



Transparency and Outcomes: Consultation Document

Response by Association of Directors of Adult Social Services

Background

The Association of Directors of Adult Social Services (ADASS) represents Directors of Adult Social Services in Local Authorities in England. As well as having statutory responsibilities for the commissioning and provision of social care, ADASS members often also share a number of responsibilities for housing, leisure, library, culture, arts, community services, and increasingly, Children Social Care within their Councils.

ADASS members are jointly responsible through the activities of their departments for the well-being, protection and care of their local communities and for the promotion of that well-being and protection through the use of direct services and the co-ordination of, and liaison with the NHS, voluntary agencies, private companies and other public authorities, as well as close working with the relatively newly transferred posts of Directors of Public Health, now set within Local Authorities.

ADASS members have leadership responsibilities in Local Authorities to promote local access to services and to drive partnership working to deliver better outcomes for local populations. They participate in the planning of the full range of council services and influence Health Service planning through formal and informal partnership arrangements.

ADASS welcomes the opportunity to contribute to the Department of Health consultation on the "Transparency in Outcomes: A framework for adult social care".

General Comments

We fully support and endorse the development of the proposed new Outcome Framework (and underpinning Quality Standards) for Adult Social Care. These are critical steps forward in acknowledging the effective and efficient contribution of adult social care towards improved outcomes for individuals, their carers and the wider population in general.

ADASS is well positioned to make a significant contribution in this work, and we welcome the "offer" to work alongside stakeholders in the development and implementation of the proposed Outcome Framework and Quality Standards.

We recognise the challenges of developing meaningful outcome measures (and corresponding standards), and welcome the opportunity to share and build upon our own local arrangements and experience, as well as to work collaboratively with other stakeholders, particularly citizens and providers, whose contribution and participation is essential.

We are already working alongside stakeholders and we acknowledge the significant progress that has been made so far. It is important that we all draw from this experience and capitalise upon elements of the existing system/framework that works, rather than start again, as well as capitalizing upon opportunities that are emerging from the broader on-going Government's public service and health agendas i.e. the DH Information Revolution, as well as existing Government strategies i.e. Valuing People Now etc.

We are fully committed to the Government's "[Vision for Adult Social Care](#)" and the recently published "[Think Local Act Personal](#)" agreement and it is critical that the proposed Outcome Framework (and associated Quality Standards) are aligned to these throughout.

As detailed in our response to the [DH Business Plan 2011-15](#) consultation, we welcome the development of an Integrated Outcome Framework (across NHS, Public Health and Adult Social Care) and we support every opportunity to work collaboratively with stakeholders at this integrated level, whilst we also support the need for transparency and accountability and the opportunity for flexibility at the local level.

In this context, we appreciate the challenges ahead of collaboratively working across the health and social care sector and with users, particularly as the current set of proposed outcome measures are drawn from existing datasets and the quality standards are not yet in place. However, we acknowledge that 2011/12 is seen as a transitional year, with ongoing work with DH on a refreshed set of measures (alongside the Zero Based Review) and development of Quality Standards by NICE not available till 2012/13 onwards.

In terms of 2011/12, we are concerned as to the effective implementation and application of the CQC framework of "Essential Standards" and we seek urgent discussion with CQC to address these issues.

We fully support the principle to create a framework that balances national imperatives alongside local flexibility and we will work with stakeholders to fully realize this opportunity (and challenge). ADASS is already working closely with LGID on Sector Led Improvement and with the DH on the Zero Based Review, both of which will help to ensure this balance is effective, efficient and stimulates improvement.

We embrace the commitment for a reduced burden, but we feel that the rhetoric has yet to be fully realised. We are concerned that the proposals do not address a reduced burden with any conviction, with one reporting

mechanism (CQC Annual Assessment) simply being replaced by another (Local Accounts), the continuation of both national measures (and the associated culture of league tables) and the underpinning dataset. Finally we note that the introduction of a new “performance framework” (Sector Led Improvement) that has yet to be fully costed and resourced.

In this context, ADASS is concerned about balancing the level of expectation associated with the proposals against the reduced availability of resources and capacity within councils, and we welcome detailed discussion with Government in addressing this.

Ultimately, we recognise that the success of the proposed Outcome Framework for Adult Social Care is largely dependent upon the local quality assurance systems operated by councils themselves. ADASS is fully committed to consolidating upon existing good practice, as well as developing innovation solutions to improving local systems where required.

Responses to Consultation Questions:

1. How should Quality Standards in social care balance guidance on service practice, cost-effectiveness, what matters to people and outcome expectations?

We welcome and support wide engagement and partnership working in developing “**balanced and realistic**” standards that are transparent across all stakeholders and clearly contribute to improved outcomes and particularly, we support the full engagement of people who use services, in contributing to the development of standards and the design of outcome measures.

We recognise the need for flexibility and localism and we support the development of overarching “national” guidance on standards and outcomes balanced alongside locally developed guidance, reflecting local standards and expectations.

We note that the Adult Social Care Quality Standards should be broader than the “medical conditions” approach characterised in the NHS Quality Standards, and ADASS welcomes the opportunity to work with NICE (and SCIE) to develop these standards to reflect a more holistic “well-being” approach to outcomes, as well as drawing upon social care expertise with ADASS to ensure standards are appropriate and realistic for the social care sector in general.

2. How can we categorise Quality Standards in adult social care, and what should be the topics for the first Quality Standards?

We note that the standards must be clearly aligned to the proposed domains in the Outcome Framework, and synchronised with the Vision for Adult Social Care and the “Think Local Act Personal” agreement.

In terms of how to categorize standards, there are two differing approaches emerging within ADASS, which we suggest are taken into account by NICE as this work evolves.

- A first approach is to categorize standards based upon the various stages in the **care pathway**, set against the self directed support model. The stages include, Advice and Information; Initial Contact; Assessment and Resource Allocation; Support Planning; and Social Care Support. We also note that these can be further broken down to reflect different service types: e.g. Preventative services (re-ablement, assistive technology etc.), community based services (domiciliary and day care), and institutional services (residential and nursing care).
- A second approach is to categorize standards based upon a hybrid between the domains in the proposed Outcome Framework, and the **seven principles** detailed in the Vision for Adult Social Care. This approach offers an opportunity to extend beyond the care pathway approach and has similarities with the previous CQC quality descriptors.

The seven principles are:

1. Prevention
2. Personalisation
3. Partnership
4. Plurality
5. Protection
6. Productivity
7. People

In terms of topics for the first Quality Standards, there are numerous suggestions, but we would suggest a good starting place is to develop a common understand of what constitutes “excellence”. This can be informed by the significant work already undertaken by CQC and SCIE on “Excellence”.

3. How can Quality Standards be developed to support service users as commissioners, and local people in their role to hold councils to account?

Local accountability must start with a defined “offer” so citizens are clear what they can expect and councils are equally clear about what they need to deliver, (whilst ensuring expectations are realistic & affordable).

It is important that this “offer” is located in a single place for citizens to easily access, understand and use for a variety of reasons, including how to hold councils to account (see ADASS response to DH Information Revolution Consultation).

It is critical that the standards clearly specify that a quality service will be supplemented by transparency from the provider, outlining their objectives,

their services and their cost and that this information is made accessible via the proposed single portal.

Finally we suggest that the standards clearly document the amount of user control and involvement in their personal care plans, the running of service provision and strategic planning and suggest that this is incorporated in the Citizen Offer, documented on the single portal.

4. Do you agree with the proposal for a single data set for adult social care, supported by a single collection and publication portal?

We agree with the proposal for a single data set, supported by a single collection and publication portal, although we recognise that Adult Social Care is complex, and that any subset of information would need to be derived from a comprehensive dataset.

We fully support the Zero Based Review and the correlation to rationalise this comprehensive dataset, identifying useful management and policy information. In this context, ADASS welcomes the ongoing partnership working with DH & IC in taking this work forward, and we acknowledge the connection of this work with the development of Sector Led Improvement, which ADASS is working alongside LGID on.

In supporting a single portal, we also acknowledge the growth of “information intermediaries” described in the consultation “An Information Revolution” and support their role as a safeguard, ensuring that available data is communicated to the public in formats they can understand.

5. Do you support the case for a consistent outcome-focused measures, which combine the best available data on social care outcomes?

As previously stated, we fully support the focus upon outcomes, but are keen not to repeat history and end up with a top-down set of “output” measures that also can be ranked, creating perverse incentives.

In this context, ADASS is already working with DH and other partners to design a set of genuine outcome measures that resist perverse incentives and has the opportunity to include local variations.

As noted elsewhere in this response, we support the principle of having both national measures balanced with local measures, and we recognise within this, the need for consistency to assist in transparency and the opportunity to compare and contrast. ADASS is already engaged in working with DH on understanding this balance.

6. Do the four domains and outcome statements proposed adequately capture the breadth of outcomes which are relevant at the highest level to adult social care?

We welcome the principles behind the structure of the proposed four domains. However, we suggest that the domains and corresponding outcome statements need to be refreshed to more accurately reflect the “Vision of Adult Social Care” and align to the recently published “Think Local Act Personal” agreement.

Specifically:

- **Domain 1**- it is suggested that overarching goal should be quality of life, rather than personalisation. Personalisation is seen as a means to an end
- **Domain 2** – the description of this domain is “illness” focused and needs to reflect the more holistic social care outcomes
- **Domain 4** – it has become apparent that the scope of this domain is not actually safeguarding but safety. This does not take into account the broader dimensions of safeguarding (and personalisation) in relationship to dignity and choice.

7. Do you have any further views on how adult social care outcomes should align with other sectors to support integrated working? How might this be put into practice?

As referenced in our responses to the consultation DH Business Plan, we support an outcomes framework that:

- promotes **joint working** (most outcomes can only be delivered by organisations working in partnership);
- Supports **public accountability**, detailing each organisation’s contribution towards improved outcomes, but also clearly identifies the lead organisation.

We support the proposed Integrated Outcome Framework detailed in the proposed DH Business Plan 2011-15, combining the three separate outcome frameworks for Public Health, NHS and Adult Social Care, under a common set of domains, although we note that the architecture of the Public Health Outcome Framework does not easily align to the frameworks for NHS and Adult Social Care. We will be commenting about this in the Public Health Consultation on Outcomes (submission date 31 March 2011).

As in previous consultation responses, we see the Integrated Outcome Framework as an important tool in the suggested critical function of the Health and Wellbeing Boards and Healthwatch to hold NHS, Public Health, Adult Social Care, and critically importantly, the new GP Consortia to account. Further, the Integrated Outcome Framework should encompass the contribution of other partner’s, such as District and Borough Councils, the Police etc. Individual organisations could still have their own frameworks to support local accountability, but the Integrated Outcome Framework would be much wider than any organisational framework, provide a sense of “place”.

8. Do you support the proposal to replace annual assessments of councils conducted by the regulator with public-facing local accounts on quality and outcomes in adult social care?

In general, we support the proposed Local Accounts approach, and welcome the opportunity to work alongside the LGID in developing Sector-Led Improvement.

Although supporting this approach, we note the burden is not lifted, as one mechanism (CQC Self Assessment) is simply being replaced with another (Local Accounts), but we equally recognise that we have an opportunity in working with LGID and DH to design a system that avoids burden where possible.

In this context, we also recognise that any such an approach is not yet costed, and with the consultation proposals to continue collecting “national outcome measures”, underwritten by an extensive database, there remains concern as to whether resources and capacity will be available to fully take this forward, and **ADASS seeks further discussion with Government to address these concerns. The development of a sector based approach in children's services is being encouraged with significant government investment and investment will be needed too in adult social care**

In designing Local Accounts (and Sector-Led Improvement), we are mindful that this must include the full engagement of citizens and providers, as well as drawing upon direct customer feedback when making assessment of quality within the proposed Local Account.

We recognise the opportunity to extend Local Accounts beyond adult social care to reflect the broader partnership arrangements within a “place”, and we suggest that an Integrated Outcome Framework will be critical tool in achieving this. ADASS is well positioned as the leader for Adult Social Care, to talk and negotiate with other sectors in seeking a common position to take this forward.

We have some concern that the “Local Account” and the “national social care data set” may not provide the same level of assurance that the annual assessment by CQC provided. We feel it is important that CQC maintain their role as regulator and endorse the need for targeted inspections where significant risks have been identified, but that this is in parallel and **complementary** to the proposed approaches to Local Accounts and Sector-Led Improvement.

In this context, ADASS is offering to work with CQC (and HealthWatch- see q 12) in developing and agreeing the “triggers” that could result in an inspection, and we are concerned that these arrangements need to be in place urgently.

9. Do you have any local examples and evidence on the benefits of a local account-type approach?

We are aware that a number of councils will be providing examples in their individual responses to this consultation.

10. What is your view on the balance between requiring standard elements in reports, and allowing freedom to fit to local circumstances?

We support the balance between national imperatives (such as identifying risks), which themselves will lead to opportunities for benchmarking, and the discretion to reflect local circumstances and freedoms.

To achieve this, we support the proposed good practice guidance, and ADASS is keen to work closely with the DH in developing this, to get the balance right and to recognise that Local Accounts are a new development for many councils, and that in this stage of development of Local Account methodology, there is a need for an approach which encourages innovation and building upon good practice.

We note that this approach could also be extended to providing both guidance on constructing local measures, and tools to support analysis of the dataset (for example, McKinsey&Company with the LGG on their "Blueprint for Data and Transparency" has produced data interrogation tools), and again this is something that ADASS can make a significant contribution towards, and anticipates will feature in it's work with LGID on Sector-Led Improvement.

11. The proposed accounts would only apply to commissioners. What further actions, if any, might be considered to promote transparency amongst service providers?

The Health and Social Care Bill and the NHS White Paper provides a potential mechanism for both HealthWatch and the Health and Wellbeing Boards to hold providers (and commissioners such as GP Consortia) to account, .ADASS suggests that such arrangements are formalised with greater clarity as to the extent of influence that HealthWatch and the Health and Wellbeing Boards can have. This is critical in ensuring transparency across the sector.

We note that CQC already publish information about providers, and that this will continue under their new framework of Essential Standards and assessing Excellence. We would argue that this new system, although providing a degree of assurance, is not as transparent as the previous quality rating scheme and could be particularly disadvantageous to self funders and people using personal budgets to arrange their own support, particularly as this new system does not distinguish between "adequate" and "better than adequate" service, and between "good" and "excellent" service, and is predicated upon a fee approach. (See q 14), Further, we are concerned that there is no timeline, implementation plan or agreement about how this system will operate.

This is an area in which ADASS would welcome further urgent discussion with CQC.

As we move into an era where increasing numbers of citizens are commissioning services themselves, we believe the mechanisms that operate in other sectors to support customer choice will need to develop in the social care market. Key developments that have given greater powers to consumers have been the evolution of price comparison websites and forums, such as “Tripadvisor”, which allow consumers to share their experiences and rate quality.

Rather than try and impose mechanisms to promote transparency amongst service providers, we suggest that the social care market should be encouraged to develop similar mechanisms to truly support citizens to make informed choices and ADASS is willing to assist in providing expert advice in helping this flourish.

Finally, as noted elsewhere in this response, we support a single accessible, transparent portal to capture and share quality of services, including costs, as well as to provide clarity as to the “offer” to citizens and expectations placed upon commissioners and providers.

12. Would you support an assurance role for the local HealthWatch in the production of accounts?

We welcome the proposed role for HealthWatch, but note concerns as to the extent to which these organisations fully understand adult social care and are truly representative of the “user voice”, based upon our previous experience of LINKs.

ADASS has extensive experience and knowledge in working with established networks of advocacy and user-led groups and there is a danger that HealthWatch will duplicate rather than build upon on this, unless this is specifically recognised in the proposals, with HealthWatch given a co-ordinating role.

ADASS feels the terminology to describe HealthWatch is misleading and would suggest that it is renamed to provide greater clarity to the public of the role of this organisation in its relationship with social care.

ADASS is keen to work closely with HealthWatch to support its critical roles in helping to secure improved outcomes and particularly to explore the potential connection between HealthWatch and the trigger of CQC risk based inspections, as well as their proposed functions to “sign off with or without qualification” Local Accounts.

13. We would also be keen to receive views on whether user and carer-led assessments could support transparency and empower local people?

We are fully committed to both transparency and empowering citizens within the context of user and care-led assessments

ADASS has been instrumental in developing genuine user and care-led assessments, and has been working closely with the DH ([Outcome Review](#)) in testing approaches that can be applied in the proposed Outcome Framework particularly as from 2012/13, when it is jointly anticipated that a fully developed and owned set of outcome measures will be available.

It is noted that this development work on a “genuine outcome measure” has involved a group of disabled people, family carers and people from a number of councils testing different approaches, but all with the same focus upon the outcomes experienced by these individuals. ADASS feels that this model “outcome based measure” has the potential to extend beyond Adult Social Care and will continue to work with DH and stakeholders to seek the full opportunity of this approach.

Furthermore, ADASS has a strong history and ongoing commitment of working with User-Led Organisations and commissioning research to capture people’s experience of social care services to improve service delivery, (i.e. the large scale ASCOT programme of research, undertaken by the Personal Social Services Research Unit over many years, looking at establishing the validity and reliability of outcome measures).

We will seek to ensure that this important work can continue to make a significant contribution to the development of an Outcome Framework and associated standards.

14. What role is there for “payment by results” or other financial incentives on providers of commissioners at a national level to support the focus on quality and outcomes?

We support the overall principle to encourage service improvement and innovation and that “payment by results” is a stimulus towards this. However, we have concerns as to whether such an approach can be translated into a national platform and we would support a more limited local approach on the following grounds that:

- Many councils have already developed schemes that incentivise quality, and imposing a national scheme could impact on these locally agreed arrangements.
- A national scheme would need to be underpinned by a national performance framework, which seems contrary to the direction proposed in the rest of the consultation document.
- The impact of personalisation and the consequent development of miscommissioning which may diminish opportunities for “payment by results” undertaken by traditional commissioners.

We note that although a number of councils already operate mechanisms to reward providers who improve and maintain quality. The previous quality rating by CQC supported this as it provided an independent assessment of the quality of a provider to supplement the council's own evidence, and without this, there is a real risk that councils will need to increase their own monitoring process, so increasing costs and adding to the "burden" upon providers.

It remains to be seen whether CQC's proposed new approach to assessing providers will be as robust as the previous quality rating methodology. Our concern is that it may favour the larger providers who have the administrative infrastructure and financial resources to apply for the "Excellence" rating.

Finally we note that any "payment by results" regime needs to be carefully designed to meet the specific outcomes and to be tailored to the circumstances, to ensure that it gives people choice and control and to avoid unintended consequences.

15. How should the Care Quality Commission ensure that future service inspections are risk-based and proportionate?

We support the role of CQC in providing public assurance of service quality through risk based inspections, and perceive the role of CQC as complementary to critical role undertaken by Councils in the context of Sector-Led Improvement.

We believe that any "CQC" Inspection team should include peer involvement from other councils, building upon Sector-Led Improvement approaches currently under development.

At the moment, these risk triggers and methodology are not in place and we remained concerned that this work needs to be prioritised urgently and that the proposals to trigger alerts are to be based upon desk top analysis, rather than on-site and consumer feedback intelligence.

We welcome the opportunity to work closely with CQC (and HealthWatch) on the risk triggers and methodology for inspection and to align this with the work on Sector Led Improvement and Local Accounts

16. Does the regulatory model of registration, compliance, and inspection provide sufficient standards for ensuring Quality Standards across adult social care?

Whilst we welcome the role of CQC in providing public assurance, our recent experience is that CQC role and influence has actually been diluted in the social care sector under new arrangements. For example the new proposals for registration and compliance for social care providers rely on desk top assessments of available evidence and may not provide the same level of safeguarding and quality monitoring as the previous approach.

It is important that CQC are able to share intelligence with councils to assist in ensuring quality standards and we welcome further discussions with CQC to put in place these arrangements.

17. How best might independent monitoring of local council arrangements for managing services be secured?

Whilst we clearly recognise the value of Sector-Led Improvement, we remain concerned as to the potential additional burden this may entail, and importantly, the scarcity of resources and capacity within councils to take this forward in a meaningful way. **This is an important conversation that ADASS wishes to hold with Government.**

As noted in our response to q 15, we recognise the importance of public assurance in the independent monitoring of council services and we would endorse the view that CQC retain the role to undertake risk based inspection to complement Sector Led Improvement approaches.

18. Are these the most appropriate criteria for assessing measures? Should other areas be considered?

The six key criteria proposed for assessing the measures are all supported but other factors also need to be taken into account such as definition and measurement issues, perverse incentives, risks/consequences of inclusion in framework and possible alternative indicators. The detailed response to the proposed indicators attached as Appendix A uses both the six key criteria and these additional factors.

19. Throughout the outcome domains, we would be grateful for your views on the particular measures proposed

A detailed response to all 22 proposed indicators is attached (Appendix A) and includes proposals for revising and replacing some indicators with the aim of achieving the best possible indicator set for 2011/12, within the significant constraint of the current set of data collections. Consideration must be given to any of the proposed indicators in terms of issues raised by councils previously. Councils are also keen to avoid the position where an indicator is flawed and councils are forced to try to defend their position because of a flaw in definition or interpretation. For this reason, it is critical that any contentious indicators are either refined or excluded. Moving forward into 2011/12, the work of the Zero Based Review will enable measures for important areas not covered in the current set of data collections to be added. Particular areas where new measures are required include prevention, reablement, assistive technology, advice and information services (including self funders), safeguarding and outcome based reviews (linked to the "three wishes" work) , with the ability to drill down to service user sub-categories such as dementia. In terms of accountability, there is also a need for value for money indicators.

It is noted that this technical response is also complemented by a separate response from the Social Services Review Group (SSRG).

20. What are your views on the proposals to repeat the Carer's Survey every two years to provide a more regular comparable source of data on outcomes for this group?

The proposal to repeat the Carer's Survey is welcomed, but we believe that if carers' issues are genuinely to be given equal weight then the Carer's Survey should be undertaken on an annual basis although this may present significant resource issues, particularly for some smaller councils. With both the Adult Social Care Survey and the Carer's Survey we would want to see a thorough review to examine issues of length, complexity and value of information produced by the surveys in relation to the emerging outcomes and how they might be measured and in terms of value for money for the work involved.

21. What are your views on designing common models for capturing outcome information at the local level, which could be adopted on a standard basis?

This is an interesting proposal and certainly worth pursuing. Councils are at different stages of implementing SDS, and it seems sensible to have models of capturing this information available to them so that they can learn from each other rather than reinventing the wheel. A key area for development would be measures that are linked closely to the service user/carer experience but are integrated into standard referral, assessment, support planning and review processes and thus monitored on a regular basis, rather than the result of an annual survey.

Various voluntary benchmarking and measurement arrangements have existed in adult social care for several years but these tend to be based on ADASS regional groups or communities of interest (for example the "three Wishes" measure developed within the ADASS South East Performance Network). Moving on from these smaller groups to national standards that all councils will adhere to will be quite challenging, given the variety of approaches and systems in use, although discussions with DH are very mature as to taking these approaches forward.

Sarah Norman: Joint Chair ADASS Standards & Performance Committee

Paul Najsarek: Joint Chair ADASS Standards & Performance Committee

Richard Jones: President ADASS

Appendix A

Domain 1: Promoting personalisation and enhancing quality of life for people with care and support needs

Measure 1A	Social care-related quality of life
Domain	Promoting personalisation and enhancing quality of life for people with care and support needs (overarching measure)
Rationale / Description	A composite measure reflecting social care users' reported experience of seven outcome domains: control, dignity, personal care, food and nutrition, safety, social participation and accommodation. Provides an overarching view of quality of life based on outcomes relevant to social care. Can be weighted and able to be developed to show 'value added' by social care within 1-2 years.
Data source	Adult Social Care Survey (Social care data collections, to be published by NHS IC from 2011)
Frequency of collection	Annual
Relevant and meaningful to the public	No – whilst the ASCOT work by PSSRU is very interesting and potentially very useful, making a composite indicator based on weighted responses to seven different survey areas “meaningful to the public” will be very challenging.
Substantially influenced by adult social care	Partial – Also of limited use in performance management at local level as result will only be available annually and will be composite of seven factors.
Comparable between local areas and over time	Yes
A measure of social care outcome	Yes – concept of social care related quality of life.
Can be disaggregated by equalities	Yes – but robust equalities analysis at a local level will need current plans for stratified sampling to be agreed and implemented
Currently collected	Yes
Definition and Measurement Issues	None identified as yet - full detail yet to be specified but will be based on PSSRU ASCOT methodology. Councils will want to see and understand the formula in the ASCOT methodology and comment on this prior to its use – although the data is not new, the formula is and the detail may need some further work to secure ownership.
Data available and statistically appropriate	Yes
Does the measure create perverse incentives?	None identified
Risks or consequences of inclusion in Framework	None identified
What alternative indicators are feasible for this area	Appears to be the best available overarching measure for social care related quality of life.
Overall comment	Include as described in national indicator framework but be aware of limitations around making it “meaningful to the public”.

Measure 1B	The proportion of people using adult social care services who have control over their daily life
Domain	Promoting personalisation and enhancing quality of life for people with care and support needs (outcome measure)
Rationale / Description	A self-reported measure, reflecting the individual's perception of their control over their daily life. Control is a key aspect of independence, and contributes to quality of life for people who use social care.
Data source	Adult Social Care Survey (Social care data collections, to be published by NHS IC from 2011)
Frequency of collection	Annual
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	Partial – Also of limited use in performance management at local level as result will only be available annually.
Comparable between local areas and over time	Yes
A measure of social care outcome	Yes – relates directly to the key issue of choice and control
Can be disaggregated by equalities	Yes – but robust equalities analysis at a local level will need current plans for stratified sampling to be agreed and implemented
Currently collected	Yes
Definition and Measurement Issues	None identified
Data available and statistically appropriate	Yes
Does the measure create perverse incentives?	None identified
Risks or consequences of inclusion in Framework	None identified
What alternative indicators are feasible for this area	Appears to be the best available measure for this area.
Overall comment	Include as described in national indicator framework.

Measure 1C	Carer-reported quality of life
Domain	Promoting personalisation and enhancing quality of life for people with care and support needs (outcome measure)
Rationale / Description	A composite measure reflecting the combination of a number of carer-reported outcomes: control, personal care, safety, occupation, time and space, social participation, support and encouragement. This is the only current measure related to quality of life for carers available, and supports a number of the most important outcomes identified by carers themselves, to which social care contributes.
Data source	Carers' Survey (ongoing status to be determined, subject to consultation views)
Frequency of collection	Biennial (to be confirmed)
Relevant and meaningful to the public	No – whilst the ASCOT work by PSSRU is very interesting and potentially very useful, making a composite indicator based on weighted responses to seven different survey areas “meaningful to the public” will be very challenging.
Substantially influenced by adult social care	Partial – Also of limited use in performance management at local level as result will only be available biennially and will be composite of seven factors.
Comparable between local areas and over time	Yes
A measure of social care outcome	Yes – concept of social care related quality of life for carers.
Can be disaggregated by equalities	Yes – but robust equalities analysis at a local level will need current plans for stratified sampling to be agreed and implemented
Currently collected	Yes – frequency of collection needs to be at least biennial, annual would give equal weight to carers issues if this was achievable.
Definition and Measurement Issues	<p>None identified as yet - full detail yet to be specified but will be based on PSSRU ASCOT methodology. Councils will want to see and understand the formula in the ASCOT methodology and comment on this prior to its use – although the data is not new, the formula is and the detail may need some further work to secure ownership.</p> <p>Also, recent work by PSSRU on the pilot Carers' Survey has indicated that variations reported between councils may be due to wide variations between carers and services they receive. There are related definitional issues in terms of the difference between carers known to councils and carers assessed/reviewed in the period. Work on these issues by the User Survey Group is in hand.</p>
Data available and statistically appropriate	Yes
Does the measure create perverse incentives?	None identified
Risks or consequences of inclusion in Framework	None identified
What alternative indicators are feasible for this area	Appears to be the best available measure for this area.
Overall comment	Include as described in national indicator framework but be aware of limitations around making it “meaningful to the public”.

Measure 1D	People with long-term conditions supported to be independent and in control of their condition
Domain	Promoting personalisation and enhancing quality of life for people with care and support needs (outcome measure)
Rationale / Description	A patient-reported measure, through which people with a long-term condition report on whether have had enough support from local services to manage their condition. This is a broader measure using NHS-sourced data, which captures a wider group of individuals than the social care user equivalent, but within the same outcome theme. Social care will be one of the major services influencing responses.
Data source	NHS GP Patient Survey (www.gp-patient.co.uk/results)
Frequency of collection	Annual
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	No – as this is a GP survey asking patients if they had “enough support from local services or organisations to help manage their long term health condition(s)”, patients will inevitably respond primarily in terms of health related issues, particularly around their experience of primary and secondary health care, and are likely to give little if any regard to social care inputs or support. Indeed, many of the people responding to the GP survey may have had no need for social care inputs or support and had no contact with social care so it will play no part in their responses.
Comparable between local areas and over time	Yes
A measure of social care outcome	No – as this is part of GP patient survey the focus will inevitably be on health rather than social care aspects and many respondents may have had no need for social care support and had no contact with social care.
Can be disaggregated by equalities	Yes
Currently collected	Yes
Definition and Measurement Issues	As this is part of GP patient survey focus will inevitably be on health rather than social care aspects and many respondents may have had no need for social care support and had no contact with social care. If instead an equivalent question was added to the annual Adult Social Care Survey, as suggested in the Zero Based Review consultations, then respondents would be answering the question in a social care context, rather than primarily a health context, and would be people who had actual experience of social care, making it a much more valid measure.
Data available and statistically appropriate	Yes – data would also be available for the alternate proposal of surveying this issue through the annual Adult Social Care Survey.
Does the measure create perverse incentives?	No – GP survey based measure would probably be seen as mainly irrelevant by most of adult social care community.
Risks or consequences of inclusion in Framework	Likely to be seen as mainly irrelevant by most of adult social care community and thus inclusion will negatively impact on the overall perception of the relevance and value of the new national outcomes framework.
What alternative indicators are feasible for this area	As stated above, if instead an equivalent question was added to the annual Adult Social Care Survey then respondents would be answering the question in a social care context, rather than primarily a health context, and would be people who had actual experience of social care, making it a much more valid measure.
Overall comment	Replace with an equivalent question added to the annual Adult Social Care Survey.

Measure 1E	Proportion of adults with learning disabilities in employment
Domain	Promoting personalisation and enhancing quality of life for people with care and support needs (outcome measure)
Rationale / Description	This measures the proportion of adults with learning disabilities known to the council who are in paid employment. It is a key outcome for people with learning disabilities, supporting improved quality of life and reducing the risk of social exclusion.
Data source	Adult Social Care Combined Activity Return (Social care data collections, published by NHS IC: http://nascis.ic.nhs.uk/)
Frequency of collection	Annual
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	Partial
Comparable between local areas and over time	Yes
A measure of social care outcome	Yes
Can be disaggregated by equalities	Partial – scope for robust equalities analysis at a local level is very limited as this is a small subset of adults with learning disabilities aged 18 to 64 years.
Currently collected	Yes
Definition and Measurement Issues	As currently defined (NI 146), this indicator measures adults with learning disabilities who are known to social care and are assessed or reviewed (mainly reviewed) in the year. It takes the actual performance on supporting people with learning disabilities in employment and filters it through the reviewing performance for adults with learning disabilities – thus a council could have an excellent employment support service but poor reviewing performance and score badly against this employment indicator.
Data available and statistically appropriate	Yes – but whilst data is available, this is a very small subset of adults with learning disability aged 18 to 64 years known to adult social care so there are doubts about its robustness as a measure.
Does the measure create perverse incentives?	Yes – as the indicator measures people reviewed who are in employment there is a perverse incentive to review people in employment rather than those not in employment, who may be in more need of support. Also, there is a perverse incentive to keep adults with learning disabilities “on the books” so they can be counted in this indicator when they should be living independently in the community without social care involvement.
Risks or consequences of inclusion in Framework	Inclusion of the current indicator in the national outcomes framework will miss the opportunity to focus solely on employment and not contaminate this with reviews.
What alternative indicators are feasible for this area	As stated above, the current national indicator could be revised to focus solely on employment without reviews element, enabling this to be monitored more robustly and social care appropriately held to account.
Overall comment	Revise the indicator to focus solely on employment without the reviews element, enabling this to be monitored more robustly and social care appropriately held to account.

Measure 1F	Proportion of adults in contact with secondary mental health services in employment
Domain	Promoting personalisation and enhancing quality of life for people with care and support needs (outcome measure)
Rationale / Description	This measures the proportion of adults in contact with secondary mental health services and on the Care Programme Approach who are in paid employment. It measures an important outcome for people with mental health problems, improving quality of life and reducing the risk of social exclusion.
Data source	Mental Health National Minimum Data Set (NHS Information Centre: www.ic.nhs.uk/services/mental-health/mental-health-minimum-dataset-mhmds)
Frequency of collection	Annual
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	Partial
Comparable between local areas and over time	Yes
A measure of social care outcome	Yes
Can be disaggregated by equalities	Partial – scope for robust equalities analysis at a local level is very limited as this is a small subset of adults with mental health needs aged 18 to 64 years.
Currently collected	Yes
Definition and Measurement Issues	As currently defined (NI 150), this indicator measures adults on the Care Programme Approach who are assessed or reviewed (mainly reviewed) in the year. It takes the actual performance on supporting people with mental health needs in employment and filters it through the reviewing performance for adults with mental health needs – thus a council could have an excellent employment support service but poor reviewing performance and score badly against this employment indicator.
Data available and statistically appropriate	Yes – but whilst data is available this is a very small subset of adults with mental health needs aged 18 to 64 years known to adult social care so there are doubts about its robustness as a measure.
Does the measure create perverse incentives?	Yes – as the indicator measures people reviewed who are in employment there is a perverse incentive to review people in employment rather than those not in employment, who may be in more need of support. Also, there is perverse incentive to keep adults with mental health needs “on the books” so they can be counted in this indicator when they should be living independently in the community without social care involvement.
Risks or consequences of inclusion in Framework	Inclusion of the current indicator in the national outcomes framework will miss the opportunity to focus solely on employment and not contaminate this with reviews.
What alternative indicators are feasible for this area	As stated above, the current national indicator could be revised to focus solely on employment without reviews element, enabling this to be monitored more robustly and social care appropriately held to account.
Overall comment	Revise the indicator to focus solely on employment without the reviews element, enabling this to be monitored more robustly and social care appropriately held to account.

Measure 1G	Proportion of people using social care who receive self-directed support
Domain	Promoting personalisation and enhancing quality of life for people with care and support needs (supporting quality measure)
Rationale / Description	Personalisation is one of the most important policy objectives for adult social care, and this measure is intended to demonstrate the success of councils in providing self-directed support (including personal budgets) to those who use services. Although this is an activity measure, it is closely related to improved outcomes and supports the aims of the Social Care Vision and partnership agreement. The definition of the existing indicator will be reviewed with the sector, and appropriate amendments made to ensure this reflects policy intent.
Data source	Referrals, Assessments and Packages of care (RAP) (Social care data collections, published by NHS IC: http://nascis.ic.nhs.uk/)
Frequency of collection	Annual
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	Yes
Comparable between local areas and over time	Yes
A measure of social care outcome	Yes
Can be disaggregated by equalities	Yes
Currently collected	Yes
Definition and Measurement Issues	As currently defined (NI 130), this indicator combines people who have followed a Self Directed Support process and those who have received a Direct Payment. Whilst it can clearly be argued that a Direct Payment gives people choice and control in how their support needs are met and is thus an outcome, it is far harder to argue that solely following a Self Directed Support process gives people an equivalent choice and control outcome. It is thus proposed that these two elements are separated out into two indicators – people receiving support following a Self Directed Support process and people receiving Direct Payments in the year (which by 2011/12 will be largely a subset of the former). The denominator for this indicator urgently needs to be revised to remove services not eligible for Self Directed Support such as reablement and rehabilitation that could cause perverse incentives.
Data available and statistically appropriate	Yes – data is also available for the alternate proposal of two indicators to separate Self Directed Support process from Direct Payment outcome.
Does the measure create perverse incentives?	Yes – as long as Self Directed Support process and Direct Payment outcome are combined in a single national indicator there is a perverse incentive to focus on Self Directed Support side and, perhaps particularly with older people, reduce this to a mere step in the assessment process that offers little real choice and control.
Risks or consequences of inclusion in Framework	Inclusion of the existing indicator in the national outcomes framework will perpetuate the shortcomings of this indicator and miss the opportunity to separate out Self Directed Support process from Direct Payment outcome.
What alternative indicators are feasible for this area	As stated above, the current national indicator could be split into two indicators to separate out Self Directed Support process from Direct Payment outcome, enabling both to be monitored separately.
Overall comment	Revise the current national indicator into two indicators to separate out Self Directed Support process from Direct Payment outcome, enabling both to be monitored separately.

Domain 2: Preventing deterioration, delaying dependency and supporting recovery

Measure 2A	Percentage of emergency admissions to any hospital in England occurring within 28 days of the last, previous discharge from hospital
Domain	Preventing deterioration, delaying dependency and supporting recovery (overarching measure)
Rationale / Description	This measure follows individuals discharged from hospitals to monitor success in avoiding emergency readmissions. Health and social care will play significant roles in putting in place the right reablement, rehabilitation and intermediate care services to support individuals to return home or regain their independence, so avoiding crisis in the short-term. This is a good overarching measure, since it captures a broad range of adults and links to the NHS.
Data source	NHS Hospital Episode Statistics (National Centre for Health Outcomes Development, NHS IC: www.nchod.nhs.uk)
Frequency of collection	Annual
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	No – whilst social care may play a part in ensuring some patients are not readmitted to hospital, many patients may have had no need for social care support and had no contact with social care so it is hard to argue that this is “substantially influenced” by social care.
Comparable between local areas and over time	Yes
A measure of social care outcome	No – it is not clear how avoiding emergency readmissions to hospital is a social care outcome.
Can be disaggregated by equalities	Partial
Currently collected	Yes
Definition and Measurement Issues	This primarily health related indicator is not in the Health Outcomes Framework for 2011/12 as there are concerns within health as to how it operates as a proxy for recovery when many readmissions are entirely unrelated to the original cause of admission. It is understood that further work will be undertaken by health colleagues during 2011/12 to develop an improved indicator with view to introduction in 2012/13. In this context, it seems premature to introduce it as a social care indicator in 2011/12.
Data available and statistically appropriate	Yes – but significant concerns about current definition and measurement.
Does the measure create perverse incentives?	None identified for social care.
Risks or consequences of inclusion in Framework	Likely to be seen as flawed and premature by most of adult social care community and thus inclusion will negatively impact on the overall perception of the robustness, relevance and value of the new national outcomes framework.
What alternative indicators are feasible for this area	Not currently known
Overall comment	Whilst it is important to link health and social care outcomes, it would be premature to include this in the national indicator set in 2011/12, given its current status in the Health Outcomes Framework and concerns about its attributability to social care. It would seem more appropriate to record a “place marker” in this area for 2011/12 with a view to further work and the introduction of an agreed appropriate measure in 2012/13.

Measure 2B	Admissions to residential care homes, per 1,000 population
Domain	Preventing deterioration, delaying dependency and supporting recovery (overarching measure)
Rationale / Description	Permanent placements in residential care homes are a good indication of increasing dependency, and local health and social care services will be working together to reduce avoidable admissions. This measure gives an indication of number of admissions to care homes, expressed in terms of the size of the local population.
Data source	Referrals, Assessments and Packages of care (RAP) (Social care data collections, published by NHS IC: http://nascis.ic.nhs.uk/) ***
Frequency of collection	Annual
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	Yes
Comparable between local areas and over time	Yes
A measure of social care outcome	Partial
Can be disaggregated by equalities	Yes
Currently collected	Yes
Definition and Measurement Issues	<p>As currently set out this indicator describes permanent admissions to residential care whereas it is probably intended to include permanent admissions to both residential and nursing care and it would probably be helpful to rename the indicator "Permanent admissions to residential and nursing care per 1,000 population".</p> <p>This is a useful indicator and quite similar to the previous national indicators PAF C72 and PAF C73 which measured the rate of permanent admissions for adults 65 years and over (PAF C72) and for adults aged 18 to 64 years (PAF C73). Whilst there is a case for looking at the rate of permanent admissions for the two age groups separately, this is probably more appropriately done at a local level as the current very small numbers of permanent admissions for people aged 18-64 years would compromise its robustness as a possible separate national measure.</p>
Data available and statistically appropriate	Yes – data is available but would need to come from the ASC CAR return as admissions are not recorded in the RAP return as stated.
Does the measure create perverse incentives?	Whilst there are no obvious perverse incentives, there is some risk of "gaming" by disguising permanent admissions as temporary admissions.
Risks or consequences of inclusion in Framework	None identified
What alternative indicators are feasible for this area	Appears to be the best available measure for this area.
Overall comment	Include as described in national indicator framework but rename to make meaning clearer.

Measure 2C	Older people discharged from hospital to rehabilitation or intermediate care, who are living at home 91 days after discharge
Domain	Preventing deterioration, delaying dependency and supporting recovery (outcome measure)
Rationale / Description	This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether and individual remains living at home 91 days following discharge. It captures the joint work of social services and health staff and services commissioned by joint teams
Data source	Adult Social Care Combined Activity Return (Social care data collections, published by NHS IC: http://nascis.ic.nhs.uk/)
Frequency of collection	Annual
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	Partial – the indicator currently includes people rehabilitated by both health and social care.
Comparable between local areas and over time	Yes
A measure of social care outcome	Yes
Can be disaggregated by equalities	Partial
Currently collected	Yes
Definition and Measurement Issues	As currently defined (NI 125), this indicator measures the rehabilitation success rate of both health and social care for older people discharged from hospital in terms of whether they are still living at home 91 days after discharge. It fails to address the availability or scale of rehabilitation services, so an area which rehabilitates only a small proportion of people (effectively “creaming off the top” those people most likely to benefit) will tend to score higher than an area which rehabilitates a much larger proportion of people with inevitably a more mixed likelihood of success in terms of living at home 91 days after discharge. It is thus proposed that this weakness in the indicator is addressed by changing the denominator to make it a rate of older people successfully rehabilitated per 1,000 older people discharged from hospital in the period.
Data available and statistically appropriate	Yes
Does the measure create perverse incentives?	As currently defined the measure creates a perverse incentive to rehabilitate a smaller number of people who are most likely to be successfully rehabilitated. The proposed change in the denominator addresses this.
Risks or consequences of inclusion in Framework	None identified
What alternative indicators are feasible for this area	As stated above, the indicator would be significantly improved by changing the denominator to make it a rate of older people successfully rehabilitated per 10,000 older people in local population.
Overall comment	Revise the current national indicator by changing the denominator to make it a rate of older people successfully rehabilitated per 10,000 older people in local population.

Measure 2D	Emergency bed days associated with multiple (two or more in a year) acute hospital admissions for over 75s
Domain	Preventing deterioration, delaying dependency and supporting recovery (outcome measure)
Rationale / Description	This measure focuses on the incidence of repeat emergency admissions to hospitals, and their subsequent impact on the NHS in terms of bed days required. Health and social care services should work together to prevent crisis and emergency admissions through intermediate care and reablement, to support older people to live independently. This measure focuses on over 75s since evidence suggests that repeat admissions are most common in this group.
Data source	NHS Hospital Episode Statistics (NHS IC: www.hesonline.nhs.uk)
Frequency of collection	Monthly
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	No – whilst social care may play a part in ensuring some patients are not admitted to hospital on an emergency basis, many patients may have had no need for social care support and had no contact with social care so it is hard to argue that this is “substantially influenced” by social care.
Comparable between local areas and over time	Yes
A measure of social care outcome	No – it is not clear how avoiding emergency admissions to hospital is a social care outcome.
Can be disaggregated by equalities	Partial
Currently collected	Yes
Definition and Measurement Issues	This primarily health related indicator is not in either the final version of the Health Outcomes Framework or the NHS Operating Framework. In this context, it seems inappropriate to introduce it as a social care indicator in 2011/12.
Data available and statistically appropriate	Yes – but major concerns about definition and measurement.
Does the measure create perverse incentives?	None identified for social care.
Risks or consequences of inclusion in Framework	Likely to be seen as flawed and of limited relevance by most of adult social care community and thus inclusion will negatively impact on the overall perception of the robustness, relevance and value of the new national outcomes framework.
What alternative indicators are feasible for this area	Not currently known
Overall comment	Whilst it is important to link health and social care outcomes, it would be inappropriate to include this in the national indicator set in 2011/12, given that it is not in either the final version of the Health Outcomes Framework or the NHS Operating Framework and concerns about its attributability to social care.

Measure 2E	The proportion of people suffering fragility fractures who recover to their previous levels of mobility / walking ability at 120 days
Domain	Preventing deterioration, delaying dependency and supporting recovery (outcome measure)
Rationale / Description	This measures the success of NHS and social care in supporting recovery for individuals who have suffered fragility fractures, usually after a fall, by measuring their mobility and walking ability 120 days after their admission to hospital. Data is collected by acute hospital so would have to be amended for council area.
Data source	National Hip Fracture Database (http://www.nhfd.co.uk)
Frequency of collection	Annual
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	No – whilst social care may play a part in ensuring some older people successfully regain their mobility following a fracture, many patients may have had no need for social care support and had no contact with social care so it is hard to argue that this is “substantially influenced” by social care.
Comparable between local areas and over time	Yes
A measure of social care outcome	Partial
Can be disaggregated by equalities	Partial
Currently collected	Yes
Definition and Measurement Issues	This primarily health related indicator is not in the Health Outcomes Framework for 2011/12 as the exact details of how the indicator will be constructed have yet to be confirmed. It is understood that further work will be undertaken by health colleagues during 2011/12 to develop an indicator with view to introduction in 2012/13. In this context, it seems premature to introduce it as a social care indicator in 2011/12.
Data available and statistically appropriate	Yes – but significant concerns about current definition and measurement.
Does the measure create perverse incentives?	None identified for social care.
Risks or consequences of inclusion in Framework	Likely to be seen as flawed and premature by most of adult social care community and thus inclusion will negatively impact on the overall perception of the robustness, relevance and value of the new national outcomes framework.
What alternative indicators are feasible for this area	Not currently known
Overall comment	Whilst it is important to link health and social care outcomes, it would be premature to include this in the national indicator set in 2011/12, given its current status in the Health Outcomes Framework and concerns about its attributability to social care. It would seem more appropriate to record a “place marker” in this area for 2011/12 with a view to further work and the introduction of an agreed appropriate measure in 2012/13.

Measure 2F	Delayed transfers of care
Domain	Preventing deterioration, delaying dependency and supporting recovery (supporting quality measure)
Rationale / Description	This measure reflects the impact of NHS and adult social care services in facilitating timely and appropriate discharge from hospitals for all adults. Although it is more focused on activity, it is a whole-system measure which remains a useful proxy for system health and efficiency, as well as being linked to better outcomes for individuals.
Data source	NHS hospital data (UNIFY2, access limited to NHS and local authority partners: http://nww.unify2.dh.nhs.uk/unify/interface/homepage.aspx)
Frequency of collection	Monthly
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	Partial - as currently defined, this indicator measures delayed transfers of care attributable to both health and social care.
Comparable between local areas and over time	Yes
A measure of social care outcome	Partial
Can be disaggregated by equalities	Partial
Currently collected	Yes
Definition and Measurement Issues	As currently defined (NI 131), this indicator measures delayed transfers of care attributable to both health and social care. However, it is possible to extract from the existing dataset delayed transfers of care solely attributable to social care and the Care Quality Commission tended to use this more focussed measure when judging performance. Revision of the current indicator to solely reflect delayed transfers of care attributable to social care would clearly improve its rating on "substantially influenced by social care". The counter argument would be that the current combined health and social care measure reflects "whole system" issues, including joint working.
Data available and statistically appropriate	Yes – data is also available for the alternate proposal of counting delayed transfers of care solely attributable to social care.
Does the measure create perverse incentives?	None identified
Risks or consequences of inclusion in Framework	Inclusion of the existing indicator in the national outcomes framework will perpetuate the shortcomings of this indicator and miss the opportunity to separately identify delayed discharges attributable to social care.
What alternative indicators are feasible for this area	As stated above, the current national indicator could be revised to solely reflect delayed transfers of care attributable to social care, enabling this to be monitored more easily and social care appropriately held to account.
Overall comment	Consider revising the current national indicator to solely reflect delayed transfers of care attributable to social care, enabling this to be monitored more easily and social care appropriately held to account. Alternately, the delayed transfers attributable to social care could be reported as a sub-indicator to the main combined health and social care result.

Measure 2G	Proportion of council spend on residential care
Domain	Preventing deterioration, delaying dependency and supporting recovery (supporting quality measure)
Rationale / Description	Councils can increase efficiencies and improve outcomes for people by focusing on lower-cost, more appropriate services, particularly for older people. The balance of overall spend on residential care is a measure of how councils are designing services, including reablement and preventative services, to avoid more costly care.
Data source	Personal Social Services Expenditure (PSSEX1) (Social care data collections, published by NHS IC: http://nascis.ic.nhs.uk/)
Frequency of collection	Annual
Relevant and meaningful to the public	Partial
Substantially influenced by adult social care	Yes
Comparable between local areas and over time	Yes
A measure of social care outcome	Partial
Can be disaggregated by equalities	Partial
Currently collected	Yes
Definition and Measurement Issues	Whilst it is a good idea to have an indicator that looks at how councils are changing their pattern of expenditure to support the new national agenda and improve value for money, this proposed indicator is unlikely to achieve this and is potentially very misleading. As it measures expenditure on residential (and presumably nursing) care, it already overlaps significantly with indicator 2B which measures the rate of permanent admissions and it is seriously compromised by the lack of relevant detail in the stated data source, the current PSS EX1 return. Crucially, PSS EX1 currently fails to distinguish between expenditure on permanent residential and nursing care and temporary residential and nursing care used to maintain people in the community such as residential rehabilitation, respite care to support carers and short stays. Thus the data from the current PSS EX1 will not support teasing out the relevant issues but will just provide a crude overall proportion of spend on all forms of residential and nursing care.
Data available and statistically appropriate	Yes – but significant concerns about current definition and measurement.
Does the measure create perverse incentives?	None identified
Risks or consequences of inclusion in Framework	Likely to be seen as flawed and premature by most of adult social care community and thus inclusion will negatively impact on the overall perception of the robustness, relevance and value of the new national outcomes framework.
What alternative indicators are feasible for this area	It would be possible to develop one or more indicators to look at the changing balance of social care expenditure and value for money. It is particularly desirable to measure investment in activities that keep people out of long term involvement with social care, such as prevention, signposting and reablement, to address the existing imbalance in the indicator set in terms of its concentration on people “on the books”.
Overall comment	This seems an ideal candidate for a “place marker” for 2011/12 to enable more useful indicators to be developed looking at both the changing balance of social care expenditure and value for money issues, to be collected through an improved PSS EX1 return in 2012/13.

Domain 3: Ensuring a positive experience of care and support

Measure 3A	Overall satisfaction with local adult social care services
Domain	Ensuring a positive experience of care and support (overarching measure)
Rationale / Description	This measures the overall satisfaction of people using social care with the services they receive from the council, as reported through a survey. Satisfaction is a more subjective outcome, incorporating expectations as well as experience. This is a high-level representation of the success of councils in achieving outcomes for people.
Data source	Adult Social Care Survey (Social care data collections, to be published by NHS IC from 2011)
Frequency of collection	Annual
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	Yes - but of limited use in performance management at local level as result will only be available annually.
Comparable between local areas and over time	Yes
A measure of social care outcome	Yes
Can be disaggregated by equalities	Yes – but robust equalities analysis at a local level will need current plans for stratified sampling to be agreed and implemented
Currently collected	Yes
Definition and Measurement Issues	None identified
Data available and statistically appropriate	Yes
Does the measure create perverse incentives?	None identified
Risks or consequences of inclusion in Framework	None identified
What alternative indicators are feasible for this area	Appears to be the best available overarching measure for this area.
Overall comment	Include as described in national indicator framework.

Measure 3B	The proportion of carers who report that they have been included or consulted in discussions about the person they care for
Domain	Ensuring a positive experience of care and support (outcome measure)
Rationale / Description	Carers should be respected as equal partners in service design for those individuals for whom they care – this improves outcomes both for the cared-for person and the carer, reducing the chance of a breakdown in care. This measure reflects the experience of carers in how they have been consulted by both NHS and social care, so provides a link to successful partnership work on supporting this group.
Data source	Carers' Survey (ongoing status to be determined, subject to consultation views)
Frequency of collection	Biennial
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	Partial – Also of limited use in performance management at local level as result will only be available biennially.
Comparable between local areas and over time	Yes
A measure of social care outcome	Yes
Can be disaggregated by equalities	Yes – but robust equalities analysis at a local level will need current plans for stratified sampling to be agreed and implemented
Currently collected	Yes – frequency of collection needs to be at least biennial, annual would give equal weight to carers issues if this was achievable.
Definition and Measurement Issues	None identified
Data available and statistically appropriate	Yes
Does the measure create perverse incentives?	None identified
Risks or consequences of inclusion in Framework	None identified
What alternative indicators are feasible for this area	Appears to be the best available measure for this area.
Overall comment	Include as described in national indicator framework.

Measure 3C	The proportion of social care users and carers who express difficulty in finding information and advice about services
Domain	Ensuring a positive experience of care and support (outcome measure)
Rationale / Description	This measure reflects social care users' and carers' experience of access to information and advice about social care. Information is a core universal provision, and a key factor in early intervention and reducing dependency. This is a combination of relevant questions in the surveys for social care users and carers – an alternative measure might look at one group alone.
Data source	Adult Social Care Survey and Carers' Survey (Social care data collections, to be published by NHS IC from 2011)
Frequency of collection	Annual
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	Partial – Also of limited use in performance management at local level as result will only be available annually.
Comparable between local areas and over time	Yes
A measure of social care outcome	Partial
Can be disaggregated by equalities	Yes – but robust equalities analysis at a local level will need current plans for stratified sampling to be agreed and implemented
Currently collected	Yes
Definition and Measurement Issues	The availability of high quality information and advice for both users and carers is central to the personalisation and choice and control agendas. However, simply surveying users and carers who are in contact with adult social care is likely to miss out people who failed to establish contact because they found it difficult to access information and advice.
Data available and statistically appropriate	Yes
Does the measure create perverse incentives?	None identified
Risks or consequences of inclusion in Framework	None identified
What alternative indicators are feasible for this area	Appears to be the best available measure for this area.
Overall comment	Include as described in national indicator framework.

Domain 4: Protecting from avoidable harm and caring in a safe environment

Measure 4A	Percentage of adult social care users who feel safe and secure
Domain	Protecting from avoidable harm and caring in a safe environment (overarching measure)
Rationale / Description	This measure gives an overview of social care user-reported experience of safety, and acts as a good overarching measure for this domain. It is a single question in the ASCS, so this is strongly linked to the SCRQOL measure. Responses on safety are likely to include factors outside of social care control, so the nature of the link to social care will have to be developed through further analysis.
Data source	Adult Social Care Survey (Social care data collections, to be published by NHS IC from 2011)
Frequency of collection	Annual
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	Partial – Also of limited use in performance management at local level as result will only be available annually.
Comparable between local areas and over time	Yes
A measure of social care outcome	Partial
Can be disaggregated by equalities	Yes – but robust equalities analysis at a local level will need current plans for stratified sampling to be agreed and implemented
Currently collected	Yes
Definition and Measurement Issues	As currently set out in the Adult Social Care Survey (question 7 “ <i>By feeling safe we mean feeling safe both inside and outside the home. This includes fear of abuse, falling or other physical harm and fear of being attacked or robbed</i> ”), this includes factors outside of the control of social care, particularly community safety issues such as the perceived risk of crime or intimidation. This could easily be addressed by rewording the question to remove these factors to make the response more directly attributable to adult social care. The counter argument is that the current question includes factors outside the direct control of social care but that are within the broader responsibilities of the council as a whole and its partners. In absolute terms, there is also the issue that some service users are more likely to feel unsafe simply because of the nature of their condition than the public in general.
Data available and statistically appropriate	Yes – data would also be available for the alternate proposal with revised wording to focus on safety issues more directly attributable to social care.
Does the measure create perverse incentives?	None identified
Risks or consequences of inclusion in Framework	Inclusion of the current indicator in the national outcomes framework will miss the opportunity to separately focus on safety issues more directly attributable to social care.
What alternative indicators are feasible for this area	As stated above, the current national indicator could be revised to focus on safety issues more directly attributable to social care, enabling this to be monitored more easily and social care appropriately held to account.
Overall comment	Consider revising the indicator with changed wording of the question to focus on safety issues more directly attributable to social care, enabling this to be monitored more easily and social care appropriately held to account.

Measure 4B	Acute admissions as a result of falls and falls injuries for over 65s
Domain	Protecting from avoidable harm and caring in a safe environment (outcome measure)
Rationale / Description	Falls are the single largest cause of emergency hospital admissions for older people, and significantly impact on long-term outcomes. A measure which reflects the success of services in preventing falls will give an indication of how the NHS, public health and social care are working together to tackle issues locally.
Data source	NHS Hospital Episode Statistics (NHS IC: www.hesonline.nhs.uk)
Frequency of collection	Monthly
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	No – falls prevention is primarily a public health responsibility and although there is a role for social care in ensuring people identified as particularly at risk of falls are put in touch with falls prevention programmes, it is hard to see that this makes it “substantially influenced” by social care.
Comparable between local areas and over time	Yes
A measure of social care outcome	Partial
Can be disaggregated by equalities	Partial
Currently collected	Yes
Definition and Measurement Issues	This primarily health related indicator is not in the either the final version of the Health Outcomes Framework or the NHS Operating Framework. In this context, it seems inappropriate to introduce it as a social care indicator in 2011/12.
Data available and statistically appropriate	Yes – but major concerns about definition and measurement.
Does the measure create perverse incentives?	None identified for social care.
Risks or consequences of inclusion in Framework	Likely to be seen as flawed and premature by most of adult social care community and thus inclusion will negatively impact on the overall perception of the robustness, relevance and value of the new national outcomes framework.
What alternative indicators are feasible for this area	Not currently known
Overall comment	Whilst it is important to link health and social care outcomes, it would be inappropriate to include this in the national indicator set in 2011/12, given that it is not in the either the final version of the Health Outcomes Framework or the NHS Operating Framework and concerns about its attributability to social care.

Measure 4C	Proportion of adults in contact with secondary mental health services in settled accommodation
Domain	Protecting from avoidable harm and caring in a safe environment (outcome measure)
Rationale / Description	This measures the proportion of adults in contact with secondary mental health services and on the Care Programme Approach who are in settled accommodation. Like the learning disabilities equivalent, it measures an important outcome for people with mental health problems, improving safety and reducing the risk of social exclusion.
Data source	Mental Health National Minimum Data Set (NHS Information Centre: www.ic.nhs.uk/services/mental-health/mental-health-minimum-dataset-mhmds)
Frequency of collection	Annual
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	Partial
Comparable between local areas and over time	Yes
A measure of social care outcome	Yes
Can be disaggregated by equalities	Partial – scope for robust equalities analysis at a local level is limited as this is a subset of adults with mental health needs aged 18 to 64 years.
Currently collected	Yes
Definition and Measurement Issues	As currently defined (NI 149), this indicator measures adults on the Care Programme Approach who are assessed or reviewed (mainly reviewed) in the year. It takes the actual performance on supporting people with mental health needs in settled accommodation and filters it through the reviewing performance for adults with mental health needs – thus a council could have an excellent performance on maintaining people in settled accommodation but poor reviewing performance and score badly against this settled accommodation indicator.
Data available and statistically appropriate	Yes
Does the measure create perverse incentives?	Yes – as the indicator measures people reviewed who are in settled accommodation there is a perverse incentive to review people in settled accommodation rather than those in unsettled accommodation, who may be in more need of support. Also, there is perverse incentive to keep adults with mental health needs “on the books” so they can be counted in this indicator when they should be living independently in the community without social care involvement.
Risks or consequences of inclusion in Framework	Inclusion of the current indicator in the national outcomes framework will miss the opportunity to focus solely on settled accommodation and not contaminate this with reviews.
What alternative indicators are feasible for this area	As stated above, the current national indicator could be revised to focus solely on settled accommodation without reviews element, enabling this to be monitored more robustly and social care appropriately held to account.
Overall comment	Revise the indicator to focus solely on settled accommodation without the reviews element, enabling this to be monitored more robustly and social care appropriately held to account.

Measure 4D	Proportion of adults with learning disabilities in settled accommodation
Domain	Protecting from avoidable harm and caring in a safe environment (outcome measure)
Rationale / Description	This measures the proportion of adults with learning disabilities known to the council who are in settled accommodation. The nature of accommodation for people with learning disabilities is linked to better outcomes, and has a strong impact on their safety and overall quality of life and reducing social exclusion.
Data source	Adult Social Care Combined Activity Return (Social care data collections, published by NHS IC: http://nascis.ic.nhs.uk/)
Frequency of collection	Annual
Relevant and meaningful to the public	Yes
Substantially influenced by adult social care	Partial
Comparable between local areas and over time	Yes
A measure of social care outcome	Yes
Can be disaggregated by equalities	Partial – scope for robust equalities analysis at a local level is limited as this is a subset of adults with learning disabilities aged 18 to 64 years.
Currently collected	Yes
Definition and Measurement Issues	As currently defined (NI 145), this indicator measures adults with learning disabilities known to social care that are assessed or reviewed (mainly reviewed) in the year. It takes the actual performance on supporting people with learning disabilities in settled accommodation and filters it through the reviewing performance for adults with learning disabilities – thus a council could have an excellent performance on maintaining people in settled accommodation but poor reviewing performance and score badly against this settled accommodation indicator.
Data available and statistically appropriate	Yes
Does the measure create perverse incentives?	Yes – as the indicator measures people reviewed who are in settled accommodation there is a perverse incentive to review people in settled accommodation rather than those in unsettled accommodation, who may be in more need of support. Also, there is perverse incentive to keep adults with learning disabilities “on the books” so they can be counted in this indicator when they should be living independently in the community without social care involvement.
Risks or consequences of inclusion in Framework	Inclusion of the current indicator in the national outcomes framework will miss the opportunity to focus solely on settled accommodation and not contaminate this with reviews.
What alternative indicators are feasible for this area	As stated above, the current national indicator could be revised to focus solely on settled accommodation without reviews element, enabling this to be monitored more robustly and social care appropriately held to account.
Overall comment	Revise the indicator to focus solely on settled accommodation without the reviews element, enabling this to be monitored more robustly and social care appropriately held to account.

Measure 4E	Percentage of all referrals to adult safeguarding services which are repeat referrals
Domain	Protecting from avoidable harm and caring in a safe environment (supporting quality measure)
Rationale / Description	This a measure of the quality of local safeguarding procedures and services, drawn from activity data supplied by councils. The measure captures repeat referrals of vulnerable adults to safeguarding services, as a proxy for success in securing safety and reducing multiple referrals for the same individual.
Data source	Abuse of Vulnerable Adults (AVA) Return (Social care data collections, published by NHS IC: http://nascis.ic.nhs.uk/)
Frequency of collection	Annual
Relevant and meaningful to the public	Partial
Substantially influenced by adult social care	Partial
Comparable between local areas and over time	Yes
A measure of social care outcome	Partial
Can be disaggregated by equalities	Yes
Currently collected	Yes
Definition and Measurement Issues	Whilst it is important to include safeguarding in the new national indicator set, it is not clear that this is the most useful indicator or that it should be the only safeguarding measure. As currently defined (in the guidance to the AVA return), all subsequent referrals for an individual within the period count as repeat referrals, irrespective of whether they are the same type of abuse or in the same setting. Thus an older person who was financially abused by a neighbour repeatedly keeping the change from doing her shopping at the start of the year and then hit by a disorientated fellow day care user at the end of the year would count as a repeat referral, even though the first episode was entirely unrelated and may have been dealt with entirely appropriately in safeguarding terms. It would seem more appropriate to at least restrict the definition of repeat referrals to the same type of abuse.
Data available and statistically appropriate	Yes – data would also be available for the alternate proposal with revised tighter definition of repeat referral relating only to same type of abuse.
Does the measure create perverse incentives?	None identified
Risks or consequences of inclusion in Framework	Inclusion of this indicator as currently defined in the national outcomes framework will miss the opportunity to focus more clearly on genuine repeat referrals concerning the same type of abuse.
What alternative indicators are feasible for this area	As stated above, the current national indicator could be revised to focus more clearly on genuine repeat referrals concerning same type of abuse, enabling this to be monitored more easily and social care appropriately held to account. There may also be other safeguarding indicators that should be added to national indicator set but further work is required on this.
Overall comment	Consider revising the indicator by changing the definition of repeat to focus more clearly on genuine repeat referrals concerning same type of abuse, enabling this to be monitored more easily. Also consider establishing a “place marker” for further/alternate safeguarding indicators to be developed in 2011/12 and implemented from 2012/13.