in hospital is complete, any delay in discharging a patient from hospital can have significant negative consequences for the patient’s health and wellbeing.

Also a clear indicator of effectiveness of joint working.</td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">Monthly returns to ISD – formal data recording procedures and definitions in place (<i>Delayed Discharges data recording manual</i>). The figures exclude people who are delayed due to complex needs (where the delay is outwith the immediate control of the NHS or local authority, such as where no appropriate facilities exist) or a patient is delayed under the Adults with Incapacity Act. This measure should cover all client care groups whose discharge is delayed regardless of where they are discharged to, including those awaiting transfer to long term continuing care and those discharged to their own home, plus those requiring extensive care packages or adaptations work on their home.</td></tr>
<tr><td>FORMULA (Numerator / Denominator)</td><td colspan="4">Number who on census date have been waiting more than three days to be discharged from short stay setting
Number who on census date have been waiting in hospital more than six weeks to be discharged</td></tr>
<tr><td>UNIT</td><td colspan="4">Number</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="4">Continuous – as required – with monthly counts.</td></tr>
<tr><td>DRILL DOWN HIERARCHY</td><td colspan="4">It may be useful to be able to drill down by the following groupings:
Care group; Geographical area/teams; Age; Gender; Minority Groups; Complex Care</td></tr>
<tr><td>COLLECTION YEAR</td><td>08/09</td><td>Yes</td><td>09/10</td><td>Yes</td></tr>
<tr><td>PROPOSED FUTURE MEASURE</td><td colspan="4">National Advisory Group on Delayed Discharge Information is considering other possible measures.</td></tr>
<tr><td>RELATED DATA</td><td colspan="4">Not applicable</td></tr>
<tr><td>TARGETS</td><td colspan="4">▪ Sustaining the zero position is a HEAT standard for all NHS Boards.</td></tr>
</table>

A2 - NUMBER OF PEOPLE WAITING FOR MORE THAN TARGETED TIME FROM REFERRAL TO COMPLETION OF ASSESSMENT PER 1,000 POPULATION

A3 - NUMBER OF PEOPLE WAITING MORE THAN THE TARGETED TIME FOR THE DELIVERY OF COMMUNITY CARE SERVICES FOLLOWING AN ASSESSMENT PER 1,000 POPULATION

Lord Sutherland's Review of Free Personal and Nursing Care was published in April 2008. The Scottish Government and COSLA have welcomed that review and accepted its findings. Implementation is due in April 2009. That will need to ensure that equity in provision of free personal and nursing care can be demonstrated across Scotland. That may lead to agreed times for delivery of free personal and nursing care across Scotland, and a requirement to demonstrate that these are being met locally.

Contributors to the design of the Community Care Outcomes Framework were unanimous in their assumption that people should not have to wait for an unreasonable time if they need a service or support. So two output measures were drafted to demonstrate organisational efficiency in meeting this expectation.

If, as seems likely, the implementation of the Review of Free Personal and Nursing Care leads to parallel measures these will be adopted as part of the Community Care Outcomes Framework and we are not proposing final definitions for these two measures until the Free Personal and Nursing Care group issues its final report.

<table>
<tr><th colspan="5">A2 - NUMBER OF PEOPLE WAITING FOR MORE THAN TARGETED TIME FROM REFERRAL TO COMPLETION OF ASSESSMENT PER 1,000 POPULATION</th></tr>
<tr><td>RATIONALE</td><td colspan="4">A key expectation is that people don't have to wait for an unreasonable time if they need a service or support. This is an output measure demonstrating organisational efficiency.</td></tr>
<tr><td>DATA SOURCE</td><td colspan="4"><i>To be determined by Working Group on Implementation of Lord Sutherland Review of Free Personal and Nursing Care</i></td></tr>
<tr><td>FORMULA (Numerator / Denominator)</td><td colspan="4"><i>To be determined</i></td></tr>
<tr><td>UNIT</td><td colspan="4"><i>To be determined</i></td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="4"><i>To be determined</i></td></tr>
<tr><td>NATIONAL MINIMUM INFORMATION STANDARDS</td><td colspan="4">Cross References:
Assessment – page 29</td></tr>
<tr><td>DRILL DOWN HIERARCHY</td><td colspan="4">It may be useful to be able to drill down by the following groupings:
Care group; Geographical area/teams; Age; Gender; Minority Groups</td></tr>
<tr><td>COLLECTION YEAR</td><td>08/09</td><td>No</td><td>09/10</td><td>Yes</td></tr>
<tr><td>PROPOSED FUTURE MEASURE</td><td colspan="4">Possibly</td></tr>
<tr><td>RELATED DATA</td><td colspan="4">Eligibility criteria (social work and housing services)</td></tr>
<tr><td>TARGETS</td><td colspan="4">To be determined by Working Group on Implementation of Lord Sutherland Review of Free Personal and Nursing Care</td></tr>
</table>

<table>
<tr><th colspan="5">A3 - NUMBER OF PEOPLE WAITING MORE THAN THE TARGETED TIME FOR THE DELIVERY OF COMMUNITY CARE SERVICES FOLLOWING AN ASSESSMENT PER 1,000 POPULATION</th></tr>
<tr><td>RATIONALE</td><td colspan="4">A key expectation is that people don’t have to wait for an unreasonable time if they need a service or support. This is an output measure demonstrating organisational efficiency.</td></tr>
<tr><td>DATA SOURCE</td><td colspan="4"><i>To be determined by Working Group on Implementation of Lord Sutherland Review of Free Personal and Nursing Care</i></td></tr>
<tr><td>FORMULA (Numerator / Denominator)</td><td colspan="4"><i>To be determined</i></td></tr>
<tr><td>UNIT</td><td colspan="4"><i>To be determined</i></td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="4"><i>To be determined</i></td></tr>
<tr><td>DRILL DOWN HIERARCHY</td><td colspan="4">It may be useful to be able to drill down by the following groupings:
Care group; Geographical area/teams; Age; Gender; Minority Groups</td></tr>
<tr><td>COLLECTION YEAR</td><td>08/09</td><td>No</td><td>09/10</td><td>Yes</td></tr>
<tr><td>CROSS REFERENCE WITH NMIS</td><td colspan="4">Cross References:
Assessment – page 29</td></tr>
<tr><td>PROPOSED FUTURE MEASURE</td><td colspan="4">Possibly. The initial development phase of the Community Care Outcomes concluded that the scope of this measure should be limited to the delivery of the following care packages, which were felt to be the priority areas on which to improve waiting times:
Equipment / Adaptations / Home Care / Specialist services</td></tr>
<tr><td>RELATED DATA</td><td colspan="4">Eligibility criteria (social work and housing services)</td></tr>
<tr><td>TARGETS</td><td colspan="4">To be determined by Working Group on Implementation of Lord Sutherland Review of Free Personal and Nursing Care</td></tr>
</table>

Theme: Support for carers

C1 - PERCENTAGE OF CARERS WHO FEEL SUPPORTED AND CAPABLE TO CONTINUE IN THEIR ROLE AS A CARER

This single measure is the culmination of long debate with carers and their representatives across Scotland, and is intended to reflect:

- concerns about the health impacts of caring
- focus on carer well-being
- carers as partners in care
- sustaining carers benefits them, the person or people they are looking after, and the interests of the statutory agencies

So the National Minimum Information Standards propose a data standard which captures the answer to the question “Does the carer feel able to continue their caring role?”.

Where a carer says no, this will be explored and addressed by the assessor/reviewer.

The data standard will generate a yes or no answer which will be gathered as part of the Community Care Outcomes Framework measure. If someone says they do not feel able to continue their caring role, the subsequent discussion in the assessment / review will directly inform the plan for carer support at practitioner level. If the experience of support addresses the carer’s concerns, they will answer yes to this question at the subsequent review of the support plan.

Data gathered in this way will therefore generate:

- A measure across the whole partnership for all client groups, which will give an indication of success in delivering this outcome, which is directly comparable with measurement in other partnerships.
- Detailed information at individual level, which can be interrogated locally at client group or geographical area level, to begin to uncover a detailed picture of the partnership’s performance locally.

There is a real concern that the methodology of capturing satisfaction data within the context of a carer assessment or support review may lead to skewed results, because the carer may feel pressurised in to saying that they feel more satisfied than they actually are. It is suggested that the positive impact on the content and nature of assessment and review will outweigh this concern. However, triangulation of summarised responses through independent survey (SWIA, Patient Experience Programme, and other bespoke local activities) will be of value in understanding any overall skewing and amending aggregated results accordingly.

<table>
<tr><th colspan="5">C1 - PERCENTAGE OF CARERS WHO FEEL SUPPORTED AND CAPABLE TO CONTINUE IN THEIR ROLE AS A CARER</th></tr>
<tr><td>RATIONALE</td><td colspan="4">This measure seeks to ensure that appropriate levels of support are provided, so that carers feel supported and able to continue in their role. This will include their on-going mental, emotional and physical well-being.
Carers across Scotland have indicated that this is the single most important outcome from their perspective.</td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">All ‘cared for person’ assessments & reviews, and carer assessments and carried out according to the National Minimum Information Standards – including those community care assessments that require appropriate NHS services.</td></tr>
<tr><td>FORMULA (Numerator / Denominator)</td><td colspan="4">All carer support plans reviewed where the carer feels able to continue their caring role / All carer support plans reviewed

Supplementary measures:
All carer assessments where the carer feels able to continue their caring role / All carer assessments completed
All ‘cared for person’ assessments where a carer is identified and recorded as able to continue their caring role / All user assessments where a carer is identified
All ‘cared for person’ reviews where a carer is identified and recorded as able to continue their caring role / All user reviews where a carer is identified

Both numerator and denominator would refer to the same time period e.g. the previous year. Each individual would be counted only once, using the latest recorded information.</td></tr>
<tr><td>UNIT</td><td colspan="4">Percentage</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="4">Continuous – as required – with annual counts.</td></tr>
<tr><td>DRILL DOWN HIERARCHY</td><td colspan="4">It may be useful to be able to drill down by the following groupings:
Care group (of cared for person); Geographical area/teams; Age (of carer); Gender (of carer); Minority Groups (of carer)</td></tr>
<tr><td>COLLECTION YEAR</td><td>08/09</td><td>No</td><td>09/10</td><td>Yes (baseline)</td></tr>
<tr><td>NATIONAL MINIMUM INFORMATION STANDARDS</td><td colspan="4">Cross references:
Assessment – page 21
Review – page 42
Carers assessment and support – page 52</td></tr>
<tr><td>RELATED DATA</td><td colspan="4">▪ Existing research evidence about carer experience in Scotland, the rest of the UK and elsewhere (SPRU, University of Glasgow)
▪ Work that SWIA does to measure user and carer perceptions of carer satisfaction in preparation for inspections
▪ Relevant pilots to test Carer Defined Service Evaluation Toolkit - CDSET (2007/08/09)</td></tr>
<tr><td>TARGETS</td><td colspan="4">▪ Target setting is purely a matter for local partnerships
▪ 100% of carers feeling able to continue is the aspiration, and this may be achievable.
▪ Performance is likely to vary across and within partnerships. However a continuous improvement approach would suggest setting challenging performance improvement targets for a partnership based on the baseline, and performance in relevant benchmark partnerships.</td></tr>
</table>

Theme: Quality of assessment, care planning and review

Q1 - PERCENTAGE OF ASSESSMENTS OF PEOPLE WHO MAY NEED COMMUNITY CARE SERVICES OR SUPPORT COMPLETED IN ACCORDANCE WITH AGREED NATIONAL STANDARDS

Q2 - PERCENTAGE OF CARER ASSESSMENTS COMPLETED IN ACCORDANCE WITH AGREED NATIONAL STANDARDS

The significance of assessment, care planning and review in determining what services or support are offered to people is self-evident. Research from York University has identified that good quality assessment, care planning and review have a key role in delivering good outcomes to service users (Glendinning et al 2006) and to carers (Nicholas 2001).

Defining quality is difficult, and needs to start with the experience of the person who may need support or services. Use of the full suite of measures in the Community Care Outcomes Framework will allow triangulation with the views of people using services or support, and carers, in terms of their satisfaction. However it remains important to try to understand the quality of the assessment care planning and review process itself. Having completed the National Minimum Information Standards (2008), the Assessment Review Co-ordinating Group is working to define quality in assessment, care planning and review. That in turn may lead to a better outcome measure for the Framework.

In the interim, as a stepping stone we recommend measuring the proportion of assessment, care planning and review activity carried out in accordance with the National Minimum Information Standards (2008). This will mean checking whether the appropriate information standards and data standards are gathered and recorded at each assessment, care plan or review. Local partnerships already have their own quality audit procedures and it may be possible to augment these to check that the National Minimum Information Standards (2008) are being used consistently. The most effective systems will be embedded in professional supervision practice and start with an element of self-assessment.

This approach is applied to the quality of assessments, care plans and reviews for people who use services or support (Q1).

The same approach will be applied to carer assessments and reviews, and counted separately (Q2).

<table>
<tr><th colspan="5">Q1 - PERCENTAGE OF ASSESSMENTS OF PEOPLE WHO MAY NEED COMMUNITY CARE SERVICES OR SUPPORT COMPLETED IN ACCORDANCE WITH AGREED NATIONAL STANDARDS</th></tr>
<tr><td>RATIONALE</td><td colspan="4">High quality assessment is the cornerstone of good provision of service or support.</td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">All comprehensive assessments of people who may need community care services or support carried out and recorded – including those community care assessments that require appropriate NHS services.</td></tr>
<tr><td>FORMULA (Numerator / Denominator)</td><td colspan="4">To be determined locally – making use of quality assurance systems in place. Suggested formula: Number of comprehensive assessments recording all relevant NMIS information standards / Number of comprehensive assessments completed</td></tr>
<tr><td>UNIT</td><td colspan="4">Percentage</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="4">Continuous – as required - with quarterly counts.</td></tr>
<tr><td>DRILL DOWN HIERARCHY</td><td colspan="4">It may be useful to be able to drill down by the following groupings:
Care group; Geographical area/teams; Age; Gender; Minority Groups</td></tr>
<tr><td>COLLECTION YEAR</td><td>08/09</td><td>No (some limited pilots)</td><td>09/10</td><td>Yes (baseline)</td></tr>
<tr><td>NATIONAL MINIMUM INFORMATION STANDARDS</td><td colspan="4">Cross References:
Personal Details – pages 9-16
Assessment – page 29
Shared Care and Support Plan – page 33, 35
Review – page 40</td></tr>
<tr><td>PROPOSED FUTURE MEASURE</td><td colspan="4">Yes – Assessment Review Co-ordinating Group is developing a tool / approach to measure quality in assessment. Intention to devise a new measure which will be an objective measure of quality based on this.</td></tr>
<tr><td>RELATED DATA</td><td colspan="4">▪ Existing research evidence about assessment practice in Scotland, the rest of the UK and elsewhere
▪ SWIA case file audit questions, which look at ways to evidence quality in preparation for inspections
▪ Relevant pilots to test UDSET and National Minimum Information Standards (2008/09)</td></tr>
<tr><td>TARGETS</td><td colspan="4">▪ Target setting is purely a matter for local partnerships
▪ 100% compliance is the aspiration, and this may be achievable.
▪ Performance is likely to vary across partnerships as National Minimum Information Standards are implemented. However a continuous improvement approach would suggest setting challenging performance improvement targets for a partnership based on the baseline and implementation plan.</td></tr>
</table>

<table>
<tr><th colspan="5">Q2 - PERCENTAGE OF CARER ASSESSMENTS COMPLETED IN ACCORDANCE WITH AGREED NATIONAL STANDARDS</th></tr>
<tr><td>RATIONALE</td><td colspan="4">High quality assessment is the cornerstone of good provision of service or support. This is equally true of carers as it is for people who may need services or support.</td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">All assessments of carers carried out and recorded – including those community care assessments that require appropriate NHS services. A generally accepted definition of a carer is “someone, who, without payment, provides help and support to a partner, child, relative, friend or neighbour, who could not manage without their help. This could be due to age, physical or mental illness, addiction or disability”. Carers may be;
▪ adults caring for adults;
▪ young carers caring for adults or another young person; or
▪ carers of adults with disabilities, regardless of whether the carer is a parent or young person.
This measure should include all new assessments and reviews of unpaid carers providing substantial and regular care to users, during the financial year. The measure focuses on that category of carers as they are the group who most need support.</td></tr>
<tr><td>FORMULA (Numerator / Denominator)</td><td colspan="4">To be determined locally – making use of quality assurance systems in place. Suggested formula: Number of carer assessments recording all relevant National Minimum Information Standards for carer assessment and review / Number of carer assessments completed within the period</td></tr>
<tr><td>UNIT</td><td colspan="4">Percentage</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="4">Continuous – as required - with quarterly counts.</td></tr>
<tr><td>DRILL DOWN HIERARCHY</td><td colspan="4">It may be useful to be able to drill down by the following groupings:
Care group; Geographical area/teams; Age; Gender; Minority Groups</td></tr>
<tr><td>COLLECTION YEAR</td><td>08/09</td><td>No (some limited pilots)</td><td>09/10</td><td>Yes (baseline)</td></tr>
<tr><td>NATIONAL MINIMUM INFORMATION STANDARDS</td><td colspan="4">Cross References:
Personal Details – pages 9-16
Assessment – pages 21, 29
Review – page 40
Carers Assessment – p. 46-54
Shared Care and Support Plan – page 33</td></tr>
<tr><td>PROPOSED FUTURE MEASURE</td><td colspan="4">Yes – building on ARCG work to determine quality of assessment.</td></tr>
<tr><td>RELATED DATA</td><td colspan="4">▪ Existing research evidence about carer assessment practice in Scotland, the rest of the UK and elsewhere
▪ SWIA case file audit questions, which look at ways to evidence quality in preparation for inspections
▪ Relevant pilots to test UDSET and NMIS (2008/09)</td></tr>
<tr><td>TARGETS</td><td colspan="4">▪ Target setting is purely a matter for local partnerships
▪ 100% compliance is the aspiration, and this may be achievable.
▪ Performance is likely to vary across partnerships as National Minimum Information Standards are implemented. However a continuous improvement approach would suggest setting challenging performance improvement targets for a partnership based on its baseline and implementation plan.</td></tr>
</table>

Q3 - PERCENTAGE OF CARE PLAN REVIEWS CARRIED OUT WITHIN AGREED TIMESCALE

This is a process measure. It is included in the Community Care Outcomes Framework because the national stakeholders strongly endorsed the message that if care plans are not reviewed, we cannot be sure we are delivering outcomes for individuals. The aspiration to review all care or support at least annually has in many areas remained an aspiration. So this measure is designed to highlight to each partnership how it is performing in offering timely review.

The National Minimum Information Standards (2008) indicate that reviews should be offered according to the pace of change in the person's needs, but at least annually. The date of the next planned review should be agreed and recorded at the time of agreeing each plan for care and support and at each review. This will allow local systems to measure at each review point whether the proposed date was met.

Q3 - PERCENTAGE OF CARE PLAN REVIEWS CARRIED OUT WITHIN AGREED TIMESCALE

<table>
<tr><td>RATIONALE</td><td colspan="4">High quality assessment is the cornerstone of good provision of service or support. Reviewing the impact of the care plan completes the cycle of planning and acting to improve outcomes for people who need services or support, and their carers.</td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">All care plans and reviews carried out and recorded.
This measures the percentage of personal care plans for users and for carers which are reviewed within the timescales agreed at the care planning stage. As the review intervals depend on need, there must be scope for managers to set appropriate timescales, but as a minimum care packages and support plans should be reviewed at least once a year.</td></tr>
<tr><td>FORMULA (Numerator / Denominator)</td><td colspan="4">Number of care plans due in period which are reviewed in agreed time scale / number of care plan reviews due in period</td></tr>
<tr><td>UNIT</td><td colspan="4">Percentage</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="4">Continuous – as required – with quarterly counts.</td></tr>
<tr><td>DRILL DOWN HIERARCHY</td><td colspan="4">It may be useful to be able to drill down by the following groupings:
Carers; Care group; Geographical area/teams; Age; Gender; Minority Groups</td></tr>
<tr><td>COLLECTION YEAR</td><td>08/09</td><td>No (some limited pilots)</td><td>09/10</td><td>Yes (baseline)</td></tr>
<tr><td>NATIONAL MINIMUM INFORMATION STANDARDS</td><td colspan="4">Cross References:
Shared Care and Support Plan – p35
Review – page 40, 44
Carers Assessment – p. 53-54</td></tr>
<tr><td>PROPOSED FUTURE MEASURE</td><td colspan="4">This measure could be extended in future to ensure all care plan reviews are completed in accordance with all standards, and not just to time.</td></tr>
<tr><td>RELATED DATA</td><td colspan="4">▪ Existing research evidence about review practice in Scotland, the rest of the UK and elsewhere
▪ Work that SWIA does to measure review practice in preparation for inspections – published in SWIA Inspection Reports
▪ Relevant pilots to test UDSET and National Minimum Information Standards (2008/09)</td></tr>
<tr><td>TARGETS</td><td colspan="4">▪ Target setting is purely a matter for local partnerships
▪ 100% compliance is the aspiration, and this may be achievable.
▪ Performance is likely to vary across partnerships as National Minimum Information Standards are implemented. However a continuous improvement approach would suggest setting challenging performance improvement targets for a partnership based on the baseline and implementation plan.</td></tr>
</table>

Theme: Identifying those at risk of admission to hospital

R1 - NUMBER OF EMERGENCY BED DAYS IN ACUTE SPECIALTIES FOR PATIENTS AGED 65+ PER 100,000 POPULATION

R2 - NUMBER OF PATIENTS AGED 65+ ADMITTED FOR ANY REASON TWO OR MORE TIMES IN A YEAR AS AN EMERGENCY TO ACUTE SPECIALTIES PER 100,000 POPULATION

These two measures are based on the assumption that for the majority of people, an emergency admission to hospital is not a desirable part of a care plan. (There are likely to be exceptions to this amongst people with long term conditions where immediate access to emergency medical services can in fact be the crucial factor in accepting the risk of continuing to live at home). Avoiding emergency admissions (replacing them with planned admissions where possible) is important primarily because of the negative impact on the patient of the experience of needing emergency care, compared with that of needing a planned admission or alternative service.

There is also significant evidence that people who have repeat emergency admissions are not consistently offered health and social care assessments once discharged home. Thus there is an anticipation that strengthened partnership working and community based services could reduce presentations for emergency admission.

Finally, the strong link between repeated emergency admissions for people over 65, and becoming delayed in hospital has been another driver for reducing the number of multiple emergency admissions. This can be seen as a proxy for life-changing events which often lead to admission to a care home. The importance of providing the right community care services or support at the right time, and thus minimising emergency admissions to hospital was a strong theme in the development of the Community Care Outcomes Framework.

These 2 measures have formed targets within the NHS HEAT suite for a number of years. Performance against both measures is monitored through HEAT and NHS Board Local Delivery Plans for 2008/09, although it is recognised that the targets can only be delivered through effective partnership working. Where suites of measures overlap, the Community Care Outcomes Framework will use the same definitions as NHS HEAT so that reporting is kept to a minimum.

A national consensus conference held in October 2008 concluded that the current measure of the number of multiple emergency admissions should be replaced by a more outcome-focussed measure. Development work is underway and the new measure will be integrated into both NHS HEAT and the Community Care Outcomes Framework once agreed. Thus at the time of writing this measure is not included in HEAT 2009/10, but it will continue to be reported via the Scotland Performs website as part of the National Performance Framework. On this basis we recommend retaining the measure in local Community Care Outcomes Framework for monitoring purposes. The Consensus conference recommended that the emergency bed days measure should be retained and this now features in HEAT 2009/10 as Target T12.

<table>
<tr><th colspan="5">R1 - NUMBER OF EMERGENCY BED DAYS IN ACUTE SPECIALTIES FOR PATIENTS AGED 65+ PER 100,000 POPULATION</th></tr>
<tr><td>RATIONALE</td><td colspan="4">▪ Promotes action to both reduce emergency admissions and average length of stay
▪ Encourages provision of non-hospital forms of care often through services that are delivered closer to home
▪ Focus on improving the delivery of treatment and planning for discharge</td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">Existing HEAT measure – target T1.2 (2008/09) and T12 (2009/10). Data collected by ISD from SMR01 hospital admissions returns submitted by NHS Boards.</td></tr>
<tr><td>FORMULA (Numerator / Denominator)</td><td colspan="4">Occupied bed days within a financial year for emergency admissions expressed as a rate per 100,000 resident population (all limited to people aged 65+)
<i>Note:</i>
<i>1. Both the numerator and denominator refer to the patient’s area of usual residence rather than area of treatment</i>
<i>2. The per 100,000 population adjustment should be based on the number of people in the area who are 65+, not the total number of people in the area regardless of their age</i>
<i>3. People admitted to psychiatric units should be excluded, at least initially.</i>
Occupied bed days = Sum of the number of occupied beds for each day of the period. Note<i>:</i> a bed which is used by an inpatient at the bed count is counted as one occupied bed day. This means that patients admitted and discharged between bed counts do not count in the bed days figures.</td></tr>
<tr><td>UNIT</td><td colspan="4">Rate</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="4">Continuous – as required – with quarterly counts.</td></tr>
<tr><td>DRILL DOWN HIERARCHY</td><td colspan="4">It may be useful to be able to drill down by the following groupings:
Care group; Geographical area/teams; Age; Gender; Minority Groups; End of life patients.</td></tr>
<tr><td>COLLECTION YEAR</td><td>08/09</td><td>Yes</td><td>09/10</td><td>Yes</td></tr>
<tr><td>NATIONAL MINIMUM INFORMATION STANDARDS</td><td colspan="4">Cross References:
Assessment – page 23</td></tr>
<tr><td>PROPOSED FUTURE MEASURE</td><td colspan="4">Advisory group now set up through ISD, initially looking at data issues. Concerns with current measure centre on its focus only on people over 65, validity of target, and challenging trajectories seen in 2006/07.</td></tr>
<tr><td>RELATED DATA</td><td colspan="4">▪ SPARRA data, Systemwatch data
▪ Existing research evidence about repeat emergency admissions in Scotland, the rest of the UK and elsewhere
▪ Long term Conditions Collaborative initiatives</td></tr>
<tr><td>TARGETS</td><td colspan="4">▪ Reduce emergency in-patient days for older patients aged 65+ by 10% by 2011, compared with 2004/05 (HEAT target)
▪ Future targets under discussion</td></tr>
</table>

R2 - NUMBER OF PATIENTS AGED 65+ ADMITTED FOR ANY REASON TWO OR MORE TIMES IN A YEAR AS AN EMERGENCY TO ACUTE SPECIALTIES PER 100,000 POPULATION

RATIONALE	▪ Fosters a reduction in acute emergency admissions and multiple admissions ▪ Encourages provision of non-hospital forms of care, often through services that are provided closer to home ▪ 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			
DATA SOURCE	Existing HEAT measure (2008/09) – target T1.1. Data collected by ISD from SMR01 hospital admissions returns submitted by NHS Boards. Target not included in HEAT 2009/10 but data will continue to be collected and published by ISD.			
FORMULA (Numerator / Denominator)	Patients aged 65+ with two or more emergency admissions to acute specialties in a financial year expressed as a rate per 100,000 resident population. ***Note:*** *1. Both the numerator and denominator refer to the patient's area of usual residence rather than area of treatment* *2. The per 100,000 population adjustment should be based on the number of people in the area who are 65+, not the total number of people in the area regardless of their age* *3. People admitted to psychiatric units should be excluded, at least initially.*			
UNIT	Rate			
MEASUREMENT PERIOD	Continuous – as required – with quarterly counts.			
DRILL DOWN HIERARCHY	It may be useful to be able to drill down by the following groupings: Care group; Geographical area/teams; Age; Gender; Minority Groups			
COLLECTION YEAR	**08/09**	Yes (target year)	**09/10**	Yes
PROPOSED FUTURE MEASURE	Yes. Outcome-focussed measure to be developed for future inclusion in NHS HEAT – measure T1.1 removed for 2009/10. New measure will be included in Community Care Outcomes Framework once available.			
RELATED DATA	▪ Existing research evidence about repeat emergency admissions in Scotland, the rest of the UK and elsewhere ▪ SPARRA data ▪ Systemwatch data ▪ Long term Conditions Collaborative initiatives			
TARGETS	▪ Reduce number of older people aged 65+ admitted as an emergency two or more times in a year by 20% by 2008, compared with 2004/05			

R3 - % OF OLDER PEOPLE AGED 65+ WITH TWO OR MORE EMERGENCY ADMISSIONS IN A YEAR WHO HAVE NOT HAD AN ASSESSMENT OF THEIR HEALTH AND SOCIAL CARE NEEDS

Evidence has emerged across the United Kingdom and Scotland over the last 5 years to suggest that a large proportion of people who have been admitted to hospital as an emergency are not otherwise known to health or social services. This in turn suggests that local partnerships are unable to offer anticipatory or preventative services focussed on individuals known to be at risk of hospital admission, and thus avoid unnecessary presentations and admissions.

This data was collected across Scotland for the first time in summer 2008, in respect of patients admitted for a second or subsequent emergency during one quarter of 2007/08. The data collected was broader than that specified in the precise measure; it encompassed health assessments, social care assessments, and (single shared) health and social care assessments.

Initial feedback from local partnerships on the value of the information gathered has been mixed. A review of the data collected and messages arising from it is underway. (The process for collecting the data will also be reviewed with an eye to improving the process in this and future years). Further details of the precise measure for 2008/09 will be provided on the basis of this review, and any related developments associated with the new Emergency Admissions measure (see above, page 27).

<table>
<tr><th colspan="5">R3 - % OF OLDER PEOPLE AGED 65+ WITH TWO OR MORE EMERGENCY ADMISSIONS IN A YEAR WHO HAVE NOT HAD AN ASSESSMENT OF THEIR HEALTH AND SOCIAL CARE NEEDS</th></tr>
<tr><td>RATIONALE</td><td colspan="4">▪ Focus on anticipatory care management, prevention and early intervention to promote well being of users of community care services
▪ Focus on preventing unnecessary emergency admissions by devising appropriate care pathways for those identified as ‘at risk of admission’
▪ People may be slipping through the care ‘net’ and assessments ought to be triggered whenever people are admitted as an emergency, and especially when they experience multiple admissions.</td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">Good quality data on admissions is available from ISD – gleaned from SMR01 returns from NHS Boards. However current systems require that named data to be returned to partnerships and then filtered against assessment records locally.
Note: Both the numerator and denominator refer to the patient’s area of usual residence rather than area of treatment.</td></tr>
<tr><td>FORMULA (Numerator / Denominator)</td><td colspan="4">Number of older people aged 65+ with two or more emergency admissions in a year who have not had an assessment of their health and social care needs / Number of older people aged 65+ with two or more emergency admissions in a year
Both the numerator and denominator will refer to the same time period.</td></tr>
<tr><td>UNIT</td><td colspan="4">Percentage</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="4">Continuous – as required – with annual counts.</td></tr>
<tr><td>DRILL DOWN HIERARCHY</td><td colspan="4">In addition to the standard analyses set out in the Introductory Guidance, partnerships may benefit from understanding more about
▪ Admission specialty
It may also be useful to be able to drill down by the following groupings:
Care group; Geographical area/teams; Age; Gender; Minority Groups</td></tr>
<tr><td>COLLECTION YEAR</td><td>08/09</td><td>Yes (based on data to end September 2007)</td><td>09/10</td><td>Yes</td></tr>
<tr><td>POTENTIAL GAMING ISSUES</td><td colspan="4">None identified</td></tr>
<tr><td>PROPOSED FUTURE MEASURE</td><td colspan="4">Possibly related to new measure being developed to replace number of repeat admissions (previously NHS HEAT Target T1.1)
Future development of this measure also requires further research on the ‘all adults’ population to gain a better understanding of the variation that exists in what is meant by ‘at risk’ for different age sub-groups.
No amendments to be made until data from 2007/08 is understood.</td></tr>
<tr><td>RELATED DATA</td><td colspan="4">▪ Existing research evidence about assessment and review practice in Scotland, the rest of the UK and elsewhere
▪ Results of first capture 2007/08 (due Autumn 2008)</td></tr>
<tr><td>TARGETS</td><td colspan="4">▪ Target setting is purely a matter for local partnerships
▪ Performance is likely to vary across and within partnerships. However a continuous improvement approach would suggest setting challenging performance improvement targets for a partnership based on the baseline, and performance in benchmark partnerships.</td></tr>
</table>

Theme: Moving services closer to users/patients

BC1 - SHIFT IN BALANCE OF CARE FROM ‘INSTITUTIONAL’ TO ‘HOME BASED’ CARE

There is no intention to develop a new overarching measure for Shifting the Balance of Care. The concept is too complex to capture in a single measure. Rather, the shift in the balance will be evidenced through accumulated evidence from the measures in the Community Care Outcomes Framework, NHS HEAT, and other strategic National Priorities, including Delivering for Mental Health, Long Term Conditions, and Palliative Care.

BC1 - SHIFT IN BALANCE OF CARE FROM 'INSTITUTIONAL' TO 'HOME BASED' CARE	
RATIONALE	▪ To deliver the Better Health Better Care policy ▪ Supporting the development of services at home or closer to home ▪ Improved and equitable access to community care ▪ To promote a shift in resources from hospital to community care ▪ To promote a shift in locus from professionals to people
DATA SOURCE	Two direct proxy measures have been identified for use (see following pages).

The HEAT measures which relate directly to shifting the balance of care are as follows:

Efficiency and Governance

E7: To increase the percentage of new GP outpatient referrals into consultant led secondary care services that are managed electronically to 90% from December 2010.
E8: NHS Scotland to reduce emissions over the period to 2011
E9: Achieve universal utilisation of CHI (radiology requests)

Access to services

A9: The maximum wait from urgent referral with a suspicion of cancer to treatment is 62 days; and the maximum wait from decision to treat to first treatment for all patients diagnosed with cancer will be 31 days from December 2011.
A10: Deliver 18 weeks referral to treatment from 31 December 2011. No patient will wait longer than 12 weeks from referral to a first outpatient appointment from 31 March 2010. No patient will wait longer than 12 weeks from being placed on a waiting list to admission for an inpatient or day case treatment from 31 March 2010.

Treatment

T4: Reduce the number of readmissions (within one year for those that have had a psychiatric hospital admission of over 7 days by 10% by the end of December 2009).
T6: To achieve agreed reductions in the rates of hospital admissions and bed days of patients with primary diagnosis of COPD, Asthma, Diabetes or CHD, from 2006/07 to 2010/11.
T7: Improvement in the quality of healthcare experience.
T8: Increase the level of older people with complex care needs receiving care at home.
T9: Each NHS Board will achieve agreed improvements in the early diagnosis and management of patients with a dementia by March 2011.
T10: To support shifting the balance of care, NHS Boards will achieve agreed reductions in the rates of attendance at A&E , between 2007/08 and 2010/11.
T12: By 2010/11, NHS Boards will reduce the emergency inpatient bed days for people aged 65 and over, by 10% compared with 2004/05.

BC2 - PERCENTAGE OF OLDER PEOPLE AGED 65+ WITH INTENSIVE CARE NEEDS RECEIVING SERVICES AT HOME (Proxy: Balance Of Care)

i) Proxy measure currently sustained

In the absence of a well-developed measure of the balance of care, the pre-existing measure of “intensive care needs” (from the Spending Review 2004) has been sustained. The target for Scotland (set in 2004) was 30% of this group to receive care at home by 2008. This was achieved across Scotland as a whole, with wide variation between community care partnerships.

This proxy measure has now been adopted within the NHS HEAT suite (Target T8) for 2009/10. NHS Boards have been asked to provide local targets and trajectories based on their current performance and that of the rest of Scotland.

It has emerged that the data used to calculate performance against this measure prior to 2007 was flawed, in that it included people with dementia receiving intensive care at home or in a care home, but excluded people supported in NHS Continuing Care Psychogeriatric beds. This has now been rectified using results from the NHS Information and Statistics Division survey of Continuing NHS Care provision (survey carried out in September 2008).

Definitions and background information are available at Scotland Performs

In looking at local data, in addition to the standard analyses set out above (page 1), partnerships may benefit from understanding more about those receiving direct payments and those who don’t.

ii) Outcome-focussed measure promoted for future use

We now propose to roll out the new definition of this measure within the Community Care Outcomes Framework for 2009/10, using the Indicator of relative Need (IoRN) to provide a common approach to measuring levels of support across Scotland. Partnerships have told us that the current proxy is unhelpful and that they want to see a measure which demonstrates the extent to which people with comparable levels of need are being supported in their own homes.

This new measure will require IoRN scores to be calculated for people with complex needs and this information to be linked to the type of service (residential or at home) that person is receiving.

BC2 - PERCENTAGE OF OLDER PEOPLE AGED 65+ WITH INTENSIVE CARE NEEDS RECEIVING SERVICES AT HOME (Existing definition)						
RATIONALE	- To deliver the Better Health Better Care policy on shifting the balance - To promote a shift in resources (measured initially in activity terms) from hospital to community and home care - Promotes greater numbers of people with high levels of need to be supported to live at 'home' – allowing retention of more independence. - Improved and equitable access to community care.					
DATA SOURCE (with Inclusions and Exclusions)	NHS HEAT measure (T8) for 2009/10. Data currently submitted by local authorities to Analytical Services Division of Scottish Government and to NHS Scotland Information & Statistics Division through continuing health care census. Intensive care at home is at present defined as a social care package at home of more than 10 hours per week. A 'home' in the context of this measure includes the following: 1. Rented accommodation 2. Private accommodation 3. Supported accommodation 4. Living with family and friends					
FORMULA (Numerator / Denominator)	Users aged 65+ receiving 'intensive care' at home / All users aged 65+ receiving 'intensive care' (i.e. care at home, in a care home, or in an NHS long stay geriatric bed (and from 2009/10 including NHS psychogeriatric bed)					
UNIT	Percentage					
MEASUREMENT PERIOD	Continuous – as required – with annual counts.					
REPORTING YEAR	**08/09**	Yes	**09/10**	Yes	**10/11**	Yes
PROPOSED FUTURE MEASURE	See next page – definition changed to focus on outcome for people					
RELATED DATA	- Linked HEAT measures for outpatients and emergency admissions					
TARGETS	- Comprehensive Spending Review (2004) Target "by 2008 30% of older people with intensive care needs should receive those services at home" - NHS Boards asked to establish targets and trajectories for 2009/10 for inclusion in Local Delivery Plans.					

<table>
<tr><th colspan="5">BC2 - PERCENTAGE OF OLDER PEOPLE AGED 65+ WITH INTENSIVE CARE NEEDS RECEIVING SERVICES AT HOME (New definition)</th></tr>
<tr><td>RATIONALE</td><td colspan="4">▪ To deliver the Better Health Better Care policy on shifting the balance
▪ To promote a shift in resources (measured initially in activity terms) from hospital to community and home care
▪ Promotes greater numbers of people with high levels of need to be supported to live at ‘home’ – allowing retention of more independence.
▪ Improved and equitable access to community care.</td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">Currently available in some local partnerships. National Minimum Information Standards for assessment care plans and review recommend use of Indicator of Relative Need (IoRN). Where this happens, data will be generated at local level.
Intensive care is to be defined as people at F or above in the IoRN bandings. This is a measure of dependency.
A ‘home’ in the context of this measure includes the following:
▪ Rented accommodation
▪ Private accommodation
▪ Supported accommodation
▪ Living with family and friends</td></tr>
<tr><td>FORMULA (Numerator / Denominator)</td><td colspan="4">People using community care services or support aged 65+ who are at IoRN Band F or above and living at home / All users aged 65+ who are at IoRN Band F or above living at home, in a care home, or in an NHS long stay geriatric or psychogeriatric setting</td></tr>
<tr><td>UNIT</td><td colspan="4">Percentage</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="4">Continuous – as required – with annual counts.</td></tr>
<tr><td>DRILL DOWN HIERARCHY</td><td colspan="4">It may be useful to be able to drill down by the following groupings:
Care group; Geographical area/teams; Age; Gender; Minority Groups; those receiving direct payments and those that don’t</td></tr>
<tr><td>COLLECTION YEAR</td><td>08/09</td><td>No</td><td>09/10</td><td>Yes (part year)</td></tr>
<tr><td>PROPOSED FUTURE MEASURE</td><td colspan="4">No change anticipated</td></tr>
<tr><td>RELATED DATA</td><td colspan="4">▪ Scotland Performs: SR2004 target for 30% of people with intensive care needs to be cared for at home
http://www.scotland.gov.uk/About/scotPerforms/indicators/CareAtHome
▪ IoRN – see National Minimum Information Standards</td></tr>
<tr><td>TARGETS</td><td colspan="4">▪ May arise in future years should a parallel measure appear in NHS HEAT as T8, or through Implementation of Lord Sutherland Review of Free Personal & Nursing Care.</td></tr>
</table>

BC3 - PERCENTAGE OF PEOPLE AGED 65+ RECEIVING PERSONAL CARE AT HOME (Proxy: Balance Of Care)

This data is collected as part of a routine statistical return from local authorities to the Analytical Services Division of the Scottish Government. Full details can be viewed at Scottish Government Quarterly Survey or Community Care Outcomes data

Like the Spending Review 2004 definition of intensive care at home, this measure is a pre-existing proxy for the balance of care.

<table>
<tr><th colspan="5">BC3 - PERCENTAGE OF PEOPLE AGED 65+ RECEIVING PERSONAL CARE AT HOME
(Proxy: Balance Of Care)</th></tr>
<tr><td>RATIONALE</td><td colspan="4">▪ To deliver the Better Health Better Care policy on shifting the balance
▪ To promote a shift in resources (measured initially in activity terms) from hospital to community and home care
▪ Providing services closer to home
▪ Improved and equitable access to community care.</td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">Currently submitted by local authorities to Analytical Services Division of Scottish Government.</td></tr>
<tr><td>FORMULA (Numerator / Denominator)</td><td colspan="4">Number of users aged 65+ receiving personal care at home or in the community / Total number of users aged 65+ in receipt of personal care services</td></tr>
<tr><td>UNIT</td><td colspan="4">Percentage</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="4">Continuous – as required – with quarterly counts and annual publication.</td></tr>
<tr><td>DRILL DOWN HIERARCHY</td><td colspan="4">It may be useful to be able to drill down by the following groupings:
Care group; Geographical area/teams; Age; Gender; Minority Groups</td></tr>
<tr><td>COLLECTION YEAR</td><td>08/09</td><td>Yes</td><td>09/10</td><td>Yes</td></tr>
<tr><td>PROPOSED FUTURE MEASURE</td><td colspan="4">Measure to be developed by the Strategic Partnership Group – Shifting the Balance of Care, as part of its work on ‘Delivering for Health’. Any future measure should ultimately focus on improving the balance of care (i.e. shift from institutional to community and home based care) in both financial and activity terms.</td></tr>
<tr><td>RELATED DATA</td><td colspan="4">▪ To be determined.</td></tr>
<tr><td>TARGETS</td><td colspan="4">▪ Target setting is purely a matter for local partnerships
▪ To be determined.</td></tr>
</table>

8. References

Petch, A., Miller, E., Cook, A., Morrison, J., Cooper, A., Hubbard, G. and Alexander, H. (2007) *Users and Carers Define Effective Partnerships in Health and Social Care* Edinburgh: Scottish Government Joint Improvement Team

Cornes, M., 22/07/2007, ‘Reimbursement in Practice: The Last Piece of the Jigsaw? A comparative study of delayed hospital discharge in England and Scotland’, (Conference paper), *Department of Health’s Policy Research Programme ‘Showcasing Social Care Research Conference’*, British Library, London.

Glendinning, C., Clarke, S., Hare, P., Kotchetkova, I., Maddison, J. and Newbronner, L. (2006) Outcomes-focused services for older people. Bristol: The Policy Press.

Nicholas, E. (2001) Implementing an outcomes approach in carer assessment and review, pp. 65-117 in Qureshi, H. (ed.) *Outcomes in Social Care Practice,* Outcomes in Community Care Practice, No. 7, SPRU, University of York, York.