SCOTTISH EXECUTIVE

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Your ref:
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4 April 2007

Chief Executives, Local Authorities
Chief Executives, NHS Boards
General Managers, Community Health Partnerships
Directors of Social Work/Chief Social Work Officers
Directors of Finance, Local Authorities
Directors of Finance, NHS Boards
Directors of Housing, Local Authorities
Chief Executive, Communities Scotland
Relevant professional, voluntary and other organisations
Joint Future Managers

Dear Colleague

NATIONAL OUTCOMES FOR COMMUNITY CARE

Introduction

The national partnership of COSLA, NHS Scotland and the Scottish Executive provides a lead on joint working in community care to support local partnerships in delivering better outcomes. This letter sets out progress so far on the development of an outcomes approach, describes what happens next and what is expected of partnerships.

We have been very grateful indeed for the contributions and engagement so far. We recognise that development and measurement of outcomes is not straightforward. But the outcomes and measures we have developed so far follow extensive engagement with stakeholders, and at this stage the framework incorporates only existing targets. The package therefore sets out the practical, initial steps required.

Implementation

The national partnership has approved this outcomes framework. We want to proceed at a pace where we know what works and what makes a difference. Although the measures were developed on a fast track basis, implementation will not be a 'big bang'. We are planning to begin implementation in 2007–08, acknowledging that we need to sustain progress throughout 2007-08 with a view to fuller implementation in 2008-09 and beyond. This is the start of the outcomes journey, and we plan to work with partnerships and stakeholders on both its initial implementation and its continued development.

This letter sets out the initial implementation arrangements. We have consulted extensively on the detail of the measures, and will continue to consult on the development of delivery standards and targets. We held an implementation seminar on 22 March for a broad range of stakeholders to

begin that process, which confirmed that this is the right approach and provided helpful pointers on its evolution.

The new framework is based on four high level national outcomes supported by 16 measures (mainly outcomes and outputs) and in due course by a broader range of targets. From April 2007 we intend to adopt the national outcomes and six of the 16 measures, but only incorporate existing, agreed targets that are already being applied, of which there are four.

Action

Action is at two levels, nationally and locally. Nationally, the Outcomes Project Board will lead the refinement and development of the framework; and the national partnership will work with stakeholders on the detailed implementation. We expect to provide more substantive guidance in the coming months. Locally, partnerships will wish to consider the issues for them, as part of the wider implementation of the performance framework for community care. More specifically, they will want to consider whether their local joint performance frameworks are sufficiently robust to combine with that nationally in a comprehensive joint performance framework for community care. They will also wish to consider whether they have a joint performance culture. And they will need to consider the information needed to move to such a position.

Finally, partnerships will be developing Local Improvement Targets (LITs) to support the new framework. They will wish to begin considering their scope and shape. More detailed information on LITs in 2007-08 will be issued shortly. Local partnerships will wish to progress these matters in parallel with the evolving framework nationally.

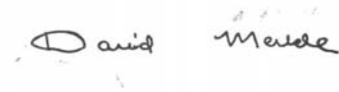
Conclusion

The national partnership believes that the package of outcomes, measures and targets will make a real difference to performance in community care. It is aspirational and comprises a journey to success. This recognises that there is more to do, on which we need to engage further with partnerships. Over all, there is a reasonable balance between the aspirations and the start of the journey in 2007-08.

We are very encouraged by the positive engagement of stakeholders as we work to develop this new performance framework. The annexes provides a more detailed description of the developing framework, together with information on its implementation. We look forward to continuing to develop the framework, working closely with you and other stakeholders.

Enquiries should be addressed in the first instance to Ruth Brankin at the address above (tel 0131 244 3744).

Yours sincerely



pp Mike Martin
MIKE MARTIN

Head of Partnership Improvement
And Outcomes Division

ALISTAIR BROWN

Deputy Director of Delivery

ANNEX A

OUTLINE GUIDE TO THE OUTCOMES FRAMEWORK

1. This annex provides more detail on the content of the framework, its development and its phased implementation. It concentrates on the suite of outcomes, measures and targets, but touches on the wider aspects that underpin the framework. It comprises our aspirations and the predicted initial steps.

2. Too much emphasis in the past was on inputs and not the outcomes for people who use services and their carers. We have been moving in that direction, but with mixed results. Outcomes should drive the agenda, and the new framework takes the existing outcomes approach in community care to a new level.

Objectives

3. The objectives of the national outcomes approach are to:

- focus on the benefits for service users and carers;
- drive performance in community care;
- re-focus on partnership working;
- ensure joint responsibility of service delivery; and
- clarify reporting both locally and nationally.

4. This letter marks the start of the new outcomes journey in community care – the first step to improving results for people who use services and their carers through better and more focused reporting of joint performance. Within that, it should support partnerships' flexibility to deliver locally.

The National Outcomes Project

5. The National Outcomes Project, chaired by Tim Davison, Chief Executive of NHS Lanarkshire, is charged with developing this performance framework. Its objectives include:

- achieving consistency of understanding of the outcomes agenda
- developing a suite of national outcomes, performance measures and targets to drive joint performance in community care;
- identifying the information needed to performance manage this agenda locally and nationally;
- reducing the burden of scrutiny for community care, as much as possible; and
- developing proposals for a coherent performance management system.

The Outcomes package

6. It is widely accepted that outcomes are the core of what we need to do, and must drive the agenda. Users and carers expect partnerships to be judged on their outcomes; and partnerships themselves see that as the right way forward. The challenge is to change the culture to enable that to happen.

7. The new outcomes framework for community care also fits the wider agendas of Public Service Reform, 'Delivering for Health' and 'Changing Lives'. Each is centred on services that:

- are more focused and personalised;
- drive up quality;
- are efficient, productive and focused on outcomes;
- are joined up; and
- are accountable to the service user.

Key components of the outcomes package

8. The new outcomes approach is critical to the success of community care. It comprises:

- Four national outcomes – see below.
- Sixteen performance measures – Annex B
- Four initial national targets – see below.

National outcomes

9. Outcomes are and will continue to be the centre of the new framework. The four national outcomes are:

- improved health;
- improved wellbeing;
- improved social inclusion; and
- improved independence and responsibility.

10. These high level outcomes are readily recognisable for community care users and carers, and also embrace the wider agendas of Public Service Reform, 'Delivering for Health', 'Changing Lives' and 'Supporting People'. They sit comfortably within community planning aspirations.

Performance measures

11. The measures are pivotal to driving continuous improvement in community care. They focus on the key result areas nationally. They underpin the four national outcomes – some relate to one, or more than one outcome; while others relate to all the outcomes. They are biased strongly towards outputs and outcomes. Over all, they cover the key parts of community care and should between them provide a sound basis for driving joint performance.

12. The measures are a mix of our aspirations and the practical, first steps. The aspirational aspect is those measures that we want, but can not yet put into place because we require further information. The practical aspect is the proxies for them, to enable us to make a start on implementing the new framework.

13. A brief description of each measure is set out in Annex B. (We will provide shortly a comprehensive description of each measure, its development and, where appropriate, the further work on its refinement.) Some measures may appear to be 'health' focussed, others 'social care' focused, and others cover the range of activities. The key point is that together they provide a sound basis to drive continuous improvement in community care, and to hold partnerships to account.

14. The suite of measures covers the key characteristics that matter to people who use community care services. In short, they should support people to:

Feel safe in their own homes	Have fewer acute admissions
Be involved in their care	Spend less time in acute hospitals
Be active socially	Spend less time waiting to be discharged to appropriate accommodation.
Have their needs assessed according to agreed national standards: • within agreed timescales • have their care plans reviewed regularly • have services delivered within agreed timescales.	If multiple admissions, have an active care plan
Their carers should also have their needs assessed according to agreed national standards	Be part of a tangible shift in the balance of care from 'institutional' care to care in people's own homes.
Their carers should feel capable and supported to continue to care.	Where they have higher level needs they will have more opportunity to be cared for at home.

15. User satisfaction is a key feature for a number of the outcome measures. But this does not necessarily mean one-off surveys. We want to develop integrated feedback loops into existing systems, to report satisfaction on a systematic, regular basis.

16. The measures have been the subject of extensive stakeholder–led development and refinement over the last few months. There is wide support for the measures but we recognise that there is further development work required, and we will over the coming months continue to listen to people's views as the measures are practically applied. This will be part of the journey to full implementation.

Targets

17. Targets should be an integral part of the new outcomes approach and should help drive joint performance. But we recognise that there is considerable sensitivity about their extent and how they should be applied. We want to get right our approach – to ensure that we don't set up partnerships to fail; and to recognise, where appropriate, the different drivers that affect performance locally. The Outcomes Project Board will consider with stakeholders where other targets or standards should be introduced for 2008-09; and what form these might take. That would include, for example, whether targets are absolute or relative, or reflect local circumstances, or are banded, or are a minimum standard or an average. The workshops on 22 March provided a helpful insight to start this consideration. Data limitations mean we are not able to introduce new targets at this stage, so the existing targets in community care will be retained for 2007-08. We are not therefore having a dedicated consultation on the initial set of targets. But this is a developmental journey, with engagement in due course, on how key targets might develop.

Local Improvement Targets (LITs)

18. Over the past three years, partnerships have been developing their own Local Improvement Targets (LITs). Partnerships view them as an integral part of their local performance systems. In JPIAF 2006-07, we asked partnerships to report on their LITs for 2006–07; but were not required to submit new LITs for 2007–08. This does not, however, mean that under the new outcomes framework there is no place for LITs. LITs should continue to underpin the national outcomes. Each partnership should set their own, having regard to the national outcomes, national performance measures and emerging national targets, but also reflecting local circumstances and

priorities. They will therefore continue to be an integral part of local performance frameworks. The Outcomes Project Board will be recommending shortly the future management and suggested scope of LITS.

Performance management system

19. The suite of outcomes, measures and targets needs to be underpinned by a performance management system that will drive continuous improvement, hold partnerships to account, manage underperformance and recognise good performance. Work on that is at an early stage. Again, the workshops on 22 March provided some helpful pointers. The Outcomes Board will be considering over the coming months what the performance management arrangements should look like.

20. Partnerships will want to ensure that they have in place appropriate local joint performance management and reporting systems to complement those nationally in a composite framework for community care. In particular, the intended reductions in reporting nationally will have implications for local reporting. We invited partnerships to develop their own performance management frameworks as part of the arrangements for JPIAF 2005-06. Their responses varied. The workshops on 22 March confirmed that there is extensive but perhaps not sufficiently focused reporting locally, and that many partnerships still have some way to go to develop local performance management systems that drive performance in community care, are focussed, engage fully with users and carers, and have effective public performance reporting at their heart. Perhaps most significantly, the workshops identified that partnerships need to develop a cultural shift to joint performance management, and to develop more substantial performance management approaches at front line management. These are issues that partnerships can begin to address as the framework develops.

Reducing the reporting burden

21. The new measures are not intended to be an added burden on partnerships. We are looking at how we can streamline other reporting streams and inspections. We have begun discussions on the Statutory Performance Indicators for local authorities, the HEAT targets for health boards, the Joint Performance Information and Assessment Framework (JPIAF), reporting on other policy areas such as mental health, learning disability, etc and on inspections with the Social Work Inspection Agency (SWIA). These discussions are proceeding positively.

22. Reducing the reporting and inspection burdens remains an imperative, and we expect to develop a programme to this effect over the coming months. We indicated earlier that this is a journey, and not a ‘big bang’. That applies equally to this dimension. The reduction in reporting is likely to be on the same kind of incremental approach as the development of measures. We will move forward on both in a steady, systematic and purposeful way.

23. Annex C sets out the link between the current performance assessment system (JPIAF) and the coverage of similar aspects in the new performance framework. This reflects the transition from the present to the future systems and ensures continuity of performance measurement in key areas.

Changing the culture

24. Joint Future has been the catalyst for a cultural shift in which joint working is now the norm. But we still need to find better ways of delivering services - quality services that are focused, personalised, joined up and accountable to the service user. The outcomes framework provides the basis for that approach and will, we believe, make a real difference to joint performance in community care.

25. The workshops on 22 March recognised the need to change cultures if this is going to be successful. Particular areas are around developing corporate responsibility for outcomes in community care, embedding the performance culture in local management, developing locally more user-led outcomes, and seeing public performance reporting as integral to performance managing community care. These wider issues need to be addressed in the over all implementation of the framework.

Implementation in 2007 – 08

26. We have described implementation of a performance framework for community care as a journey. We intend to start that journey in 2007-08. The suite of outcomes, measures and targets sets out our aspirations for a new performance framework. Making a start reflects the desire at all levels to move on. We intend to make a sensible and pragmatic start, not a 'big bang' approach. We will start with a number of proxies and existing targets – six measures and four targets - as set out below. The object is to embed the new framework as quickly as possible, and to develop it with stakeholders as we move to the more aspirational aspects. During this period we will also develop a comprehensive performance management system. Finally, we will continue the work to reduce the reporting burden, where possible.

27. The lack of available data means that it will be possible to introduce six measures from the outset, as follows:

- Number of patients waiting more than 6 weeks to be discharged into a more appropriate care setting.
- Number of occupied bed days (OBD) for unscheduled admissions in all hospitals per 1,000 population.
- Number of patients admitted for unscheduled admissions in all hospitals per 1,000 populations.
- Percentage of older people receiving intensive home care.
- Percentage of older people receiving personal care at home.
- Number of older people with 2 or more unscheduled admissions who have a care package.

28. These measures will be underpinned by the existing national targets for delayed discharge, emergency admissions and intensive home.

Developments in 2007 – 08

29. We recognise that partnerships have found the fast track approach to developing the measures something of a challenge. However, it is important to recognise that we are only at the start of a journey, and that we want to take partnerships with us as the journey progresses. We started discussions on implementation of the new measures and targets with partnerships at the national outcomes event on 22 March. We will use the next few months to engage partnerships and stakeholders generally in moving to the new performance framework.

2008 – 09 and beyond

30. Our objective is to embed the change process as quickly as possible, with the expectation of full or close to full implementation in 2008-09. But this is about continuous improvement, and while implementation may be completed in 2008-09, the framework and its contents will continue to be developed and refined. We will therefore need to keep under review the measures and targets to ensure that they support achieving better outcomes.

OUTCOMES FOR COMMUNITY CARE – BRIEF SUMMARY

<table>
<tr><th colspan="5">OC5 - PERCENTAGE OF USERS OF COMMUNITY CARE SERVICES FEELING SAFE</th></tr>
<tr><td>SUMMARY DEFINITION</td><td colspan="4">The purpose of this indicator is to ensure:
o a systematic approach is taken to safeguarding adults in vulnerable situations
o the promotion of safety and security in people's homes, with alarms and aids easily accessible to people who require them,
o the promotion of self-protection and personal empowerment
o people are effectively safeguarded against abuse and neglect

This measures users' perceptions of their safety, either in their own homes or in those elements of the external environment in which community care services are provided (for example, care at a day centre).</td></tr>
<tr><td>RATIONALE</td><td colspan="4">▪ To identify those vulnerable and at risk
▪ To provide a safe and secure living environment for service users
▪ To empower, enable and respect people.</td></tr>
<tr><td>FORMULA</td><td colspan="4">Number of people satisfied/Number of people who responded.</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="2">Annual</td><td></td><td></td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">Proposed integral feedback systems/surveys.</td></tr>
<tr><td>REPORTING YEAR</td><td>07/08</td><td>No (Possibility of a limited pilot)</td><td>08/09</td><td>Yes</td></tr>
<tr><td>KEY ENABLERS</td><td colspan="4">The following actions are required to implement this measure:

▪ Define the key determinants of 'feeling safe'
▪ Determine the best method of collecting the required information e.g integrating the data collection into the assessment and care planning systems/surveys
▪ Progress pilots to test the feedback systems.
▪ Implement an agreed approach across all partnerships from 2008/09.</td></tr>
<tr><td>TARGETS</td><td colspan="4">No target set for 2007/08.</td></tr>
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<table>
<tr><th colspan="5">OC7 - PERCENTAGE OF USERS OF COMMUNITY CARE SERVICES & CARERS SATISFIED WITH INVOLVEMENT IN THEIR HEALTH AND SOCIAL CARE PACKAGES</th></tr>
<tr><td>SUMMARY DEFINITION</td><td colspan="4">This measures separately the percentage of community care users and carers who are satisfied with their level of involvement in the selection of their health and social care package, including the level of control that they have over the nature and timing of service provision.</td></tr>
<tr><td>RATIONALE</td><td colspan="4">The underlying goals of this indicator are to promote:
▪ Influence over the type and quality of the services being provided including real choice over the care environment.
▪ partnership with clients/patients
▪ person centred services
▪ independence and self management
▪ increased confidence for service users
▪ good quality services.</td></tr>
<tr><td>FORMULA</td><td colspan="4">Number of people satisfied/Number of people who responded.</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="2">Annual</td><td></td><td></td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">Proposed integral feedback systems/surveys.</td></tr>
<tr><td>REPORTING YEAR</td><td>07/08</td><td>No
(Possibility of a limited pilot)</td><td>08/09</td><td>Yes</td></tr>
<tr><td>KEY ENABLERS</td><td colspan="4">Following actions are required to implement this measure:
▪ Defining the key determinants of people’s satisfaction with their involvement
▪ Determining the best method of collecting the required information e.g. integrating the data collection into the assessment and care planning systems/surveys
▪ Possible use of the survey that SWIA uses to measure user and care satisfaction in preparation for inspections (see PR1a)
▪ Progress pilots to test the feedback process
▪ Implement an agreed approach across all partnerships from 2008/09.</td></tr>
<tr><td>TARGETS</td><td colspan="4">No target set for 2007/08.</td></tr>
</table>

<table>
<tr><th colspan="5">OC9 - PERCENTAGE OF USERS OF COMMUNITY CARE SERVICES REPORTING SATISFACTION WITH THE OPPORTUNITIES PROVIDED FOR MEANINGFUL SOCIAL INTERACTION</th></tr>
<tr><td>SUMMARY DEFINITION</td><td colspan="4">This measures the satisfaction of users with the opportunities they have to (re) engage in activities for social contact which are meaningful to them (e.g. employment/volunteering, learning, leisure, hobbies and interests, faith groups).</td></tr>
<tr><td>RATIONALE</td><td colspan="4">▪ 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
▪ Has a positive impact on the individual and the community.
▪ To help users be more economically active.</td></tr>
<tr><td>FORMULA</td><td colspan="4">Number of people satisfied/Number of people provided with opportunities for social interaction.</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td>Annual</td><td colspan="2"></td><td colspan="2"></td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">To be determined.</td></tr>
<tr><td>REPORTING YEAR</td><td>07/08</td><td>No (Possibility of a limited pilot)</td><td>08/09</td><td>Yes</td></tr>
<tr><td>KEY ENABLERS</td><td colspan="4">The following actions are required to implement this measure:

▪ Defining the key determinants of people’s satisfaction with their opportunities for social interaction
▪ Determining the best method of collecting the required information e.g. integrating the data collection into the assessment and care planning processes/surveys
▪ Progress pilots to test the feedback process
▪ Implement an agreed approach across all partnerships from 2008/09.</td></tr>
<tr><td>TARGETS</td><td colspan="4">No target set for 2007/08.</td></tr>
</table>

PR1a - PERCENTAGE OF USER ASSESSMENTS OF NEEDS COMPLETED IN ACCORDANCE WITH AGREED NATIONAL STANDARDS				
DEFINITION	Assessment is the cornerstone of community care. It needs to be provided to a consistently high standard across Scotland. Minimum standards should include that all assessments should be anticipatory, enabling and rehabilitation focussed. This may include establishing whether the person: ▪ has an informal carer ▪ has required hospital admission within the last year ▪ has a medical condition(s) requiring on-going care Also all people undergoing an assessment should be offered income maximisation to ensure they are getting all the benefits to which they are entitled.			
RATIONALE	▪ To ensure that assessments are carried out effectively and consistently, so that service users' care needs are properly identified. ▪ To engage users in health prevention programmes ▪ Improve self management and get the appropriate support and care.			
FORMULA	Number of user assessments carried out according to national standards/ Total number of user assessments required (based on total number of service users).			
MEASUREMENT PERIOD	Quarterly or annual			
DATA SOURCE	User assessments.			
REPORTING YEAR	**07/08**	No	**08/09**	Yes
KEY ENABLERS	▪ Develop detailed standards for user assessments (September 2007.) ▪ Consult on standards. ▪ Issue revised standards (to be adopted as soon as practicable after consultation).			
TARGETS	No target set.			

PR1b - PERCENTAGE OF CARER ASSESSMENTS OF NEEDS COMPLETED IN ACCORDANCE WITH AGREED NATIONAL STANDARDS				
SUMMARY DEFINITION	Assessment is the cornerstone of community care. It needs to be provided to a consistently high standard across Scotland. Minimum standards should include that all assessments should be anticipatory, enabling and rehabilitation focussed. This may include establishing whether the person: ▪ has an informal carer ▪ has required hospital admission within the last year ▪ has a medical condition(s) requiring on-going care Also all people undergoing an assessment should be offered income maximisation to ensure they are getting the full benefits to which they are entitled. The scope of this measure is limited to those carers providing substantial and regular care. It is similar to PR1a.			
RATIONALE	▪ To ensure assessments are being carried out effectively and consistently, so that carers support needs are properly identified ▪ To engage carers in health protection programmes ▪ Improve self management and get the appropriate support and care.			
FORMULA (Numerator / Denominator)	Number of carer assessments carried out according to the national standards / Total number of carers who accepted the offer of an assessment.			
MEASUREMENT PERIOD	Quarterly or annual			
DATA SOURCE	Carer assessments.			
REPORTING YEAR	**07/08**	No	**08/09**	Yes
KEY ENABLERS	▪ Develop detailed standards for carer assessments (September 2007). ▪ Consult on standards. ▪ Issued revised standards (to be adopted as soon as practicable after consultation).			
TARGETS	No targets set.			

<table>
<tr><th colspan="5">OC8a - PERCENTAGE OF OLDER PEOPLE AGED 65+ WITH INTENSIVE CARE NEEDS RECEIVING SERVICES AT HOME (Proxy)</th></tr>
<tr><td>SUMMARY DEFINITION</td><td colspan="4">This measure aims to enable more people with relatively high care needs to live appropriately in their own home. The proxy measure focuses on those receiving ‘intensive care’ at home expressed as a percentage of all users receiving ongoing ‘intensive care’ in residential and hospital settings as well as at home.

(The intention is that this proxy measure will be superseded once the Indicator of Relative Need (IoRN) methodology has been applied comprehensively to older people, and then extended to identify people of all ages with higher relative needs).</td></tr>
<tr><td>RATIONALE</td><td colspan="4">Promotes greater numbers of people with high levels of need to be supported to live at ‘home’ – allowing retention of more independence.</td></tr>
<tr><td>FORMULA</td><td colspan="4">People aged 65+ receiving ‘intensive care’ at home/People aged 65+ receiving ‘intensive care’ (i.e. care at home, in a care home, or in an NHS long stay geriatric bed).

The future measure will use the IoRN to determine whether people’s relative needs equate to their care setting, especially those with relatively high needs living at home. At present the IoRN applies only to older people, and initially the scope of this measure would be limited to those aged 65 and over - until the IORN methodology can be developed to meet the needs of the entire adult population.</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="2">Quarterly or annual</td><td></td><td></td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">JPIAF National Return.</td></tr>
<tr><td>REPORTING YEAR</td><td>07/08</td><td>Proxy</td><td>08/09</td><td>Future measure</td></tr>
<tr><td>KEY ENABLERS</td><td colspan="4">▪ Agree refined definition of ‘intensive care’ at home. An alternative definition should recognise the contributions of a wider basket of services including relevant NHS services that enable people 65+ with intensive care needs to live at home
▪ Further development and national roll-out of the IoRN to include all adults and all care groups (2008/09).</td></tr>
<tr><td>TARGETS</td><td colspan="4">▪ Proxy: Use SR2004 target that by 2008 30% of older people with intensive care needs will receive those services at home
▪ Future: No target set.</td></tr>
</table>

OC8b - PERCENTAGE OF OLDER PEOPLE AGED 65+ RECEIVING PERSONAL CARE AT HOME (Proxy: Balance Of Care)				
SUMMARY DEFINITION	This measures the shift in activity from 'institutional' to 'community' or 'home based' health and social care services for older people aged 65+.			
RATIONALE	▪ 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.			
FORMULA	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.			
MEASUREMENT PERIOD	Quarterly or Annual			
DATA SOURCE	The Scottish Executive Health Department (SEHD) and ISD.			
REPORTING YEAR	**07/08**	Proxy	**08/09**	Future measure
KEY ENABLERS	▪ Further work to develop the detailed definition of this proxy measure. ▪ Further work to measure financial and service shifts in the balance of care is being taken forward in the Strategic Partnership Group - Shifting the Balance of Care (see IP1).			
TARGETS	No target set.			

<table>
<tr><th colspan="5">OC3 - PERCENTAGE OF CARERS WHO FEEL SUPPORTED AND CAPABLE TO CONTINUE IN THEIR ROLE AS A CARER</th></tr>
<tr><td>SUMMARY DEFINITION</td><td colspan="4">This measures the on-going emotional, mental and physical well-being of carers to ensure that appropriate levels of support are provided, so that carers feel supported and able to continue in their role.</td></tr>
<tr><td>RATIONALE</td><td colspan="4">▪ Concerns about the health impacts of caring
▪ Focus on carer well-being
▪ Promote working in partnership with carers
▪ Sustaining carers benefits them, the person they are looking after and statutory agencies.</td></tr>
<tr><td>FORMULA</td><td colspan="4">Number of carers determined healthy during an assessment or review / Total number of carers.</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td>Quarterly or Annual</td><td colspan="2"></td><td></td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">The data for this measure can be captured by using:

▪ Numerator: carer assessment of health and well-being (to be developed)
▪ Denominator: GP Register for Carers or SSA of users.</td></tr>
<tr><td>REPORTING YEAR</td><td>07/08</td><td>No</td><td>08/09</td><td>Yes</td></tr>
<tr><td>KEY ENABLERS</td><td colspan="4">An assessment questionnaire based on key parameters to determine the health status of carers.</td></tr>
<tr><td>TARGET</td><td colspan="4">No target set.</td></tr>
</table>

IP1 - SHIFT IN BALANCE OF CARE FROM 'INSTITUTIONAL' TO 'HOME BASED' CARE				
SUMMARY DEFINITION	This measure tracks the shift of finance and other resources from acute to community based care. It was initially stated as "percentage financial shift from institutional to home based care". It was agreed that this measure in its updated form should be developed by the Strategic Partnership Group -Shifting the Balance of Care as part of its work on Delivering for Health. Any proposed future measure should ultimately focus on improving the balance of care (i.e. shift from hospital to community and home based care) in both financial and activity terms.			
RATIONALE	▪ To promote a shift in resources from hospital to community care ▪ Supporting the development of services at home or closer to home ▪ Improved and equitable access to community care.			
FORMULA	To be determined			
MEASUREMENT PERIOD	To be determined			
DATA SOURCE	To be determined			
REPORTING YEAR	**07/08**	TBC	**08/09**	TBC
KEY ENABLERS	To be determined			
TARGETS	To be determined			

OP6 - NUMBER OF PATIENTS WAITING MORE THAN SIX WEEKS TO BE DISCHARGED INTO A MORE APPROPRIATE CARE SETTING				
SUMMARY DEFINITION	This measures the number of patients who are delayed in hospitals longer than the specified target time after they have been assessed as clinically ready for discharge.			
RATIONALE	▪ Reduces the number and length of stays in hospital that are longer than clinically necessary ▪ The underlying goal is well supported with joint commitment from all partnerships ▪ Clear indicator of effectiveness of joint working ▪ An existing HEAT indicator.			
FORMULA	Number who on census date have been waiting more than six weeks to be discharged.			
MEASUREMENT PERIOD	Quarterly (monthly if possible in future)			
DATA SOURCE	ISD			
REPORTING YEAR	**07/08**	Yes	**08/09**	Yes
KEY ENABLERS	▪ Design and implement qualitative audit mechanism for "appropriate" care. ▪ Review the reasons for admission and delay in discharge and explore possible association with multiple admissions/emergency re-admission in order to identify better those at future risk of delayed discharge ▪ With a view to informing commissioning of local/regional services complete a comprehensive review of needs of patients for whom there are no suitable alternative facilities.			
TARGETS	▪ Reduce number of patients delayed by over six weeks by 50% by April 2007, as compared to the April 2006 targets, and to zero by April 2008 ▪ Reduce number of patients delayed in short stay beds by 50% by April 2007, as compared to April 2006 outcomes, and to zero by April 2008.			

OP8 - PERCENTAGE OF CARE PLAN REVIEWS CARRIED OUT WITHIN AGREED TIMESCALE				
SUMMARY DEFINITION	This measures the percentage of personal care plans, separately for users and carers, that are reviewed within the timescales agreed at the care planning stage. As a minimum the care plans must be reviewed at least once a year.			
RATIONALE	▪ Important to review care packages regularly to ensure they continue to meet appropriately the health and social care needs of users and carers ▪ Focus on prevention to promote well being ▪ Identify people at risk and track their changing needs for health and community care.			
FORMULA	Number of care plans reviewed in agreed time scale / Total number of care plans.			
MEASUREMENT PERIOD	Annually *(more frequent once electronic Data Standards implemented)*			
DATA SOURCE	Personal care plans			
REPORTING YEAR	**07/08**	No	**08/09**	Yes
KEY ENABLERS	▪ Development and implementation of care plan review guidelines by ARCG (2007/08) ▪ Implementation of systems to gather the care plan review data (2007/08).			
TARGETS	No target set.			

<table>
<tr><th colspan="5">OP5a - NUMBER OF PEOPLE WAITING FOR MORE THAN TARGETED TIME FROM REFERRAL TO COMPLETION OF ASSESSMENT, PER 1,000 POPULATION</th></tr>
<tr><td>SUMMARY DEFINITION</td><td colspan="4">This measures the number of users that have to wait more than the target time (yet to be determined) from their referral for an assessment through to its completion.</td></tr>
<tr><td>RATIONALE</td><td colspan="4">▪ Measures the speed of assessment – effective service delivery depends on needs being assessed quickly
▪ Indicates the accessibility & responsiveness of services
▪ Fosters reduced waiting times
▪ Promotes more rapid access and delivery of services that effectively meet the assessed needs of users
▪ Provides continuity in process terms with the measure on service delivery (OP5b).</td></tr>
<tr><td>FORMULA</td><td colspan="4">Number waiting longer than target time per 1000 population.</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="2">Quarterly or annual</td><td></td><td></td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">Electronic assessments (to be put in place).</td></tr>
<tr><td>REPORTING YEAR</td><td>07/08</td><td>No</td><td>08/09</td><td>Yes</td></tr>
<tr><td>KEY ENABLERS</td><td colspan="4">▪ Electronic data sharing and information systems available across Scotland to capture the critical data for the start and completion of assessments (TBC)
▪ Analytical study to determine typical waiting time periods across Scotland (2007/08).</td></tr>
<tr><td>TARGETS</td><td colspan="4">No target set (awaiting findings from analytical study).</td></tr>
</table>

<table>
<tr><th colspan="5">OP5b - 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>SUMMARY DEFINITION</td><td colspan="4">This measures the number of users that have to wait longer than the target time (yet to be determined) for the delivery of the health and social care services agreed following an assessment.</td></tr>
<tr><td>RATIONALE</td><td colspan="4">▪ Measures the speed of access to services – quicker access may increase independence and reduce institutionalisation
▪ Indicates the accessibility & responsiveness of services
▪ Fosters reduced waiting times
▪ Promotes more rapid access and delivery</td></tr>
<tr><td>FORMULA</td><td colspan="4">Number waiting longer than target time per 1000 population</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="2">Quarterly or annual</td><td></td><td></td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">Electronic care plans (to be put in place)</td></tr>
<tr><td>REPORTING YEAR</td><td>07/08</td><td>No</td><td>08/09</td><td>Yes</td></tr>
<tr><td>KEY ENABLERS</td><td colspan="4">▪ Electronic data sharing and information systems available across Scotland to capture the critical data for the delivery of care packages (TBC)
▪ Analytical work to determine appropriate delivery timescale targets for different types of care packages (2007/08)
▪ Further specific clarification required whether adaptations in owner occupied houses are to be included in the scope of the measure or not (2007/08)</td></tr>
<tr><td>TARGETS</td><td colspan="4">No targets set (awaiting findings from analytical study)</td></tr>
</table>

<table>
<tr><th colspan="5">OP7a - NUMBER OF EMERGENCY BED DAYS IN ACUTE SPECIALTIES FOR OLDER PATIENTS AGED 65+ PER 100,000 POPULATION</th></tr>
<tr><td>SUMMARY DEFINITION</td><td colspan="4">This measures bed occupancy during a year from emergency admissions, other than to psychiatric units, for adults aged 65+ in all hospitals measured as a number of occupied bed days for emergency admissions per 100,000 population.

This measure is similar to the HEAT key measure 4.08.K. However, OP7a is expressed as a rate rather than the absolute number used in HEAT, providing more meaningful comparisons.</td></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
▪ Similar to the existing HEAT measure (see below).</td></tr>
<tr><td>FORMULA</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+).</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td>Quarterly or annual</td><td colspan="2"></td><td></td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">ISD/ Hospital Admissions (SMR01) Data.</td></tr>
<tr><td>REPORTING YEAR</td><td>07/08</td><td>Yes</td><td>08/09</td><td>Yes</td></tr>
<tr><td>KEY ENABLERS</td><td colspan="4">Future development of this and the corresponding HEAT measure should be co-ordinated.</td></tr>
<tr><td>TARGETS</td><td colspan="4">The existing target is to reduce emergency in-patient days for older patients aged 65+ by 10% by 2008 (in the HEAT LDP this will be measured at financial year end), compared with 2004/05.</td></tr>
</table>

<table>
<tr><th colspan="5">OP7b - NUMBER OF OLDER PATIENTS AGED 65+ ADMITTED FOR ANY REASON TWO OR MORE TIMES IN A YEAR AS AN EMERGENCY TO ACUTE SPECIALTIES PER 100,000 POPULATION</th></tr>
<tr><td>SUMMARY DEFINITION</td><td colspan="4">This measures the number of emergency admissions, other than to psychiatric units, for older people aged 65+ in all hospitals admitted two or more times in a year per 100,000 population.

This measure is the same as HEAT key measure 4.02.K.</td></tr>
<tr><td>RATIONALE</td><td colspan="4">▪ 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
▪ Existing HEAT measure.</td></tr>
<tr><td>FORMULA</td><td colspan="4">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 (all limited to people aged 65+).</td></tr>
<tr><td>MEASUREMENT PERIOD</td><td colspan="2">Quarterly or annual</td><td></td><td></td></tr>
<tr><td>DATA SOURCE</td><td colspan="4">ISD/ Hospital Admissions (SMR01) Data.</td></tr>
<tr><td>REPORTING YEAR</td><td>07/08</td><td>Yes</td><td>08/09</td><td>Yes</td></tr>
<tr><td>KEY ENABLERS</td><td colspan="4">Future development of this and the corresponding HEAT measure should be co-ordinated.</td></tr>
<tr><td>TARGETS</td><td colspan="4">The existing target is to reduce number of older people aged 65+ admitted as an emergency two or more times a year by 20% by 2008/09, compared with 2004/05.</td></tr>
</table>

OC2 - 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 PER 100,000 POPULATION (PROXY)				
SUMMARY DEFINITION	Number of older people aged 65+ who have been admitted as an emergency two or more times in a year and have not had an assessment of their health and social care needs, per 100,000 population.			
RATIONALE	▪ Focused on anticipatory care management ▪ Focus on 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 being identified as 'at risk of admission'.			
FORMULA	Patients aged 65+ with two or more emergency admissions in a financial year who have not had an assessment of their health and social care needs, expressed as a rate per 100,000 resident population.			
MEASUREMENT PERIOD	Quarterly or annual			
DATA SOURCE	To be determined (based in part on ISD's hospital admission data).			
REPORTING YEAR	**07/08**	Proxy	**08/09**	Future measure
KEY ENABLERS	▪ Ensure systems are in place to identify locally those patients who are at risk of having two or more emergency admissions in order that an assessment of need can be carried out and a co-ordinated package of health and social care provided where appropriate. ▪ Further consideration is envisaged of the exact terms of this measure to ensure it supports the underlying objectives effectively.			
TARGETS	No target set.			

ANNEX C

Links between the Joint Performance Information and Assessment Framework (JPIAF) and the New Performance Measures under the National Outcomes Framework

JPIAF	**New Outcomes Framework**
JPIAF 6 – Single Shared Assessment (SSA): waiting times	**OP5 –** A) Number of people waiting for more than targeted time from referral to completion of assessment per 1000 population. B) Number of people waiting more than the targeted time for the delivery of community care services following an assessment per 1000 population.
JPIAF 8 – Access to resources, following SSA, across agency boundaries	**-**
JPIAF 10 – Whole Systems Indicator	**OC8 –** A) Percentage of older people aged 65+ with intensive care needs receiving services at home. B) Percentage of older people aged 65+ receiving personal care at home. **OP6 –** Number of patients waiting more than six weeks to be discharged into a more appropriate care setting. **OP7 –** A) Number of emergency bed days in acute specialities for older patients aged 65+ per 100,000 population. B) Number of older patients 65+ admitted for any reason two or more times in a year as an emergency to acute specialities per 100,000 population. **OC2 –** Number of older people aged 65+ with two or more unscheduled admissions in a year who have not had an assessment of their health and community care needs, per 100,000 population.
JPIAF 11 – Local Improvement Targets on • Delayed Discharges • Emergency admissions • Intensive home care • Single shared assessment • Rapid response services • Equipment and adaptations • Carers support and respite care	**OC8 –** A) Percentage of older people aged 65+ with intensive care needs aged 65+ receiving care at home. B) Percentage of older people aged 65+ receiving personal care at home. **OP6 –** Number of patients waiting more than six weeks to be discharged into a more appropriate care setting. **OP7 –** A) Number of emergency bed days in acute specialities for older patients aged 65+ per 100,000 population. B) Number of older patients 65+ admitted for any reason two or more times in a year as an emergency to acute specialities per 100,000 population. **OC2 –** Number of older people aged 65+ with two or more unscheduled admissions in a year

	who have not had an assessment of their health and social care needs per 100,000 population.
	OC5 - Percentage of users of community care services feeling safe.
	OC7 - Percentage of community care users and carers satisfied with involvement in their health and social care packages.
	OC9 - Percentage of service users reporting satisfaction with the opportunities provided for meaningful social interaction.
	PR1 – A) Percentage of user assessments of needs completed in accordance with agreed national standards. B) Percentage of carer assessments of needs completed in accordance with agreed national standards.
	OC3 – Percentage of carers who feel supported and capable to continue in their role as a carer.
	IP1 – Shift in balance of care from institutional to home based care.
	OP8 – Percentage of care plan reviews carried out within agreed timescale.