

RESHAPING CARE FOR OLDER PEOPLE

CHANGE FUND: GUIDANCE FOR LOCAL PARTNERSHIPS: 2012/13

1. Background

1.1 The principal policy goal of the Reshaping Care for Older People programme is to optimise independence and wellbeing for older people at home or in a homely setting. The implications of the current financial situation and demographic changes make this a challenging task, as an increasing number of people will require improved services, care and support.

1.2 It is widely recognised that maintaining the status quo will not suffice and significant shifts to anticipatory and preventative approaches are required to achieve and sustain better outcomes for older people. A philosophy of care based on the principles of co-production and achieved through effective partnership working across the statutory and non-statutory sectors, is at the core of the Reshaping Care for Older People programme.

1.3 The Scottish Government established the Change Fund for older people's services to enable health, social care, housing, Independent and Third sector Partners to implement local plans for making better use of their combined resources to improve outcomes for older people. All 32 Partnerships agreed local Change Plans and received their allocations of the £70m Change Fund available for 2011/12. Partnerships are making progress in implementing their Change Plans and are developing organisational capacity for joint commissioning as well as engaging stakeholders and supporting and evaluating local changes.

1.4 Following the 2012 Spending Review, Ministers have announced that an £80m Health and Social Care Change Fund will be available for Partnerships in 2012/13, with £80m committed for 2013/14 and £70m for 2014/15, to drive the development of services that optimise the independence and wellbeing for older people at home or in a homely setting. Partners should use this Fund to change the way the total resource - approximately £4.5 billion per year (figures from 2008-09) - is spent on health and social care provision for people aged over 65 years. They should have a clear strategy to invest upstream in anticipatory and preventative approaches that will help to both manage demand for formal care, and support carers when more older people are at home.

1.5 All 32 Change Plans and overview reports from a variety of perspectives are accessible on the following website¹ to support the sharing of ideas and good practice and Partnerships should consider this advice in the development of 2012/13 Plans.

1.6 Developments undertaken using the Change Fund 2012/13 will consolidate those actions commenced in 2011/12 and must continue to build on the wide range

¹ <http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/change-fund-plans/>

of innovative work already underway across Scotland². Through this, the Change Fund will support progress towards the Ambitions set out in the Healthcare Quality Strategy for NHS Scotland, local Single Outcome Agreements and other national performance frameworks. The National Strategy for Housing for Older People³ is due for publication by the Scottish Government in December, and developments using the Change Fund should seek to build on this.

1.7 Partnerships must continue to incorporate the Third and Independent sectors as equal Partners, and to engage with carers and the public to develop strategic plans for older people that support independence and wellbeing and put in place the care and support services that local communities require. Non-statutory partners in particular have a significant role to play in bringing about change and improvement for older people.

1.8 Central to this guidance is the full engagement of the teams who deliver services directly to older people including multidisciplinary clinical teams (from both primary and secondary care), social work teams, Third and Independent sector representatives and the management that supports them in the planning of service options. It is these professionals, together with carers and older people themselves, who will be able to give assurance that the new services and pathways of care will deliver the required outcomes for older people.

2. Measuring Outcomes and Assuring Performance

2.1 It is essential that the delivery of national and local outcomes using Change Fund resources is recorded and evidenced by each Partnership. The annexes to this document set out how Partnerships should record progress towards improved outcomes for 2012/13 progressing through to next year's allocation. The data and evidence presented within the Change Fund template demonstrating outcomes must show the additionality of the Change Fund resource to wider system performance; lack of evidence may be interpreted as lack of progress.

2.2 In recording this evidence, Partnerships should show how their actions have impacted on nationally available outcome measures and indicators, local improvement measures and Partnership resource use, as outlined in the Reshaping Care Core Improvement Measures note of July 2011⁴ and the Community Care Outcomes Framework highlighted at Annex B. Partners will also want to take account of Care Inspectorate grading or advice when making decisions on the use of Partnership resources. Evidencing change in these measures will give the Ministerial Strategic Group the assurance it requires.

2.3 Partnerships should have mechanisms in place that gather data and evaluate success to enable them to identify the relative contributions of the different interventions they have put in place using their Change Fund allocation and decide

² Including the [Community Care Outcomes Framework](#), the [Integrated Resource Framework](#) (IRF), the Long Term Conditions Action Plan, the [Rehabilitation Framework](#), [Self-directed Support](#), [Palliative Care](#), [Dementia](#), [telecare/telehealth](#) and [Carers](#) strategies.

³ <http://www.scotland.gov.uk/Topics/Built-Environment/Housing/access/ROOPH>

⁴ <http://www.jitscotland.org.uk/action-areas/reshaping-care-for-older-people/improvement-measures/>

which pattern of services to retain and which to alter or dispense with once the Change Fund comes to an end (section 3.3 and 3.4 of Annex A).

3. Sustainability of Changes

3.1 Partnerships must plan now to sustain the right mix of services, care and support and shift appropriate resources before the Change Fund closes. Changes in service provision should demonstrate significant shifts in investment and activity into communities from institutional provision. Substantial service redesign is envisaged, therefore an outline of how the local public are being, and will be engaged, should be included in Change Plans, especially where institutional capacity will be changed or reduced in order to facilitate investment in community based alternatives.

4. Anticipatory Care and Preventative Spend

4.1 Partnerships must make the best use of this transitional Change Fund to lever genuine shifts in the totality of their health and care spend and to rebalance care, support and service provision towards anticipatory care and preventative services that will support older people to stay in their own homes. Partnerships must consider pathways of care and shift resources to build the services that support people at the very beginning of their care journey including through self directed support mechanisms. The provision of housing-related services including equipment and adaptations, physical activity, tele(health)care, handyperson services and specialised housing for older people, for example, can significantly reduce the incidence of falls and optimise the independence and wellbeing of older people and support them to remain safely at home or in a homely setting. Support to carers through early identification is also part of the preventative approach.

4.2 Central to understanding and measuring this shift in focus and activity is monitoring spend along the Reshaping Care pathway (Annex C). Over the four years of the Change Fund we would expect to see the proportion of funding allocated to 'Preventative and Anticipatory Care' and 'Proactive Care and Support at Home' increase. Partners will be required to record this information, using the Integrated Resource Framework mechanisms for analysing spend, activity and variation, in the Change Plan template (Annex A) and progress will be monitored over the whole course of the Change Fund lifecycle.

5. Forthcoming Legislative Programmes

5.1 Two new legislative programmes on integration and self directed support will have a direct impact on Partnerships, and will guide and influence the preparation and submission of Change Plans and Joint Commissioning Strategies from 2012/13.

Integration of Health and Social Care

5.2 Scottish Ministers have announced their intention to further integrate health and social care and are currently developing proposals to enable this. It is likely that changes will require full consultation and primary legislation. This agenda will ensure closer working between statutory Partners to deliver better outcomes for all adults

accessing health and social care services⁵. It will support Partnerships in bringing together health and social care resources, both financial and operational, for the benefit of people and local communities.

Self Directed Support

5.3 The Self Directed Support Bill will be introduced to the Scottish Parliament in this session. If the Bill is successfully passed, it will impose duties on Local Authorities to offer the individual as much choice and control as they want to have over the support provided to them and to give effect to the individual's decision⁶. The Self Directed Support 10 Year Strategy⁷ places this agenda within the social care context and draws the links to reshaping care, integration and other key policies. This document will help Partnerships ensure that Self Directed Support is central to the service options developed under the Change Fund.

6. Carers

6.1 As part of the Scottish Government's ongoing commitment to support carers, from 2012-13 onwards at least 20% of the Change Fund spend will be dedicated to supporting carers to continue to care for older people. Partnerships must ensure that this is additional to existing carer support funding streams and must not be used as a substitute for existing core funding. This includes Carer Information Strategy funding, existing funding and support to local carers services, including short breaks, by Local Authorities⁸.

6.2 For Partnerships to deliver this commitment it is necessary to set out what constitutes support to carers so they are able to clearly ensure and demonstrate that at least 20% of their allocation is spent in this way (section 6 of Annex A). The evidence base⁹ demonstrates that direct support to carers benefits people who are cared-for by reducing admissions and readmissions to acute facilities and supporting planned discharges. It is clear that if carers are not adequately supported there is a greater likelihood of the cared-for being admitted to hospital and carers' own health being compromised.

6.3 Services aimed at older people with carers also improve the welfare of both the carers and the cared-for. This allows people who are cared-for to remain within their communities for as long as is possible and appropriate.

6.4 The optimum way of supporting carers is likely to be through a planned combination of direct carer support and support for the cared-for. Where support for the cared-for is being considered, with beneficial impact on the carer, Partnerships

⁵ An Integration webpage is in development and will be circulated to Partnerships shortly.

⁶ This website gives details of the draft SDS bill <http://www.scotland.gov.uk/Topics/Health/care/sdsbill>

⁷ Self Directed Support; A National Strategy for Scotland; The Scottish Government; Oct 2010; <http://www.scotland.gov.uk/Publications/2010/11/05120810/0>

⁸ Should Partnerships have queries identifying existing carer funding streams please contact; Moir.Oliphant@Scotland.gsi.gov.uk

⁹ Supporting Carers: The Case for Change; The Princess Royal Trust for Carers/Crossroads Care, 2011 & Caring Together: The Carers Strategy for Scotland 2010-2015; Scottish Government and COSLA; July 2010

must keep the process under review as the caring role may become more substantial over time.

6.5 Services that Partnerships might wish to consider include, but are not limited to:

- Direct support to carers such as short breaks/respice especially where the carer and the cared-for person both benefit, carer training, the provision of information and advice and emotional support to improve carers' health and well-being;
- Community capacity building to ensure a network of community-based support demonstrating how carers will benefit from this approach;
- Direct support to older people, including people with dementia, demonstrating how carers will benefit. Since many people with dementia can live on their own or with minimal support, Partnerships must be clear about those they are supporting who have carers who may not live in the same household;
- The provision of telecare to older people who have carers¹⁰, demonstrating how the telecare will support the carers;
- Re-ablement services to enable older people with carers to become more independent.

7. Joint Commissioning Strategies

7.1 Long term iterative planning between Partners for the care of older people is essential to ensure that the quality of care continues to improve and better value for money is achieved. The Scottish Government signalled to Partnerships in the 2011/12 Change Fund guidance that the forthcoming year's Change Plans should feature in the development of longer term Joint Commissioning Strategies covering the period 2012-2020. The Scottish Government encouraged partnerships to start considering how best to compile these Joint Commissioning Strategies.

7.2 The preparation of Joint Commissioning Strategies and associated governance arrangements provides an important opportunity for the Third and Independent sectors and carers to become fully embedded in the planning arrangements established by Partnerships, and to further strengthen the cross sector arrangements that have been established during the first year of the Change Fund.

7.3 Developing effective Joint Commissioning Strategies is a complex process¹¹. To allow time for the development of these capabilities, you are not required to submit a signed off Joint Commissioning Strategy at this stage, but to indicate work underway in your Partnership to develop the systems and processes to enable your

¹⁰ A Weight off my mind! Exploring the impact and potential benefit of telecare for unpaid carers in Scotland: Kara Jarrold & Sue Yeandle, University of Leeds (2010)

¹¹ Guidance and support on preparing your Joint Commissioning Strategy for Older People can be found at <http://www.jitscotland.org.uk/action-areas/commissioning/>

partnership to produce a first iteration of a Joint Commissioning Strategy during 2012/13 to support the 2013/14 Change Fund allocations. The 2012/13 Change Plans should reference this work in order that the Ministerial Strategy Group can be confident that Change Fund proposals are consistent with the shared vision of local Partners for older people's services and align with anticipated, significant, longer term, whole system re-design proposals and resource shifts.

7.4 The availability of suitable housing is essential if the outcomes of Reshaping Care are to be achieved. Partnerships should ensure that the housing consequences of their Joint Commissioning Strategies are identified and incorporated in the Local Housing Strategy and Strategic Housing Investment Plan (SHIP).

7.5 It is anticipated that the Scottish Government will establish a development programme and associated support to equip partnerships with the capabilities needed to develop their Joint Commissioning Strategies during 2012/13. Details of the development programme will be made available in due course.

8. Accessing the Change Fund

8.1 Each of the 32 local Partnerships is invited to submit a Change Plan for spend in 2012/13, a financial return for the monies allocated in 2011/12 and a self assessment of the outcomes achieved to date. We recognise that service developments will be in their infancy and Partnerships should demonstrate a clear strategy for gathering further evidence. It is important that Partnerships share information about work that has been successful and about projects that have not progressed to plan. This will help to support the knowledge base of effective interventions for supporting older people and share knowledge across Partnerships.

8.2 The Change Fund will continue to be distributed through NHS Boards as part of their 2012/13 allocation using a formula based on NRAC and GAE following a formal review by the Delivery Group. For planning purposes Partnerships should base allocations on last year's funding with the appropriate uplift to account for the increased size of the overall fund. Once the allocations have been confirmed further information will be made available.

8.3 A Plan template is provided at Annex A and these should be prepared and submitted through local Community Planning Partnership processes, acknowledging that this may be taken forward through delegated and devolved arrangements such as CHPs/CHCPs or other local health, housing and social care Partnership frameworks. Plans must be prepared, agreed and signed off by the Health Board, the Local Authorities, Third and Independent Sector Partners.

8.4 Completed Change Plan templates should be submitted by 17 February 2012 to Grant Hughes (grant.hughes@scotland.gsi.gov.uk) to allow time for them to be considered by the Ministerial Strategic Group for Health and Community Care before release of funds at the beginning of the new financial year (1 April 2012). The Ministerial Strategic Group is chaired by the Deputy First Minister and its membership consists of four Local Authority elected members, four Health Board Chairs and elected representatives of the Third and Independent Sectors. The

Ministerial Strategic Group will oversee the implementation of the Change Fund process nationally and will look for assurance that Partnerships are delivering improved outcomes for older people.

9. Support

9.1 The Scottish Government will continue to provide support through the Joint Improvement Team to Partnerships as they develop and implement their Change Fund Plans. This will include support that is tailored to the Integration of Health and Social Care and the development of Joint Commissioning and Dementia Strategies. In addition, the existing Reshaping Care Improvement Network will continue to enable Partnerships to share best practice and develop key skills. Extensive resources relating to the Change Fund and the Reshaping Care for Older People programme can be found online¹².

9.2 A Core Group has oversight of the Improvement Network's activities and outcomes. Membership includes representatives from the Third sector, Scottish Care, NES, SSSC, CHP Association and Partnerships. The Core Group links to a wider Reshaping Care Action Group which provides linkage across Scottish Government work streams.

10. Summary of Submission

Actions that need to be completed before submission by 17 February 2012

1. Fill out the Change Plan Template (Annex A) following both the Change Fund guidance and the accompanying notes in Annex A.
2. Each Change Plan needs to be prepared, agreed and signed off through community planning processes (as outlined above), with signatures from the **Health Board**, the **Local Authority**, and representatives of the **Third and Independent sectors** required before submission.
3. In providing a self assessment against 2011/12 performance (section 4 in Annex A), please note that the section entitled 'Successes and lessons learnt' will be used to help other Partnerships with similar projects.
4. Details of how well progressed Joint Commissioning Strategies are at the time of submission should be included with the Change Fund application (section 8 in Annex A), emphasising how the Strategy will link in with the Change Plan.

Additional notes on submissions

When considering your Change Fund submission please bear the following points in mind:

1. High priority should be given to developing anticipatory care and preventative measures, with a view to increasing the proportion of Change Fund monies to these areas in subsequent years;

¹² <http://www.jitscotland.org.uk/>

2. 20% of the Change fund allocation for 2012/13 from each Partnership needs to be allocated to support options and services for carers. Partnerships must ensure that this is in addition to existing carer support and is not used as a substitute for existing core funding.
3. In line with the 2011/12 Change Fund guidance, Partnerships must ensure that the Change Fund is used to enable accelerated development of services and supports that will deliver better models of care.

11. Contact

11.1 For further information please contact the following

Queries regarding the Change Fund, submission of Change Plans and this guidance should be directed to – Grant Hughes:

Tel: (0131) 244 3588

e-mail: Grant.Hughes@Scotland.gsi.gov.uk

Queries regarding Improvement Support should be directed to the Joint Improvement Team – Brian Spence:

Tel: (0131) 244 3656

e-mail: Brian.Spence@Scotland.gsi.gov.uk

Change Plan Template

1. Name of Partnership

See Note 1

2. Partner Organisations

2.1 Partners signed up to the Change Plan

See Note 2

2.2 Professional Engagement in the development of Plans

See Note 3

2.3 Public engagement in the development of Plans

See Note 3

3. Finance

3.1 Resources available to Partnerships
see Note 4

| From | Amount £ | Difference from 2011/12 |
|--|----------|-------------------------|
| Monies carried forward from 2011/12 allocation | | N/A |
| Initial central allocation | | |
| Added by NHS Board | | |
| Added by local authority | | |
| Other | | |
| TOTAL | | |

3.2 Reasons for financial 'carry forward'

See Note 5

3.3 Change Fund allocation by pathway

See Note 6

| | Preventative & Anticipatory Care | Proactive Care & Support at Home | Effective Care at Time of Transition | Hospital & Care Homes | Enablers |
|---------|----------------------------------|----------------------------------|--------------------------------------|-----------------------|----------|
| 2011/12 | | | | | |
| 2012/13 | | | | | |
| 2013/14 | | | | | |
| 2014/15 | | | | | |

3.4 Total resource allocation by pathway

See Note 6

| | Preventative & Anticipatory Care | Proactive Care & Support at Home | Effective Care at Time of Transition | Hospital & Care Homes | Enablers |
|---------|----------------------------------|----------------------------------|--------------------------------------|-----------------------|----------|
| 2011/12 | | | | | |
| 2012/13 | | | | | |
| 2013/14 | | | | | |
| 2014/15 | | | | | |

4. Self Assessment Against 2011/12 Performance

4.1 Nationally available outcome measures and indicators

See Note 7

4.2 Local improvement measures

See Note 7

4.3 Partnership resources

See Note 7

4.4 Successes and lessons learnt

See Note 8

5. Governance

5.1 Describe your Partnership governance framework and financial framework to enable Partnership decisions if they have changed since 2011/12

See Note 9

6. Carers

6.1 Describe the range of services that improve outcomes for carers

See Note 10

6.2 Indicate the total amount of Partnership resource allocated to support carers to enable them to continue to care

See Note 11

7. Support Mechanisms

7.1 What support has helped you so far? What didn't?

See Note 12

7.2 What support, if any, could you offer other Partnerships?

See Note 13

8. Joint Commissioning Strategy for Older People

In terms of your Joint Commissioning Strategy:

- what Partners will be involved in the preparation of the Strategy;
- what are the estimated total resources for the Strategy;
- what governance arrangements are you planning on implementing;
- what is the timeline involved;
- how will your Joint Commissioning Strategy link in with your Change Fund application?

See notes 14-17

This Change Fund Plan has been prepared and agreed by the NHS, Local Authority, Third Sector and Independent Sector interests.

Signed

NOTES

Note 1. This should be based on the Local Authority area – however it is open, by agreement with all parties, for the purposes of the Change Fund, to vary the Partnership boundaries (e.g. if neighbouring councils wish to combine along with their NHS and voluntary/independent sector Partners).

Note 2. Change Plans must be agreed by NHS Boards, Local Authorities and Third Sector and Independent Sector Partners. Partnerships should specify the names of organisations directly engaged in preparing the Change Plans. Partnerships should highlight differences if any in the organisations from 2011/12 and the reasons for change.

Plans should indicate how older people themselves and carers will be engaged to support both the preparation of the Change Plan and the development of longer term Strategic Plans or Commissioning Strategies, and how they will help directly shape the form of new services and supports to ensure the principles of co-production are achieved in practice.

Note 3: Describe how multidisciplinary clinical teams (from both primary and secondary care), social work teams, third and independent sector representatives and the management that support them have been engaged in the process of developing Change Plans. Please include details of how this engagement will be assured on a continuing basis via the Primary & Secondary Care clinical and social work leaders who help to shape engagement through the professions. Please also include an outline of how the local public are being, and will be engaged.

Note 4: This section should record the total size of the Change Fund allocation, any monies carried forward from the Partnership allocation from 2011/12 and any supplementary funding from other sources. This might include Resource Transfer, delayed discharge, housing support, Lottery funding or other funding not specifically committed (e.g. community care commissioning budgets). In some cases, Partnerships might want to state the totality of the resource available for older people and pool the entire budgets.

It is for Partnerships to agree locally how to deal with underspend /slippage as long as this meets the objectives of your Change Plan. Any request for NHS Boards to carry forward underspends should be agreed with Scottish Government Health Finance colleagues.

Note 5: This section should record the reasons why Partnerships have been unable to spend their allocation from 2011/12. It should include detail about how this resource will be utilised within the 2012/13 period.

Note 6: Partnerships are asked to provide an indicative summary of how the Change Fund and total resource have respectively been divided between the stages of the reshaping care pathway. Where initiatives support more than one stage, resources should be divided proportionally. This information is for illustrative purposes and indicative figures should be used. Annex C describes the reshaping care pathway in more detail.

Note 7: This section should include the key measures and outcomes that the Partnership was focussed on delivering in 2011/12. It should indicate the progress made against the three levels outlined within the Core Improvement Measures paper (Annex B); nationally available outcome measures and indicators; local improvement measures and Partnership resource use. The data presented should, as far as possible, be clearly attributable to the joint resource and the Change Fund monies, not wider system performance.

Note 8: This section should outline the main successes and lessons learnt in delivering planned outcomes. It should also account for any targets that have been missed and detail what actions have been put in place to ensure continuous improvement through 2012/13.

Note 9: This Section should outline the governance arrangements that are in place to ensure accountability for outcomes and financial spend for Partners. It should note the links to the Community Planning Partnerships and Single Outcome Agreements, and where applicable Community Health Partnerships and HEAT targets.

Note 10: Partnerships should summarise the services they have put in place to support carers and the cared-for with regard to the 20% of total resource commitment.

Note 11: Partnerships should provide detail of the total proportion of Change Fund resources allocated to support carers and the cared-for.

Note 12: Partnerships should describe what support has been beneficial and what has not added value through the Change Fund process.

Note 13: This section should indicate where Partnerships feel they would be able to support other Partnerships to improve outcomes and deliver the aims of the Change Fund. This can include the organisational arrangements put in place to progress Partnership working, specific service developments, the development of a Joint Commissioning Strategy or any area the Partnership feels it has made particularly good progress.

Note 14: This section should note the Partners involved in developing and agreeing the Joint Commissioning Strategy.

Note 15: This section should outline the total resource that the Joint Commissioning Strategy covers.

Note 16: This section should highlight the governance arrangements for the delivery of the outcomes noted within the Joint Commissioning Strategy. It should demonstrate the links made to Single Outcome Agreements and HEAT targets.

Note 17: This section should outline the process that will be undertaken to develop the Joint Commissioning Strategy and the timescale for doing so.

Reshaping Care for Older People: Core Improvement Measures

A: Nationally Available Outcome Measures and Indicators

A1. Emergency inpatient bed day rates for people aged 75+ (NHS HEAT 2011/12)

A2. a. Patients whose discharge from hospital is delayed and

b. Accumulated bed-days for people delayed (NB further detailed guidance on b. will be issued soon.

A3. Prevalence rates for diagnosis of Dementia (NHS QOF)

A4. Percentage of people aged 65+ who live in housing, rather than a care home or a hospital setting (ISD)

A5. Percentage of time in the last 6 months of life spent at home or in a community setting.

We also recommend that Partnerships continue to develop their use of:

A6. Experience measures and support for carers from the Community Care Outcomes Framework (Community Care Benchmarking Network)

B: Local Improvement Measures

Anticipatory and preventative care

B1. Proportion of people aged 75 and over living at home who have an Anticipatory Care Plan shared with Out-of-Hours staff

B2. Waiting times between request for a housing adaptation, assessment of need, and delivery of any required adaptation

B3. Proportion of people aged 75+ with a telecare package

Responsive / flexible home care and carers

B4. Reduction in hours of support required after reablement service provided

B5. Respite care for older people per 1000 population

Demand for acute care

B6. Rates of 65+ conveyed to Accident & Emergency with principal diagnosis of a fall (Data from Scottish Ambulance Service)

Effective flow in acute care

B7. Proportion of frail emergency admissions who access comprehensive geriatric assessment with 24 hours

Use of long term residential care

B8. Rate and proportion of new entrants admitted from home; acute hospital specialty; following intermediate care; graduate from emergency respite

C: Partnership Resource Use

C1. Per capita weighted cost of accumulated bed days lost to delayed discharge

C2. Cost of emergency inpatient bed days for people over 75 per 1000 population over 75

C3. A measure of the balance of care (e.g. split between spend on institutional and community-based care).

IRF data will support use of these C measures in particular.

OUTCOMES FRAMEWORK FOR COMMUNITY CARE

The Community Care Outcomes Framework helps Partnerships to understand their performance at a strategic level in improving outcomes for people and their carers who use community care services or support. The Framework also allows Partnerships to share information with each other and compare performance directly on the basis of consistent, clear information.

National Outcomes

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

Performance measures and targets – user and carer experience

| Themes | Code | Measure ¹³ | Type | Data Source / Status |
|----------------------------------|------|---|---------|-----------------------|
| Satisfaction / Experience | S1 | % of community care service users feeling safe. | Outcome | Data drawn from NMIS* |
| | S2 | % of users and carers satisfied with their involvement in the design of care package. | Outcome | Data drawn from NMIS* |
| | S3 | % of users satisfied with opportunities for social interaction. | Outcome | Data drawn from NMIS* |
| Support for carers | C1 | % of carers who feel supported and capable to continue in their role as a carer. | Outcome | Data drawn from NMIS* |

*NMIS is the National Minimum Standards for assessment, shared care and support plans and review (July 2008)

¹³ The full Community Care Outcomes Framework, and the definition for each measure, can be found at: <http://www.scotland.gov.uk/Topics/Health/care/JointFuture/CommunityCareOutcomesF/Definitions>.

RESHAPING CARE PATHWAY

