

Title: Transparency in Outcomes: A Framework for Quality in Adult Social Care Lead department or agency: Department of Health Other departments or agencies: Association of Directors of Adult Social Care Local Government Group The Information Centre for Health and Social Care	Impact Assessment (IA)
	IA No: 7020
	Date: 31/03/2011
	Stage: Final
	Source of intervention: Domestic
Type of measure: Other	

Summary: Intervention and Options

What is the problem under consideration? Why is government intervention necessary?

There is considerable variation in the quality and outcomes of adult social care services. Variation indicates that local commissioners of these services are not putting sufficient pressure on providers to improve service quality, at least in some areas. Central government is responsible for shaping incentives governing local services commissioners, including through provision of comparative information.

Government intervention is necessary to promote and facilitate improvement in both quality and outcomes. In addition, it is very difficult for carers and people using services to judge quality before experiencing services unless they receive transparent data to support them.

What are the policy objectives and the intended effects?

To strengthen incentives and information for local commissioners to improve service quality by:

- enabling the public to understand outcomes and quality of care in their area, in comparison with other areas and over time, and use the information to hold their council to account and influence decisions; and
- enabling councils themselves to benchmark trends in quality and outcomes to seek ways to improve them.

This must be achieved while reducing the burden on councils of data collection and reporting.

The intended effect is to promote improvement in the quality and outcomes for users of social services primarily by reducing the variability in the quality of services.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

1. Do nothing
2. Put in place a basket of outcomes measures - the Adult Social Care Outcomes Framework - and develop the single data list for adult social care on a comparable basis across councils to facilitate accountability and improvement. Also put in place additional national mechanisms to support local accountability: (i) introduce NICE Quality Standards for social care and (ii) support councils in publishing local accounts of social care.

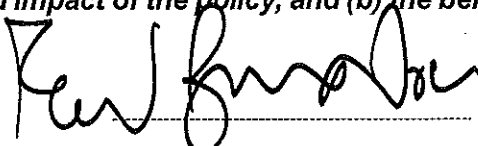
Will the policy be reviewed? It will be reviewed. If applicable, set review date: 4/2014

What is the basis for this review? PIR. If applicable, set sunset clause date: Month/Year

Are there arrangements in place that will allow a systematic collection of monitoring information for future policy review?	Yes
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SELECT SIGNATORY Sign-off For final proposal stage Impact Assessments:

I have read the Impact Assessment and I am satisfied that (a) it represents a fair and reasonable view of the expected costs, benefits and impact of the policy, and (b) the benefits justify the costs.

Signed by the responsible Minister:  Date: 22/3/11

Summary: Analysis and Evidence

Policy Option 1

Description:

Put in place a national Adult Social Care Outcomes Framework and reform the underlying single data list; councils to publish a "local account" of social care.

Price Base Year 2011	PV Base Year 2011	Time Period Years 5	Net Benefit (Present Value (PV)) (£m)		
			Low: Optional	High: Optional	Best Estimate:

COSTS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low	0.1	0.45	2.35
High	0.55	1	5.55
Best Estimate	0.4	0.75	4.15

Description and scale of key monetised costs by 'main affected groups'

There are on-going analytical and developmental costs estimated at £150,000 - £200,000 per year.

Costs to the public sector of data collection to support measures identified for the Outcomes Framework, beyond current collections, range from £300,000 - £800,000.

National and local costs of putting in place new data collections range from £100,000 - £550,000

Other key non-monetised costs by 'main affected groups'

Costs to central government and the IC to develop and put in place new data collections and disseminate data. Costs of putting in place new data collections and returning data to the IC will fall on councils.

Where authorities set local ambitions against framework indicators, there is also the cost of diverting resources to achieve them.

Production and publication of local accounts are estimated to cost up to £700,000 and sign-off of accounts by HealthWatch up to £250,000. As accounts are not mandated these are not included in the cost figures.

BENEFITS (£m)	Total Transition (Constant Price) Years	Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional	Optional	Optional
High	Optional	Optional	Optional
Best Estimate			

Description and scale of key monetised benefits by 'main affected groups'

It is not possible to monetise benefits to local people related to the level of ambition their council sets against the proposed measures because the level of ambition will be at the discretion of each council.

Other key non-monetised benefits by 'main affected groups'

Some data collections may be abolished or reduced following the ZBR.

If the measures are well chosen, the benefits arising from councils improving the quality of services and outcomes should exceed the opportunity costs incurred in so doing.

Measures that are shared with the NHS and Public Health Outcome Frameworks are expected to drive joint working, resulting in savings from reduced "cost-shifting" between services.

Key assumptions/sensitivities/risks

Discount rate (%)

The option relies on the availability of robust data and measures on quality and outcomes relevant to councils that present an accurate picture of the state of social care in a given area.

There are risks of whether the measures selected can be improved via social care interventions and whether those interventions are cost effective.

There are risks around measurements skewing priorities or impeding integrated working.

The key risk is that people and councils will not engage with the data.

Direct impact on business (Equivalent Annual) £m):			In scope of OIOO?	Measure qualifies as
Costs:	Benefits:	Net:	No	NA

Enforcement, Implementation and Wider Impacts

What is the geographic coverage of the policy/option?		England			
From what date will the policy be implemented?		01/04/2011			
Which organisation(s) will enforce the policy?		DH			
What is the annual change in enforcement cost (£m)?		N/A			
Does enforcement comply with Hampton principles?		Yes			
Does implementation go beyond minimum EU requirements?		No			
What is the CO ₂ equivalent change in greenhouse gas emissions? (Million tonnes CO ₂ equivalent)		Traded: N/A		Non-traded: N/A	
Does the proposal have an impact on competition?		No			
What proportion (%) of Total PV costs/benefits is directly attributable to primary legislation, if applicable?		Costs: N/A		Benefits: N/A	
Distribution of annual cost (%) by organisation size (excl. Transition) (Constant Price)	Micro	< 20	Small	Medium	Large
Are any of these organisations exempt?	No	No	No	No	No

Specific Impact Tests: Checklist

Set out in the table below where information on any SITs undertaken as part of the analysis of the policy options can be found in the evidence base. For guidance on how to complete each test, double-click on the link for the guidance provided by the relevant department.

Please note this checklist is not intended to list each and every statutory consideration that departments should take into account when deciding which policy option to follow. It is the responsibility of departments to make sure that their duties are complied with.

Does your policy option/proposal have an impact on...?	Impact	Page ref within IA
Statutory equality duties¹ Statutory Equality Duties Impact Test guidance	Yes	23
Economic impacts		
Competition Competition Assessment Impact Test guidance	No	
Small firms Small Firms Impact Test guidance	No	
Environmental impacts		
Greenhouse gas assessment Greenhouse Gas Assessment Impact Test guidance	No	
Wider environmental issues Wider Environmental Issues Impact Test guidance	No	
Social impacts		
Health and well-being Health and Well-being Impact Test guidance	Yes	23
Human rights Human Rights Impact Test guidance	Yes	23
Justice system Justice Impact Test guidance	No	
Rural proofing Rural Proofing Impact Test guidance	No	
Sustainable development Sustainable Development Impact Test guidance	No	

¹ Public bodies including Whitehall departments are required to consider the impact of their policies and measures on race, disability and gender. It is intended to extend this consideration requirement under the Equality Act 2010 to cover age, sexual orientation, religion or belief and gender reassignment from April 2011 (to Great Britain only). The Toolkit provides advice on statutory equality duties for public authorities with a remit in Northern Ireland.

Evidence Base (for summary sheets) – Notes

Use this space to set out the relevant references, evidence, analysis and detailed narrative from which you have generated your policy options or proposal. Please fill in **References** section.

References

Include the links to relevant legislation and publications, such as public impact assessments of earlier stages (e.g. Consultation, Final, Enactment) and those of the matching IN or OUTs measures.

No.	Legislation or publication
1	Consultation Impact Assessment
2	NHS Outcomes Framework Impact Assessment
3	Review of Arms-Length Bodies Impact Assessment
4	Health and Social Care Bill

+ Add another row

Evidence Base (for summary sheets)

A. What is the problem under consideration? Summary of analytical narrative.

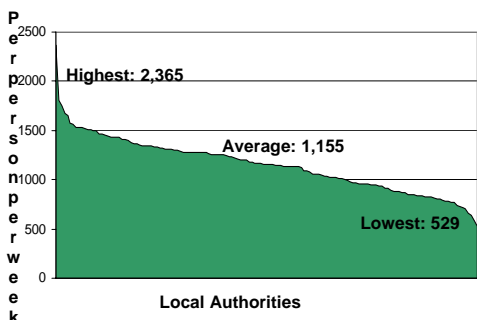
i. Characterise the underlying problem

1. There is a growing body of evidence that the quality, outcomes and user experience related to social care in England varies widely and that satisfaction compares unfavourably with some peer countries.
2. Discussion with council representatives and analysts also suggests that the current performance management system is burdensome without generating enough valuable information to justify this. At the same time, there are a number of issues with the current data collections, where we do not have adequate information on some areas, are not sufficiently focused on outcomes, or data is not valuable locally.
3. In previous times of financial difficulty, anecdotal evidence (from those involved in social care in the early 1990s) indicates that squeezing prices on care providers has led to a decline in the quality of the market.

Examples of variability in efficiency, quality, outcomes and user experience

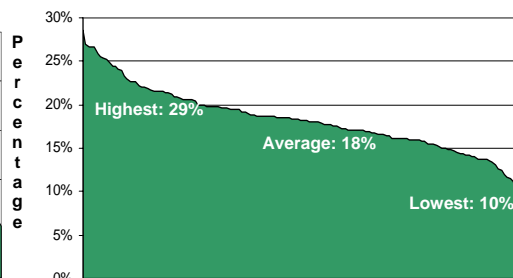
4. There is large variation in the number of people who use different types of services and unit costs in councils. This is to some extent attributable to normal factors, for instance the differing level of needs of local people, but is likely to also relate to variability in access, quality and efficiency.

Unit Cost of Residential and Nursing Care for Adults aged 18-64 with Learning Disabilities 2008-09



Source: NHS IC – PSSEX1 Proforma Unit Costs Summary

Percentage of All Clients Receiving Residential or Nursing Care Services by Local Authority as at 31st March 2009



Source: NHS IC - RAP Proforma P2s and ASC-CAR Proforma S1

5. Data from the previous National Indicator Set (NIS) also shows wide variation between councils and regions in a number of priority areas. Examples include:
 - For personalisation, the proportion of people who use services and carers receiving self-directed support varies from 3.3% to 58.7%;
 - For reablement, the proportion of over-65s receiving a reablement service who were still at home three months after discharge ranged from 50.3% to 94.5%;
 - The proportion of people with learning disabilities living in settled accommodation varied from 27.1% to 85.9%;
 - The proportion of people with learning disabilities in paid employment varied from 0% to 36.4%.
6. The proportion of people who were satisfied with the way they had been treated in the context of a particular type of service (equipment and minor adaptations) ranged from 72.5% to 96.4%.¹
7. In December 2009, CQC also published analysis of council commissioning practices which found that the proportion of council-supported residents in care homes rated good or excellent varied

¹ Figures exclude statistical outliers where sample size is too small to be statistically robust.

from 45% to 97.2%. Although there are normal factors that can contribute to this, the extent of the variation implies inconsistency in the success of commissioning strategies.²

8. Variable quality and outcomes are also reflected in the results of recent surveys related to social services:
 - A survey of adult carers in England found that the proportion of carers who were either extremely or very satisfied with the services they and the person they cared for had received over the last 12 months ranged from 24.8% to 66.3%. On the key outcome for care support – carers' quality of life – the proportion of those who rated their quality of life as "good" or better varied from 20.2% to 52.4%.³
 - A survey of home care users aged 65 and over found that the proportion of people who were either extremely or very satisfied with the services they received varied from 44.6% to 74%. The survey also showed that the proportion of people feeling in control of their lives – a key outcome for home care support – varied from 75.3% to 92.4%.⁴
9. There was also variability in the timeliness of commissioning: the percentage of new users of adult social care waiting less than four weeks for an assessment varied from 45.2% to 97.9% and the percentage of those waiting less than four weeks for the delivery of their care package once assessment was completed varied from 73.1% to 99.2%.⁵
10. Although limited measurement of outcomes to date makes it difficult to evidence variability, those instances where we can measure outcomes, such as carer quality of life and people feeling in control of their lives, show significant variation. In addition, the variation in the quality of services provided implies similar variation in outcomes, although it is not possible to quantify this correlation.

Examples of poor satisfaction

11. In a survey on perceptions of care services in European countries⁶, the UK ranked poorly on a number of subjects. Of 29 countries where the survey took place, the UK ranked:
 - 22nd for perceived availability of professional care at home;
 - 26th for perceived availability of appropriate help and long term care; and
 - 20th for overall positive experience of care services.
12. It should be noted that these are not objective measurements and may in part reflect higher expectations in the UK than in some other countries, and that a high proportion of people chose the "Don't Know" option for the UK relative to some other countries, which affects scores on positive ratings. Even allowing for these factors however, the figures represent comparatively poor satisfaction with services.
13. Additionally, a 2009/10 survey of adult carers in England found that only 54 per cent of carers reported that they were either extremely or very satisfied with the support or services they and the person they cared for had received in the last 12 months from Social Services.⁷

Examples of sub-optimal quality

14. The CQC report from December 2009 also found that while quality of social care providers had generally improved, there were still significant gaps in that:

² Our statement on the quality of adult social care" 3 December 2009:

http://www.cqc.org.uk/newsandevents/newsstories.cfm?cit_id=35577&FAArea1=customWidgets.content_view_1&usecache=false

³ "Personal Social Services Survey of Adult Carers in England - 2009-10": <http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/personal-social-services-survey-of-adult-carers-in-england--2009-10>

⁴ "Personal Social Services Home Care Users in England aged 65 and over, 2008-09 Survey": <http://www.ic.nhs.uk/statistics-and-data-collections/social-care/adult-social-care-information/personal-social-services-care-users-aged-65-or-over-england-2008-09-survey>

⁵ Figures from 2008/9 results for NI 131 and NI 132 of the National Indicator Set

⁶ European Commission report, "Health and long-term care in the European Union"; Special Eurobarometer 283/ Wave 67.3 – TNS Opinion & Social

⁷ op cit "Personal Social Services Survey of Adult Carers in England - 2009-10"

- One quarter of councils are rated only adequate in terms of giving people choice and control over their care.
- A third of councils must do more to care for people with dignity and respect.
- One in six providers is rated only poor or adequate.

15. The report stated that “councils must help get rid of poor quality care by purchasing from providers more effectively”.⁸

Examples of burdensome data collection with insufficient value

16. The annual Grant-Funded Survey return collects information on the number of people who are helped to live at home as a result of schemes provided through voluntary and other organisations funded via grants from the Council. This is a very resource-intensive data collection, estimated at costing around £500,000 nationally, which is a disproportionately high cost for the value of the information obtained.

Examples of issues with current data collections

17. One over-arching aim with reforming social care data collection will be to measure true outcomes for people wherever possible (as opposed to service activity as a proxy). For example, we currently measure the proportion of carers receiving a needs assessment or specific carers’ service (or information and advice) as a proxy for the level of support for carers in a given area. Consultation responses have supported the proposal to replace this with a survey of carers would move the focus onto whether they actually feel supported.

18. We will also seek to ensure that data is of value locally first and nationally second – this will be partly achieved by making measurements disaggregable, so that councils can identify more specific areas for improvement. The new Adult Social Care Survey is one example of this new direction.

19. On specific policy areas, examples of gaps in current collections that we would like to address as part of this work include:

- Dementia – there is only limited data to identify people with dementia in receipt of adult social care and so broader measures cannot be disaggregated to focus on dementia.
- Integration between health and social care – flows of individuals between health and care systems can demonstrate whole-economy efficiency and improve outcomes.
- Reablement – we currently have limited information to measure quality in reablement.
- Safeguarding – there remains limited scope to assess quality and outcomes in safeguarding at a local level

ii. Set out the analytical narrative

20. There are two main underlying causes of variable service quality and outcomes that we are trying to address: a lack of robust comparable information about social care outcomes and a lack of support and incentives for improvement in quality. This has led to variable quality and outcomes, as per the evidence set out above.

21. The policy objective is to make available good quality information to promote accountability of social care services to the public. This should incentivise commissioners and providers to take actions to improve quality and outcomes.

22. In order to achieve the objective, the following actions are proposed:

- putting in place the Adult Social Care Outcomes Framework to recast the focus of information on outcomes rather than service activity and ensure comparability of quality and outcomes around the country;

⁸ op cit “Our statement on the quality of adult social care” 3 December 2009”

- reforming the current set of social care data collections to create a more streamlined, robust single data list for adult social care that captures the key data on social care that is needed for national comparison;
- support the use of this more robust information by supporting councils to co-produce local accounts of social care in their area with people using services and other stakeholders; and
- bringing clarity to what high quality looks like for social care through the production of Quality Standards by the National Institute for Health and Clinical Excellence (NICE).

23. In order to meet the current gap in robust information we need to reform the current single data list for adult social care and put in place the Outcomes Framework, with appropriate dissemination and support for the use of the data. It is important to put in place these mechanisms now and begin to engender a culture of engagement within social care services; while we work to fill in placeholders in the outcomes framework and reform the data list. Without these measures, local people will not be able to hold services to account in a robust way.

24. We have tested these proposals through a consultation called *Transparency in outcomes: a framework for adult social care*, which ran from 16 November to 9 February. The consultation saw very broad support for the proposals and our assertion that a “do-nothing” approach is not tenable.

B. What are the underlying causes of the problem?

25. **There is a lack of robust comparative measures relating to quality and outcomes.**

- For example the difficulty of defining success in social care – most social care work is about managing long-term conditions and improving the lives of people with disabilities, so success can be less objective than in health (for example) where treatments can be simply either successful or not. For the same reason a “good” result is often relative, so a lack of clear benchmarking across different councils contributes to this difficulty.
- Related to the above, the lack of clarity on what quality means in social care – whereas health has NICE Quality Standards and other mechanisms, social care has had relatively little support in defining quality, which has contributed to the variability in outcomes discussed above.

26. **There is currently insufficient support and incentives for quality and outcomes to improve.**

- For example, councils receive limited national support in commissioning social care services strategically to drive up quality; this has contributed to variability because levers for commissioning quality are similarly inconsistent.
- A legacy of the poor transparency in the previous regime is a lack of public understanding of social care information and how to use this to hold local services to account – any approach will need to include measures to engender a cultural shift so that people are aware of and use the power they will hold.
- Related to this, we want to empower people with clear information about quality in social care to enable them to make informed choices about service provision to drive quality. This will be especially powerful as personal budgets become more prevalent.

27. There is a potential third underlying cause that is not addressed under these proposals – variable funding of social care services, which is to some extent at the discretion of councils and to some extent dependent on council tax receipts.

28. The relative contribution of the three underlying causes identified is not established, however it is reasonable to anticipate that improvement would result from availability of more robust comparative information.

C. What are the policy objectives and the intended effects?

29. The policy objective is to promote improvement in the quality and outcomes for users of adult social services by engendering a shift in focus towards outcomes rather than service activity and reducing the variability in the quality of services, in line with *A Vision for Adult Social Care: Capable Communities and Active Citizens*. Central government will not have a direct role in holding commissioners and providers to account, instead government will:
- enable the public to understand outcomes and quality of care in their area, in comparison with other areas and over time, and use the information to hold their council to account; and
 - enable councils themselves to benchmark trends in quality and outcomes to seek ways to improve them.
30. It is necessary to put the definition of success on a firm footing and enable Councils and local people to measure quality and outcomes in a meaningful way. This means defining quality social care and measuring quality and outcomes for people and their experiences, instead of service activity.
31. Government support to ensure that Councils, the regulator and the public understand quality and can identify when it may be at risk will be essential to prevent a dip in quality similar to previous times of financial difficulty.
32. A key part of this will be to support local accountability, by empowering local people with clear, robust information on the results achieved by their Council with regard to social care. At the same time, we will need to engender a wider cultural shift so that people engage with social care services more widely and use the information to hold them to account in this way.
33. It will be important to put in place the right incentives for providers, commissioners and users to take the necessary action to make improvements in quality and outcomes. To achieve this, data on social care should be used in the following ways:
- Local councils can benchmark their results achieved against other councils to identify areas of improvement and inform strategic commissioning;
 - Local councils can use clearer definitions of quality to inform commissioning;
 - Local people can hold their local councils to account for effectiveness and efficiency;
 - Local people can use clear definitions of quality to make informed decisions when choosing services, driving quality through competition;
 - Providers can use the Quality Standards to help them identify improvements in quality to respond to a more informed market;
 - National Government can use aggregated data to give a picture of quality and outcomes nationally that will inform policy development where relevant and support Ministerial accountability to Parliament; and
 - Any other organisation will have access to exactly the same data as national and local Government and can use this for any other purpose such as advocacy or policy development.
34. The ultimate aim of these improvements is to promote delivery of improved outcomes for social care services users and their carers. This needs to be done while minimising the burden on Councils in terms of data collection and reporting.

D. What policy options have been considered? The Do Nothing Option (Option 1) and Derivation of Other Options

i. **Set out the baseline against which other options are assessed.**

Current National Data Set

35. Following the abolition of the National Indicator Set (NIS), which previously contained measurements around social care based on the data collections, the baseline option would be to keep the current collections, with no replacement measurements to provide context to the data.
36. The current set of data collections is of sometimes questionable value relative to the burden it imposes on councils and there is a need to revise this data set to ensure data reporting is restricted only to that which is truly valuable and justifies the burden it imposes. At the same time, there are some gaps in the current data set (for instance around dementia) that need to be addressed.
37. However, even if the shortcomings of the current data set are addressed, to be truly empowered local people need standardised measurements that are easily understandable – if we want to engender the culture shift discussed above, we cannot always expect people to sift through raw data on spending and results to come up with their own quality and outcome measurements.
38. Having tested this through the consultation with Council representatives, analysts and policy leads, and people using services, their carers and families, it was determined that only nationally assured outcome measurements would achieve the requisite clarity to empower local people.
39. Local people and Councils need to be able to compare local quality and outcomes achieved with that of other Councils. Without consistent nationally agreed measurements, Councils will put in place different measurements of the same areas of work, meaning that people would not be able to compare “apples to apples” on any kind of consistent basis.
40. Experience from national data returns shows that guidance around nationally agreed measurements will be interpreted differently by different Councils, so national assurance (by the NHS Information Centre) is required to ensure that results are truly comparable.

Sector-led Improvement

41. We have previously announced that the current system of annual performance assessment will be abolished, to be replaced by a more proportionate and localist approach. Some of the proposals contained in the consultation on *Transparency in Outcomes* were related to the replacement for the previous system.
42. Since the consultation document was published, a decision has been taken to take forward some of the proposals around this through a system for improvement that the adult social care sector is currently developing independently of central government.
43. As the proposals will not be taken forward by the Department of Health they are out of scope of this Impact Assessment, however it is important to note this interlinked work.
44. In line with consultation responses, a sector-led improvement system might be expected to include the following elements:
 - Supporting CQC in its role of ensuring basic or ‘essential’ standards of quality in service provision through registration and compliance processes.
 - A remit to monitor risk in Council commissioners through an early system for poor performance and setting triggers for CQC risk-based inspections.
 - A system of peer review between Councils, based partly on the shared data set, would be established to support Councils in the benchmarking which they already find valuable.
 - Put in place national leadership to promote the Quality and Outcomes agenda in more detail by advising on quality and promoting information-sharing.
45. Without national assurance of data and local accounts to facilitate peer review, this system of sector-led improvement would not be expected to achieve the same level of efficacy, so again the do nothing option is not preferred.

ii. **Explain how the short-listed options considered in this IA were derived:**

46. *A Vision for Adult Social Care: Capable Communities and Active Citizens*⁹ has set out seven principles for a modern social care system: personalisation, prevention, plural, productivity, partnership, protection, and people. In support of these principles, it is desirable to put in place measurements that will enable Councils (and local people) to evaluate results in these key areas and drive improvement.
47. The *Vision* is published against a backdrop of a major shift towards localism under the new Government, where the Public Service Transparency Framework published by HM Treasury have set out a new approach that will end top-down performance management of local Councils and instead create transparent data sets that will empower local people to hold services to account.
48. Any more localist replacement of the previous system would provide an opportunity to address the issues discussed above:
- Evidence shows that there is significant variability in social care outcomes and quality across England.
 - To improve quality and outcomes, there is evidence from Councils that benchmarking against each other is very helpful in setting realistic levels of ambition locally and identifying areas for improvement.
 - We need to make all information publicly available to empower local people to hold their services to account and create a culture of engagement with these services.
 - To prevent a dip in quality similar to previous times of financial difficulty, it is necessary to define and measure quality in a meaningful way that empowers Councils and local people to drive quality from the bottom upward.
 - To address gaps in the current data collections and remove burdensome collections that do not generate enough valuable information, a new more focused approach should be developed.
49. In order to address the issues outlined above, **Option 2** was developed. This would establish a single national social care data set, supporting a basket of outcome-focused measures, as follows:
50. **The single data list for adult social care.** Over time, we aim to evolve the current data collections into a smaller single data list focused on what is truly valuable. This development will be co-produced with Councils and people who use services to determine what data should be shared above local level for the different purposes of accountability, benchmarking, information and choice.
51. From the data list there will be an agreed set of outcome-focused measures called the **Adult Social Care Outcomes Framework** that will allow Councils and citizens to interpret the raw data and paint a picture of what social care is achieving locally.
52. Additionally, there was concern that Councils or local people would not make adequate use of the single data list and other information – thereby rendering the burden of data collection unjustifiable – unless steps were taken to support this use. This is particularly relevant because we are trying to engender a “Big Society” culture of people using information to engage with Councils on performance, where only limited instances of such conversations exist currently. It was also felt that publication of these data alone would not go far enough to match the aims for fuller transparency of public services and would not provide sufficient information for people to make informed decisions and drive competition.
53. Accordingly a package of measures at national level has been developed, in addition to the sector-led improvement structure discussed above, to support local accountability and choice. These measures would be:

⁹ Can be found at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_121508

- Developing NICE Quality Standards for social care, as already exist for health, using a proven development process to provide context and clarity around definitions of quality.
- Publish best practice for standardised elements to be included in a council's annual local account of their local priorities on quality and outcomes for social care, giving an accessible summary of results and providing a coherent narrative into which individual data measurements would fit, making them more understandable.

54. In defining best practice, we also see NICE Quality Standards empowering local people to make informed decisions when choosing providers, promoting competition on a basis of quality rather than price.
55. CQC will be consulting separately on developing an "excellence" rating for providers, to allow Councils to target commissioning and personal budget-holders to make informed choices, in order to support improvement in quality across the local provider market. Because it is subject to a separate consultation, the proposal is not considered in this Impact Assessment.
56. A further option proposed was for a system of financial incentives supported at national level, similar to the CQUIN system used by the NHS, to drive improvement in quality. However this will not be taken forward as there has not been sufficient support for this in the consultation.

E. Impacts, Costs and Benefits of Option 2

i. **Set out the mechanisms by which Option 2 is intended to work, its expected scale of impact , and evidence supporting these expectations**

Mechanisms

57. The national single data list will provide the underlying, raw data on social care outcomes, activity and finance. The purpose of the data list is to provide robust and comparable data on social care for both the public and councils. The aim of this is to support councils and the public to benchmark practice against their peers to promote improvement in quality and outcomes.
58. Consultation responses have been very supportive of a single data list for adult social care, although with acknowledgement of the importance of reviewing this to make collections fit for purpose. This reinforces the expected impact of a more robust data list in supporting accountability and improvement.
59. The supporting outcome-focused measures will be the means by which the most important available outcomes related to the service are articulated. There will be a small set of measures which describe both the picture of what social care-related outcomes are being achieved in every place, and how efficiently individual services contribute to those outcomes. The data required will be drawn from existing collections initially and in the future from new collections and other relevant sources beyond local government. The domains and outcome statements for the Adult Social Care Outcome Framework for 2011/12 are set out overleaf.

<i>Domain</i>	<i>Outcome statements</i>
Enhancing quality of life for people with care and support needs	<ul style="list-style-type: none"> ▪ People live their own lives to the full and achieve the outcomes which matter to them by accessing and receiving high quality support and information. ▪ Carers can balance their caring roles and maintain their desired quality of life. ▪ People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs. ▪ People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.
Delaying and reducing the need for care and support	<ul style="list-style-type: none"> ▪ Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs. ▪ Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services. ▪ When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.
Ensuring that people have a positive experience of care and support	<ul style="list-style-type: none"> ▪ People who use social care and their carers are satisfied with their experience of care and support services. ▪ Carers feel that they are respected as equal partners throughout the care process. ▪ People know what choices are available to them locally, what they are entitled to, and who to contact when they need help. ▪ People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.
Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	<ul style="list-style-type: none"> ▪ Everyone enjoys physical safety and feels secure. ▪ People are free from physical and emotional abuse, harassment, neglect and self-harm. ▪ People are protected as far as possible from avoidable harm, disease and injuries. ▪ People are supported to plan ahead and have the freedom to manage risks the way that they wish.

60. The full Outcomes Framework is set out in **Annex 5**.

61. Consultation responses have also been supportive of outcome measures in providing context and a more direct form of accountability, again reinforcing the expected impact.

62. Consultation responses have been broadly supportive of the proposal to publish an annual local account on quality and outcomes in social care, as a key tool for transparent reporting to their local population. The intended outcome is to make information more accessible to the public to

enable users and carers to make well-informed choices about their care and hold local services to account. Local accounts are not mandatory. However best practice will be developed with LGG and ADASS and councils to promote a new consistent approach. The expected actions this would entail are:

- Developing, producing and publishing annual accounts locally
- Actions that may need to be taken as a result of challenges from local people based on the account.

63. Legislation will be put in place to expand the role of NICE to include adult social care from 2012/13. A process for commissioning Quality Standards for social care will be developed which sets out guidance on evidence-based best practice. We expect the first Quality Standards to be produced in 2012/13. NICE uses a collaborative, evidence-based process to develop the quality standards. Therefore, it is intended that these Quality Standards be adopted by social care services to improve the quality of provision, although they will not be mandatory.
64. The impact of this expanded role of NICE is examined in the overall Impact Assessment related to the Health and Social Care Bill¹⁰ and is therefore not considered further here.

Development

65. To develop the national data list a 'zero-based' review of social care data is being co-ordinated by the NHS Information Centre to co-produce with councils a new social care data list that measures only what is truly valuable. The zero-based review will initially set out the data requirements, with the next phase to put in place data collection mechanisms to collect these data. The aim of the work is to put in place a robust, fit-for-purpose data list and reduce burdens on councils of data collection. A separate consultation process is being conducted on the details of the zero based review which will seek views on (a) what new data should be collected; (b) what data collections should be amended; and (c) existing collections which are no longer needed.
66. Regarding the Outcomes Framework, consultation responses were largely in agreement about the most important criteria for assessing measures to support the selection process, acknowledging that these do not aim to include every angle, but rather to highlight the most critical dimensions, as a means of assuring a common data quality. Whilst there are other aspects which may be part of defining a robust measure, and indeed other sets of criteria used in different frameworks, the most appropriate to the aims and principles of Transparency and Outcomes were agreed as:
- Relevant and meaningful to the public – measures should be intelligible and reflect what matters to people;
 - Substantially influenced by social care – measures must be relevant to the work of adult social care to support accountability;
 - Can be compared between local areas and over time – measures must be consistent to promote transparency;
 - A measure of a social care-related outcomes (for overarching and outcome measures), or consistent with the outcome focus (for quality data and measures) – we should be clear about the level of the measure its fit within the outcome domain;
 - Disaggregation by equalities – measures should be able to be broken down to support a focus on equalities; and,
 - Currently collected – measures should, at least from 2011/12, be currently available from an existing data source (naturally this does not apply to placeholders).
67. The assessment of the appropriateness of the measures also relied on the availability of evidence on interventions which can drive improvement in outcomes, and their cost-effectiveness, where this was available. There is generally a lack of good quality robust evidence in the social care sector on the cost effectiveness of interventions linked to improvement in outcomes, however we have taken account of this evidence where possible – details of this evidence are set out in **Annex 3**.

¹⁰ Can be found at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_123582.pdf

68. The selection of measures for inclusion has been agreed by the Department, the Association of Directors of Adult Social Services (ADASS) and the Local Government Group (LGG). It drew on responses and evidence from the consultation and other research as well as advice from analysts specifically on the issues related to cost effectiveness.
69. A template was developed to analyse each measure against these factors, setting out evidence to support this evaluation. The templates were then circulated to a variety of stakeholders for an iterative process of comment and revision. Once this process was complete, the templates formed the basis of discussions between the partners – DH, ADASS and LGG – to agree the measures for inclusion in the final Outcomes Framework. An example of the template used in this work is included in **Annex 6** for reference – the work for each indicator included assessment against the above criteria, as well as an analysis of any risks associated with inclusion and of any possible alternative measures.
70. This discussion also sought to determine whether the measures represent the breadth of social care work by assessing the balance of measures across the four domains set out in the Consultation and other key criteria. The key criteria for this assessment were:
- the domains of the Outcome Framework, and
 - the existing client groups (18-64 physical disability, 18-64 mental health, 18-64 learning difficulties, 65+, carers).
71. This assessment led to further areas for development being identified to balance the basket of measures – for example in expanding measures on employment to include all working age adults in contact with social services, rather than focussing on those with mental health and learning disabilities only; and in identifying the need for further measures of the effectiveness of safeguarding.
72. However it should be noted that there is no such thing as a completely objective assessment of a basket of measures and in some cases value judgements have been made between partners about what constitutes “balance”. So for example a specific measure on people using services feeling they have control over their daily lives has been included because research has shown this to be the single most important aspect of quality of life to people using services.
73. As noted in section Dii, the Outcome Framework is in part designed to support the policies outlined in the *Vision* for adult social care, as these have been agreed with councils through the Association of Directors of Adult Social Care. For example, we included a measurement of the number of people receiving self-directed support (including direct payments) in order to support the vision that all eligible people who want one should be provided with personal budgets, ideally as direct payments, by 2013.
74. The current set of outcome measures also includes several “placeholders” for areas of work where measures need to be developed – this means that in its first iteration the Outcomes Framework will not provide a complete picture of social care work.
75. The measures are not ‘priorities’ – the question of prioritisation is one for local partners to decide together, using these data and other mechanisms such as the Joint Strategic Needs Assessment. There will be no targets set against the indicators aside from what is agreed locally; nor will they be used nationally for performance management.

On-going Analysis and Consultation

76. We see three key analytical tasks in ensuring that the Outcome Framework is fit for purpose and achieving the desired outcome of reducing variability and supporting accountability:
- Adjustment for exogenous factors that have a bearing on the outcome measures;
 - Setting out evidence of incremental contributions to overall outcomes of each outcome measure, in order to support local services in prioritising and local people in holding them to account; and
 - Annual review of the measures as a representative “basket” to ensure that the balance of the Framework is not skewing local priorities.

77. Analysis will be needed to **adjust for factors that affect outcomes that are beyond the control of local services** (exogenous factors), for instance demographic factors and level of need locally. This will ensure comparability of data between councils to give both councils and local people the power to judge the results they are achieving. In order to ensure comparability, an assessment will need to be made of whether such an adjustment is appropriate and feasible. This will be informed by analysis of the data and the judgement of experts in the field. Analytical work will then be needed to develop and test a methodology for adjustment.
78. An example of such an adjustment would be for the indicator “Permanent admissions to residential and nursing care homes, per 1,000 population”, where DH and ADASS have agreed that this should be weighted by age and gender, as these are key demographic factors that influence the number of admissions, which are beyond the control of local services.
79. We are looking at the feasibility of strengthening the evidence base in this area and the possible methodologies for adjustment. We will aim to have completed this task by March 2012 in order to apply adjustments to the data for the 2011/12 Framework – a plan for the analysis underpinning these adjustments will be published with the “data definitions” for the Outcomes Framework in by May 2011.
80. For those measures where numerical adjustment is not appropriate or not feasible, councils may choose to form “comparator groups” to compare results with other councils that have similar demographic, socioeconomic and public health circumstances. Such benchmarking is already established practice in councils and there will be a continuing role for this over and above formal analytical adjustment of indicators.
81. There will also be an analytical task to **seek, evaluate and set out evidence on the likely incremental contribution of each indicator to overall outcomes** for users and carers as far as the evidence allows. This will need to be considered on a measure-by-measure basis. The evidence base to support this work is currently weak; however data provided from the Adult Social Care Survey may give valuable new evidence in providing insight into how improvement in various social care outcomes contributes to overall improvement in quality of life.
82. A key aspect of the approach will be **a rigorous annual review of the Outcomes Framework** to ensure that the measures are robust and fit for purpose, are understandable to local people and do not create perverse incentives. It will be very important for this review to assess the measures as a whole to ensure they represent a balanced view of social care and do not risk skewing local priorities by placing an undue emphasis on a particular client group or area of work. This annual review will employ the methodology for assessing the measures as a basket discussed in the “Development” section above.
83. This process will be informed by analysts, experts on council data reporting, the broader local Government sector, people using services and their carers and others, making use of established mechanisms such as the ADASS Standards and Performance Group and the TASC Co-production Group. It will be undertaken by the Outcomes and Information Development Board¹¹ (co-chaired by the Department and ADASS) so will be fully transparent and subject to independent scrutiny.

Process

84. The expected process for both the development and implementation of the single data list for adult social care and the Outcomes Framework are:
- development of the data requirements and required collections for the data list following the ZBR;
 - implementation of new data collections for the new data list and supporting measures;
 - seek and set out evidence on the likely contribution of each indicator to overall outcomes as far as evidence allows and where appropriate adjust indicators for external factors such as demographics;

¹¹ Formerly the Strategic Improving Information Programme (SIIP) board

- dissemination of data and supporting measures; and
- local impacts where areas choose to prioritise action in a particular area to improve performance against a measure.

85. The impacts of these are discussed further below.

i. Set out the costs and benefits of the option arising from the impacts listed in section E(i).

Costs

Costs of developing, collecting and disseminating a new data list

86. The cost associated with the development of the data requirements and required data collections for the national data list will be borne mainly by the Department of Health and the NHS Information Centre. To carry out this work, staff time will be needed at a range of levels. In addition, the process will include joint working and consultation with the sector which will involve the input and resources of colleagues from councils, although this input should not involve a high resource commitment.

87. The data list for 2011/12 is not introducing any new data collections. However, it is likely that some new data collection requirements will be introduced alongside further reductions as we move towards a more focussed, relevant data list. Depending on the new requirements agreed, the implementation of new data collections may incur significant one-off costs to councils and to a lesser extent the Information Centre and Department of Health. Based on previous data collections that have been developed in adult social care, for example the abuse of vulnerable adults data collection and the grant funded services data collection, we estimate the central costs to the IC of developing and implementing a new data collection covering a specific area as up to £200,000. The costs to councils of implementing a new data collection are harder to estimate and depend to a large extent on the degree to which the information required is already held locally. An estimate of the costs to councils of collecting data for the GFS return where in the main data was not already held routinely by councils is of the order of £350,000. It is likely that changes to data collections will be less burdensome than the GFS return, so costs are estimated at between £100,000 and £350,000.

88. We are committed to significantly reducing the on-going burden of collections in part by focussing on data that is valuable to councils (and hence likely to be collected by them already), however it is inevitable that there will be one-off costs associated with these changes.

Costs from diverting Social Care expenditure to collecting and disseminating the outcome indicators

89. In the majority of cases the indicators in the outcomes framework have been derived from existing data sources in order to minimise the costs associated with setting it up. The baseline costs for this are £2.2m, which are included in the “do nothing” option. However there are some instances in which new data systems or existing data systems will need to be modified to capture the information required to populate measures – estimates of these costs are included below.

90. In addition some further analytical work will be required to:

- develop the definition of measures:
- take forward work where appropriate to adjust indicators for factors beyond the control of social services such as age and need; and
- seek, evaluate and set out evidence on the likely incremental contribution of each indicator to the overall outcomes for users and carers as far as the evidence allows.

91. For the indicators identified for inclusion in the framework the additional costs of collection and dissemination are set out below.

Domain 1

92. ***Social care related quality of life; and***

The proportion of social care users who say they have control over their daily lives

The measure is based on an existing data list. We will look at the feasibility of developing an adjusted measure of social care related quality of life which is comparable between councils. A longer term aspiration would be to develop a value added measure which measures social services contribution to this outcome.

93. ***Carer-reported quality of life***

This measure is reliant on the introduction of a new Carer's Survey. Responses to the consultation have been overwhelmingly supportive of the Carers Survey, with a clear view that the burden of introducing this is outweighed by the value of the information obtained. The introduction of the new Carers Survey is estimated to cost the whole system somewhere between £300,000 and £800,000. These estimates have been derived from feedback received from a survey of carers that was undertaken by councils on a voluntary basis.

94. ***Proportion of adults with learning disabilities in employment; and***

Proportion of adults in contact with secondary mental health services in employment

Proportion of adults in contact with secondary mental health services in settled accommodation

Proportion of adults with learning disabilities in settled accommodation

These measures are derived from existing data lists and therefore there are no additional costs incurred.

95. ***Placeholder for:***

Proportion of working age adults in contact with social services in paid employment

This measure would replace the separate measure for those with learning disabilities and in contact with mental health services. They may require additional data to be collected from councils. Further work will need to be done to establish the additional burden if any that this will cause to councils.

96. ***Proportion of people using social care who receive self-directed support***

The current definition of this measure is derived from an existing data source. However there are proposals to do some development work on this measure so that it measures the number of people receiving self directed support as a proportion of those for whom self directed support is appropriate. This will require data on activity to be collected in a different way than in the past and this is being considered as part of the zero based review. Further work will need to be done to establish the additional burden if any that this will cause to councils.

Domain 2

97. ***Placeholder: Percentage of emergency admissions to any hospital in England occurring within 28 days of the last, previous discharge***

NHS outcomes framework IA says: "There are issues surrounding the interpretation of this indicator. Further work will be needed to better understand how readmissions can be interpreted and, if possible, to develop a more meaningful indicator based on readmissions data.

98. ***Admission to residential and nursing care homes, per 1,000 population***

Data for this measure is routinely available. Some work will need to be done to develop and agree a methodology for weighting the measure by age and need and also to do some further analysis of the data to aid interpretation.

99. ***Older people discharged from hospital to rehabilitation or intermediate care, who are living at home 91 days after discharge***

There is a concern that this indicator does not ensure that hospitals discharge patients into rehabilitation services in the first place. Further work will be needed to determine how this can be addressed using existing data sources.

100. **Placeholder: The proportion of people suffering fragility fractures who recover their previous levels of mobility/walking ability**
Further work will need to be done to understand the contribution that social care makes to this outcome. Data for this measure will be available from an existing data source from 2012-13.

101. **Placeholder: Effectiveness of prevention**
This was identified as a current gap in the framework. It is not yet known what form this measure might take and therefore it is not possible to estimate the costs of any associated data collection.

102. **Delayed transfers of care**
Data for this measures it routinely available.

Domain 3

103. **Overall satisfaction with local adult social care services**
This measure uses data from an existing data source.

104. **Overall carers' satisfaction**
Proportion of carers who report they have been included or consulted in discussions about the person they care for
See the description of costs for the carer quality of life measure (domain 1).

105. **Proportion of social care users and carers who express difficulty in finding information and advice about services**
Data on users is derived from an existing data source. Data on carers will be taken from a new Carer's Survey. See above.

Domain 4

106. **Proportion of adult social care users who feel safe and secure**
Percentage of adult social care users who say social services has helped them to feel safe and secure
See the description of costs for the social care related quality of life measure (domain

107. **Placeholder for effectiveness of safeguarding services**
The aim is to develop a new measure in this area. The likely sources of data for this are CQC information on the extent to which providers meet safeguarding criteria, an additional question in the adult social care survey or additional information collected as part of the AVA return. Depending on which option is pursued there may be additional costs to LA of collecting information although it is likely that these will not be significant as the framework and vehicles are already in place. There were also be a minimal cost to DH and stakeholders to develop the proposed measure.

Analytical Tasks

108. It is estimated that costs associated with the ongoing analytical tasks, excluding those that have already been specified above, will be around £150,000 - £200,000 a year.

Costs of diverting council social care expenditure at a local level to achieve improvements in outcome-focused measures

109. Using evidence from benchmarking and other sources, councils can choose to prioritise expenditure locally to achieve improvement on selected measures, as befits their local priorities. Different levels of ambition can be chosen for each supporting measure depending on the feasibility and cost of improvements, or councils can chose to set no level of ambition at all. It can be useful to consider several generic levels of ambition that can be chosen for each measure (set out in increasing order of ambition):

- Measuring and publishing the outcome measure
- Achieving year-on-year improvements in the outcome measure

- Making progress towards convergence with comparable authorities or towards the high-achieving comparable authority

Feasibility of different levels of ambition

110. *Measuring and publishing the outcome measure:* This level of ambition should be feasible for all outcome measures. This should be ensured by the outcome measure selection process as, by definition, anything that is not measurable would not be useful and therefore not included in proposals.
111. *Achieving year-on-year improvements in the outcome measure.* Feasibility will depend on the current performance in each measure selected. Because the performance of the outcome measure may follow a time trend, this level of ambition could be specified in terms of improving on the trend rather than in absolute terms. In this way, a measure that is already improving could be required to improve faster than the existing trend.
112. *Making progress towards convergence with comparable authorities:* Feasibility for measures where there are shortfalls compared to the England average or high-performing comparable authorities will depend on the current performance in the measure selected and its historical trend, but also on the performance of other authorities. An authority is not in a position to control or know what the future performance of other authorities will be, therefore setting levels of ambition to close the gap may be challenging. An alternative approach would be to require year-on-year reductions in the shortfall.

Cost of different levels of ambition

113. *Measuring and publishing the outcome measure:* The costs from this level of ambition are likely to vary between different types of measures. Many of them will already be published and so there will be no additional cost. For others, the frequency of collection at the local level may need to be improved in order to be useful as measures of quality and outcomes.
114. *Achieving year-on-year improvements in the outcome measure:* The cost of this will depend on the current performance of the council on each measure chosen, but also on the technical aspect of producing specific improvements in the measure. The costs will depend on the interventions that councils decide to put in place to achieve the desired improvements according to their locally-defined priorities. It has not been possible to estimate the likely costs of interventions to improve outcomes for a number of reasons. First and foremost there is generally a lack of robust evidence in the social care sector on the cost effectiveness of interventions linked to improvement in outcomes. In addition at a local level there are a range of possible forms of interventions that could be implemented to achieve improved outcomes, which it would not be possible to model. **Annex 2** sets out the evidence for cost effectiveness that is available.
115. *Achieving a level similar to comparable authorities:* The cost of this will depend on the council's performance but also on concurrent performance of other authorities. While an authority can control the former, the latter is outside of its control and may introduce uncertainty to the cost of achieving the ambition. This uncertainty can have a knock on effect on the cost of achieving the outcome and its affordability. An approach which uses comparisons with other authorities to specify year-on-year improvement would therefore be preferable with the longer-term aim of achieving a specific level.
116. The cost of interventions to improve quality will fall on providers (independent sector and council) but are likely to be passed on to commissioners (councils and self-funders).

Local accounts on quality and outcomes

117. Local Accounts are not statutory, hence councils' approaches and costs are at their own discretion. Where they choose to develop local accounts, there will be costs incurred by councils to develop, produce and publish them, although we know that many Councils are already engaged in this type of activity either alone for social care or more corporately. The level of the costs involved is difficult to estimate, however costs set out in a parallel impact assessment for an NHS "quality account" scheme broadly similar to that envisaged for social care were in the

region of £4,500 per organisation. This would equate to a cost across all councils of £675,000, rounded up to £700,000 to include printing and other dissemination costs. We know some councils already publish similar accounts, so not all of this would be new cost.

118. If local accounts were signed-off by the local HealthWatch we estimate the national cost in terms of working hours of HealthWatch staff to be £100,000 - £250,000 if all areas chose to pursue this approach.
119. If councils are challenged by the public on the level of the quality of services based on the accounts and choose to take action to make improvements as a result, there will be additional costs. The level of cost will vary depending on the measures on which improvement is focused and the level of improvement achieved.

Benefits

120. The expected impact of having an improved national data list and the specification of supporting outcome-focused measures is to provide Councils with the tools to assess the quality and outcomes of the services they are providing and for people using services and others to hold them to account for improvement. The intention is that this will provide a sufficient incentive for Councils to focus improvements in services in areas where they are most needed and are cost effective.
121. There is a rationale for how the improvement in each of the measures, identified as part of the framework, can be linked to improvement in outcomes for users or carers. **Annex 3** sets out the details for each of the measures.
122. As discussed earlier there is generally a lack of good quality robust evidence in the social care sector on the cost effectiveness of interventions linked to improvement in measures in the framework. **Annex 2** summarises for each of the measures the evidence on cost effectiveness identified. For the majority of measures this suggests that there are strategies that councils can adopt to improve outcomes for users and carers. This suggests that it is plausible that councils and providers will find ways of making improvements cost-effectively.
123. A methodological issue which makes the measurement of cost effectiveness in the social care sector problematic is the ability to quantify the benefits of interventions. In the health sector, the QALY is often used for this purpose but there is currently no such measure for the social care field. A basis for this work already exists in the form of the Adult Social Care Outcomes Toolkit (ASCOT), which was developed by Personal Social Services Research Unit (PSSRU) at the University of Kent. For more details please see:

<http://www.pssru.ac.uk/ascot/>
124. Different projects funded by DH, the Health Technology Assessment programme and Office of National Statistics have contributed to the development of this tool and moving towards the creation of a Social Care QALY and development work is ongoing.
125. Where Councils choose to use the national data list and supporting measures to set improvement goals locally, the improved quality and outcomes could provide substantial quality of life benefit gains to the users and carers affected. The level of benefit will vary depending on the measures on which improvement is focused and the level of improvement achieved. Analysis based on a social care QALY tool to set out incremental gains in overall outcomes attributable to various indicators could prove very useful to councils in setting levels of ambition locally based on strategic priorities.

Local accounts on quality and outcomes

126. These local accounts should be designed to make information about local services more accessible to users, carers and the public more generally. Consultation responses have been supportive of the idea that this will empower the public to hold local services to account, which would then result in action to improve the quality and outcomes of services. Also, the publication

of this account may act as an incentive for councils to take actions to improve performance on quality and outcomes.

iii. Set out the assumptions upon which projections for Option 2 have been based, and the risks to which they are subject.

127. This option relies on the availability of robust data and measures on quality and outcomes that councils see as relevant to them. Some of the data collections and measures proposed are fairly new and therefore there is a risk that either there will be issues relating to the robustness of the data or the suitability of measures.
128. We are also assuming that measuring outcomes in specific areas will not skew priorities set locally. We are confident that a strong message that priorities are for Councils and local people to determine in consultation with local partners will avoid this. This message is already clear in Government communications such as those related to the NHS Command Paper *Liberating the NHS: legislative framework and next steps* and the Localism Bill.
129. There is also a risk that demographic pressures will mean Outcome Measures are not fully comparable – meaning that results cannot be benchmarked nationally and people cannot fully hold services to account. As discussed in section Ei, work will be taken forward to adjust for factors beyond the control of local services that affect outcomes. Councils will also be able to use the Outcome Framework to support benchmarking where they compare themselves to other similar councils as well as the national average.
130. If these interventions do not ensure that the measures in the Outcome Framework can be compared accurately, there is a risk that the framework will lead to distorted priorities and consequently misallocation of resources. There is also a risk that the framework, and so the overall approach to transparency in outcomes, will be discredited if people do not feel they can use it to robustly compare their local area with others around the country.
131. In addition, the Health and Social Care Bill includes a proposal to create a Health and Wellbeing Board that will bring together key players in local health and care with democratically accountable councillors. This creates a crucial link between empowered people engaged in social care quality and democratic accountability, which, if working correctly, should effectively hold councils to account for the results achieved in social care. Therefore, councils will be driven primarily by what is important to them and to local people, with the outcome measurements as a lever of engagement.
132. There is a risk that aligned data sets across the NHS, Social Care and Public Health will not sufficiently support integrated working. By sharing some outcome measurements across the three different areas and aligning others to support local conversations such as that to develop the Joint Strategic Needs Assessment and Joint Health and Wellbeing Strategy, it is hoped that this risk will be mitigated. We recognise that as part of longer-term reviews of data collections there is further potential for alignment between frameworks and this should be pursued.
133. There is a risk that councils and the public do not engage with the single data list and supporting measures. If this happens, there will be no additional benefits from their introduction beyond their use in triggering CQC risk-based inspections.
134. Similarly, if Councils and the public take no action as a result of the publication of local accounts, there will be no benefits as a result.
135. The impact assessment assumes that the selected outcomes will represent accurately the outcomes and quality of social care provided by councils. A potential risk is that the specific outcomes chosen, or the interventions that councils choose to implement locally, may not represent the best use of limited resources and may distort incentives and behaviours in an undesirable way. **Annex 4** includes an assessment of the basket of measures and how they represent the totality of social care work in terms of people served.
136. In addition, as discussed in section Ei, work will be progressed to seek, evaluate and set out the evidence on the likely incremental contribution of each indicator to the overall outcomes for users

and carers as far as the evidence allows. If this work is not taken forward there is a danger that councils will not focus resources in the most appropriate areas.

137. The financial climate over the coming years may undermine councils' ability to focus on the quality and outcomes agenda.

iv. Set out expected impacts upon Equality and Human Rights

138. Please refer to separate Equality Impact Assessment published alongside this Impact Assessment.

v. Set out expected impacts upon Health and Wellbeing

139. Please refer to the "Benefits of Option 2" section above for a discussion of the expectation that efforts by councils to generate improvements against the measures in the Outcomes Framework will lead to health and wellbeing gains.

140. Other specific impact tests have been considered and are not relevant to this Impact Assessment.

F. SUMMARY AND WEIGHING OF OPTIONS

141. As stated above our intention is to balance a robust approach that will achieve the stated aims with minimising the burden on councils. Our preferred option is Option 2, with specified Government intervention to support the use of a transparent single data list, including bringing clarity to quality and facilitating benchmarking, but leaving Government in a supporting role rather than actively driving improvement in a top-down role.
142. We feel that doing nothing, Option 1, is not a viable approach because neither Government nor local people will be empowered to hold their Councils to account in an area of work that involves some of the most vulnerable people in society.
143. Option 2 will also have the benefits of bringing clarity to quality, making it easier for people to engage with the information, incentivising quality, supporting benchmarking, and replacing the assessment regime.

Costs of Options 2

144. In total, the quantifiable transition costs of Option 2 are estimated at between £100,000 and £550,000; taken from:

- Up to £200,000 costs to the Information Centre for developing a new data collection in support of further outcome measures; and
- Between £100,000 and £350,000 cost to councils to put in place new data collections.

145. The quantifiable on-going costs of Option 2, over and above the baseline cost, are estimated at between £450,000 and £1,000,000 annually; taken from:

- £300,000 - £800,000 to carry out the new Carers Survey in support of the Outcomes Framework (assumed to be annual although it may be biennial);
- £150,000 - £200,000 average yearly cost for on-going analytical and developmental work through to 2013/14 (and assumed consistent over five-year period).

146. Production and publication of Local accounts are estimated to cost up to £700,000, although as accounts will not be mandated this is not included in the cost figures above.
147. If local accounts were signed-off by the local HealthWatch we estimate the national cost in terms of working hours of HealthWatch staff to be £100,000 - £250,000 if all areas chose to pursue this approach. Again, because this will not be mandated, this is not included in the cost figures above.
148. There are also non-monetised costs related to achieving improvements on levels of ambition set locally.

Benefits of Option 2

149. Benefits for Option 2 cannot be monetised, but are expected to include:
 - Benefits to people using services and their carers resulting from the level of ambition their council sets against the proposed measure;
 - Benefits of improved performance due to increased accountability;
 - Cost savings from reduced burden of data collections following the “zero-based review”;
 - Cost savings from reduced “cost-shifting” between services due to align Outcome Frameworks for social care, public health and the NHS;
150. Having reviewed the evidence, we are confident that the benefits of the interventions outlined in Option 2 will outweigh the cost.

Annex 1: Post Implementation Review (PIR) Plan

Basis of the review: [The basis of the review could be statutory (forming part of the legislation), i.e. a sunset clause or a duty to review, or there could be a political commitment to review (PIR)];

Political commitment

Review objective: [Is it intended as a proportionate check that regulation is operating as expected to tackle the problem of concern?; or as a wider exploration of the policy approach taken?; or as a link from policy objective to outcome?]

The objective of the review will be to determine whether the Outcomes Framework is justifying its cost (including opportunity cost) and whether the approach could be improved. This will be based on an assessment of whether the Framework is delivering the intended effects of driving improvement in outcomes and reducing variation.

The post-implementation review of Quality Standards will be undertaken by NICE; local accounts by individual councils; and changes to the national single data list by the Information Centre. Therefore, while it will be very important to ensure that links to this wider work are taken into account, the scope of the review will be the Outcomes Framework only.

Review approach and rationale: [e.g. describe here the review approach (in-depth evaluation, scope review of monitoring data, scan of stakeholder views, etc.) and the rationale that made choosing such an approach]

Key methods of review will be:

- We will use established informal methods of feedback via ADASS and LGG to review the approach on an ongoing basis, and the formal PIR will involve a more thorough use of these channels through feedback sessions and possibly surveys.
- Similarly, we will review the Outcomes Framework each year to assess the balance of measures as a basket and their representation of social care outcomes (using the methodology outlined in Eii above). The formal PIR should use these assessments to help determine the overall balance of the framework over the three years.
- We will also use consultation with established co-production groups and information from local HealthWatch groups (representing both users and carers) and other fora to form a view on the level of general engagement with the information.
- Through analysis and development work, we hope to establish the incremental contribution of each measure to overall outcomes by the time of the review. This will help determine the appropriateness of the measures selected for inclusion in the framework.

Baseline: [The current (baseline) position against which the change introduced by the legislation can be measured]

We will look to compare current evidence of variability in quality and outcomes (set out in part A of the main document) with that at the time of PIR. In order to identify the contribution of the Outcomes Framework to any reduction in variability and improvement in outcomes, we will look to identify international comparator countries that do not have Outcomes Frameworks. We will also compare different areas of the country where engagement and support have been effective with those where it has been less so, in order to determine the potential of the Framework.

Success criteria: [Criteria showing achievement of the policy objectives as set out in the final impact assessment; criteria for modifying or replacing the policy if it does not achieve its objectives]

The review will look at the first three years of the Outcomes Framework to establish whether:

- outcome measures have support councils in identifying areas for improvement;
- local people have been adequately supported to engage with the information and are using this to hold local services to account; and
- the Framework has provided an accurate picture of social care services that has not distorted local priorities.

Monitoring information arrangements: [Provide further details of the planned/existing arrangements in place that will allow a systematic collection of monitoring information for future policy review]

As set out above, we will use informal channels of feedback to supplement information from the national single data list in monitoring the success of the framework. We also see an increasing role for HealthWatch in providing information around engagement and support as it transitions to its new role.

Reasons for not planning a review: [If there is no plan to do a PIR please provide reasons here]

N/A

Annex 2: Evidence of Cost Effectiveness

Cost and benefits of diverting social care expenditure at a local level to achieve improvements in outcome focussed measures

As discussed in Section Ei above, there is generally a lack of good quality robust evidence in the social care sector on the cost effectiveness of interventions linked to improvement in outcomes. This is in part due to the inability to quantify the benefits of intervention in a standardised way, in the manner of the QALY in the health sector, as also discussed in Ei above.

A methodological issue which makes the measurement of cost effectiveness in the social care sector problematic is the ability to quantify the benefits of interventions. In the health sector the QALY is often used for this purpose but there is currently no such measure for the social care field.

The assessment of measures for selection in the framework drew together evidence on cost effectiveness that was readily available and this was used to inform the overall process for selecting measures. We will look at the feasibility of expanding the evidence base in this area and the possible ways to do this, going forward.

The section below summarises the evidence on cost effectiveness which was identified for each of the measures.

Domain 1

Social care related quality of life

The Evaluation of the Individual Budgets (IB) Pilot Programme¹ used the ASCOT tool to compare the outcomes for those receiving IBs compared to the control group. A key finding was that higher levels of control were expressed by members of the group who were part of the IB pilot compared to the control group although there was some variation by client group. The differences between the IB pilot and control group in the other domains were not statistically significant although the direction of differences in the other domains was generally positive. However when the domains were aggregated using preference weights people in the IB group appeared to benefit from significantly better social care outcomes, other things being equal ($p < 0.05$). The research also suggests that individual budgets are cost neutral to social services when start up costs are excluded but healthcare costs appeared to be higher for the IB group.

An evaluation by the York Health Economics Consortium of telecare schemes in Scotland² found that telecare offers considerable potential to reduce the use of care home beds and the numbers of home care check visits and sleepovers required and possible also the use of acute hospital beds. The study report notes that the achievement of such impacts may require other community-based services to be available. It also notes that it is difficult to measure events (such as hospital admissions) avoided. The report also said that about 60% of questionnaire respondents felt that their current quality of life was either “a bit better” or “much better” than before.

A model was developed to examine potential public and private savings associated with delayed admissions to care homes in England as a result of the commissioning of memory services for early diagnosis and intervention for dementia. Early intervention has been shown to have positive effects on the quality of life of people with dementia³ and their family carers⁴.

Research suggest that if ten years all people with dementia have had a chance to be seen by the new services a gain of between 0.01 and

¹IBSEN (SPRU, PSSRU, Social Care Workforce Research Unit) (2008) Evaluation of the Individual Budgets Pilot Programme, Final Report

² York Health Economics Consortium, Evaluation of the Telecare Development Programme, January 2009

³ Banerjee S, Willis R, Matthews D, Contell F, Chan J, Murray J. Improving the quality of dementia care – an evaluation of the Croydon Memory Service Model. *International Journal of Geriatric Psychiatry* 2007 **22**, 782-788.

⁴ Mittelman MS, Roth DL, Clay OJ, Haley WE. Preserving health of Alzheimer caregivers: impact of a spouse caregiver intervention. *American Journal of Geriatric Psychiatry*, 2007 **15**, 780-789.

0.02 QALYs per person year would be sufficient to render the service cost-effective. These relatively small improvements seem very likely to be achievable⁵.

The proportion of social care users who say they have control over their daily lives

A key finding of the Evaluation of the Individual Budgets (IB) Pilot Programme⁶ is that higher levels of control were expressed by members of the group who were part of the IB pilot compared to the control group although there was some variation by client group. The research suggests that individual budgets are cost neutral to social services when start up costs are excluded but healthcare costs appeared to be higher for the IB group.

The Office of Fair Trading reported that uptake of direct payments made those people happier with the service they receive (*Choice and competition in public services: a guide for policy makers* (2010, OFT/Frontier Economics)

The Audit Commission's report on the Financial management of personal budgets found that personal budgets used well not only benefited social care users, but that "Councils will face the challenge of demographic change better prepared: flexible, more suitable care will be available and councils will have developed affordable and equitable long-term financial plans" (Financial management of personal budgets, Audit Commission, 2010).

SCIE have published research on older people and mental health users experience of PBs⁷.

Carer-reported quality of life

Improved and/or more information benefits carers and the people they support by helping them to have greater choice and control over every aspect of their lives. This may help to sustain caring relationships through for example, reduction in stress, improved welfare and physical health improvements.⁸ These benefits accrue only where information is accessed that would not otherwise have been accessed, or in those cases where the same information is obtained more easily.

Research from evidence gathered from 13 pilot sites for individual budgets across England provides some evidence on the positive benefits of personal budgets on carers.⁹

Compared to conventional social care, individual budgets (IBs) were associated with statistically significant positive effects on carers' quality of life and, when other factors were controlled for, on carers' social care outcomes. These positive outcomes were achieved despite no higher public expenditure costs, suggesting that IBs for service users are cost-effective for carers.

Local councils are increasingly utilising personal budgets and direct payments to allow carers to use how they wish, to take a break. Evidence on the cost-effectiveness of utilising direct payments and personal budgets to access breaks is not definitive but shows high levels of user satisfaction and some improvement in carers' health.¹⁰

There are 12 demonstrator sites exploring various ways in which breaks can be provided for carers with particular regard to collecting data on value for money and outcomes for carers and the people they care for. Information from the demonstrator sites is being collected by CIRCLE at Leeds Univ and their independent evaluation should be made available to us in September 2011.

This should help to strengthen the evidence base on interventions for carers that improve outcomes. But a division between a health or social care intervention could be arbitrary and dependent on who pays eg

⁵ Banerjee, S, Wittenberg, R (2009) Clinical and cost effectiveness of services for early diagnosis and intervention in dementia.

⁶ Evaluation of the Individual Budgets Pilot Programme, Final Report: IBSEN (SPRU, PSSRU (Kent, London, Manchester), Social Care Workforce Research Unit)

⁷ Report 40: Keeping personal budgets personal: learning from the experiences of older people, people with mental health problems and their carers: <http://www.scie.org.uk/publications/reports/report40/index.asp>

⁸ Carers UK (2006) In the know The importance of information for carers
<http://tinyurl.com/3xjuvw8>

⁹ Glendinning, C et al (2009) Individual budgets: Impacts and outcomes for carers, Research Findings, Social Policy Research Unit, University of York, York

¹⁰ Centre for International Research on Care, Labour and Equalities (CIRCLE) (2010) National Carers Strategy Demonstrator sites National Evaluation Interim Report: <http://tinyurl.com/2auefu8>

for a break from caring. And we are encouraging PCTs and councils to pool budgets in supporting carers.

Proportion of adults with learning disabilities in paid employment

Evidence from North Lanarkshire¹¹ and Kent¹² demonstrated that investment into supported employment can produce significant savings at the local authority and taxpayer levels. The studies found that the cost of supported employment was lower than for an equivalent day services place. In North Lanarkshire, supported employment cost £7,216 per annum per job compared to £14,998 for a day service place. In Kent, supported employment cost £9,910 per annum per job compared to £11,200 for a day service place. There are savings of £7,782 and £1,290 respectively. Ongoing costs to maintain a person in employment are considerably lower as additional assistance is only provided to adapt to change at work or for continued career development, and savings increase as more people are supported into work.

The studies found that there were additional savings from a taxpayer perspective with the flow-backs. In North Lanarkshire, there was a net saving of £6,894 per person per year; and in Kent, there was a net saving of £3,564 per person per year. If this is looked at for 50 people per year placed in employment, this is a saving of £344,700 and £178,200 respectively.

There are also numerous case studies from the Valuing People Now employment demonstration sites. Evaluation reports for these will be available in March 2011

Proportion of adults in contact with secondary mental health services in paid employment

Individual Placement and Support (IPS) is the most effective and cost-effective method of helping people with severe mental health problems to achieve sustainable competitive employment¹³.

Looking at the costs and benefits of IPS in absolute terms and compared to other forms of support, evidence shows that IPS is cost-effective. The case is even stronger when allowance is made for benefits which cannot easily be measured in monetary terms, such as improved quality of life and reduced social exclusion. It is also likely that the balance of costs and benefits becomes increasingly favourable the longer the period of time over which it is measured. (CMH, 2009).

Proportion of adults in contact with secondary mental health services living independently, with or without support

There has been positive evidence on the cost effectiveness of Supporting People compared to alternatives (namely residential care).

Analysis of the Supporting People Outcomes data set shows that for the mental health client group, the top outcomes achieved for long term housing support services was to maintain independent living (95%), maintain accommodation (95%) and maximise income (95%). The best overall estimate produced by CapGemini for DCLG in 2009 of net financial benefits from the Supporting People Programme for people with mental health problems is £560 million per annum (against an overall investment of £254 m).¹⁴

Proportion of adults with learning disabilities living in their own home or with their family

There has been positive evidence on the cost effectiveness of Supporting People compared to alternatives (namely residential care).

The best overall estimate produced by CapGemini for DCLG in 2009 of net financial benefits from the Supporting People Programme for people with learning disabilities is £711m per annum (against an overall investment of £369m).¹⁵

Proportion of people using social care who receive self-directed support

¹¹ Beyer, S. (2008) *An evaluation of the outcomes in supported employment in North Lanarkshire*. North Lanarkshire Social Work Service

¹² Kilsby, M and Beyer S. (2010) *A financial cost: benefit analysis of Kent Supported Employment: establishing a framework for analysis – interim report*. Kent Social Services

¹³ <http://www.dwp.gov.uk/policy/welfare-reform/legislation-and-key-documents/realising-ambitions/>

¹⁴ DCLG (2009) "Research into benefits of the Supporting People programme"

¹⁵ Frontier Economics (2010) *Financial benefits of investment in specialist housing for vulnerable and older people*

The Office of Fair Trading reported that uptake of direct payments made those people happier with the service they receive (*Choice and competition in public services: a guide for policy makers* (2010, OFT/Frontier Economics))

The Audit Commission's report on the Financial management of personal budgets found that personal budgets used well not only benefited social care users(, but that "Councils will face the challenge of demographic change better prepared: flexible, more suitable care will be available and councils will have developed affordable and equitable long-term financial plans" (Financial management of personal budgets, Audit Commission, 2010)

SCIE have published research on older people and mental health users experience of PBs¹⁶.

A key finding of the Evaluation of the Individual Budgets (IB) Pilot Programme¹⁷ is that higher levels of control were expressed by members of the group who were part of the IB pilot compared to the control group although there was some variation by client group. The research suggests that individual budgets are cost neutral to social services when start up costs are excluded but healthcare costs appeared to be higher for the IB group.

Domain 2

Permanent admissions to residential and nursing care homes, per 1,000 population

Evidence on the cost effectiveness of intermediate care services¹⁸ suggests that the costs of this intervention may be covered by the cost if it is successful in avoiding admissions to residential care at least 26% of cases. This assessment does not take account of the QALY gains from voiding admissions to residential care, we can assume that if these were included the "success rate" needed to break even would be lower.

Evidence on falls prevention (falls in older people are a common reason for care home admission) suggests that falls prevention strategies are roughly cost neutral¹⁹.

Older people discharged from hospital to rehabilitation or intermediate care, who are living at home 91 days after discharge

Research suggests that, apart from the costs of the re-ablement itself, those receiving re-ablement had higher health care costs in the first eight weeks. However in the remaining 10 months of the study those receiving reablement had similar health care costs to those receiving standard home care.²⁰

People receiving reablement use 60% less home care in the first year than those receiving standard care. When costs of re-ablement are included, there are no significant savings to social care in the first year after re-ablement.

Individuals receiving reablement benefit from improved health and social care related quality of life scores (HRQoL & SCRQoL).

The study concluded that taking into account health care, social care and reablement costs there is no difference in the costs of all services for those receiving reablement compared to the control group. However it does appear to improve quality of life scores compared to those not receiving reablement. We can surmise from the evidence on QOL that effective reablement may make it more likely that people could remain at home.

Delayed transfers of care

Intermediate care is a service that can be used to avoid delayed transfers of care. Evidence on the cost effectiveness of intermediate care services²¹ suggests that the costs of this intervention may be covered

¹⁶ Report 40: Keeping personal budgets personal: learning from the experiences of older people, people with mental health problems and their carers: <http://www.scie.org.uk/publications/reports/report40/index.asp>

¹⁷ Evaluation of the Individual Budgets Pilot Programme, Final Report: IBSEN (SPRU, PSSRU (Kent, London, Manchester), Social Care Workforce Research Unit)

¹⁸ www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106378.pdf

¹⁹ www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106379.pdf

²⁰ Glendinning, C et al (2010) Home-care re-ablement services: Investigating the long term impacts (prospective longitudinal study)

²¹ www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_106378.pdf

by the cost if it is successful in avoiding admissions to residential care at least 26% of cases. This assessment does not take account of the QALY gains from voiding admissions to residential care, we can assume that if these were included the “success rate” needed to break even would be lower.

Domain 3

Overall user satisfaction with local adult social care services

Satisfaction has been shown to be associated with quality of care services and outcomes^{22,23}

Therefore interventions identified as improving the outcome and quality of social care may have an impact on overall levels of satisfaction.

Overall carer satisfaction with local adult social care services

No specific information related to carer’s was identified but see above for users.

Proportion of carers who report they have been included or consulted in discussions about the person they care for

No evidence identified.

The proportion of people using services and carers who find it easy to find information about services

Improved and/or more information benefits carers and the people they support by helping them to have greater choice and control over every aspect of their lives. This may help to sustain caring relationships through for example, reduction in stress, improved welfare and physical health improvements.²⁴ These benefits accrue only where information is accessed that would not otherwise have been accessed, or in those cases where the same information is obtained more easily.

Domain 4

Proportion of adult social care users who feel safe and secure

Percentage of adult social care users who say social services has helped them to feel save and secure

No evidence identified.

²² Netten, A et al (2004) Performance and quality: user experiences of home care services

²³ Malley, J. (2010) A comparison of options for indicators from the Adult Social Care Survey (ASCS) PSSRU Discussion Paper 2736

²⁴ Carers UK (2006) In the know The importance of information for carers
<http://tinyurl.com/3xjuvw8>

Annex 3: Explanation of how measures are linked to improvements in outcomes for users and carers

Domain 1

Social care related quality of life

This indicator gives an overarching view of the quality of life of users based on outcomes identified through research that are relevant to social care. The ASCOT questions used in this indicator measures outcomes that are important to users. The body of work developing ASCOT has involved consultation with stakeholders and has drawn upon the substantial literature reporting social care service users' definitions of social care outcomes and their quality of life to develop the domains of outcome assessed in the measure²⁵²⁶²⁷²⁸.

The proportion of social care users who say they have control over their daily lives

This indicator measures one component of the overarching indicator social care related quality of life. A preference study conducted by PSSRU et al (ref) found that members of the public gave this domain of the 8 included in the ASCOT measure the highest weight i.e. of all the domains included in the ASCOT measure this is the one that is considered by the public to be the most important.

Carer-reported quality of life

This indicator gives an overarching view of the quality of life of carers based on outcomes identified through research. The questions that are used for this composite measure are aspects of quality of life which carers have said are important to them²⁹.

Proportion of adults with learning disabilities in paid employment

The indicator is intended to improve the employment outcomes for adults with learning disabilities reducing the risk of social exclusion. There is a strong link between employment and enhanced quality of life, including evidenced benefits for health and wellbeing³⁰ and financial benefits³¹.

Proportion of adults in contact with secondary mental health services in paid employment

The indicator is intended to measure improved employment outcomes for adults with mental health problems reducing their risk of social exclusion and discrimination. Supporting someone with their employment aspirations is a key part of the recovery process³². Employment outcomes demonstrate quality of life and are indicative that social care support is personalised. Employment is a wider determinant of health and social inequalities.

Proportion of adults with learning disabilities living in their own home or with their family

The indicator is intended to improve settled accommodation outcomes for adults with learning disabilities. The nature of accommodation for people with learning disabilities has a strong impact on their safety and overall quality of life and reducing social exclusion.

²⁵ MALLEY, J., SANDHU, S. & NETTEN, A. (2006) Younger Adults' Understanding of Questions for a Service User Experience Survey: A Report to the Information Centre for Health and Social Care. PSSRU Discussion Paper 2360. Canterbury, Personal Social Services Research Unit.

²⁶ NETTEN, A., BEADLE-BROWN, J., TRUKESCHITZ, B., TOWERS, A.-M., WELCH, E., FORDER, J., SMITH, J. & ALDEN, E. (2010a) Measuring the Outcomes of Care Homes, PSSRU Discussion Paper No. 2696/2. Canterbury, Personal Social Services Research Unit, University of Kent.

²⁷ NETTEN, A., MCDAID, D., FERNANDEZ, J.-L., FORDER, J., KNAPP, M., MATOSEVIC, T. & SHAPIRO, J. (2005) Measuring and understanding social services outputs. Canterbury, PSSRU.

²⁸ NETTEN, A., RYAN, M., SMITH, P., SKATUN, D., HEALEY, A., KNAPP, M. & WYKES, T. (2002) The development of a measure of social care outcome for older people. PSSRU.

²⁹ Malley, J et al (2010) Developing a Carer's Experience Performance Indicator

³⁰ Vigna, E., Beyer, S. and Kerr, M. (2011) The role of supported employment agencies in promoting the health of people with learning disabilities. Cardiff: Welsh Centre for Learning Disabilities.

³¹ Beyer, S. (2008) *An evaluation of the outcomes in supported employment in North Lanarkshire*. North Lanarkshire Social Work Service

³² Waddell, G. & Burton, A. (2006). *Is Work Good for your Health and Well-being?* London: TSO

Proportion of adults in contact with secondary mental health services living independently, with or without support

The indicator is intended to improve settled accommodation outcomes for adults with mental health problems improving their safety and reducing their risk of social exclusion.

Placeholders for:

Proportion of working age adults in contact with social services in paid employment

Proportion of people using social care who receive self-directed support

Enabling people to have the means to design support and care arrangements that suit them best should lead to improved satisfaction and outcomes. This is supported by research³³.

Domain 2

Placeholder: Percentage of emergency admissions to any hospital in England occurring within 28 days of the last, previous discharge

Permanent admissions to residential and nursing care homes, per 1,000 population

Avoiding permanent placements in residential care homes are a good indication of delaying dependency, and local health and social care services will work together to reduce avoidable admissions. Research suggests where possible people prefer to stay in their own home rather than move into residential care.³⁴

Older people discharged from hospital to rehabilitation or intermediate care, who are living at home 91 days after discharge

This measure attempts to assess the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining the ability of an individual to remain living at home (i.e. not needing residential care) following discharge.

Placeholder: The proportion of people suffering fragility fractures who recover their previous levels of mobility/walking ability

Placeholder: Effectiveness of prevention

Delayed transfers of care

This indicator measures the impact of hospital services (acute, mental health and non-acute) and community-based care in facilitating timely and appropriate transfer from all hospitals for all adults. This measures the ability of the *whole system* to ensure appropriate transfer from hospital for the entire adult population, and is an indicator of the effectiveness of the interface within the NHS, and between health and social care services. Minimising delayed transfers of care and enabling people to live independently at home is one of the desired outcomes of social care.

Domain 3

Overall satisfaction with local adult social care services

This measures the satisfaction with services of people using social care which is directly linked to a positive experience of care and support. Analysis of surveys suggests that this question is a good predictor of the overall experience of services users and quality³⁵.

Overall carers' satisfaction

This measures the satisfaction of carers with support that they and the person that they care for has received from social services.

Proportion of carers who report they have been included or consulted in discussions about the person they care for

³³ Evaluation of the Individual Budgets Pilot Programme, Final Report: IBSEN (SPRU, PSSRU (Kent, London, Manchester), Social Care Workforce Research Unit)

³⁴ Joseph Rowntree Foundation (2009) *Older people's vision for long-term care*

³⁵ Netten, A et al (2004) Performance and quality: user experiences of home care services

Carer's 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 breakdown in care³⁶. This measure reflects the experience of carers in how they have been consulted by both the NHS and social care.

The proportion of people using services and carers who find it easy to find information about services

This measure reflects social services users' and carers' experience of access to information and advice about social care. Information is a core universal service, and a key factor in early intervention and reducing dependency.

Improved and/or more information benefits carers and the people they support by helping them to have greater choice and control over every aspect of their lives. This may help to sustain caring relationships through for example, reduction in stress, improved welfare and physical health improvements.³⁷ These benefits accrue only where information is accessed that would not otherwise have been accessed, or in those cases where the same information is obtained more easily.

Domain 4

Proportion of adult social care users who feel safe and secure

This indicator measures one component of the overarching indicator social care related quality of life. It provides an overarching measure for this domain.

Safety is fundamental to the well-being and independence of people using social care (and others). There are legal requirements about safety in the context of service quality, including CQC essential standards for registered services. There is also a vital role of being safe in the quality of the individual's experience.

Percentage of adult social care users who say social services has helped them to feel safe and secure

Safety is fundamental to the well-being and independence of people using social care (and others). There are legal requirements about safety in the context of service quality, including CQC essential standards for registered services. There is also a vital role of being safe in the quality of the individual's experience.

Placeholder for effectiveness of safeguarding services

³⁶ Glendinning, C et al (2009) Individual budgets: Impacts and outcomes for carers, Research Findings, Social Policy Research Unit, University of York, York

³⁷ Carers UK (2006) In the know The importance of information for carers
<http://tinyurl.com/3xjuvw8>

Annex 4: Assessment of Basket of Measures

It is important that the group of measures selected provide a broad assessment of the quality and outcomes in social care and therefore do not skew local priorities in a way that would be detrimental to services. Therefore, as well as looking at measures individually, it is important to ensure that the range of measures included in the framework appropriately cover the breadth of social services.

This assessment led to further areas for development being identified to balance the basket of measures – for example in expanding measures on employment to include all working age adults in contact with social services, rather than focussing on mental health and learning disabilities only; and in identifying the need for further measures of the effectiveness of safeguarding.

However it should be noted that there is no such thing as a completely objective assessment of a basket of measures and in some cases value judgements have been made between partners about what constitutes “balance”. So for example a specific measure on people using services feeling they have control over their daily lives has been included because research has shown this to be the single most important aspect of quality of life to people using services.

The spreadsheet included here gives an assessment of the basket.



Annex 3 Assessing
the basket of measur

The key factors considered are:

- domains proposed in the consultation document, and
- the existing client groups (18-64 physical disability, 18-64 mental health, 18-64 learning difficulties, 65+, carers).

The assessments have been aggregated at the bottom of the table to show how many measures cover each of the key factors identified.

To aid making a judgement on whether the balance is appropriate. The second worksheet contains some relevant contextual information.

It is also important to note that the current set of outcome measures also includes several “placeholders” for areas of work where measures need to be developed – this means that in its first iteration the Outcomes Framework will not provide a complete picture of social care work.

Annex 5: Full 2011/12 Adult Social Care Outcomes Framework

1

Enhancing quality of life for people with care and support needs

Overarching measure – *Frames the outcome domain at the highest level*

1A. Social care-related quality of life

Outcome measures – *Describe the outcomes relevant to the domain*

People manage their own support as much as they wish, so that are in control of what, how and when support is delivered to match their needs.

1B. The proportion of those using social care who have control over their daily life

1C. Proportion of people using social care who receive self-directed support, and those receiving direct payments

Carers can balance their caring roles and maintain their desired quality of life.

1D. Carer-reported quality of life

People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation.

1E. Proportion of adults with learning disabilities in paid employment

1F. Proportion of adults in contact with secondary mental health services in paid employment

XX. *Proportion of working age adults in contact with social services in paid employment* (to replace 1E/1F)*

1G. Proportion of adults with learning disabilities who live in their own home or with their family

1H. Proportion of adults in contact with secondary mental health services living independently, with or without support

* Placeholder in 2011/12

2

Delaying and reducing the need for care and support

Overarching measures – *Frame the outcome domain at the highest level*

2A. Permanent admissions to residential and nursing care homes, per 1,000 population
*XX. Effectiveness of prevention/preventative services**

Outcome measures – *Describe the outcomes relevant to the domain*

Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs.

*XX. Effectiveness of prevention/preventative services**

Earlier diagnosis, intervention and reablement means that people and their carers are less dependent on intensive services.

2B. Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services
*XX. Effectiveness of early diagnosis, intervention and reablement: avoiding hospital admissions**

When people develop care needs, the support they receive takes place in the most appropriate setting, and enables them to regain their independence.

2C. Delayed transfers of care from hospital, and those which are attributable to adult social care
*XX. Effectiveness of reablement: regaining independence**

* Placeholder in 2011/12

3

Ensuring that people have a positive experience of care and support

Overarching measure – Frames the outcome domain at the highest level

People who use social care and their carers are satisfied with their experience of care and support services.

- 3A. Overall satisfaction of people who use services with their care and support
- 3B. Overall satisfaction of carers with social services

Outcome measures – Describe the outcomes relevant to the domain

Carers feel that they are respected as equal partners throughout the care process.

- 3C. The proportion of carers who report that they have been included or consulted in discussions about the person they care for

People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.

- 3D. The proportion of people who user services and carers who find it easy to find information about support

People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.

This information can be taken from the Adult Social Care Survey and used for analysis at the local level.

4

Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

Overarching measure – *Frames the outcome domain at the highest level*

4A. The proportion of those using adult social care who feel safe

Outcome measures – *Describe the outcomes relevant to the domain*

Everyone enjoys physical safety and feels secure.

People are free from physical and emotional abuse, harassment, neglect and self-harm.

People are protected as far as possible from avoidable harm, disease and injuries.

People are supported to plan ahead and have the freedom to manage risks the way that they wish.

4B. The proportion of those using adult social care who say that services have made them feel safe and secure

XX. *Effectiveness of safeguarding services**

* Placeholder in 2011/12

Annex 6: Individual templates for each measure

As set out in the main document, consultation responses were largely in agreement about the most important criteria for assessing measures to support the selection process for the Outcomes Framework. These criteria were:

- Relevant and meaningful to the public – measures should be intelligible and reflect what matters to people;
- Substantially influenced by social care – measures must be relevant to the work of adult social care to support accountability;
- Can be compared between local areas and over time – measures must be consistent to promote transparency;
- A measure of a social care-related outcomes (for overarching and outcome measures), or consistent with the outcome focus (for quality data and measures) – we should be clear about the level of the measure its fit within the outcome domain;
- Disaggregation by equalities – measures should be able to be broken down to support a focus on equalities; and,
- Currently collected – measures should, at least from 2011/12, be currently available from an existing data source (naturally this does not apply to placeholders).

The assessment of the appropriateness of the measures also relied on the availability of evidence on interventions which can drive improvement in outcomes, and their cost-effectiveness, where this was available. There is generally a lack of good quality robust evidence in the social care sector on the cost effectiveness of interventions linked to improvement in outcomes, however we have taken account of this evidence where possible.

A template was developed analysing each measure on these factors and setting out evidence to support this evaluation. The templates were then circulated to a variety of stakeholders for an iterative process of comment and revision. Eventually, the templates formed the basis of discussions between the co-badged partners – DH, ADASS and LGG – to agree the measures for inclusion in the final Outcomes Framework. An example of the final template is included below for reference – the template involves assessment of each measure against the above criteria, as well as an analysis of any risks associated with inclusion and of any possible alternative measures.

A – GENERAL DETAILS

Measure	
Domain Name and no.	
Nature of the measure (overarching/outcome/quality)	
Recommendation	

B . The Measure

<p>1. Proposed area and measure with associated definition. Including indicator title and construction - details of numerator and/or denominator where appropriate</p>	
<p>2. Rationale and support Why is this indicator a potential component of the outcomes framework including: (a) relationship to domain outcome (b) stakeholder views</p>	
<p>3. A measure of social care outcome</p>	
<p>4. Significantly influenced by social care</p>	
<p>5. Relevance and meaningful to the public</p>	
<p>6. Available at local level and comparable across areas</p>	
<p>7. Available equalities disaggregations</p>	
<p>8. Evidence the measure can be improved by social care interventions Set</p>	

<p><i>out an assessment of their cost effectiveness</i></p>	
<p>9. Data availability</p>	
<p>10. Statistically appropriate <i>Include, current position, trend and simple projection - or data not available and feasibility to obtain</i></p>	
<p>11. Does the measure create perverse incentives?</p>	
<p>12. Risks or consequences of inclusion in Outcomes Framework</p>	
<p>13. What alternative indicators are feasible for this improvement area ?</p>	
<p>14. Any other relevant information</p>	