National Indicator Set Consultation
December 2007

Combined comments on the indicators for ADASS response to DCLG consultation.

Provided by ADASS regions West Midlands, South West, South East, and London.

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Part 1 – Adult Social Care specific

NI 125: Achieving independence for older people through rehabilitation/IC

Q1. Is the Technical Definition of this indicator clear?

The formula states we count any intermediate care service that includes input from the local authority. Is that in relation to any LA department? Also how are we measuring what an input is? Is the measure of still being at home the most effective? The work of CSED has looked at the care package people have been in receipt of as a result of intermediate care. Isn’t this a better measure? Also how do we track people with whom we have no contact after the intermediate care package? There also seem to be some ongoing issues with regard to what exactly is intermediate care. These could impact upon effective monitoring against the indicator.

We were confused about how to count people who are in hospital 3 months from discharge - are they excluded from the numerator (definition section) or only excluded if in hospital temporarily (Formula section). What is the definition of ‘temporarily’? The only permanent hospital stays we could think of would be Mental Health.

If this indicator is to be used, it will require much more careful definition. For example, the rationale and formula sections are currently contradictory - the rationale states that this indicator does not distinguish between health and social care, whereas the formula implies that only rehab schemes with a local authority element will be counted (and this is in the denominator but not in the numerator, to confuse things further). It is also not clear whether social care-only schemes without a health element will be counted as the formula section only refers to ‘joint’ services - there are many social care-only services and health-only services, which also contribute to outcomes. A clearer definition of what could and could not be included would be needed to avoid problems of incomparability of data across authorities. The definition also needs to be clear about what constitutes a period of rehab/intermediate care.

Would multiple admissions of the same person potentially affect the calculation of the indicator?

Need clear definition of rehabilitation. Also clarification that population are Local authority residents (not residents registered to GPs within LA).

 referenced.' 'Clear Intention' which is open to abuse. For example some authorities may make wider use of rehab services than others, and provide them to people ‘at the margins’ who perhaps are less likely to return to their own home but may still benefit. Those authorities would be penalised, even though they are producing better outcomes for people. A reaction to this could be to separate clients into those where there was a 'clear intention' and include them in this PI, and not include those where is was an 'aspirational intention' thus boosting their figures considerably.

Requirement for 3 months after discharge should be clarified as 91 days, and should be measured from entry into the rehab service which is easier to measure (and in most cases will be the same as the discharge date).

Is it restricted to discharges from Acute hospitals or all hospitals?

If based on 3 months we would need to report on a financial year basis on those people who had entered the rehab service during the calendar year. i.e. where are the people who went into rehab between 1 Jan to 31 Dec 3 months later?
Need clarity on three months and the reporting period - e.g. a client discharged on 31st March would need to be living in their home on 30th June, which reporting year would this client fall into?

Comment is difficult as it is stated that the indicator will be piloted and then introduced half way through 2008/09.
The definition currently has a number of ambiguities e.g. what is meant by '3 months'; 'a clear intention'; what is the situation with repeat episodes?

a. Some of it is rather vague and open to interpretation

b. The term ‘Extra Care Housing’ needs to be fully defined as it can mean different things to different people / LAs

b. The definition of an 'intention' needs to be explicitly defined. Temporary v Permanent etc?

3 months is a vague term, would prefer a number of days be stipulated e.g. 90 days.
The term 'short-term' intervention is clarified with the phrase 'typically lasting no longer than 6 weeks' - what would we do with clients who had care for 7 or 8 weeks i.e. at what point do we discount clients from the denominator?

Definition involves too much value judgement (what is 'rehab', what is 'clear intention'). This would make it too loose to use as a P.I. Better to address from outcome survey approach given the complexity. Noted that this will be piloted.

Conflict between formula definition and worked example (worked example is correct). X + Y definition should match other than the 3 months after discharge in X

There is no clarity as to what would constitute a 'clear plan for their return home'.

(a) Require clear definition of rehabilitation and intermediate care. SAS records 4 variations by setting (community, residential) and direction (facilitate discharges, prior to admission).

(b) How do you deal with 3 month time period for reporting purposes?

Can use:
(i) Those at home at 3 months irrespective of date of discharge - means reporting on people discharged in previous year.
(ii) Those discharged in the year - means reporting 12 months later on those discharged within 3 months of year end.

(c) How do you define ‘Joint IC service on a rehab service’? Are all such services deemed ‘Joint’?

Clarification is required on whether the 12 month period relates to the date of discharge or the date that the three months is complete.

E.g., Will periods of intermediate care completed in 08-09 be counted in that year despite the fact that the discharge was in the previous 12 month period.

Clarification required as to how deaths within 3 months will be treated.

if someone has two episodes in the year how is this treated (example - someone is discharged and supported at home successfully for 4 months but then is again admitted to hospital and goes through the same process - are people counted or episodes?)

Does it include community hospital discharges as well as acute?

**Q2. Does the Technical Definition for this indicator have any unintended consequences?**

Authorities could maintain people at home with large home care packages when residential care would actually be a more appropriate. Hence the point about looking at the size of care package.

a. Decisions over permanent long term care may not have been taken within 3 months, especially if the Intermediate Care has lasted for 6 weeks. This could be due to good practice by giving the client every chance to remain at home, or councils could deliberately delay the decision in order to improve performance.

b. Extend the period to e.g. 4 months? This creates a different problem as it increases the chance that the client may have developed completely unrelated medical problems
Likely to lead to use of resources simply to collect data that is currently not collected and not needed for any care and support purpose (see below).

One way to avoid this unintended consequence might be to collect the data immediately following the intervention rather than 3 months after discharge. The indicator will not measure outcomes from periods of rehabilitation and intermediate care that were provided in order to prevent a hospital admission.

There is an October 2008 deadline for setting up a totally new database for every Local Authority/PCT. This seems very tight.

Fails to take account of Intermediate Care Packages put in place to PREVENT hospital admission. This could be avoided by having two parts to the indicator, those where services prevent admission and those where services facilitate.

May encourage local authorities to give large home care packages when residential/ nursing placements may be more appropriate.

Penalised for clients who die or are readmitted to hospital for a totally unrelated condition as they are counted in the denominator and not in the numerator.

Only focuses on hospital discharges not preventing hospital admissions. Will fail to count clients who receive intermediate care soon after hospital discharge because the service user is experiencing problems.

Authorities could decide to include or exclude some specific services depending on the interpretation of ‘rehabilitative’

Could encourage authorities to only provide rehab services to people who are more likely to return to their own homes, and not to people for whom it is less likely. This could either mean some authorities cutting back or others not extending services to those people.

Can monitor the raw numbers to see if authorities are cutting back their services but cannot see how you can address issue of it being a barrier to extending rehab services further. This would require new systems and processes to be put in place to capture a clients status at three months.

It may stop clients being accepted by Intermediate Care Service if the outcome is likely to be unfavourable.

a. On current definition patients can be included in the numerator more than once.

b. Clearer definition

People who die are included in the denominator but not the numerator, therefore, we are penalised for this.

Complex nature of the indicator definition makes this difficult to report upon - increases burden and complexity of information request on Authority

1 Unrelated hospital admissions during 3 months after discharge will show up as failures of intermediate care.

2 No incentive to prevent first admission to hospital, only focusing on post-discharge intermediate care work, not on the role of intermediate care to avoid unnecessary admission. Where there is lack of clarity of definition it will by applied differently, and consequently comparisons will not be valid.

It focuses only on hospital discharge but arguably, admission prevention is of equal or more importance. Likely that this will act on a purchase?? incentive and from investment on discharge not prevention.

Prediction of going home is difficult to validate and therefore open to abuse. For example stretching the definition to suggest that, the person is due to go home until such time as there is a completed permanent residential contact in place.

Greater clarity would be possible if the indicator measured 3 months from the end of the period of intermediate care.

It will encourage intermediate care teams to be cautious about accepting difficult/high risk cases from hospitals. It will ignore cases where people leave hospital without an IC package where the IC team are called in when the service user has problems soon after discharge – not an uncommon situation.

Q3. Will Technical Definitions work in practice?

The indicator will be particularly difficult to measure. Although we agree broadly with what the indicator is trying to measure the burden of trying to measure this needs to be addressed within the pilot. There is also the issue of those that cannot be traced.

How do we track people after discharge - what if we are not in contact with them at 3 months.
There are multiple potential problems with this indicator, as highlighted above. A further issue is that currently there are no mechanisms to track people following a period of rehabilitation or intermediate care, unless they are both eligible for our service and require an ongoing package of care from Adult Social Services. It would be unnecessary intervention in people's lives, and inefficient use of resources to introduce such tracking mechanisms. Hence the only method of collecting this data would be via survey or sampling methodology, or by introducing follow-up systems requiring additional resources simply to collect data for this indicator. That is not a good use of resources.

Need clear definition of rehabilitation.

How are authorities expected to count clients who cease to have a service with the authority after 3 months? In-house systems will need to be modified in order to capture this information, requiring extra resources for this to be set up and collated.

This data will be collected by the KS1 return in which guidance has yet to be published for 2008/09. System processes cannot be designed until guidance on this return is published, in order to ensure the system can record all data required.

Confusion as to definition of 'rehabilitative'

Concerned at how you would be able to determine where people are 3 months later if they are not in receipt of ongoing services afterwards - e.g. if they are self-funding. Are we or the PCT supposed to phone these people up, and if so there are resource implications (in our case for the PCT) and also how should we handle the situations when we call relatives to find out the patient has died? These calls are also likely to prompt discussions on other issues, additional referrals, etc which need to be responded to.

Difficult to track clients after discharge from Intermediate Care Services and no further ongoing support is being provided.

Not well defined and too open to different interpretations

Will be very difficult to track people through from hospital who were discharged to intermediate care and position at 3 months later.

Date of discharge from IC not currently collected

1 Requires 3 month follow up of successful discharges/intermediate care referrals, where individuals may no longer be in contact with services.
2 Indicator does not differentiate between different levels of community based support required 3 months after discharge.
3 Difficulty extracting data at Council level from shared PCT Int Care resource.

(a) Aforementioned definitional problems.
(b) How will you prevent LA's 're-classifying' ‘failed cases’ in order to improve reported performance. Intermediate/rehab services are defined solely by ‘purpose’.

To accurately report on this indicator requires combining information currently held on NHS systems (hospital admission and discharge) with information held by Social Care (Admission and exit from Intermediate care). This information is currently not shared routinely across the two organisations and detailed information protocols and systems would need to be put in place.

Where data on intermediate care services are held on social care systems we do not have access to hospital discharge dates or readmission dates.

It will be hard to distinguish between people temporarily in acute units and people who are unlikely to return home.

**Q4. Is indicator defined at the right spatial level?**

We will need to examine information by hospital to evaluate the discharge procedures.

**Q6. Any other Comments?**

We cannot currently monitor this, it will require significant joint work with health and new processes (following confirmation of more detailed technical guidance) to collect this indicator. This would require a lengthy lead-in time.

The timescales issue highlighted in response to Question 2 seems critical.

Will need to set up systems to identify people discharged for rehab, with dates and that they're in/not in res/nursing care 3 months later.
There will be significant practical difficulties in establishing the status of people at 3 months who are no longer in contact with social services.

Denominator: Who knows the number of people discharged to IC or Rehab?

We will need a new way of Ensuring recording of this element In Swift - e.g. the discharge reason on the notification field? This should be being completed for clients In Hospital as the Issue of a Section 2 triggers this recording (not to say Its happening)

Need a report on nos of clients with sec2 'contact' or Profile note and NO notification recorded

NO Sec 5

Numerator - number discharged where to IC/Rehab where there Is no provision of LT res/nursing at discharge plus 3 months - Where there has not been another hosp admissions (sec2)?? Is this right?

Report - number of people with a profile not showing 'ward' hosp' and NO sec 2

Q6. Any other Comments?

Will be issues regarding tracking some people 3 months after discharge such as:

• Hard to contact if no longer in receipt of any care
• Identifying relevant clients on our care management system
• Hard to track self funders
• Some information from PCT may be hard to track

It will be hard to set up an effective new data collection system by Oct 2008.

Wont measure preventive rehab/IC aimed at preventing hospital admission

Might discourage picking very difficult/high risk cases for rehab

What about people no longer in contact with ASC or moved away before 90 days

Recording of sexual orientation could pose problems as services users are likely to see this as irrelevant to the care package the LA is providing.

If clients have to be contacted within 3 months of hospital discharge when services by the local authority have ceased this will require additional work from the LA's to collect this information. All clients would therefore have to be informed prior to the start of their rehabilitation services that they may be contacted after three months regardless of whether or not they are still in receipt of services to see how they are getting on. Contacting such clients could cause distress to the service users relatives/ friends if the service user is back in hospital or has even died.

In theory this indicator is useful but will be hindered by the wide interpretation of what a ‘rehabilitation service’ is.

Has restricted itself to joint services only, which means we will be excluding a lot of services producing the same outcome but provided through different means by the CSSR or PCT individually. This is fine, but you have to understand that this will influence the numbers provided by Councils as we all differ as to how much of our rehab we provide jointly with the PCT and individually.

It would make sense for the indicator to measure the three months from the date of the end of the IC episode rather than the date of discharge from hospital.

Secondly, this would require new systems and processes to be put in place to capture a clients status at three months.

Perhaps the indicator should be defined from when a person leaves intermediate care rather than discharge from hospital

For the IWC LA and the PCT/HA this will require additional harmonisation of recording policies across organisational boundaries. Recording from October 08, pilot information collection report in March 09, full reporting year March 2010.

Lead in time for systems change to capture this data will be longer than the 6 months indicated.

This is not part of existing KS1 statutory return, nor is it collected on core systems, but would have to be collected through preventing dependency teams (where it is not currently collected). High client turnover and joint team issues will make the required data processing problematic (e.g. joint management issues).

Recording of ‘sexual orientation’ is highly problematical and is often viewed as ‘irrelevant’ or ‘intrusive’ by service users. This has been raised with the Information Centre by SIGASC and national research and
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guidance is required.

People who die after discharge are not counted in numerator but are included in denominator [alternative is to exclude from both]

We are in a good position on this indicator because the data is already held on the social care system. However we will have serious problems tracking service users whose cases were closed within 3 months of discharge – we will need to change the data protection act statement to tell service users that we may contact them 3 months after the start of intermediate care to find out how they are doing. This may cause distress to relatives if the service user is back in hospital or even dead. It will also be costly to collect – but it will give us good outcome information

**NI 127: Self reported experience of social care users**

**Q1. Is the Technical Definition of this indicator clear?**

Satisfaction” is not the same as “experience”; careful thought needs to be given to nature of questions to gather experience outcomes

This is subject to approval by SIGASC before being properly consulted on with the timing and ‘location’ of the survey also uncertain.

Awaiting technical definition - though surveys have not been an issue in the past

Definition to be confirmed

Limiting the survey to Home Care users is a major weakness

The definition talks about Social Care Users and then states that the question will be added to the Home Care Users Experience Questionnaire. Is the indicator designed to look at all Social Care or Homecare?

**Q2. Does the Technical Definition for this indicator have any unintended consequences?**

The instruction implies that Home Care users will be surveyed once a year. If we are expected to survey other users, there will be two surveys which could involve the same people (home care users also getting other services. There may be survey fatigue. There is a danger that surveys will miss significant groups – such as carers & direct payments clients

limiting this survey to homecare only excludes too many service users. We should gather this info from review process not by survey. Those who state ‘satisfied’ should also be included. The terms extremely satisfied and very satisfied are very subjective.

a. There is potential conflict with 128. People might receive more than one survey asking similar questions.
b. Look at combining the two surveys

a) Growing danger of survey fatigue amongst respondents.
b) Require the administration of the survey to occur at either the annual or six monthly review

If limited to Home Care users, it de-values the other community based services provided

There is disagreement about the rating scale used to determine ‘performance’. ‘Satisfied’ or ‘Quite Satisfied’ are excluded, but there is no good case for doing this. It makes untested assumptions about how people think and the ‘meaning’ of language. For example: a person may say ‘I am quite satisfied, thank you very much’ meaning:

(a) A high level of satisfaction.
(b) An ‘average’ level of satisfaction.

As it stands, the proposed measure cannot differentiate between:

(a) Satisfied
(b) Not satisfied.

If Direct Payments and Individualised care is believed to be the most positive experience for service users, and the survey is only for Homecare users, the results are likely to be suppressed by the exclusion of DP users.
**Q3. Will Technical Definitions work in practice?**

Satisfaction questions should have even number of options to avoid mid-point selection. To some people “quite satisfied” means fully satisfied.

Survey work will have diminishing completed returns as a result of survey fatigue amongst clients not known.

**Q6. Any other Comments?**

There are a number of issues that need to be raised:

1) Is there a danger of survey fatigue in relation to the number of different user surveys and pieces of user engagement the new framework proposes?

2) Could we try and look at either factors that contribute to satisfaction of home care service users or alternatively look at the effect that the care has had upon service users?

Indicator falls out of the rolling survey programme. It is essential that we have early confirmation of the questions in the questionnaire and that the questions are passed through the ethical committee etc before they are released to LAs. We need a long lead-in time for these surveys as they have to go through our internal Research Governance process before we can commence with the implementation of the survey. Essential that LAs are involved with the formulation of the questionnaire.

Obviously we await consultation from SIGASC. We have had problems with vastly varying satisfaction levels in previous surveys, partly due to an understandable failure of service users to understand who is delivering the service. I fear that SIGASC are carrying out complex analyses of information that may not be totally reliable, which we presume is why the annual surveys were put on hold. We would be happier with a weighted PI.

Subjectivity an issue.

This is a key outcome measure for ASC users. The current UES is fine but done on a triennial cycle it will take many years to survey even a sample of all service users. There will be no meaningful repeat data on increases/decreases in satisfaction until repeat surveys are done (only Home Care for older people by 2010/11). This will be well outside the 3 year period.

In our locality we are piloting the use of a few key questions from the UES (in satisfaction and quality of life) and Patient Survey (dignity and respect) in existing user surveys and reviews.

Building nationally validated key outcome Qs into an extended RAP if it survives (extended to include outcomes as well as processes) or new standard outcome data set would seem an effective way forward in the longer term. Nationally you just want to know if peoples outcomes have been met and if satisfaction has gone up. Locally we want to know the detail about which services, from which providers, users and carers feel have benefited them most and least so we can use the data for contract monitoring, service commissioning and value for money research.

Numerator should include those responding “Quite Satisfied”? Cannot answer re unintended consequences as we do not know detail of question.

We have concerns over response rates (as for any use of surveys) and the fact that they are three-yearly means that any progress is going to take a long time to appear.

This should not be limited to homecare. We need to capture the views of other types of service user. It will exclude all of those accessing Direct Payments etc.

Regarding this indicator specifically but also relating to the wider approach reflected in the full set of National Indicators dealing with Adult health and Well-being we are concerned that this new approach neither reflects sufficiently well or directly ties in with the Healthcare Commission and DoH's seven outcomes which have been placed at the heart of our collective approach to modernising social care.

There is potential confusion with 128, depending on the final definition of 128. The question about the satisfaction should remain as the first question in any survey. If the two surveys are not the same, there is a risk of bias, with one leading to different responses.

Allowing additional optional questions applicable to individual LAs could impact on LA comparability.

Internal Comment - Surveys are resource intensive and this impacts on the teams undertaking survey work - even if survey questions picked up at review the analysis and presentation of the results takes additional resources.
The danger of reviewing the satisfaction question and who to consult being a triennial cycle prevents this from being a measure that has consistent trend data. For us to successfully measure improvement/drop in perceptions of our service users – it needs to be the same questions with a sound rationale around random selection across all primary service user groups (PSUG) (with appropriate breakdowns by age, area, race, disabilities etc).

Only by undertaking annual surveys can service improvements be made as a result of findings - 3 yearly is not frequent enough to be useful.

These surveys do not provide a useful measurement as a Performance Indicator. The limitations are acknowledged in the draft and the opportunity should be taken to shift towards locally valuable outcome/performance information rather than a relatively unhelpful P.I.

Recording of ‘sexual orientation’ is highly problematical and is often viewed as ‘irrelevant’ or ‘intrusive’ by service users. This has been raised with the Information Centre by SIGASC and national research and guidance is required. As for NI 124, there could be a possible impact if the Patient Survey is administered at the same time due to similar client groups and questions being asked. poor ethically and may lead to potential survey fatigue?

**NI 128: User reported measure of respect and dignity in their treatment**

**Q1. Is the Technical Definition of this indicator clear?**

No detailed information on what is being asked at present. Which Group will be leading the development work & piloting of this proposed indicator?

Work is on-going

Need to be clear about point of collection:

? at assessment

? once services in place

? or at review

Definition to be determined

Not yet defined. It is unclear how similar this will be to 127 and whether there will be any conflicts.

a) Is the patient experience survey still going to operate? How will this be co-ordinated with yet another Council survey?

b) Needs to all be in one survey - the place survey?

Awaiting technical definition - though surveys have not been a issue in the past

It is appreciated this is to be ‘defined via a series of surveys’ questions, but it is not immediately apparent how you could quantify things to comprise a coherent definition of dignityWhilst most people would have a working knowledge of the word dignity, inclusion of the phrase ‘Human Rights’ relies on people specifically understanding their human rights and how they are potentially affected by delivery of the service.

**Q2. Does the Technical Definition for this indicator have any unintended consequences?**

a. There is potential conflict with 128. People might receive more than one survey asking similar questions.

b. Look at combining the two surveys

a) As it stands a user could be asked the same question twice in 2 different surveys.

b) Only use one survey, or have I misunderstood the definition?

The term modesty is in appropriate in the context of this indicator. Whilst it is reasonable for people to comment whether or not there dignity is not diminished, surely receiving personal care from a home carer could be construed by most to compromise their modesty.

**Q4. Is indicator defined at the right spatial level?**

Unknown at present.

**Q6. Any other Comments?**

As per NI 127 danger is around survey fatigue. A picture needs to be developed that maps all of the
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potential survey work that will occur to ensure that users are not being bombarded with surveys. 

Please can some general guidance on this indicator be issued as soon as possible. 

Obviously we await the CSCI report. It would be sensible if this were the second PI (after NI 127) to come from a User Survey. 

Questions to users should not be couched in jargon terms as may lead to confusion. Anecdotal evidence that “professionals” don’t necessarily understand the terms or they mean different things to different people. It needs to be spelt out to clients. 

How many surveys are there going to be in total and how are they going to be co-ordinated to avoid the same people being sent multiple surveys in any one year. Surely it is better to design an over-arching one that gathers all of the relevant information or use service user reviews as an alternative. 

There is potential confusion with 127, depending on the final definition. 

If the two surveys are not the same, there is a risk of bias, with one leading to different responses. 

Logically, this would form a further question on the survey undertaken to ascertain NI 127 - needs to be wider in scope than just Home Care users, and annually to be useful as a quality improvement tool. 

There are resource issues for the local authority to undertake surveys though the process would be more manageable if fair treatment was dealt with in terms of customer satisfaction, rather than a notion of dignity. The resource issues remain, in this case exacerbated by the fact that the survey would have to be conducted across both Health and Local Authorities. 

We know a question on dignity is likely to be included in the annual User Experience Surveys for ASC. However the rationale is to collect information on respect and dignity from health users as well possible using the Patient Experience Questionnaire. Not sure how an overall score could be calculated from 2 different surveys which will have different sample sizes and number of responses (therefore different margins of error). Values placed on respect and dignity differ between individuals and communities regardless of how comprehensive cognitive testing may try to standardise the definition. It would be imperative that only one survey be used to collect data from ASC and Health thereby sharing the sample used. Sharing a sample of users between the organisations and then administering the survey will be more complicated however.

**NI 130: Social Care clients receiving Self Directed Support (Direct Payments and Individual Budgets)**

**Q1. Is the Technical Definition of this indicator clear?**

How exactly are we defining an individual budget? With the move to self directed care within Birmingham we will have a range of individualised care. In addition it is unclear if one off payments will continue to be included in the indicator. 

The proposed definition for this indicator includes carers in receipt of a direct payment. This would require direct payments to carers to be identified separately on the RAP C2 forms (at present they are indistinguishable from carers' breaks and other specific carers' services). This could then be added to the number of clients receiving direct payments during the year, from RAP P2f. Can you clarify whether this is the intention? 

Reference to RAP does not give the RAP form number - this is essential because the form currently used to calculate this indicator does not include carers, whereas the indicator definition implies that direct payments to carers will be included. This may be problematic. 

The current PI (PAF C51) only counts ongoing Direct Payments as a snapshot indicator but the new definition implies that all DPs (including one-offs and DPs through the year but closed before 31 March) will be counted. It would be useful to confirm that this is the intention of the new indicator more clearly in the technical guidance. 

Result should be to one decimal point. 

Need to clarify whether one-off payments (e.g. for equipment) with minimal assessment are included 

Implies that one off payments may be included
Should be just collected from RAP??

As part of the self determined service process can involve clients assessing themselves and arranging the provision of their care, this initiative can militate against quick assessment and provision of services to vulnerable people. As we are saying to clients that they should be assessing themselves, our score against NI 132 is likely to deteriorate as this indicator aims to measure quick assessment of clients. NI 133 might deteriorate also if the process of setting up DP is delayed by clients, because this indicator aims to measure quick provision of all parts of a care plan. The clients who self-assess and take direct payments are not compelled to act quickly as such. The technical definitions should recognise this contradiction.

How are individual budgets defined?
What RAP proforma will be used to collect this data?
Not clear enough that this indicator includes all DP's and IB's that are provided throughout the year, rather than at a snapshot date.
Clarification required as to whether or not the indicator includes service users receiving one off Direct Payments or only those in receipt of ongoing payments.
Define what an IB is £1 has same weight as £1000. Carers DP included or not?
Need clarification of the definition of Direct Payments and Individual Budgets.
The worked example only makes mention of direct payments although Individual Budgets are now included too.
Calculation is very complicated - will mean very little to the public
Definition appears to extend the current C51 definition to include one-off Direct Payments, which provides a more accurate reflection of uptake.
There will need to be a clear definition of what constitutes an Individual Budget for the purposes of this indicator
Both Direct Payments - Individual Budgets require better definitions and thresholds. Is a Direct Payment of £1 per week equivalent to a Direct Payment of £200 per week?
Clarification is required as to whether or not the indicator includes service users receiving one off Direct Payments or only those in receipt of ongoing payments.

Q2. Does the Technical Definition for this indicator have any unintended consequences?

May cause councils to force people to have Direct Payments where it is not appropriate or they don't want it. Direct payments are intended to promote choice and control: we need to recognise that some people will choose not to take up a direct payment.
Will add a confusion about which RAP forms include carers and which do not. Potential double counting of carers in P return and C return in RAP.
It may be that new databases have to be developed because existing direct payments systems may not cope with the flexibility of IBs.
If one off payments are included presumably you can score highly if you give users and carers a small one off payment as opposed to going through the full IB and support brokerage process
Could mean performance against NI 132 and NI 133 deteriorates.
Calculation is complicated and makes no allowances for the size of the social care 'market'.
Could drive small sums up without major impact on independence. Adverse impact on councils with a high population of older people
A better measure would be if the denominator was the number of service users as opposed to the population. Easy to manipulate figures by making numerous small one off payments.
What is the impact on the existing C62 indicator, should Carers DPs be counted again in C62?
a) Makes no allowance for size of Social Care 'market'.
b) Yes, the population should be 'need' weighted as per NI136.
Very difficult to explain the calculations to a lay person/manager
Currently don't include carers with direct payments in C51 - seems like new definition includes them - will we be able to count them again in C62?
Low level DPs can be provided and appear to indicate a much higher level of coverage than a smaller number of higher dependency user packages, which is a reflection of CSSR inputs and outputs more than
customer related outcomes
The inclusion of carers and the fact that the measure is of people throughout the year, coupled with the definitional problems noted at (1) will inevitably lead to over-inflated figures. An authority could achieve speculative results through a large number of small, one-off Direct Payments. Unless this measure is tied to the overall investment in Direct Payments, it is likely to be useless e.g.: 

LA1:  
People receiving DP's = 1000  
Budget for DP's = £1000  
Cost per DP = £1  

LA2:  
People receiving DP's = 1000  
Budget for DP's = £10,000  
Cost per DP = £10  

If the indicator includes one off Direct Payments, there is an incentive to provide an increasing number of small payments for services such as OT equipment. This does not necessarily advance the agenda for self directed care. 

a. Carers receiving Direct Payment will be double counted in this indicator and NI135. 

b. Separate measure for Carer's on DP/IB, but using same definition

**Q3. Will Technical Definitions work in practice?**

If the new indicator is measured throughout the year it could lead to possible over inflated figures i.e. a local authority could provided higher than average results through a large number of small one off direct payments. Further information required on how carers data will be obtained, current RAP proformas used to count direct payment exclude services provided to carers.

**Q6. Any other Comments?**

The developments that Birmingham are making with regard to self directed care cannot be linked to the proposed indicators due to lack of clarity. We will need specific guidance in relation to the points that assessment start and end and services are delivered within this new framework. There must be at least one decimal place for this PI result.

I am dubious that 2009 will see the full implementation of Individual Budgets nationally, bearing in mind that the reports from pilots are just starting to emerge. We are also concerned that the ability of software houses to write systems which will sufficiently satisfy financial control. Need clarification about one-off DP. 

Denominator should be a needs weighted population, as N136; or the denominator should changed back to its original form, i.e. number of people supported to live independently (thus to make the indicator itself the % of people getting services who get self directed support).

RAP C51  
BUT to include Individual budgets  
How do we record IB?? Presumably it’s another Care Item like a DP BUT with a variable cost against it  
Assume in later years that In Control and similar projects will be included  
The inclusion of carers, and changing from a snapshot to a full period, are welcomed  
Will DPs for carers be included? Can we also count them for NI 135 as they will certainly be receiving services just in the DP way.  

Systems changes will be required in order to support individual budgets. Recording of sexual orientation could pose problems as service users are likely to see this as irrelevant to the care packages that the LA is providing. Definitions would need to be tightened to ensure local authorities do not count one-off payments in their calculations.
It includes carers which were specifically excluded from the previous direct payments indicator so presumably it will need to take information from the carers section of RAP as well as P2s. We feel this definition has been improved as it relates to people who received support throughout the year, not just on a snapshot date.

Note: Many LA's will only be reporting on Direct Payments as Individualised Budgets are not widely implemented as yet. Work would be needed to ensure collection of IB information is part of the implementation plans for IB.

Welcome the inclusion of one-off Direct Payments, if these are now to be counted in this indicator. Direct Payments are comprised of social care funding only, while Individual Budgets may comprise funding from a number of sources, which should perhaps be reflected in the overall title? There is no clear indication of how Self Directed Support might be defined, only that it includes DPS and IBs, if all clients receive an IB then all would be receiving SDS?

**NI 131: Delayed transfers of care from hospitals**

**Q1. Is the Technical Definition of this indicator clear?**

Although this definition is clear for LAs, PCTs measure something similar but not quite the same: the two need to be harmonized so both are working to the same outcomes.

There need to be clear, agreed, protocols about how the 'ready for discharge' decision is made. A "Clinical Decision" this phrase may be open to misinterpretation.

Does it cover all delays, regardless of responsibility?

The indicator doesn't specify whether the indicator counts acute and/or non-acute delays.

Doesn't specify what types of hospital discharges are included. Are community based hospitals to be included in this indicator?

Need to state clearly that PI relates to both delays due to NHS and delays due to social care.

Needs to specify that the indicator is now counting Acute and non-acute delays (as reported on STEIS).

We also need a clear definition of what type of beds are acute and what type of beds are non-acute.

Doesn't detail which types of hospital discharges are included [e.g.: is the current indicator extended to include community hospitals or specialist MH hospitals].

It is unclear whether this Indicator is to include community based hospitals, or whether it is just acute hospitals. Given the move to opening more community hospitals, this might be a more realistic reflection of the care sector and how long people are being delayed in hospital.

Is this the same as the current D41 Delayed Transfers of Care - please clarify.

The Rationale refers to measuring 'the ability of the whole system…' Is the intention therefore to begin reporting on both acute AND non-acute DToC? This needs to be clarified.

**Q2. Does the Technical Definition for this indicator have any unintended consequences?**

Does not take into account the length of time that people have been delayed. Hence an authority might have a lot of people delayed for a short period of time and appear to be performing worse than one that has fewer people who wait for a long time.

The addition of non-acute delays will make historical comparisons impossible.

Could conflict with developments around providing care closer to home – re-design of Community Hospital services.

The indicator does not capture information on how long people have been delayed. I.e. an authority may have a high number of delayed transfer of care, as there are a high number of people delayed for a short period of time; as opposed to an authority who has fewer delayed transfers of care but for far longer periods of time.

Easily misunderstood by Patient Groups.

A number of indicators and this is one of them depends heavily on ONS mid-year population estimates this does have the impact of changing the estimated end of year returns after
submission and makes it difficult to predict performance. See 1 above. Clarity of definition is needed. It is also necessary to recognise that the measure is dependent on available hospital beds in the authority, and will be skewed by this. Possibly - if non-acute delays are included in the indicator then this will increase pressures on Adult Social Care and Health services to clear these beds. Resources to do so would likely have to be increased, which would come with a financial burden. The reporting of acute bed delayed transfers of care did however drive performance improvements, so if correctly implemented and in a timely fashion, there may be a benefit to be seen from changing the indicator.

**Q3. Will Technical Definitions work in practice?**

Yes, but only as long as health partners are using the same measure

Need to state clearly that PI relates to both: delays due to NHS and delays due to social care

North Somerset has no access to ‘STEIS’ - nor does UNIFY2 appear to work and we no way of checking the quality of data entered

Clarity of definition and caveats as mentioned previously need to be taken into account.

**Q4. Is indicator defined at the right spatial level?**

Does it cover PCT or Council boundary?

Adding the whole population in the denominator may cause misleading outturns, as the majority of delays are for people over the age of 65. Should the indicator be split by age group?

Coterminosity with our health colleagues largely removes spatial considerations for this LA

Possibly be extended to all categories of hospital

The change with this indicator is that it is now proposed to cover all the adult population in terms of numerator and denominator. The end result could be misleading given that by far the majority of relevant situation will relate to older people and the PI could be distorted by the 18-64 population.

Better to split 18-64 and 65+ or stick with 65+ as at present.

**Q6. Any other Comments?**

This is a negative indicator. It would be clearer if as many indicators as possible could be positive. Although it is right that health & social care should both be, jointly, responsible for delays this will be undermined if health are judged on an indicator which only picks up delays for health reasons

How robust is STEISS? Will LA’s be able to agree data, prior to submission onto STEISS?

This is a negative indicator.

Recording of sexual orientation could pose problems as service users are likely to see this as irrelevant to the care packing that the authority is providing.

Should still be possible to disaggregate between agency at fault and the reasons for delay.

CSCI no longer seem to receive this information monthly, so it may be that it is only available annually. If this is the case then it will be difficult to know how we are doing during the year.

There should be Evidence or validation on STEIS that councils have agreed to all the delays reported.

Numerator - change in definition will adversely affect this LA's reported success rate as it substantially broadens the number of bed types eligible. Denominator - possible counter balancing effect will be felt as the population count will increase. Figures will not be comparable between the previous indicator and the new one.

Not sure how data from all hospitals will be picked up in a timely manner and whether local variations in the interpretation of the guidance will have an impact.

N Somerset has been quoted a cost of £1535.13 connection charge with monthly maintenance charge of £105 for access to STEIS. CSCI used to provide a monthly report for free. This gave the opportunity to check data.

Recent inability of Councils to access STEIS system has undermined the value of this indicator.

It is unclear whether this Indicator is to include community based hospitals, or whether it is just acute hospitals. Given the move to opening more community hospitals, this might be a more realistic reflection of the care sector and how long people are being delayed in hospital.
**NI 132: Timeliness of social care assessment**

**Q1. Is the Technical Definition of this indicator clear?**

How do we deal with the issue of self assessment. The indicator does not take into account the point at which assessment should end for these clients. Will we need to say to service users that they have 28 days to complete their self assessment so that we adhere to the PI requirements?

An indication was previously given that this indicator definition was being extended from the existing over 65 PI, to all adults. The definition of this indicator does not give an age banding, suggesting that it is all adults, whereas its partner indicator NI 133 is defined as over 65 only. Clarification and consistency on this would be useful.

The data source does not specify which RAP forms will be used.

The current indicator is in two parts - first contact to assessment start, and completion of assessment. It would be useful to clarify whether the first part is definitely being dropped as implied by the definition.

What age band does the indicator cover, it states “new clients” is that 18+? or 65+?

As part of the self determined service process can involve clients assessing themselves and arranging the provision of their care, this initiative can militate against quick assessment and provision of service to vulnerable people. As we are saying to clients that they should be assessing themselves, our score against NI 132 is likely to deteriorate as this indicator aims to measure quick assessment of clients. NI 133 might deteriorate also if the process of setting up DP is delayed by clients, because this indicator aims to measure quick provision of all parts of a care plan. The clients who self-assess and take direct payments are not compelled to act quickly as such. The technical definitions should recognise this contradiction.

Doesn’t consider the self assessment process, would an authority get penalised if a client takes more than 28 days to complete their self assessment?

Clarification required does the indicator now include 18-64 and 65+?

Clarification required has D55 part (i) been deleted from this new indicator?

The worked example doesn't make sense. The numerator looks at all clients whose assessment has been completed within 28 days. The denominator however only counts those clients who have been assessed and provided with a package of care.

Does not specify how a client should be counted if they have more than one assessment event in the year.

First contact: the definition is not clear. When should first contact be measured? Is it the date of the initial referral, or when the authority contacts the client for the first time?

Is completion of assessment measured by the completion of the initial assessment or the whole assessment process?

This is not an existing indicators suggested. The current indicator is in two parts and only applies to older people. It is not clear whether this is i one part or two parts.

Unclear whether under 65s are included in this indicator.

What about cases where

a) Worked example for the denominator should be all new clients assessed?

b) Not to include those with services.

In the worked example the definition for the denominator is different to the one used in the explanation

a. The worked example implies only those clients who go on to receive services should be counted.

b. Assessments completed that may or may not lead to a service? (to be in line with current definition)

Client contacts social services. Is this the first contact? or is the response to the client from Social services the first contact?

Unclear whether existing D55 indicator has been extended to include 18-64 age groups.

Trying to pin down processes which are in reality ongoing and multi-disciplinary, is a fraught process, and services are often put in before assessment processes are complete to avoid user distress and delay. There needs to be more clarity about whether we are identifying all assessments or the initial/ contact
assessment process? In the infancy of IB pilots, the assessment process takes longer to complete (e.g. when a self assessment), plus a RAS covers different aspects; which is no bad thing for customers but will look poor in terms of performance.

There is no clear definition of ‘first contact’.

In the formula, \( Y = \) total no of new clients contacted, whilst \( X = \) new clients contacted who are assessed within 4 weeks. Not all of those in \( Y \) will have gone on to have an assessment. Should \( Y \) be total new clients contacted who had an assessment completed?

Worked example changes halfway from timeliness of assessment to timeliness of care packages

The definition makes reference to ‘new clients’, does this mean both service users and carers?

a. In the worked example, the denominator counts new clients whose assessment was completed and who went on to receive all services. How about those assessments completed but no services was offered?

b. Denominator should all assessments completed within the year

Q2. Does the Technical Definition for this indicator have any unintended consequences?

Focus of the PI is on speed of assessment as opposed to the quality of the assessment.

For some services such as Mental Health the assessment process is of necessity an ongoing relationship throughout the whole support process.

May militate against NI 130

Looks at the speed of the assessment not the quality

The new indicator takes away the LAs incentive to contact clients within 48 hours as this is no longer part of the measure.

Measure is from first contact to completion. This creates a perverse incentive not too contact a client immediately. A client could sit on a waiting list for 2 years and then receive a first contact

Could encourage LA’s to minimise the number of new clients - to manage down the denominator

With the current indicator the clock starts at the time the person contacts us; for the new indicator it start when we contact them and undermines all of the work we have done to improve the timeliness of our response.

a. This claims to be an existing indicator but in the newly stated form what would be the incentive to respond quickly?

b. Clarify first contact

Does not match with next indicator NI 133 - NI 132 counts all ages 18-64, NI 133 counts only people aged 65+

a. Missing the 48 hour component from the existing PAF D55 PI. This is an important measure of early contact with the service user

b. Yes - include this element

By being derived from the RAP, which is a statutory return based on the components of Care Management; for authorities moving towards a process of Self Directed Support, the timeframes for assessment are very different e.g. the control the ‘CSSR’ has over the Self Assessment Process, which rightly is defined around what the customer wants and when s/he wants it. Likewise the parameters of service delivery under SDS are different, as they are not commissioned by a statutory provider but arranged alongside the customer through a range of delivery options external to the statutory body.

LA’s can improve reported performance by manipulation of the concept of ‘first contact’.

If the assessment is never fully put in place it is not registered as a negative on this indicator.

Q3. Will Technical Definitions work in practice?

Because the mental health assessment process follows a different time-line, accurate figures will be difficult to obtain

The numerator and denominator relate to different data populations.

The indicator relates to different populations. The numerator relates to completed assessments within 4
weeks, the denominator relates to all contacts with clients. A contact made may not lead to assessment or the assessment is terminated. This will lower performance - not a true measure

**Q4. Is indicator defined at the right spatial level?**
Coterminosity with our health colleagues largely removes spatial considerations for this LA

**Q6. Any other Comments?**
Why has the requirement to start assessments with 48 hours been taken out of the performance indicator? This is a development of D55 and is already collected on RAP.
The extension of the indicator to 18-64s is welcomed but will lead to difficulties with MH data
If this is a key NI we would like better access to STEIS to monitor progress and take action as necessary.
The NI should measure delays due to the NHS as well as CASSRs
The worked example appears incorrect.
Recording of sexual orientation could pose problems as service users are likely to see this as irrelevant to the care packing that the authority is providing.
Need to ensure that all local authorities comply to the definitions and ensure that all services are included (including Occupational Therapists). Need to also clarify what age group or service area the performance indicator relates to.
Agree with existing comments
The current definition (Of PAF D55(ii)) reads: ‘of the cases where assessment has been completed in the period, the percentage completed within 28 days’. This would be more suitable.
The definition for PAF D55 works well and we would recommend keeping this definition but to report performance for all age groups.

The worked example in the form appears to be incorrect as it relates to care packages
No 5. Is difficult for LA’s with a very low level of ethnicity as outcomes are super sensitive to small changes.
132 is stated as an existing indicator - presumably D55 which makes no mention of assessments leading to services.
This indicator takes no account of complex specialist assessments
Further thought should be given on the relevance and definition of this indicator to the Self Directed Support process.
Definition shows that this is an existing indicator whereas it is not. The definition has changed substantially, leaving out the current part (a) - contact in 2 days and now covers all service user groups not just older people.
Recording of ‘sexual orientation’ is highly problematic and is often viewed as ‘irrelevant’ or ‘intrusive’ by service users. This has been raised with the Information Centre by SIGASC and national research and guidance is required.

There are two proposed changes – one is to extend the indicator to cover 18-64 year olds as well as the 65+ covered at present, which I don’t think we have an issue with. The second is that whereas at the moment the indicator is an average of the % of assessments started within 2 days and the % completed within 28 days, the new indicator is only taking the second element. We think it should still be the average of the two.

**NI 133: Timeliness of social care packages**

**Q1. Is the Technical Definition of this indicator clear?**
Need clarity with regard to the point of measurement for those who opt for self directed care. The key points need to be mapped in relation to NI 132 so we are clear for those people who take all or some of the route through self assessment and self directed care.
An indication was previously given that this indicator definition was being extended from the existing over
65 PI, to all adults. The definition of this indicator gives an age banding of over 65, whereas its partner indicator NI 132 has an undefined age banding. Clarification and consistency on this would be useful.

The data source does not specify which RAP forms will be used.

Assuming that N132 refers to 18+, the definition for this indicator states new clients aged 65+ - not consistent with N132?

As part of the self determined service process can involve clients assessing themselves and arranging the provision of their care, this initiative can militate against quick assessment and provision of services to vulnerable people. As we are saying to clients that they should be assessing themselves, our score against NI 132 is likely to deteriorate as this indicator aims to measure quick assessment of clients. NI 133 might deteriorate also if the process of setting up DP is delayed by clients, because this indicator aims to measure quick provision of all parts of a care plan. The clients who self-assess and take direct payments are not compelled to act quickly as such. The technical definitions should recognise this contradiction.

Unclear why the indicator 132 has been expanded to capture 18-64 and this indicator remains as just a 65+ PI.

The numerator states the age group of 65+ but the denominator does not mention the age group. Why is this indicator just measuring the over 65's rather than all age groups as in the complementary indicator on waiting times for assessments?

Further clarification on how self directed support would be measured is required.

Need consistency with NI 132 as the age band in 132 is unclear.

Not in terms of Self Directed support timelines as this in itself has not been defined.

The definition and part X of formula refer to only those aged 65+, however part Y does not specify an age group. The definition makes reference to ‘new clients’, does this mean both service users and carers?

Q2. Does the Technical Definition for this indicator have any unintended consequences?

Where service being provided is professional support e.g. for Mental Health Clients there is no completion date for delivery of service until they are discharged.

It may work against NI 130

Unclear why the indicator 132 has been expanded to capture 18-64 and this indicator remains as just a 65+ PI.

If a service in a care package is never put in place it will never count as a negative, the only negatives captured are when a service goes in after 28 days.

If age groups are not consistent for 132 and 133 it will be difficult to make effective use of these indicators.

It will make for confusion with NI 132, in that this one appears restricted to over 65's but the assessment one does not.

As some CSSRs are moving away from a care package approach there will be an uneven playing field for activity under this indicator, and e.g. it is unclear when a service would start under a system of Self Directed Care. The definition does not accommodate a multi-care/sector approach where the services are not commissioned by the statutory body. Under the RAP too much premium is placed on the last service delivered, even if it is by no means the most relevant to the user.

The linkage with NI 132 is now severed by this PI relating only to the over 65 population. Should the definition of this PI be changed to be consistent?

If the package is never fully put in place it is not registered as a negative on this indicator.

This indicator could encourage organisations to concentrate on those service users included in the indicator rather than those who are in greatest need.

This indicator does not take account of the quality of the care put in place.

Q3. Will Technical Definitions work in practice?

If the points raised above are clarified and made explicit within the guidance
Yes, if clarification is given on the above

**Q6. Any other Comments?**

The developments that Birmingham are making with regard to self directed care cannot be linked to the proposed indicators due to lack of clarity. We will need specific guidance in relation to the points that assessment start and end and services are delivered within this new framework.

This is a development of D56 but is only partially (i.e. 65 and over) currently collected on RAP.

There seems little reason not to include 18-64s in this indicator.

Data quality checks to see if the service intended was actually provided at the right time make this a very time consuming PI for our Council at present. Extending it to under 65s would mean considerable extra resources to produce. We welcome the restriction to 65+s at present as it is consistent with NI 125 (but might welcome extension of both in future after the burden of the new NIs has been assessed).

Recording of sexual orientation could pose problems as service users are likely to see this as irrelevant to the care packing that the authority is providing.

As this is a continuing performance indicator no problems are anticipated.

I query the rationale for having 132 and 133 measuring different client groups, when they appear (to the untrained eye) to be complementary for the same cohort.

Expanding this indicator to all age groups should be considered to bring it in line with the waiting times for assessment indicator.

No 5. Is difficult for LA’s with a very low level of ethnicity as outcomes are super sensitive to small changes.

Unlike NI 132, this indicator appears to be limited to older people, aged 65+. This is inconsistent with the wider scope of NI 132.

Some residual concerns about the difference between ‘actually delivered’ and ‘intention to deliver’.

All services subject to ‘intention’ rule should be unambiguously defined and specified. i.e. Suppose the care plans specifies a range of services to be provided (Home Care, Day Care, Meals) but none delivered as:

(i) The persons first service is a 6-week residential rehabilitation service.
(ii) The person is on holiday for 5 weeks.

**NI 135: Carers receiving needs assessment or review and a specific carer’s service, or advice and information**

**Q1. Is the Technical Definition of this indicator clear?**

The RAP guidance makes this clear rather than the indicator definition. The definition says that carers services are only counted if they have received an assessment or a review during the year. This is different to the rule used for clients helped to live at home (who are counted regardless of whether they have been reviewed during the year). Is this stipulation re: carers’ services intended to continue for the new indicator?

We will need to be sure that authorities are defining ‘information and advice’ in a consistent manner. To this end, some firming up of the RAP guidance may be worthwhile.

Does not specify which form in the RAP return this relates to. Does not specify if this replaces or is an amendment to RAP form C2.

If carers are also to be included in NI 130 (Direct Payments), these services will be counted twice - is this the intention?

Need clarification of definition - carers to be assessed for advice/information – if just given a leaflet, then excluded?

All authorities need to count information and advice in an appropriate manner; firm guidance is therefore needed on information and advice.

There is no clarity on 'service specifically for the carer' what if the service benefits both the client and the carer?

Does the indicator include carers of people under the age of 18?
Need a clear definition of what constitutes information and advice. The phrasing of the title and the definition are inconsistent and the ambiguity of ‘or advice and information’ leaves the indicator open to wide-ranging interpretation.

a. What is the threshold for advice and information?

b. Lack of distinction between benefit of ‘carer’ and ‘cared for’ is currently a difficult and rather arbitrary decision to make (for C62, which this is merely an extension of), so it would be helpful if we could count all services to carers.

Needs clarity of definition of ‘Advice and Information’

Further clarification of what constitutes sort of advice is required to count in this indicator

It is hard to see how anyone could do a carers assessment or review and not give information or advice so all carers assessments & reviews will be “hits”

Q2. Does the Technical Definition for this indicator have any unintended consequences?

The danger of adding in the information and advice is that people can in effect offer this instead of a carers break service and still do well on the PI. Possibly double counting - see above.

The information from a SPECIFIC Carers’ Advice Service will not pick up all advice, e.g. advice given to carers at general Advice Centres or given directly by Professional staff.

Inclusion of advice & information in indicator may encourage mail outs of basic information packs for all carers and not stimulate the other, potentially more supportive, carer services

Including ‘information & advice’ is tantamount to counting all carers assessed or reviewed. Only measures carers identified & supported via social care – what about health-supported carers?

It might be possible to maximise the result by giving everyone a leaflet and calling it ‘info and advice’. If the intention is to get the highest number this would help, but it might not distinguish between ‘real’ personalised and often expensive services for a carer and a piece of paper

Local Authorities will apply wide ranging interpretations resulting in an inability to benchmark.

There is a danger that authorities can offer very little specific carer services but still perform well in this indicator because of the inclusion of information and advice.

Why are assessments and reviews included? Couldn’t the same methodology be used as service users and just count new clients in this PI.

The definition is still based on RAP and excludes the majority of services that are provided through the voluntary sector without coming through adult social care.

If we count information and advice then virtually all carers will receive this, resulting in 100% carers receiving carers services which is not very helpful.

Authorities may become complacent about providing other carers services

The indicator appears to encourage LAs to provide more Carers with Information and Advice in order to improve performance in this indicator. It is unlikely that any assessment or review would not result in the giving of advice or information.

a. a target could be deemed to be achieved if Carers rings the council and receives a leaflet/sign-posting to another service ie they have received advice/information

b. tighten the title of the indicator to ‘Carers receiving needs assessment or review and a specific carer’s advice and information service’

Creates a disincentive to actually provide actual support services to carers as information and advice is included, which can be vague.

a) Information and advice not currently/reliably collected.

b) a return to the C62 definition of the numerator

(a) The inclusion of ‘information’ virtually guarantees 100% of carers will have carers services.

(b) The denominator is fundamentally flawed as there is no good evidence to suggest that there is a fixed relationship between the number of carers identified and the number of recipients of community based services. This is likely to vary widely as a consequence of demography. e.g. A retirement area will have high numbers of service users, but low numbers of carers.

Research is needed on the special distribution of carers and performance measures weighted accordingly.

(c) The conflation of assessments and reviews is not helpful and reported performance will be affected by the reviewing practice of LA’s. It would be better to adopt a similar methodology just based on new
assessments. Including reviews simply adds a complexity which makes clear interpretation of this indicator highly problematic.

By including advice as a service the argument could be made that any advice given however little is a positive contribution to this indicator. In effect if a small amount of advice is given at the time of assessment or review would mean that in reality there is no separate service for the carer merely an assessment or review.

Alternatively sending out a single leaflet once a year would be counted, this does not appear to drive forward real improvements in Carers services.

a. Nearly all, if not all, carer assessments or review will receive some form of information or advice.

If this definition were to be implemented, all carer assessments/reviews might be construed as services provided.

b. Be more specific about definition for 'information or advice', such as advice/info leading to a service provided by third sector etc.

It does not include parent carers, that is carers where the person cared for is under 18. This group is not well cared for nationally and should be the focus of more attention and it’s a shame the problem hasn’t been flagged up for attention.

**Q3. Will Technical Definitions work in practice?**

Not without clarification of guidance.

The advice or information will not all be delivered from a specific Carers' Service.

Possibility of double counting

There is no standardisation included although there is information available in the census to identify the number of carers in each Local Authority area.

See number 2

Because all assessments & reviews result in the provision of advice & information. On the other hand at least we do not need to ask staff to work out whether the services we do provide are for the benefit of the service user or the carer – when most services benefit both and often carers are service users in their own right.

**Q6. Any other Comments?**

Aren't we encouraging CSSRs to just provide information as opposed to 'real' services for carers by including the advice and information element?

As regards question 5, it is useful to break this indicator down by the characteristics of both the carer and the cared-for person. Breakdowns by ages and RAP code of the cared-for person are currently included in RAP C1 and C2, but it would be interesting to expand upon this, as suggested above.

This is a development of C62.

Ethnicity & age of person cared for are collected in RAP.

Virtually all carers which are assessed or reviewed will be given advice/information.

RAP C62 to Include Info and advice

No of Carers Assessed where: Outcome Is services/Info advice; Carer Service provided (from provisions - carer Grant or Respite)

Report - Have all clients with Respite: (1) got a carer recorded and (2) got a carer assessment completed this year?

What about carers’ services funded through grants and not necessarily accessed via a review or assessment. This indicator misses out a huge swathe of carers who are not known to councils

The indicator (particularly with information & advice included) does not measure the impact on carers.

This indicator will not include carer’s services that are not accessed by the assessment provided by the voluntary sector who are funded by CSSR grants.

Recording of sexual orientation could pose problems as service users are likely to see this as irrelevant to the care packing that the authority is providing.
Definition would need to consider services provided through the voluntary sector without going through a formal assessment from adult social care - otherwise the PI could reflect differences in the ways services are provided than differences in real performance. Revised RAP guidance may clear this area up.

I would urge clarity in the definition of what counts as the various service types, and the definition of to minimise the risk of divergent practice (and apparent performance) between LAs. The current performance indicator, PAF C62 works well and would recommend keeping this definition.

Internal - additional information needed in Swift associated training.

Guidance says this is a new indicator. The data appears to be the same as already captured on RAP which means it is a revised indicator rather than a new one.

This is an extremely difficult indicator and there are a few problems that we would like to see some resolution on before escalating this into the national set. For instance there isn’t a clear concise description around what is or isn’t a carers service. With capturing the work undertaken with carers by other organisation (how do we avoid double counting and tackle difficulties around sharing client information). Having to make an artificial decision around ‘who benefits for a service that both the cared for and carer receive’ is basically a flawed approach.

Welcome the inclusion of information and advice services into this measure.

**NI 136: People supported to live independently through social services (all ages)**

**Q1. Is the Technical Definition of this indicator clear?**

a. Need to ensure that all authorities are interpreting the Grant Funded Services guidance in the same way. At present, we feel that the guidance is open to various interpretations, which could render comparisons between different authorities’ figures unreliable.

b. A further exercise, such as that undertaken last year to analyse authorities’ interpretations of the guidance and use this as the basis for improvements to the guidance document, would be beneficial.

Unclear definition - need resolution on delegated Mental Health assessments, for which current guidance is still contradictory - this has an impact on statutory returns and makes it difficult to compare data between authorities.

Need to clarify that carers identified in GFS1 should not be included.

The existing C29-32 are problematic as a meaningful measure. The GFS is a new collection and different authorities or agencies may be interpreting guidance in different ways. Its use may be unreliable particularly as the issue of double counting has not been addressed

How would this relate to other “service” indicators e.g. care plans, reviews when they are not formally recognised as an open case on our database?

The GFS return is open to various interpretations which will lead to discrepancies across authorities. Unclear if this indicator is based on cumulative snapshot data.

Can services provided by supporting people be counted in this indicator?

Not clear whether it is a snapshot as at 31st march or people receiving a service through the year

Potential for double counting between RAP and GFS1 data.

Will any mechanisms be introduced to prevent double-counting of people who receive a council service and a grant-funded service (implication that we need to start collecting the names of grant-funded places thus increasing the administrative burden)?

Does the grant funding have to come from the Adult Social Services budget or can we count people who benefit from the council’s wider grants programme (implication that we can start to include luncheon clubs and other low-cost, high volume placements). This may need to trigger a change in the council’s policy on grant allocation.

a) The definition appears unfinished. The treatment of double counting across RAP and GFS1 clients, and for GFS1 clients in different LA’s needs to be addressed

b) Exclude Grant Funded services, i.e. only include cases fully care managed by the LA.

Does the indicator relate to people supported on a snapshot date or throughout the year? (we would like to see throughout the year)

Calculation is very complicated, will it make sense to the public?

Unclear whether this captures a cumulative figure for the entire year, or is a snapshot at a given date.
Q2. Does the Technical Definition for this indicator have any unintended consequences?

The two cohorts of data are not mutually exclusive, i.e. some funded via grants may also be clients on our database, resulting in double counting. Estimated 20% from Grant Funded Services Return could be double counted if added to RAP output.

It may be necessary to use a separate database rather than relying on monitoring forms from Grant-Funded organisations.

By excluding people supported by core/infrastructure funding there is a danger that authorities will be motivated to move that funding to specific person-centred support.

The indicator misses those services which are neither care-managed nor provided by voluntary organizations.

There is potential to miss people receiving services through GFS organisations. Is it only people we direct/refer to GFS or do we include those who self present as well?

Q2. Does the Technical Definition for this indicator have any unintended consequences?

The strong possible of double counting between the RAP and GFS returns and therefore undermines the integrity of the indicator.

The indicator could lead to authorities providing smaller grants to more organisations in order just to improve performance.

It will lead to double counting on a large scale. If this indicator still includes professional support it is meaningless because authorities measure this component very differently. This indicator still does not address the need to count people supported to live at home through provision of equipment.

Discourages LAs from trying to eliminate double counting within GFS1. Combining the four existing helped to live at home indicators could result in LAs commissioning lower level services which reach a wider group of people rather than focusing on clients with more intense needs.

Could encourage dependence on the council or affiliated voluntary sector organisations

a) If an LA's performance is low, they could pay £1 to any organisation so as to include their activity.

b) Set a threshold for the level of grant required to be allowable as CSSR support

a) Excessive recording requirements on vol orgs may discourage them from receiving grants from local Gov't. Thus reducing service availability.

b) With the use of the need weighted population figures are grant funded data necessary?

a) 1. Difficult or explain to the providers of grant funded services 2. GSFI subject to double counting both internally and with the RAP 3. Grant funded organisations struggle with the current GFS1 in terms of supplying data.

b) Resolve double counting issues and work with grant funded organisations to develop collection methods

Will not show if disparity exists amongst client groups as all groups put together - no idea whether an area is serving one group better than another with this indicator just a generalisation. Avoid by splitting the client groups

The double counting and care level issues (high and low level care differing between councils) could give rise to not comparing like with like.

There is already concern about the quality of information collected through the GFS1 return.

Councils have not yet been able to write into their contracts/agreements the requirement for organisations to return the information requested and therefore not all organisation return accurate data.

There are issues around collecting information in relation to services that provide drop in or telephone line services. It is not possible to identify the number of individuals receiving these services.

The amount of duplication possible undermines the integrity of this indicators.

An incentive would be produced to provide an increased number of small grants to an increased number of organisations in order to secure higher numbers despite the fact that this may not be the most effective intervention.
As mentioned in the definition document, there are issues of double counting for those assessed for service and those receiving a grant-funded service, plus within grant-funded services.

**Q3. Will Technical Definitions work in practice?**

As acknowledged in the draft guidance, the issue of double counting is a major factor. At present, we do not see how we can avoid double counting of people between datasets. Grant Funded organisations are required only to provide a headline figure for the GFS1 return. A full list of people receiving a service during the sample week would be necessary to rule out double counting, preferably with inclusion of a shared unique identifier e.g. NHS number or NI number. In the absence of a unique identifier, significant time must be spent undertaking data matching between datasets to identify and correct for any people appearing on more than one dataset.

Requesting collation of a unique identifier may be problematic where people who require ongoing support prefer to access this in an informal manner, or where people cannot recollect their NHS or NI numbers.

It is unclear how the RAP and GSFR data will be amalgamated.

The GFS collection is not frequent enough or detailed enough (Missing person data to prevent double counting) – but asking smaller vol orgs for more data may stretch their resources - & have information sharing/ consent implications. The GFS collection is not frequent enough or detailed enough (Missing person data to prevent double counting) – but asking smaller vol orgs for more data may stretch their resources - & have information sharing/ consent implications.

Double counting and interpretation by agencies in GFS is a major problem and could skew results. Dependent upon the capacity of the Voluntary Sector to provide robust information.

By merging 2 returns together it will be impossible to avoid double counting.

Since the Grant Funded Services is a relatively new return further work needs to carried out to ensure compliance and common understandings of services that should and should not be included.

The indicator is essentially a numerical count which does not address the quality of support for independent living. It is difficult to see how this will ‘signal the importance of cost - effective’ etc approaches as stated in the rationale to either practitioners or more importantly citizens of areas.

The indicator is essentially a numerical count which does not address the quality of support for independent living. It is difficult to see how this will ‘signal the importance of cost - effective’ etc approaches as stated in the rationale to either practitioners or more importantly citizens of areas.

Response rates for the GFS may well vary enormously thus making cross council comparison meaningless.

Double counting between RAP and grant funded services

Double counting within grant funded services - if client attends more than one service

Cannot link grant funded services to people living in the borough

People if grant funded services may be in residential care e.g. attending a grant funded day care centre

Double counting issues identified within the current GFS1 return

Difficult to avoid duplication and capture data at detail level across the equality strands. Also unclear whether GFS will continue as a weekly snapshot

Data from voluntary orgs does not enable auth to count individuals - double counting will occur and will be extremely difficult to eradicate

Difficulty collating robust data on individuals supported by Grant Funded Organisations, with attendant issues of double counting.

Old RAP (C29-C32) fails to capture the range of services provided beyond care management, but the new grant funded services return does not capture activity and concentrates on the amount of money spent across care sectors. There is a huge resource overhead in avoiding double counting for services to smaller voluntary groups which provide important services but who under the terms of the Compact should not fairly be asked to provide D.O.B etc of their users. Partnership funding with health is not traceable by user activity, it is part of a collective pot and there are not always contract mechanisms to monitor activity.

Double counting will be inevitable.
Q4. Is indicator defined at the right spatial level?
Very difficult to disaggregate. Some voluntary sector partners cover more than one spatial level - difficult to untangle, calculate and prevent double-counting

Q6. Any other Comments?
It is crude and cumbersome to just amalgamate so many flawed indicators - why! Massive issues of consistency of recording and counting and double counting that will need to be addressed for this to be of any value. Bear in mind that this never happened in all the time we had the HTLH Indicators
We are interested by the inclusion of the term 'disability' in question 5 above, and would like to know how you have interpreted this: does it refer to people who are registered disabled, or do you see disability as being self-defined, for example?
We would also be interested in breaking indicators down by client category (e.g. RAP code), rather than disability alone, as factors other than disability can affect a person's need for social care support. These can include mental health issues, substance misuse, and temporary illnesses.

The production of the GFSR is very difficult for two tier authorities which have different routes regarding the provision of grants to assist residents to live independently.
This is a merger and development of C29-32. The difficulty that we envisage is in verifying the return if the Service Users are not on the Authority's Client database.
Age & Ethnicity already collected in RAP. Age groups are collected in GFS1. Getting ethnicity information from other organisations will be difficult and would be an extra burden for them.
How will double counting of service users getting direct provision and services from grant funded organisations be avoided?

Unless needs weighted population numbers are used this will be a worthless indicator.

RAP plus GFS  18+ so C29-32
This will be population based

How do we eliminate double counting between our services and GFS?
Do we need to add a care Item to say that a person is receiving a GFS
List from GFS Providers showing
  Client Name
  Client Address
  Client DOB
  SSD Client Ref n known
To enable matching across to current clients

OR

Allow GFS providers access to add their own provisions to their own clients

NI 145: Adults with learning disabilities in settled accommodation

KS1 - LD client category - as for NI 149
Accommodation types need to be recorded
  Who will define which address types go with which return code
Look at NI 147 which is similar but for Care leavers - can we use the same method of recording?
Does it cover the same people potentially?

Double counting of grant funded services an issue
As stated, double counting (between GFS agencies and between GFS and Care managed services) needs to be addressed. Will the agencies be audited? Who by?
There have been a number of long standing concerns with the existing C29-32 which only measure people on the books on the last day and not the number supported during the year (and is also open to interpretation about what ‘services’ can be counted). Our council still accepts ‘moderate’ cases and taking a
preventive/maximising independence approach means we often provide an enabling service and then close the case. A council which encourages dependency, is less efficient and doesn't close cases would have a much higher score. We would prefer to use P2f rather than P2s to give a truer picture of the number of individuals helped during the year. It would also give a much higher figure of people supported to live at home nationally and help meet the DSO (probably even without the GFS).

Merging data from a snapshot week and a snapshot of people ‘on the books’ on the last day of a year seems strange especially given the problems with both sets of data and the issue of double counting

The indicator requires a need weighted population or it would be worthless. Wasn't the GFS return introduced as a stop gap measure? Recording of sexual orientation could pose problems as service users are likely to see this as irrelevant to the care packing that the authority is providing

With the addition of the Grant Funded Services data it makes it difficult to routinely monitor the performance. There is also the danger that the PI reflects differing FACS levels that are served rather than real performance issues. The guidance issued relating to the GFS requires the capture of people who used a service in a given time frame; RAP requires the capture of people who could use a service. To be accurate and robust, one of these definitions will have to be changed.

Cannot see the usefulness of amalgamating all client groups into one indicator

Will there be any measures around intensive home care to complement this indicator? Need to ensure consistency between councils, particularly around reporting of the GFS1 return

Further more in line with previous comments concerning the mis-match of approaches taken by these indicators and the inspection bodies there is no national indicator that focusses on or includes any element of safeguarding vulnerable adults. This will potentially have the unintended consequence of putting the focus on hitting agreed targets that are process driven and taking it away from developing quality of service.

Removing the Grant Funded element will mean that LA’s are more directly comparable, as I suspect there are SIGNIFICANT differences in the way this would be counted by different authorities.

Given the current limitations of the grant funded services return - not too include this in the definition

Need to work with grant funded organisations to ensure they are able to capture their data effectively. The one aspect of this indicator that is welcomed but is also a concern is the move away from measuring independence by types of clients that gave us a structure around types of vulnerable clients picked up in this measure. The expansion into low level services provided by grant funded services could pick up individuals they support that might not fit one of the traditional client groups that social care would be expected to work with. The way this is worded it doesn’t even put the parameters around the adult being vulnerable. Will Adult Social Care still be expected to provide information by primary service user for the old help to live at home indicator? The issues of double counting from collecting/sharing data across organisations will be the biggest hurdle to tackle. Are we being asked to count a ‘one off’ service provided by a GFS without a formal assessment process or does it need to be an ‘on-going’ service forming part of a package of care? Doing a snap shot week for GFS does not provide a robust set of data – will we need to move to an on-going collection of data throughout the year? Capturing consistent/reliable information is going to be difficult.

The voluntary agencies supply data on numbers not names as for the current GFS survey. The chances of double counting exist. Is the intention to count anyone receiving services through the year or a snapshot? This indicator is reliant on the robustness and currency of the RNF data, which has not been used for this purpose before.

Lack of consistency amongst Grant Funded Organisations over data interpretation and willingness to share data may undermine comparability of local results.

(a) This proposal is far too complex and the resultant indicator value virtually meaningless at local and comparative level. If LA (a) has a score of 0.27 and LA (b) a score of 0.29, what can you conclude? What would good performance be?

(b) The GFS was only introduced as a ‘stop gap’ measure and is nowhere near robust enough to either continue or be used as an ‘add on’ to what is essentially the old C29-C32 indicators.
(c) As with C29-C32, it really fails to take into account the reality of joint working and the contribution that health makes.
Part 2: Health and Social Care interface indicators

**NI 40: Drug users in effective treatment**

**Q3. Will Technical Definitions work in practice?**
Measuring from a baseline will make comparisons between different authorities difficult. How will be good or poor performance be judged. For example, a Council with a high baseline would experience smaller increases, the converse with an authority with a low baseline. Who is performing better?

**Q6. Any other Comments?**
The NDTMS seems to be very unreliable in that data is constantly up-dated because of incorrect entry which affects our understanding of progress towards the target. This PI does not acknowledge its ancestry, but seems to be based on A80. Removes the importance of retention in treatment for the duration of the episode.

**NI 124: People with a long-term condition supported to be independent and in control of their condition**

**Q1. Is the Technical Definition of this indicator clear?**
More details of the Patient Survey are required - how are the patients selected ? is there any guarantee that any of those surveyed will be social care users ?
Clarification on “long term condition”?
Further information is required re :the patient survey; but we have concerns over the interpretation of ADLs - are we to consider 1 as a long term condition ?
Further clarity required on the definition of a long-term condition and what constitutes support. As the further guidance section makes clear there is no guarantee that the questions will be included in the 2007-08 survey: there would be no baseline data to help target setting.
Definition of ‘long term conditions’ not clear. Definition of ‘supported by …’ needs work.
Lack of clarification exactly what constitutes a long term condition and to what degree e.g. asthma.
Lack of clarification on what would constitute ‘support’.

**Q2. Does the Technical Definition for this indicator have any unintended consequences?**
CSSRs are encouraging take up of direct payments and individualized budgets but patients on these may not interpret this as ‘support’ in the context of the survey.
What if the survey respondents say they do not have a longer term condition but answer yes to being supported. This could skew results if included.
Misinterpretation of a long term condition
a) only surveys those known to Primary Care Trust, may exclude people only relying on Social Care.
b) Use the place survey instead.
Does not support expansion of community based, rather than acute support. Lack of clarity of definition would give rise to incomparable meaningless results. Definitions need further thought.

**Q3. Will Technical Definitions work in practice?**
CSSRs are encouraging take up of direct payments and individualized budgets but patients on these may not interpret this as ‘support’ in the context of the survey.
Not sure what the indicator tells us, not a measure of quality, support or impact of services.

Does the person have to receive both health & social care or either/or, if the latter how do we differentiate?
Need to be clearer as to what constitutes a long term condition in terms of ADLs.
As a self-reporting indicator which requires sophisticated understanding of a ‘definition’ of long term condition this indicator would be subject to considerable variation of interpretation.
It appears that we are asking for a volume indicator of people receiving support, or a satisfaction indicator, measuring outcome of that support.

Q4. Is indicator defined at the right spatial level?
Gathering this information from the patient survey will exclude the majority of those people with a long-term condition

Q6. Any other Comments?
As defined this comes from NHS patient survey – may be similar questions should be included in Place Survey
We have concerns about the general low response rates to existing Healthcare Commission surveys and the weight put on them when the response rates are so low.

Unclear how this indicator will capture those individuals receiving social care or community based support, not necessarily within the scope of the Patient survey.
It is not clear whether this might require a question from a user with a LTC at contact stage, or following receipt of a service.
Survey sample size must be large enough to cover equalities strands.

Survey sounds similar to statutory Adult Social Care User Experience Surveys. These are carried out in Feb-Apr each year. Indicator NI 127 will use this social care survey to inform performance.
There is clear overlap between ASC and Health users so when the patient survey is conducted is an issue as we may be duplicating the same survey.

NI 149: Adults in contact with secondary mental health services in settled accommodation

Q1. Is the Technical Definition of this indicator clear?
- The definition talks about people 'known to' the Council, are these just people who have an 'open case' and meet our FACS criteria, or wider than this? It would be difficult for us to collect data on anything other than the current accepted definition of 'on the books'. This needs to be clarified.
Age group just says 18+, does this mean 18-64 or does it include 65+?
- The categories are unclear, no's 2 and 3 are not mutually exclusive as many people will be in accommodation with housing related support, and a tenant in their right - is the issue here whether the accommodation is linked to the support and cannot be occupied if the person no longer needs support? In which case this needs to be clarified.
- The separation of 'Unsettled' and 'Settled' accommodation confuses the return.
- There is no category for, where a person is not a tenant or owner occupier in their own right but living in a partner's home or the family home - this is a common form of accommodation for this client group.
Guidance required on accommodation with varying degrees...
What is 'known to the CSSR'
What if a client is temporarily unsettled?
There is no timeframe mention is it a cumulative figure or at a snapshot?
If a cumulative figure how should a client be counted if they have been both settled and unsettled within the reporting period?
Age group is not clear.
Why is living with family not classed as settled accommodation?
Need to define more clearly what in contact with secondary services means.
Lack of clarity on definition of settled accommodation.
Although the data source for this indicator is the Mental Health Minimum Dataset, it does not contain information on settled accommodation.

Will this indicator only cover those who currently receive a service from the local authority or will anyone known be counted in (implication, we need to keep in touch with people who are not necessarily ‘on the books’) - but who have had an assessment in the past? Will the cut off date by Age 18 - what about transition cases who are being managed by C&F until they are 24?

How often will this data be expected to be updated (will an annual telephone review suffice – does this present an administrative burden?).

Do people have to have employment / accommodation or just at any time within that year?

What evidence is required?

Will the local authority be expected to check the employment for every individual or will a self-classification be adequate?

Clarification on the term 'in contact with' is needed.

Further clarification is required on the definition of 'in contact with'. When will the clients accommodation status need to be recorded and reported i.e. will it be at the point they are being assessed/reviewed, or at a fixed date (31st March) or some other method?

Require clarity on 'in contact' Is this the number of CPA during the year? If yes, does this relate to standard, enhanced or both.

Awaiting guidance of definition of ‘settled accommodation’.

Does living with family count as settled accommodation?

**Q2. Does the Technical Definition for this indicator have any unintended consequences?**

Not sure at the moment.

Depending on the definition 'known to the CSSR' it could encourage dependency rather than independence.

Could reduce the denominator to improve overall performance

New systems and processes would need to be put in place to capture this data

Could encourage seasonal schemes for employment to tick the box?

Lack of clarity around settled accommodation - may prevent comparison

**Q3. Will Technical Definitions work in practice?**

The data source for this indicator is the Mental Health Minimum Data Set, but the MHMDS does not contain information on settled accommodation.

Not as they are - they need to be more clearly defined and include categories to cover all types of situations.

If LAs are monitor this, then some way of tracking MHMDS data will need to be arranged

Too open to interpretation and would need further guidance on how to make the assessment of 'settled accommodation' before further comments can be made.

This will depend on further clarification

Some concerns about the reasons above

This would depend on further clarification for the comments made in response to question 1.

Known to the LA is not the same as supported or receiving services and there are people who are 'known' whom we would not have this level of detail on depends on clarity of guidance

**Q6. Any other Comments?**

This information is not held electronically by the PCT and therefore cannot be reported on by the informatics team. The PCT will review it` s position with regards to setting up a collection method for recording accommodation status outside of the MHMDS in the coming months.

The Data Source is the Key Statistic 1 which has not been agreed at this point, and would not currently collect information to the detail required.

We would need to collect a number of new data sets and the extent of this work would depend on the
ADASS Performance Networks combined response to NIS – (2) Health & Social Care Interface Indicators

comments made in Issue 1.

KS1 - MH client category as for NI 145
Accommodation types need to be recorded
Who will define which address types go with which return code
Look at NI 147 which is similar but for Care leavers - can we use the same method of recording?
Does it cover the same people potentially?
Depending on definition of 'known to the CSSR' this could be intrusive to non clients.
Recording of sexual orientation could pose problems as service users are likely to see this as irrelevant to the care packing that the authority is providing.
I don’t feel that the rationale helps to understand what outcome these are measuring it is therefore difficult to comment on the value of having these as national indicators.
Why is this limited to MH and LD – what not extend to PD and Older People. Collection of data should not be too onerous however having a number of different types of accommodation with uncertain status is not helpful - different interpretations across the country will discredit the reliability of using these as comparative indicators.
Additional reporting burden to extract information on accommodation status across all MH service users.

No major problems except:
(a) More work required on definition of ‘settled accommodation’, specifically in relation to those cases where judgements are to be made by the care worker.
(b) Unless the definition of ‘settled’ is more sharply drawn, then it is likely that all Trusts will achieve close to 100%.

NI 150: Adults in contact with secondary mental health services in employment

Q1. Is the Technical Definition of this indicator clear?
- The definition talks about people ‘known to’ the Council, are these just people who have an 'open case' and meet our FACS criteria, or wider than this? It would be difficult for us to collect data on anything other than the current accepted RAP definition of 'on the books'. This needs to be clarified.
- There is no clear definition of ‘employment’, which is essential to this indicator. Does this relate to 'paid' work only, or something else? All kinds of forms of employment exist and we need to be clear about which should be counted, for example supported employment, voluntary employment, work experience or employment in specific schemes for people with mental health problems.
- Does this relate to clients in residential AND community support?
- Age group is 18 - 69. Is this a typo? It does not link with any other data set, or employment related target [retirement age]?
- How were the hours per week devised? Does it relate to any of the DWP guidelines?

What is ‘known to the CSSR’?
Further definition required for employment. Does it include paid work only? Is casual work counted?
There is no timeframe mention is it a cumulative figure or at a snapshot?

Need to be clear on the definition of in contact with secondary services; does the employment include voluntary work or is it just paid?
Lack of clarity on definition of employment- does it include unpaid and voluntary employment?.

Will this indicator only cover those who currently receive a service from the local authority or will anyone known be counted in (implication, we need to keep in touch with people who are not necessarily 'on the books') - but who have had an assessment in the past? Will the cut off date by Age 18 - what about transition cases who are being managed by C&F until they are 24?
How often will this data be expected to be updated (will an annual telephone review suffice – does this present an administrative burden?).

Do people have to have employment / accommodation or just at any time within that year?
What evidence is required?
Will the local authority be expected to check the employment for every individual or will a self-classification be adequate?
Clarification on the term 'in contact with' is needed. This could be a very narrow definition. Further clarification is required on the definition of 'in contact with'. When will the clients employment status need to be recorded and reported i.e. will it be at the point they are being assessed/reviewed, or at a fixed date (31st March) or some other method? Require clarity on 'in contact' Is this the number of people on CPA during the year? If yes, does this relate to standard, enhanced or both. 1 Unclear whether this includes all paid employment, and excludes voluntary/unpaid work 2 Does this include adults with MH known to CASSR, but not in receipt of any services. There needs to be a clear definition of what constitutes employment or self employment. For example people in supported enterprises. Perhaps employment could relate to being in receipt of a wage of at least the national minimum wage. The definition essentially says that if anyone is working for 1 hour per week (minimum) at or above the minimum wage OR may be working 40 hours per week for no pay for a relative, then this counts as 'employment'. Further thought has to be given to whether this really constitutes or measures 'inclusion'.

Q2. Does the Technical Definition for this indicator have any unintended consequences?

Doesn't fall in line with data collected for Employment-related schemes and so would increase the volume of data collection.

There are likely to be big differences between authorities re who is 'known to' or 'on the books', which will make comparability of data problematic.
Clarification needed on the definition 'known to the CSSR'
Reduce the denominator to improve overall performance
New systems and processes would need to be put in place to capture this data
Could encourage seasonal schemes for employment to tick the box?
   a. If the definition of in contact is narrow partners this may increase inequalities
   b. have a clear definition to cover a wide number of the MH population.

Q3. Will Technical Definitions work in practice?

The data source for this indicator is the Mental Health Minimum Data Set, but the MHMDS does not contain information on employment status.
If LAs are monitor this, then some way of tracking MHMDS data will need to be arranged
Need to be clearer as to what determines 'in contact' with secondary mental health services.
This will depend on further clarification. Although the data source for this indicator is the Mental Health Minimum Dataset, it does not contain information on employment
Some concerns about the reasons above
This would depend on further clarification for the comments made in response to question 1.
The separation of time lines into categories appears to be irrelevant is there another purpose for capturing those time lines (currently our systems do not collect these three time lines).

Q6. Any other Comments?

Although employment status is recorded electronically on our electronic system, it is not mandated and is not routinely collected. If it was reported on it would give a completely inaccurate percentage. The PCT will review it's position with regards to recording this information outside of the MHMDS in the coming months.
The draft states that this is an existing indicator, but we believe it is not. We do not think the Mental health Trust currently collects this data, so are unsure as to where it is thought to be reported.
The worked example uses huge numbers of people which gives the impression that the target group is much higher than it may be.
The Data Source is the Key Statistic 1 which has not been agreed at this point, and would not currently
collect information to the detail required.

We would need to collect a number of new data sets and the extent of this work would depend on the comments made in Issue 1.

KS1 - LD client category - as for NI 146
We do not currently record this against any client
We need some Care Items for Employment
Depending on definition of 'known to the CSSR' this could be intrusive to non clients.
Recording of sexual orientation could pose problems as service users are likely to see this as irrelevant to the care packing that the authority is providing.
Lacks clarity as to why under the definition there are three categories with number of hours of employment per week – this is merged for the formula. Similar issue to NI145/149 why select these two client groups what about PD and Carers?
NI 149 presumably covers any client aged 18 and over. NI 150 age band stated overlaps with standard 65 and over boundary for older people.
What is the status of individuals currently in employment, but on sickness absence due to re-occurrence of MH problems?
Part 3: Social Exclusion

**NI 141: Number of vulnerable people achieving independent living**

**Q2. Does the Technical Definition for this indicator have any unintended consequences?**

- a. By focusing only on service users in the Supporting People regime other vulnerable people are missed out.
- b. Providing a wider definition beyond the supporting people regime

Possibly - there has proven to be confusion in the past regarding the use of the term ‘vulnerable’. In an Adult Social Care setting it refers to the Protection of Vulnerable Adults scheme and links with ‘No Secrets’ and ‘In Safe Hands’. There has proven to be confusion in the past regarding the definition of ‘vulnerable’ and to whom it refers, so using the term across all NIs, but with different intended meanings may lead to further confusion.

**NI 142: Number of vulnerable people who are supported to maintain independent living**

**Q2. Does the Technical Definition for this indicator have any unintended consequences?**

- a. By focusing only on service users in the Supporting People regime other vulnerable people are missed out.
- b. Provide a wider definition of vulnerable people

Possibly - there has proven to be confusion in the past regarding the use of the term ‘vulnerable’. In an Adult Social Care setting it refers to the Protection of Vulnerable Adults scheme and links with ‘No Secrets’ and ‘In Safe Hands’. There has proven to be confusion in the past regarding the definition of ‘vulnerable’ and to whom it refers, so using the term across all NIs, but with different intended meanings may lead to further confusion.

**Q6. Any other Comments?**

It seems strange that while they are now allowing us to include Grant Funded services provided to support vulnerable people to live at home, irrespective of whether they have a care plan and no matter which Dept funds it, they are not allowing us to include services provided by other departments which achieve a similar aim. For example, our leisure services have done a lot of work to make them inclusive for people with learning difficulties. Or work on security measures in the home which has increased older peoples’ confidence to the extent that they felt confident to remain in their own home for longer.

**NI 145: Adults with learning disabilities in settled accommodation**

**Q1. Is the Technical Definition of this indicator clear?**

1. What does 'known to CASSR' mean? Does it just cover open clients of Adult Social Care receiving services or all Plymouth residents identified as having Learning Disabilities? Some services will be provided by Health only to people with Learning Disabilities - are these included?

What about people receiving services from Supporting People?

2. Definitions of settled accommodation - where are people who live in their parent’s home counted? What
about people at college with a parents address?
3. If people are temporarily unsettled, e.g. in hospital or in transit between homes due to a change in circumstances, are they counted as cat. 3 Unsettled?
4. Is this report a snapshot at a certain date? No time frame is mentioned.
5. People in Unsettled accommodation - some of these people could have Learning Disabilities but may not be either clients or on any LD register. Unless their details were recorded (which may be difficult to do in practice) they may be missed off this indicator completely.

- The definition talks about people ‘known to’ the Council, are these just people who have an ‘open case’ and meet our FACS criteria, or wider than this? It would be difficult for us to collect data on anything other than the current accepted definition of ‘on the books’. This needs to be clarified.
- Age group just says 18+, does this mean 18-64 or does it include 65+?
- The categories are unclear, no’s 2 and 3 are not mutually exclusive as many people will be in accommodation with housing related support, and a tenant in their right - is the issue here whether the accommodation is linked to the support and cannot be occupied if the person no longer needs support? In which case this needs to be clarified.
- The separation of 'Unsettled' and 'Settled' accommodation confuses the return.
- There is no category for 'living with family carers', where a person is not a tenant or owner occupier in their own right but living in the family home - this is a common form of accommodation for this client group.

Settled accommodation should included reference to the family home
The definition of “known to the Council” needs to be clarified
There needs to be more guidance on how to decide about accommodation with varying degrees
Will this include just people receiving services during the year, ‘on the books’ or all adults with LD ever known. Since disability registration became voluntary some people may not be ‘known’ or have chosen not to be ‘known’ to services.
Further clarification around judgement on “settled accommodation” would be needed also.

Need greater clarity re what is “known to CASSRs”
As far as I can tell, the information required should be accessible and available form within Housing and Community Care. The only point to clarify would be the definition of settled accommodation.
Is this pertaining to people with learning disabilities who are living in private sector accommodation or does it mean the number of people with a learning disability who are in accommodation other than temporary.
What is 'known to the CSSR' 
What if a client is temporarily unsettled?
There is no timeframe mention is it a cumulative figure or at a snapshot?
If a cumulative figure how should a client be counted if they have been both settled and unsettled within the reporting period?
Age group is not clear.
Why is living with family not classed as settled accommodation?
Concerns over the definition of ‘known to the council’ - this should be clarified. Need further information on the guidance in determining the ‘settled accommodation’ is needed before further comments can be made.

**NI 145: Adults with learning disabilities in settled accommodation**

**Q1. Is the Technical Definition of this indicator clear?**
Further clarity on the definition of who is Known to the CSSR -
Definition lacks clarity. Data will be very difficult to collect. Need to be very clear about who should be included in this indicator.
Will this indicator only cover those who currently receive a service from the local authority or will anyone known be counted in (implication, we need to keep in touch with people who are not necessarily ‘on the books’) - but who have had an assessment in the past? Will the cut off date by Age 18 - what about
transition cases who are being managed by C&F until they are 24?
How often will this data be expected to be updated (will an annual telephone review suffice – does this present an administrative burden?).
Do people have to have employment / accommodation or just at any time within that year?
What evidence is required?
Will the local authority be expected to check the employment for every individual or will a self-classification be adequate?
Clarification on the term 'are known to' is needed.
a. Status of people living at home with their parents (which cover a significant proportion of people with LD) is unclear.
b. Guidance on the period in question would be useful e.g. on 31st March
Further clarification is required on? the definition of 'know to the council'.
When will the clients accommodation status need to be recorded and reported i.e. will it be at the point they are being assessed/reviewed, or at a fixed date (31st March) or some other method?
What does 'known' to the CSSR mean? Are these people known in the borough and who not under care management
What is meant by people known to council with CASSR responsibility? Is it just those known to Social Care or wider?
Awaiting guidance of definition of 'settled accommodation'.
Does living with family count as settled accommodation?
There will need to be a clear understanding of how people who are living at home with family are counted within this P.I. This will be a large group especially of the younger people with learning disabilities.
Further clarity required around the concept of 'being known to CASSRS', especially in relation to Learning Disability clients accessing Supporting People services.
It is unclear what the definition of 'people with learning disabilities known to the Council' is. Does this refer to people receiving and assessment AND being in receipt of services, or does it also apply to people who have been assessed but are not in receipt of services?
It is unclear whether the numerator and denominator refer to a snapshot, or will be a full year figure. This needs to be clarified.
It is mentioned that further guidance will be provided for sub-dividing 'varying degrees of tenure' into settled/unsettled. This too needs to be clarified.

Q2. Does the Technical Definition for this indicator have any unintended consequences?
Not sure at the moment.
Interpretation of settled/unsettled as relates to category 2 could lead to significant variances between local authorities.
Depending on the definition 'known to the CSSR' it could encourage dependency rather than independence.
Could mean the LAs are encouraged to use inappropriate accommodation to ensure good performance.
This will require new systems and processes to capture this information
Encourages LAs to have fewer people 'known' to them.
Could encourage seasonal schemes for employment to tick the box?
With good performance being shown by increasing percentages and hospitals / long stay / residential facilities included in the count there is a tension with the ambition of securing greater independence and leaving people in hospital/residential facilities.
Suggest that the 4 bullet points currently in section 2 of the definition are redistributed as follows.
Bullet 1 moved to section 3;
bullet 2 moved to section 1
bullet 3 moved to section 1
bullet 4 moved to section 1.
Using a calculation method of clients 'known' to the council could encourage a situation where service users become dependent rather than independent
How do people become 'known'. Are people in settled accommodation more likely to be 'known' than those who are not. All depends on definition.
Requires LA's to hold and collect greater amounts of personal information from the LD service users than is currently the practice. Collection, front line training implications.
There is an incentive to have fewer known to CSSR to reduce the indicator and improve performance.

Q3. Will Technical Definitions work in practice?
The current guidance is not specific enough. Councils would interpret the definition in different ways making comparisons across councils invalid.
Information on accommodation is not currently collected or available unless Plymouth CC funds it.
Not as they are - they need to be more clearly defined and include categories to cover all types of situations.
The definition of “known to the Council” needs to be clarified.
There needs to be more guidance on how to decide about accommodation with varying degrees would work with clarification on interpretation.
See answers from previous questions.
As it stands, the PI will not work - further guidance is required on determining ‘settled accommodation’.
Needs further guidance.
Some concerns about the reasons above.
As above the definition currently encourages the perpetuation of a long-term hospital-based residential approach.
This would depend on further clarification for the comments made in response to question 1.
Potentially burdensome for the LA to collect - dependent on the interpretation of ‘known’
Known client is different to known and active client. A non-client who is known to the CSSR is entitled to refuse to disclose the information. Depends on clarity of guidance.

Q4. Is indicator defined at the right spatial level?
We do not currently collect accommodation status for all ASC LD clients, and we do not have a register of all people with Learning Disabilities in Plymouth area. This indicator will require possible system changes and changes to business processes in order to collect the information.
Classification fields would need to be set up on CareFirst.
For this information to be accurate and meaningful the level should be restricted to Social Services clients.

Q6. Any other Comments?
The Data Source is the Key Statistic 1 which has not been agreed at this point, and would not currently collect information to the detail required.
We would need to collect a number of new data sets and the extent of this work would depend on the comments made in Issue 1.
If the indicator is just counting those in settled accommodation (as per formula) then there shouldn’t be any problems.
New data collection with resource implications (depending on definition of ‘known’)
The KS1 return will be used to collect this data, this information is currently not collected so further guidance on this return is required.
Depending on definition of ‘known to the CSSR' this could be intrusive to non clients.
Recording of sexual orientation could pose problems as service users are likely to see this as irrelevant to the care packing that the authority is providing.
The assessment of settled accommodation is too open to interpretation as it stands It is unclear why users of LD services are still separated out between council and health when the vast majority of services are now joint.
DCLG guidance is not the same as that given in a letter dated 28th Sept 07 from ‘The Information Centre for Health and Social Care’ (contact: Annabelle McGuire 0113 254 7157) IC Guidance says: ‘PI will collect information on the client's current employment status (i.e. over the 7 DAYS preceding the client's REVIEW) using the following 6 categories...’
Concern this measure is intrusive to the privacy of non clients that are known to the CSSR, cannot see any real benefit identified to account for the intrusion. Internally increases the resource needed to administer the PI - close coordination with Supporting People and Housing.
Assumes guidance on settled accommodation will be clear
Additional reporting burden to extract information on accommodation status across all LD service users.
No major problems except:
(a) More work required on definition of ‘settled accommodation’.
(b) Unless the definition of ‘settled’ is more sharply drawn, then it is likely that all LA’s will achieve close to 100%.
(c) The concept of ‘known to councils’ is open to wide interpretation.
(d) Should more work be done on how long a person has been in their accommodation? Settled implies stability over time.

**NI 146: Adults with learning disabilities in employment**

**Q1. Is the Technical Definition of this indicator clear?**

- The definition talks about people ‘known to’ the Council, are these just people who have an ‘open case’ and meet our FACS criteria, or wider than this? It would be difficult for us to collect data on anything other than the current accepted RAP definition of ‘on the books’. This needs to be clarified.
- There is no clear definition of ‘employment’, which is essential to this indicator. Does this relate to ‘paid’ work only, or something else? All kinds of forms of employment exist and we need to be clear about which should be counted, for example supported employment, voluntary employment, work experience or employment in specific schemes for people with learning disabilities.
- Does this relate to clients in residential AND community support?
- Age group is 18 - 69. Is this a typo? It does not link with any other PLD data set, or employment related target [retirement age]?
- How were the hours per week devised? Does it relate to any of the DWP guidelines?
- Is a risk this indicator will only capture people who work on a regular, long-term basis. It needs to include in addition people who work on a contracted ‘as and when’ basis and people who have left jobs during the year. The definition of “known to the Council” needs to be clarified
- Need greater clarity re what is “known to CASSR’s”
- Is this paid employment (i.e. not voluntary)? Does it include voluntary work?
- Further definition required for employment. Does it include paid work only? Is casual work counted?
- There is no timeframe mention is it a cumulative figure or at a snapshot?
- Concerns over the definition of ‘known to council’ and how it is interpreted. Does the PI relate to just paid employment or does it include volunteering?
- What does Known to the Council mean? What does Known to the CSSR mean? Does employment include voluntary, unpaid and work experience?
- Same issues around people known to the CASSR as per NI 145. Additionally, need to know is this a snap shot measure or covering a full year? How should voluntary workers be counted?
- Will this indicator only cover those who currently receive a service from the local authority or will anyone known be counted in (implication, we need to keep in touch with people who are not necessarily ‘on the books’) - but who have had an assessment in the past? Will the cut off date by Age 18 - what about transition cases who are being managed by C&F until they are 24?
- How often will this data be expected to be updated (will an annual telephone review suffice – does this present an administrative burden?).
- Do people have to have employment / accommodation or just at any time within that year?
- What evidence is required?
- Will the local authority be expected to check the employment for every individual or will a self-classification be adequate?
- Clarification on the term ‘are known to’ is needed.
- Guidance on the period in question would be useful e.g. on 31st March
- Further clarification is required on the definition of ‘know to the council’. When will the clients employment
status need to be recorded and reported i.e. will it be at the point they are being assessed/reviewed, or at a fixed date (31st March) or some other method?
What does 'known' to the CSSR mean? Is this people known in the borough and who not under care management
'Known to the council' is too vague. Does it cover people working for the council but not in receipt of a service. And how broad a definition of learning disability can be included i.e. Asperger's or dyslexia?

1  Unclear whether this includes all paid employment, and excludes voluntary/unpaid work
2  Does this include adults with LD known to CASSR, but not in receipt of any services.
   Is voluntary work counted?
There needs to be a clear definition of what constitutes employment or self employment. For example people in supported enterprises. Perhaps employment could relate to being in receipt of a wage of at least the national minimum wage.
The definition essentially says that if anyone is working for 1 hour per week (minimum) at or above the minimum wage OR may be working 40 hours per week for no pay for a relative, then this counts as ‘employment’. Further thought has to be given to whether this really constitutes or measures ‘inclusion’.
Please explain the reference to adults aged 18-69, is this a typing error?

Further clarity required around the concept of 'being known to CASSRS'.

Does the employment in question need to be paid employment?
It needs to be clarified whether this definition pertains to a snapshot or a full year.

We would need to collect further information to supply details of employed subgroups. It needs to be clarified why this subdivision is in place if the figures will be combined to provide a numerator.
What is meant by “in contact with” the CASSR?
We have strict eligibility criteria so would only be providing services to people with critical or substantial needs, so these are the cases that we would be reviewing and have detailed knowledge about. It seems unlikely that many of these will be in employment. There are others with LD where we have assessed their needs and put them in touch with other support mechanisms but we would not keep these cases open so would not be reviewing them or tracking their employment status.

Q2. Does the Technical Definition for this indicator have any unintended consequences?
Doesn't fall in line with data collected for Employment-related schemes and so would increase the volume of data collection.

There are likely to be big differences between authorities re who is 'known to' or 'on the books', which will make comparability of data problematic.
It excludes ALD who gain valuable experience as volunteers or for whom the work experience can only be achieved through volunteering thereby it doesn't fully reflect the benefit of work/life experience for users.
Clarification needed on the definition 'known to the CSSR'
People may limit what is included in the denominator to make overall performance look better.
Removes the incentive for voluntary work and work experience
New systems and processes have to be put in place to capture the required dataset
As per NI 145.
Could encourage seasonal schemes for employment to tick the box?
Using a calculation method of clients 'known' to the council could encourage a situation where service users become dependent rather than independent
How do people become 'known'. Are people in settled accommodation more likely to be 'known' than those who are not. All depends on definition
a) Requires LA's to hold and collect greater amounts of personal information from the LD population than is currently the practice. Collection, front line training implications
b) Restrict to open/active cases

Has the potential to search wide for people in employment rather than shaping services to enable people to find employment and support them once they are there. Previous equivalent questions in SAS have asked for numbers in voluntary work. Care needed if comparisons with earlier data are to be made. Voluntary work placements should be counted.

There is an incentive to have fewer known to CSSR to reduce the indicator and improve performance. Good data protection process would take people off our system when we’re not working with them but there is an incentive here to keep them open & intrude unnecessarily into their lives.

Q3. Will Technical Definitions work in practice?

No - see 2

See answers from previous questions.

Need to be clearer on the denominator - if it is all people known regardless of whether they are still in contact with the council it would be hard to capture such data.

Depends on further clarification

Definition not clear enough.

Some concerns about the reasons above

This would depend on further clarification for the comments made in response to question 1.

Potentially burdensome for the LA to collect - dependent on the interpretation of 'known'

Known client is different to known and active client. A non-client who is known to the CSSR is entitled to refuse to disclose the information.

The separation of time lines into categories appears to be irrelevant is there another purpose for capturing those time lines (currently our systems do not collect these three time lines).

Clarity needed - see above

Yes, but authorities following best practice in data protection will perform poorly.

Q4. Is indicator defined at the right spatial level?

New classifications would need to be set up on CareFirst.

For this information to be accurate and meaningful the level should be restricted to Social Services clients.

Q6. Any other Comments?

The draft states that this is an existing indicator, but it is not. The existing SAS collection records helped into employment, which covers unpaid and paid work and schemes to support people towards employment. The existing SAS measure does not count the employment status of the whole learning disability population on the books of Adult Social Services.

The worked example uses huge numbers of people which gives the impression that the target group is much higher than it may be.

The Data Source is the Key Statistic 1 which has not been agreed at this point, and would not currently collect information to the detail required.

We would need to collect a number of new data sets and the extent of this work would depend on the comments made in Issue 1.

KS1 - LD client category - as for NI 150

We do not currently record this against any client

We need some Care Items for Employment.

The definition seems clear however. I would like to raise the following point. The definition states that it will measure on the age group 18-69. I assume that the age limit has been raised to reflect the changing age of retirement. However, this is an unlikely final working age for people with a learning disability, especially in view of statistical evidence, which puts this group at the bottom of the table in respect of employment opportunities and life expectancy.
The KS1 return will be used to collect this data, this information is currently not collected so further guidance on this return is required.
Depending on definition of 'known to the CSSR' this could be intrusive to non clients.
Recording of sexual orientation could pose problems as service users are likely to see this as irrelevant to the care packing that the authority is providing.
It is unclear why users of LD services are still separated out between council and health when the vast majority of services are now joint.
Concern this measure is intrusive to the privacy of non clients that are known to the CSSR, cannot see any real benefit identified to account for the intrusion. Internally increases the resource needed to administer the PI - close coordination with Supporting People and Housing.
Lacks clarity as to why under the definition there are three categories with number of hours of employment per week – this is merged for the formula. The separation of time lines into categories appears to be irrelevant is there another purpose for capturing those time lines (currently our systems do not collect these three time lines). Similar issue to NI145/149 why select these two client groups what about PD and Carers? don’t feel that the rationale helps to understand what outcome these are measuring it is therefore difficult to comment on the value of having these as national indicators. Why is this limited to MH and LD – what not extend to PD and Older People.
Not an existing PAF/KS1 indicator, as stated in the technical definition description.
This data is not currently collected via the Key Statistics 1
Not that this is not an existing P.I. although it does form part of the information provided in the Self Assessment Survey to CSCI
We will be trying to incorporate the collection of this data into all reviews & reassessments so that we can use it to track outcomes for people with PD and older people – this helps with the POPP project monitoring as well.
Part 4: Indicators to be collected through the “Place Survey”.

NI 119: Self-reported measure of people’s overall health and wellbeing

Q1. Is the Technical Definition of this indicator clear?

No definition provided

There is no clear definition / criteria by which a person is to define their overall health and well being. Usefulness of such information would therefore be questionable (e.g. similarly levels of asthma could be reported differently by different people). Tighter definition and criteria would be necessary for this information to be useful.

Q2. Does the Technical Definition for this indicator have any unintended consequences?

Lack of clarity / clear criteria would give rise to questionable and incomparable information.

Q4. Is indicator defined at the right spatial level?

Needs to be some clarity about whether covering specific categories of Young People, Working Age Adults, Older People, People with Specific Disabilities, Long-term illnesses, and so on

Q6. Any other Comments?

The quality of the information will be dependent on the method in which the Place Survey is administered. It must ensure a representative and large enough cross sample of the community. Peoples’ `subjective ` observations about their own lives are critical, but are not a sensible basis for a sub Census type survey, where the results have to be quantified in a more objective and statistically valid manner. It is also unclear whether people's observations are to be collected during or at some stage after service delivery?

Selecting a large and diverse enough sample is crucial to extracting useful data from the New Place survey especially if it is being used to inform National indicators.

It is unlikely we could analyse data by sexual orientation as we do not hold such information on residents prior to sampling.

The survey would need to clarify who would complete the survey. If postal would it be the Household Reference Person only. If so then there is a danger of skewing towards male responses who generally have poorer health, especially in BME communities.

Issue about who would administer it and the methodology used - if LA's administer the survey then CLG must ensure strict standardised methodology is applied nationally to remove bias and allow comparability.

NI 138: Satisfaction of people over 65 with both home and neighbourhood

Q1. Is the Technical Definition of this indicator clear?

Further information from the Place Survey is required

Q6. Any other Comments?

Further information from the Place Survey is required before comments can be made.

This measure encompasses 2 questions contained in The Survey of English Housing. How would they
combine to create a single NIS result? Also after discussions with CLG staff that administer the survey, they admit that the sample they use means they CANNOT perform analyses at the LA level by ethnicity, tenure etc.. because the sample of returns is too small. Instead they can offer it at GOL areas or higher.

The SEH tends to be completed by the Household Reference Person only. If so then there is a danger of skewing towards male responses who generally have poorer health, especially in BME communities which will affect NI119 and NI137.

Issue about who would administer it and the methodology used - if LA’s administer the survey then CLG must ensure strict standardised methodology is applied nationally to remove bias and allow comparability. Selecting a large and diverse enough sample is crucial to extracting useful data from the New Place survey especially if it is being used to inform National indicators.

The Place survey will be going to people of all ages so why does the indicator concentrate on 65+ - younger adults with disabilities are also vulnerable.

**NI 139: The extent to which older people receive the support they need to live independently at home**

**Q1. Is the Technical Definition of this indicator clear?**

Need further information on the Place Survey before comments can be made

**Q2. Does the Technical Definition for this indicator have any unintended consequences?**

Wide open to interpretation by the people completing the survey - questions must be clear and not give room for ambiguity of response.

**Q6. Any other Comments?**

Needs tighter definition regarding information provided

Further information from the Place Survey is required before additional comments can be made.

Not clear if this will be whole pop survey or a sample - if sample how is this to be arrived at?

As this indicator focuses on Older people the sample will need to be large enough to collect robust data, probably over 500 responses. There is a danger that the number of responses will not be large enough to perform analysis by equalities strands.

Issue about who would administer it and the methodology used - if LA’s administer the survey then CLG must ensure strict standardised methodology is applied nationally to remove bias and allow comparability. Selecting a large and diverse enough sample is crucial to extracting useful data from the New Place survey especially if it is being used to inform National indicators.
Part 5: Other indicators in the NIS

**NI 7: Environment for a thriving third sector**

**Q2. Does the Technical Definition for this indicator have any unintended consequences?**

Could be used as a tool in negotiations between vol orgs and local authorities.

**Q6. Any other Comments?**

Further information is required from the proposed Third Sector survey before further comments can be made.

**NI 14: Avoidable contact: The average number of customer contacts per resolved request**

**Q1. Is the Technical Definition of this indicator clear?**

There is no definition as such of what a `contact' is and what a `request` is, only a list of options without a clear sense of how that would be measured e.g. for Adult Social services would a contact be from when a self referrer spoke to a local Meals on Wheels service provided under contract.?

**Q2. Does the Technical Definition for this indicator have any unintended consequences?**

a) Could encourage the avoidance of necessary contact with clients who may actually need more contact with the service
b) Set a separate threshold for social care or include in the definition a clear understanding of when a contact is resolved - e.g.: passed to service/case managed

Collection of this data requires a system that can capture data on the `information journey` of each client, even if they are signposted externally, which is highly likely in many cases. There is no separation between contacts of this type and contacts from people in receipt of services directly from the CSSR. Also there is an impact on services provided through contracts, whose terms may need to be renegotiated to cover specifications of the NIS.

**Q3. Will Technical Definitions work in practice?**

People may contact the Council for unrelated issues both could be resolved but if in two weeks this would count as unresolved
This could happen frequently in relation to social care when dealing with vulnerable adults whose needs may change frequently
In social care context very difficult to enumerate

Requires a CRM system and single point of contact for all customer calls. LBI does not operate in this way. Calls can be received at different places and details need not necessarily be recorded
Lack of definitions means data would lack differentiation

**Q6. Any other Comments?**

Where will this be collected? RAP?
Numerator: Total number of customer contacts
The number of times a client contacts us about a problem/query/request
In swift a count of `contacts' and `profile notes'
What about contacts from family for more info
What about contacts from social workers for more info
What about contacts from social workers re the choice of services?
What about contacts to/from providers about the services?
How do we define what the contact is about?
If the contact is about one thing and brings up a new issue what so we do then?
When is a contact a countable contact. Do we need to clarify when a contact is recorded (i.e. a contact is only recorded for a new piece of work NOT for the next phone call about this piece of work)?

Denominator: Number of resolved customer contacts
What is a resolved customer contact?
In SWIFT could be a ‘contact’ with outcome of ‘deal with…’
What about the outcome ‘progress to referral’ - is this resolved? or is this not resolved until the referral is closed?
What about contacts ‘progressed to specialist assessments’ - are the resolved at assessment or service?

Note - OT regularly have 2 or more contacts due to the waiting list

Collecting this kind of data is very worthwhile, and a fundamental part of "lean thinking" of course, however, our client record system (SWIFT) and the corporate CRM system are not linked - and we currently run a separate work intake/duty service

There are considerable practical problems in defining when a subsequent customer contact should be classed as a "failure"..... E.g. there may be a legitimate need for a number of contacts that "add value" to the assessment process - how would we differentiate these from "failures"? SWIFT does not lend itself to this!

# we have used this approach locally, as part of lean systems approaches to improving our processes, but not by using SWIFT. I think it's been done by manually judging and counting "failure" demands as they come into our helpdesk - fine for a time limited and bounded project - but not for routine data capture!

The growth in this type of reporting will need significant resourcing - even if the surveys are designed and produced centrally by the Information Centre, chasing and collating the data locally is becoming increasingly time-consuming.

Customers may not be happy to disclose personal details at first contact (e.g. data protection issues) to set them up for tracking within the CRM model. Even if reference numbers where issued instead of personal details being taken some of the customers are vulnerable and may not remember reference codes.

Strong case to exclude social care contacts from this indicator virtually oxymoronic and include social care contacts if a by theme is customer focused for the socially excluded. There are issues about what questions should be asked of contacts when the nature of many contacts is general and it is inappropriate (from a customer perspective) as the basis of personal questions about them. Additionally it is questionable whether it is appropriate to hold information at a client level at this stage of the process.

**NI 38: Drug-related (Class A) offending rate**

**Q1. Is the Technical Definition of this indicator clear?**

Need to be clearer on what users are to be counted and in what period. Perhaps should explicitly state current users.

Does this mean that DATs will need to share names of clients in treatment with the Police in order to cross reference with PNC? This may cause some problems with confidentiality; clients do not consent to their data being used for this purpose.
**NI 123: 16+ current smoking rate prevalence**

**Q1. Is the Technical Definition of this indicator clear?**

The definition (quitters) does not fit the indicator (prevalence)

The definition per se is clear however there is a disconnect between it and the aim implied in the indicator title. As reflected in the definition itself ‘the intention is to develop …. for forthcoming years’ we are being asked to continue to use a recognised 'weak' proxy but now under a title which misleadingly suggests something more sophisticated.

The use of a simple ‘good performance = increasing rate over time’ also fails to reflect both the starting point for different areas and that at some point one would actually want to see the rate decreasing to reflect the outcome of work to reduce smoking start up.

**Q2. Does the Technical Definition for this indicator have any unintended consequences?**

Possibility that people can ‘quit’ several times

By continuing to use the existing ‘4-week’ based definition the indicator is not genuinely looking at prevalence and does not look at health gain. For example if 50% of smokers quit for 4 weeks but only 25% of the 4 week quits remain non-smoking after 52 weeks then although a target of x smokers may have been reached and the LAA achieved in reality 75% of the smokers who quit at 4 weeks have had little or no health benefit. The unintended consequences are that health inequalities at best will not have changed and worst deteriorated.

b. The definition of the indicator needs to be focussed on prevalence not service delivery

**Q3. Will Technical Definitions work in practice?**

Self reporting is likely to be unreliable in the context of quitting

Not if the aim of the indicator is to show public health benefit and reduce inequalities

It states ‘good performance is typified by an increase rate over time.’ The rate calculates number of smokers on 4-week quit programmes against the general population. However excellent performance in an area will mean there are fewer smokers to go on such courses resulting in a lower rate which under the current definition translates into poor performance. This was healthier areas are penalised more. The definition should be proportion of smokers on quit courses against number of self-defined smokers

**Q6. Any other Comments?**

It is essential that this indicator is also included in the Health performance framework to ensure similar accountability for health partners

**NI 129: End of life care – access to appropriate care enabling people to be able to choose to die at home**

**Q1. Is the Technical Definition of this indicator clear?**

It is unclear as to why we are excluding people who die in a residential or nursing home from the indicator. For some people this is the most appropriate place for them to pass away.

Are all deaths counted or just those in touch with health/ social care services ?

Unclear why people who die in residential or nursing homes care excluded from being counted as dying at home. These placements can be identified by the person as their own home.

What is the age range for this indicator as this is not specified?

The indicator doesn't take into consideration whether or not the person had a terminal illness.

Can extra care housing and adult placement schemes being counted as the clients own home?

The measure is essentially an output number and does not address the issue implied in the title of ‘access to appropriate care’.

The age of people included in death statistics (18+, 65+)
Whether the person had a Long-term condition or terminal illness prior to death

Numerator - How are people nearing death differentiated from all registered deaths. Can ONS cross-reference?

Q2. Does the Technical Definition for this indicator have any unintended consequences?

a. The indicator is not based upon the choice of the person and could create the perverse incentive whereby people are actively encouraged to die at home even if they didn’t want to.
b. I can not think of a simple amendment that could alleviate this problem
    Sending someone home to die, however inappropriately, would improve the indicator
This indicator is not based on patient choice; there is a risk that people could be convinced to die at their home when this is not the person true wishes, just to satisfy this indicator.
Could mean that users are inappropriately moved back to homes.
a. The definition focuses on deaths at home and does not provide information on the pathways to or take up of appropriate care therefore the consequence is patients can die at home (achieving the target) with no support or access to appropriate care.
b. a definition that looks at the quality of care provided (based on gold standard) should be applied to this indicator

Q3. Will Technical Definitions work in practice?

Does not measure choice (dying where I want to) but output (where I died); what of those who choose to die in e.g. a hospice?
Inability to count nursing & residential home deaths as home (even though it is the only residence) will distort the figures
See answers from previous questions

Q6. Any other Comments?

Many clients choose to die in a residential/nursing home setting as they consider this to be their home, therefore this should be included
Recording of sexual orientation could pose problems as service users are likely to see this as irrelevant to the care packing that the authority is providing.

NI 134: The number of emergency bed days per head of weighted population

Q1. Is the Technical Definition of this indicator clear?

Existing collection by PCTs does not include the weighted population so the precise nature of this aspect, and its implications, need defining

Q3. Will Technical Definitions work in practice?

Existing collection by PCTs does not include the weighted population so the precise nature of this aspect, and its implications, need defining

NI 137: Healthy life expectancy at age 65

Q1. Is the Technical Definition of this indicator clear?

These Place Survey NIs (137-140) are among the potentially most useful outcome measures (with 119 and 128). They will have to be defined and tested carefully with users. Although they are in the Adult health and well being section they appear to be surveyed via the general Place Survey.
There will be difficult technical issues re wording and sampling. Will the general survey pick up many ASC users &/or people with long term conditions (a relatively small number)?

**Q6. Any other Comments?**

New data collections with resource implications. How often will surveys be done. How will samples be stratified esp. for hard to reach groups?

How could/will a general Place Survey pick up people using different services (and therefore, for example, talking about different groups of staff treating them with respect and dignity or satisfaction levels)?

Will perceptions of life expectancy be linked to actual quantitative measures (mortality/morbidity)?

Will NI 138 use the 2 Housing Survey Qs?

Are 137 and 138 and possibly 139 just for older people? Will carers be included? Will older people get their own survey or Qs just for them in the Place Survey?

Having said that, we strongly welcome the introduction of self reported user outcome measures. Could the wording of any questions re the 7 CSCI outcomes or related NIs be published on a website when agreed as many LAs would like to pilot them in existing surveys and reviews. Not many ASC users are likely to be picked up in Place Surveys so they (LAs) would have more frequent, ongoing trend data of a much larger sample to complement the small number in the Place Surveys.

Any agreed validated, reliable and hopefully Plain English outcome questions should be published for Councils and their partners to pilot/use locally.

A triennial or one service at a time survey like NI 127 is unlikely to provide meaningful data on improved outcomes across H&ASC in 3 years. CLG/DOH/ Care Commission should be providing/arguing for providing extra resources to local partners to build outcome measures into their local information systems so they can measure on a case by case basis and reduce the use of surveys and survey fatigue - a kind of successor/extender to RAP, which stops when the care package is provided and excludes any kind of outcome.

Selecting a large and diverse enough sample is crucial to extracting useful data from the New Place survey especially if it is being used to inform National indicators.

Although baseline data is available from 2001 (if they intend to use the same question) however this question is under review for 2011 and may well be changed.

It is unlikely we could analyse data by sexual orientation as we do not hold such information on residents prior to sampling.

The survey would need to clarify who would complete the survey. If postal would it be the Household Reference Person only. If so then there is a danger of skewing towards male responses who generally have poorer health, especially in BME communities.

Issue about who would administer it and the methodology used - if LA's administer the survey then CLG must ensure strict standardised methodology is applied nationally to remove bias and allow comparability.

**NI 140: Fair treatment by local services**

**Q1. Is the Technical Definition of this indicator clear?**

No definition included - would need to know what services older are asked to give views on and also need to understand which services they have specifically used.

**Q6. Any other Comments?**

As this indicator focuses on Older people the sample will need to be large enough to collect robust data that enables analysis by the different equalities strands.
It is unlikely we could analyse data by sexual orientation as we do not hold such information on residents prior to sampling.

The survey would need to clarify who would complete the survey. If postal would it be the Household Reference Person only. If so then there is a danger of skewing towards male responses who generally have poorer health, especially in BME communities.

Issue about who would administer it and the methodology used - if LA's administer the survey then CLG must ensure strict standardised methodology is applied nationally to remove bias and allow comparability.