

Association of Directors of Adult Social Services

Revising Adult Social Care Outcomes Framework (ASCOF) Developing the right narrative for Adult Social Care

Part One – Reviewing the Current ASCOF

March 2020

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Introduction

The Adult Social Care Outcomes Framework (ASCOF) is increasingly experienced by Directors of Adult Social Services (DASS) as an outdated performance framework of adult social care, rather than an outcomes framework, whose metrics measure, to a certain degree at least, outmoded methods of adult social care delivery.

Therefore, the Association of Directors of Adult Social Services (ADASS) wish to explore potential revisions to the framework to ensure that ASCOF offer a vehicle for providing the 'right narrative' for adult social care, and which better reflects how it is meeting changes in national and local policy and its statutory responsibilities defined in the Social Care Act (2014), which includes;

- Commissioning a sufficient, high quality and affordable market of care and support providers;
- The importance of prevention and early intervention in promoting independence and wellbeing;
- Integration with the NHS and our interfaces with it, in line with the objectives of the Better Care Fund;
- The efficiency and effectiveness of local authorities in their use of resources.

Additionally, ADASS wish to

- realise the potential of technological developments.
- maximise the potential benefits of planned shifts from annual aggregate returns to more frequent client-level data integrated with data from the NHS.
- to ensure that any revision to ASCOF is looking to the future – 5 to 10 years

However, ADASS are conscious that the burden of collection and analysis should not increase as local authority capacity has in some cases reduced and that NHS Digital has reorganised, decreasing the size of its adult social care team.

The process of revising ASCOF

This project is funded and supported by the Department of Health and Social Care (DHSC) and through ADASS, it has asked the Institute of Public Care (IPC) Oxford Brookes University, to support the project

- November to end of January
 - Undertake initial contact and gather the views of a diverse range of sector stakeholders, including a survey of DASS;

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- Detailed analysis through workshops, including a workshop in each ADASS region and others involving national stakeholders including ADASS policy leads;
 - February to end of March
 - Proposals and testing – a report of findings, ultimately to ADASS Executive and to the DHSC Data and Outcomes Board.
 - Presentation to ADASS Spring Seminar

Purpose of this report

This report has been prepared at the end of the initial engagement and survey stage and is intended to offer a commentary and summary of the key themes emerging from this phase. In addition, the report offers a draft design for a revised performance framework – i.e. a number of underpinning principles and characteristic that help form its purpose, construction and recommendations for suggested performance indicators.

It is proposed that following DHSC and ADASS consideration of the draft and direction of travel that has been informed by a detailed analysis of the survey return, that IPC undertakes a further set of targeted engagement activities to support the development of options for DHSC and ADASS to discuss further.

Our work is structured in two parts:

Part One (this paper) briefly describes the current ASCOF and findings from our engagement activities and survey

Part Two explores the options for developing the right ‘performance narrative’ and performance framework for Adult Social Care.

Part One – Reviewing the current ASCOF

1 ASCOF: Purpose and Design

The Adult Social Care Outcomes Framework (ASCOF) measures how well care and support services achieve the outcomes that matter most to people. The ASCOF is used both locally and nationally to set priorities for care and support, measure progress and strengthen transparency and accountability.

The measures are grouped into four domains which are typically reviewed in terms of movement over time. These domains are:

- enhancing quality of life for people with care and support needs
- delaying and reducing the need for care and support
- ensuring that people have a positive experience of care and support
- safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm

The ASCOF aims to give an indication of the strengths and weaknesses of adult social care in delivering better outcomes for people who use services and is used both locally and nationally to set priorities for care and support, measure progress and strengthen transparency and accountability, specifically the key roles of the ASCOF are:

- Locally, the ASCOF provides councils with robust information that enables them to monitor the success of local interventions in improving outcomes, and to identify their priorities for making improvements. Local Authorities can also use ASCOF to inform outcome-based commissioning models.
- Locally, it is also a useful resource for Health and Wellbeing boards that can use the information to inform their strategic planning and leadership role for local commissioning.
- Locally, the ASCOF also strengthens accountability to local people. By fostering greater transparency on the outcomes delivered by care and support services, it enables local people to hold their council to account for the quality of the services that they provide, commission or arrange. Local authorities are also using the ASCOF to develop and publish local accounts to communicate directly with local communities on the outcomes that are being achieved, and their priorities for developing local services.
- Regionally, the data supports sector led improvement; bringing councils together to understand and benchmark their performance. This, in turn, stimulates discussions between councils on priorities for improvement, and promotes the sharing of learning and best practice.

- At the national level, the ASCOF demonstrates the performance of the adult social care system as a whole, and its success in delivering high-quality, personalised care and support. Meanwhile, the framework supports Ministers in discharging their accountability to the public and Parliament for the adult social care system, and continues to inform, and support, national policy development.

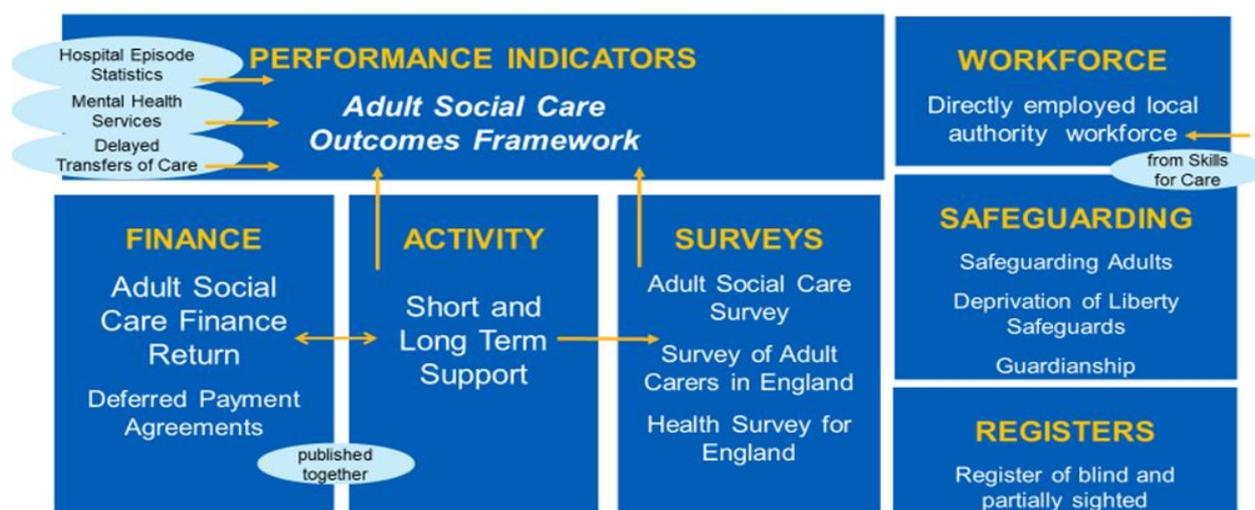
The Government does not seek to performance manage councils in relation to any of the measures set out in this framework. Instead, the purpose of ASCOF is to inform and support improvement led by the sector itself, underpinned by strengthened transparency and local accountability.

The measures were developed by the Department of Health and Social Care (DHSC), the Association of Directors of Adult Social Services (ADASS), and the Local Government Association (LGA).

1.1 Providing the right ‘narrative’ for Adult Social Care – the current picture

Currently, ASCOF is one of a set of long-established performance frameworks (see diagram below) which gathers and analyses (through NHS Digital) a range of quantitative (financial, activity, output) data to form a summary of how adult social care is performing.

Suite of Adult Social Care Collections and Official Statistics in England



The following data sets are of particular note:

Short and Long Term Support (SALT)

The Short and Long Term Services (SALT) collection relates to the social care activity of Councils with Adult Social Services Responsibilities in England. It is published annually based on data drawn from council administrative systems.

The purpose of the publication is to enable key aspects of the provision of social services across England to be assessed, at both national and local level.

Data from the SALT collection are used to create a number of the measures in the Adult Social Care Outcomes Framework (ASCOF).

The data are aggregate (counts of service users, carers, and events).

The data collected aim to track client journeys through the social care system.

Adult Social Care Finance Return (ASC-FR)

This collection gives expenditure by Councils with Adult Social Services Responsibilities (CASSRs) on services for adults aged 18 and over, by service provision and primary support reason. Information on a number of accounting categories is also included such as income from the NHS, grants provided to voluntary organisations and gross and net expenditure. It's also used for the calculation of unit costs - the cost of social services per person per week.

The purpose of the ASC-FR is to provide central government and local authorities with financial information to assess their performance in relation to their peers. It's also available for use by researchers looking at CASSRs performance and by service users and the public to hold CASSRs and government to account. The data is also used to produce the Personal Social Services: Expenditure and Unit Costs National Statistics publication.

National Minimum Data Set for Social Care

The National Minimum Data Set for Social Care (NMDS-SC) is managed by Skills for Care (SfC) on behalf of the Department of Health and Social Care and has been collecting information about social care providers and their staff since early 2006.

There are three parts to the NMDS-SC return that councils are required to submit. Details of number of jobs at each establishment, starters, leavers, vacancies and capacity and utilisation are recorded in the establishment or team section. The individual worker level section contains worker level data including employment details and demographic information. The data is used to produce the Personal Social Services: Staff of Social Services Departments National Statistics publication.

Service User and Carer Surveys

In addition, the collection of qualitative data through the annual client¹ and biannual carer² surveys provide a useful descriptor (see extract of 2018/19 NHS Digital Report below) of

¹ Personal Social Services Adult Social Care Survey (ASCS)

² Personal Social Services Survey of Adult Carers (SACE)

how those individuals who were in receipt of a service at the time of the survey see the impact of social services on the following areas:

- Overall Satisfaction with Care and Support
- Quality of Life
- Knowledge and Information
- Your Health
- Layout of Home and Surrounding Area
- Help from Others

Key findings

 38.6% of people who had received services said that they were very or extremely satisfied with the support and services received. 7.2% said that that were extremely or very dissatisfied

 The majority of carers (65.4%) have been carers for over five years. Almost a quarter (23.5%) have been caring for 20 years or more

 60.6% of carers reported that caring had caused them feelings of stress, compared with 58.7% in 2016-17. This was a significant increase

 53.4% of carers reported that their caring caused them no financial difficulties. 10.6% of carers said that caring caused them a lot of financial difficulties, which is a significant increase from the 2016-17 figure of 9.6%

Key findings

 Almost two thirds (64.3 per cent) of service users were very or extremely satisfied with the care and support they received. 2.0 per cent of service users were very or extremely dissatisfied with the care and support they received.

 58.5 per cent of service users in a residential care support setting report feeling they had as much social contact they want with people they like. Service users in the community reported the lowest levels of feeling they had as much social contact they want with people they like (41.9 per cent) and the highest levels of feeling socially isolated (7.3 per cent).

 63.0 per cent of service users who have as much social contact as they want, felt they were not anxious or depressed on the day they completed the survey, 4 per cent report they were extremely anxious or depressed. For service users that have little social contact and feel socially isolated, 16.3 per cent reported not feeling anxious or depressed and 36.7 per cent felt they were extremely anxious or depressed.

 43.7 per cent of service users reported they had never tried to find information or advice about support and services in the past year, this was a statistically significant increase from 25.8 per cent in 2017-18.

 Almost half (48.0 per cent) of service users reported receiving regular practical help from someone living in another household. 40.8 per cent reported receiving help from someone living in their household. Around a fifth of service users (20.5 per cent) reported not receiving any regular practical help from a husband / wife, partner, friend, neighbour or family member.

2018/19 Adult Social Care Survey

2018/19 Survey of Adult Carers

As can be seen in the table below, the focus of the surveys can be aligned to outcomes in the Care Act:

Care Act	Focus of Survey
Personal dignity	Dignity,
Protection from abuse and neglect	Safe and secure,
Control by the individual over day to day life	Control over daily life
	Personal safety

Care Act	Focus of Survey
Physical and mental health emotional well-being	Personal cleanliness and comfort Self-care
Participation in work, education, training and recreation	Occupation
Individual's contribution to society	Space and time to be yourself
Social and economic well-being	Social participation and involvement
Domestic, family and personal relationships	Social participation
Suitability of living accommodation	Accommodation
	Feeling encouraged and supported

Minimising changes within each framework over the last number of years has meant that adult social care has been able to establish performance trends in key areas of resource allocation, activity and ‘impact’.

Whilst not featuring in the above diagram as the data is not collected by NHS Digital, the Care Quality Commission annual report “State of Care”, their annual assessment of health and social care in England, which also looks at trends, highlights examples of good and outstanding care, and identifies factors that maintain high-quality care does provide an additional source (albeit not exclusively) on the narrative for adult social care.

This data described above sits alongside:

- Local Authority Revenue Expenditure and Financing – Ministry of Housing, Communities and Local Government
- Improved Better Care Fund Quarterly and Year Ending Reporting – Ministry of Housing, Communities and Local Government
- Personal Social Services Staff of Social Services Departments – NHS Digital
- Guardianship under the Mental Health Act – NHS Digital
- Mental Capacity Act 2005 – Deprivation of Liberty Safeguards – NHS Digital
- Delayed Transfers of Care – NHS England
- Better Care Fund Quarterly Reporting – NHS England
- Public Service Productivity: Adult Social Care – Office for National Statistics

- Unit Costs of Health and Social Care – Personal Social Services Research Unit
- The state of the adult social care sector and workforce in England – Skills for Care
- National Public Health Profiles – Public Health England
- Care Quality Commission Annual Report
- Local Government and Social Care ombudsman Annual Report

2 Reviewing ASCOF - Stakeholder Engagement: exploring stakeholder views on the current ASCOF

This section describes a summary and emerging analysis of the comments and feedback completed at the end of January through the engagement of a range of stakeholders attending the regional ADASS workshops and conversations with key sector representatives (see Appendix 1 for details). Further and more specific analysis provided by individual DASS survey responses are shown in Section 3

2.1 Comments on the current framework

ASCOF is divided into two distinct and separate parts –

- A questionnaire seeking the views of users and carers and
- A set of measures which are expected to measure some of the outcomes of the social care system run by councils.

The feedback given to us on the questionnaire covered the following areas though they might equally apply to the performance measures:

2.2 Central Co-ordination of the data

The first main observation is that no one in the health and care system appears to have responsibility for pulling all of this data together in a coherent way at a national level. Some local authorities still produce a “local account” to tell their story to local people and there is a lot of Regional activity that looks at benchmarking the data, but the full data set is not formally pulled together in one place.

The NHS Digital team do handle some of the data sets and CQC produce an annual report on the state of social care. However much the ASCOF framework is improved, this is still a significant gap for Local Government Association (LGA), ADASS, DHSC and others to tell the full story as to what is happening in adult social care.

The development of the “LGA inform³” programme is welcomed by local authorities. This database looks to hold some of the data collected from local authorities for Adult Social Care and to assist them in understanding what the data might mean for individual local authorities. However, there is limited access to this data base (which is still in its

³ <https://lginform.local.gov.uk/>

relatively early stages) and certainly wasn't known to stakeholders outside of local government.

STORY WE WANT TO TELL:

- INVESTMENT IN COMMUNITY ASSETS
VOLUNTARY SECTOR, ALTERNATIVE MODELS
CONNECTING PEOPLE, SOCIAL PRESCRIBING
- ⇒ TRACKING PEOPLE THROUGH THE SYSTEM
 - MEASURING THE QUALITY OF THE OFFER.
 - METRICS - LONGITUDE =
- EVIDENCE BASE FOR ALL CHAPTERS
- MAXIMISING INDEPENDENCE -
- MEASURE COMPLEXITY OF COHORT
- LONG-TERM SUPPORT - POPULATION
- USE OF RESOURCES (PUBLIC HEALTH)

WHAT'S THE STORY? ①

- ① THE STORY OF THE LOCAL POPULATION - WE ONLY TELL THE STORY OF PART OF THE LOCAL POPULATION.
- ② LOCAL CONTEXTS IN DIFFERENT BOROUGHS ARE DIFFERENT
EG. PEOPLE WITH LEARNING DISABILITY - NOT ALL ARE IN CONTACT WITH SERVICES.
- ③ EXPECTATIONS OF MICROPOPULATIONS AT THE FRONT DOOR
ARE WE CLEAR ABOUT WHO AUDIENCE IS - IE. GOVT OR LOCAL POPULATION
NEED TO ARTICULATE TO GOVT + ALSO NEED TO BENCHMARK.
- ④ QUS ABOUT SATISFACTION / QOFLIFE - WHAT DOES THAT MEAN?
- ⑤ HOW DOES IT FEEL FOR PEOPLE? ASCOF DOES NOT TELL US THAT. REGULAR FEEDBACK NEEDED (EG FRIENDS + FAMILY TEST).
- ⑥ ACCOUNTABILITY TO RESIDENTS. CARE ACT AS THE BENCHMARK
HOW DO WE APPLY RULES - EG AROUND FORWARD PLANNING
AS WELL AS BEING EXPLICIT ABOUT WHAT PEOPLE ARE GETTING.
- ⑦ NEED TO REFLECT INTEGRATION BETWEEN HEALTH + SOCIAL CARE
- ⑧ WE HAVE TO COLLECT DATA TWICE - EG CARERS - ONCE FOR HEALTH AND AGAIN FOR SOCIAL CARE.
- ⑨ NEED TO HAVE THE THINGS THAT SOCIAL CARE IS DIRECTLY DELIVERING.
- ⑩ BUT THEN WHAT ABOUT CAPTURING PREVENTION AND WELLBEING - THIS SHOULD BE CAPTURED AT SYSTEM-LEVEL.
- ⑪ IF WE ARE TO GET THINGS RIGHT WE NEED TO LOOK AT HEALTH AND SOCIAL CARE (AND HOUSING...)

It may be considered that the framework needs to assist in different ways –

- To enable local councils to report to their communities on what is happening e.g. the Local Account.
- To enable regions to compare data and make progress in learning and sharing best practice, and
- To enable a national picture to merge as to what is happening in adult social care.

- To assist wider stakeholders (especially national and local organisations) and users and carers to understand what is happening in adult social care in order that they can best influence local and national practice and resources.

However, for the latter to work, one body needs to take a comprehensive view of the data and to help interpret the information in a way that will assist with national planning for the future.

2.3 User/Carer Survey Questionnaire

1. **The view of the “Experts by Experience” who contributed to this review was the language used in the questionnaire and the *methodology used to obtain the scores (especially the “quality of life score”) is not clear.***

The groups who support Think Local Act Personal (TLAP) are particularly keen for the future of the questionnaire to examine their framework – “Making it Real”⁴? This is quite similar to the outcomes framework developed by the Welsh Government⁵. Can the framework cover the principles – ‘can we lead the life we want to lead?’ It is worth noting that “Making it Real” has traction with many other stakeholders including the Care Quality Commission, NHS Improvement England (NHSIE) and others who are looking at quality frameworks for health and care. On the other hand, the “Making it Real” statements are designed to assist those who are receiving long term personalised care and support. It doesn’t aim to capture the experiences of those who require shorter term interventions from which they might expect to experience some form of recovery nor does it really capture the experiences of people who may have found solutions to their care and support needs in their local community (see below).

A further, more specific criticism of the current focus of ‘quality of life’ comes from TLAP who commented:

“The current ASCOF is system centric and rooted in the gift model. There is no sense that the data are helping develop an understanding of what it is that matters to individuals and how they wish to live their life. Neither does there appear to be any measures in place around if/how inequalities are being addressed”

In addition, there was a plea to make the survey and its conclusions more transparent; simpler and with a clearer language. (This links well to the work that IPSOS MORI are already undertaking).

⁴ <https://www.thinklocalactpersonal.org.uk/makingitreal/>

⁵ <https://gov.wales/social-services-national-outcomes-framework>

2. Can the survey distinguish responses from people with different levels of need – the higher the level of need the less likely there will be higher satisfaction with life?

There were strong views expressed that the outcomes achieved and reported by customers would most influenced by their level of needs. The survey takes no consideration of the level of needs of the person who has completed the questionnaire. It was suggested that a simple measure of need such as the ADL approach⁶ looking at whether people need help in one (or more) of the following areas would be a useful way of indicating the level of need that was being assisted:

- Bathing and Grooming.
- Dressing and Undressing.
- Meal Preparation and Feeding.
- Functional Transfers.
- Safe Restroom Use and Maintaining Continence.
- Ambulation.
- Memory Care and Stimulation (Alzheimer's and Dementia)

So, the question posed is should the results distinguish between the different levels of needs of those who completed the questionnaire?

There are also comments that in the results of the survey it was found that those who had a care worker to assist them in completing the survey reported higher levels of satisfaction compared to all other service users. This raises questions about the validity of the survey results. Could independent advocates be used to assist those who require help to complete the questionnaire?

3. Is it worth considering the different “types” of people who are likely to benefit from help for their care needs?

This is linked to the above point on the level of need. People with different levels of needs will expect very different outcomes from the health and care system. The services and the early help on offer from councils do vary and the local offer is significantly different from one place to the next.

- There are people who can **be diverted by councils and signposted** to local community, voluntary sector or other family resources that can assist them in meeting their needs. This helps to keep some people out of the formal care system

⁶ <https://www.adlsmartcare.com/>

when it is not necessary for them. The level and range of help on offer does vary. This may include some people who receive advice about obtaining services which they have to fund themselves. Most people who are receiving help from the community, the voluntary sector or other informal networks will find their activities are hardly included in any of the current data sets.

- There are people who can be **helped to progress and make changes in their lives** based on rehabilitation, recuperation, recovery, skills for daily living etc. This is those people who are helped to progress from their current levels of need in order to meet their stated objectives, to build confidence and skills. As a result of the way in which these people are helped in the short term they may require less formal assistance in the long term. The level and range of these services does vary between councils. There are also people who are in long term care but can be helped to make progress to greater independence e.g. people with challenging behaviours may be assisted by cognitive or behavioural therapies. There is limited coverage for these people in the current data sets.

Finally, there are people **who will need longer term help that sustains their quality of life** and enables them to maximise their opportunities given the conditions they experience. This will include helping people to live better with (multiple) long term conditions. Of course, the level of these services and the outcomes they can gain will vary. These people are well covered in the current data sets and supported through the work of the Care Quality Commission. Each of these sets of people will expect different types of help and different types of outcomes. A number of participants within this consultation also thought ASCOF should focus on the different outcomes achieved by the different types of services or the different interventions that are offered to people in order to assist them. The help on offer does vary so much from one council to another. For example, what are the different outcomes for a person in a Shared Lives⁷ scheme and how does that vary from a person placed in a residential care home or supported living (with similar needs)?

There was also the point made that the survey might ask “what it would be like for you if you did not get the service you need?”

4. Survey structure – “too long, too complex”

Many local authority performance leads suggested that the current survey is too long, too complex to complete and to administer and does not help to distinguish between the different types of customers that are being asked questions. There were many suggestions including that there might be different use of surveys depending on who was being asked the question. For example, they thought more use might be made of

⁷ <https://sharedlivesplus.org.uk/the-difference-shared-lives-make/>

real time surveys for those who had been diverted away from councils and those that had received short term help and assistance.

5. A common observation was that *there is little or no information covering either those who fund their own care (though some of this data is collected by the CQC and by Skills for Care).*

Several people made this observation and wanted a consideration as to whether this latter group could be added to the scope of the current questionnaire. There was a view expressed that ASCOF should focus on measures for outcomes achieved through councils efforts and should not focus on the wider social care system. This is a matter for further discussion.

In addition, there were a number of briefer points made in relation to the questionnaire:

- Could the survey take place more frequently – biannual or quarterly?
- Could the data be collected more frequently via the use of brief text questions?
- Can we find out more about people’s needs that are met outside the formal care system?
- Can we understand more people’s experience at the first point of contact with the council?
- Can we distinguish between specific populations (from Public Health Data) and the data that shows the impact of adult care? – Can we understand better the characteristics of people in the formal care system?
- Can we understand better the impact of variations in the quality of the supply side?
- Can we measure the impact of Individual Service Funds or Direct Payments?
- Should we be able to know about each customer who completes a survey – their needs, the help they have or are receiving and the outcomes they expect?
- There was much comment on the lack of understanding of the “quality of life” score.

2.4 The outcome measures

The general view is *that the measures don’t measure outcomes but inputs.*

In their written response, (see 2.5) the LGA state that there needs to be a greater clarity on the “purpose and remit of ASCOF”

“We need clear consensus on the primary purpose and values of adult social care and support and a common understanding of what good looks like. We should start with the ‘vision’ and then find the measures that help us to assess that rather than focusing on what data we have”.

There were a number of contributors who thought the measures might better be able to demonstrate the progress being made by councils in integrating their services with the NHS services. Work is being undertaken by the NHS improvement Team (England) that is looking to explore a range of metrics that might assist in seeking the outcomes achieved in an integrated care system.

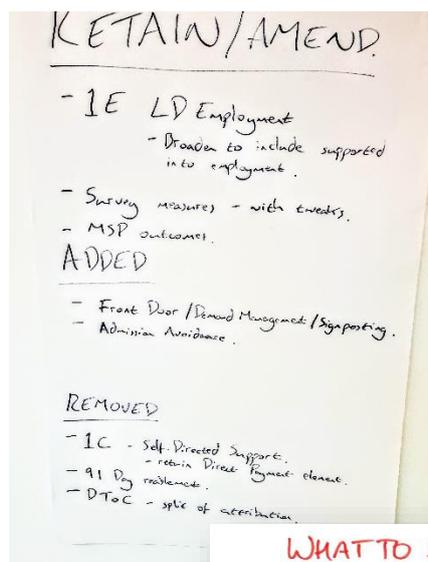
It is interesting to note that the LGA concur with this view, but also see the current challenges in developing this approach:

“We also need to maximise the use of detailed client level data that is recorded in local and national health and care systems through the provision of direct care. High level aggregated data can be used for the overarching outcome measures but the detail in the underlying data sources must be better utilised to support more granular interrogation of the information to support evidence-based understanding of key challenges, and monitoring progress. The DHSC led client level data approach supports this development and the LGA’s work on the Market Analysis project has shown how this can work. However, given that detailed information is already held in many of the NHS based patient level data, but not made accessible through the data reported, highlights the need for us to also put some focus on ensuring that the right systems and processes are put in place to enable easy and timely access to this information – and most importantly outside of the NHS firewalls.”

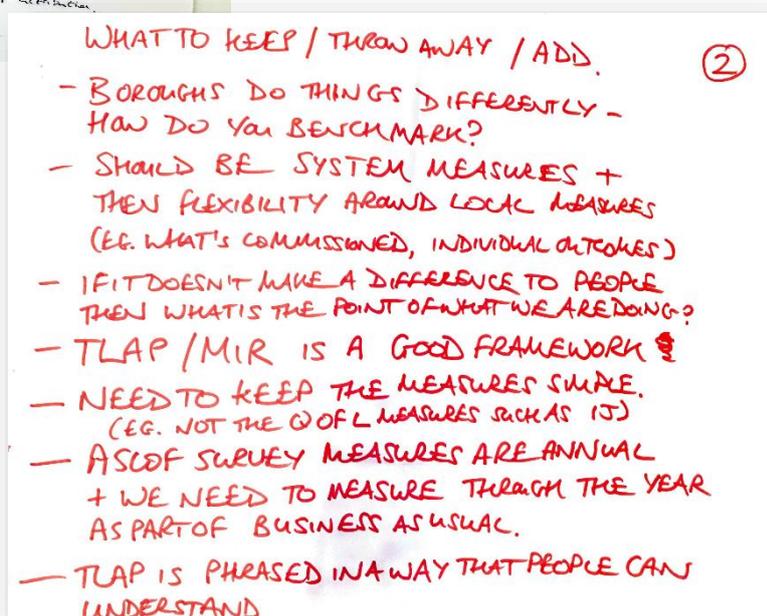
The work on these metrics has been attracted to the “Making it Real” statements developed by TLAP (see above). However, it is in our view, a limited approach to outcomes for people who may receive some help or support from social care.

Many of the respondents and participants in the workshops and the survey confused the data that is collected from an outcomes framework such as ASCOF and other data that might be collected in another way e.g. the SALT return. These observations cited below demonstrate the confusion between the different data collection points and the **lack of clarity on either the purpose of each data set or the bigger fact that it is not always brought together in a coherent way.**

- The importance of the emphasis of prevention and early intervention was also a common contribution from ADASS participants.
- Should the adult social care narrative also include a focus on ‘place and communities’ in the context of prevention?
- Can we capture and report more on the signposting activity at the ‘front-door’ of adult social care?
- Can we report on the quality and impact of information and advice at the front door?
- Can there be a better set of measures that demonstrate the impact of local commissioning policy and practices?
- Should the impact of commissioning be a part of ASCOF, or should it sit within SALT?

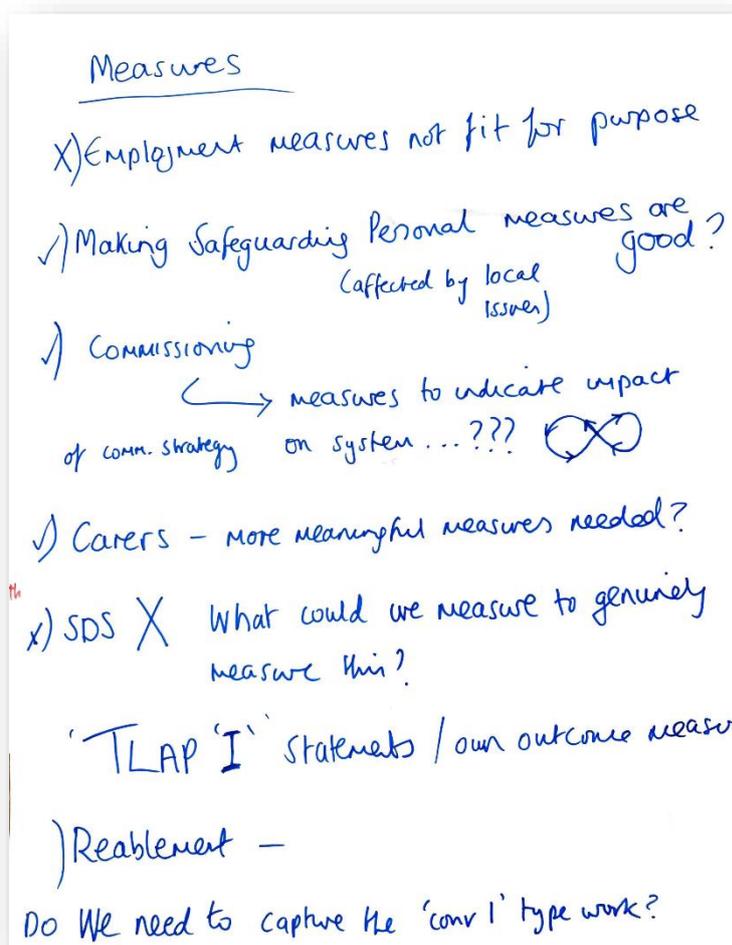


- Can we report on the issue from Continuing Health Care policy?
- Should we include housing and homelessness?
- Can we report on Extra Care Housing separately (currently included in data for domiciliary care)?
- Should the narrative be a more 'system-wide' perspective that includes both the Council and health?
- How can CQC data be included in the local story?
- How do we report safeguarding – can we bring the voluntary reporting into the statutory framework?



- How do we report on DOLS?
- Can we better report on Direct Payments?
- How do we report on strengths-based practices?
- Should we include inclusion?
- Can we report on numbers in permanent residential care – rather than on new admissions?
- Can we better identify permanent residential care numbers by age profile and choice of placement?
- Can we distinguish between the different services that people do receive – e.g. LD at home covers a range of different scenarios?

- Can we include people with autism as a separate group to people with learning disabilities? Can we use some of the data from the Autism Self-Assessment Framework⁸ for this purpose?
- Are lengths of stay in hospital a key indicator?
- How do we measure the impact of “Reviews”?
- We should scrap every indicator – and only use the customer experience?
- Services only make a small contribution to someone life – do we measure the impact of the services or the person’s life?
- Can we measure ‘social connection’?



- Can we measure ‘negative’ and ‘positive’ outcomes of a service (i.e. as proposed by Shared Lives)
- Importance of looking at Out of Hospital care beyond delayed discharges
- Can we measure the use of technology?
- Can we look at the role of informal care?

⁸ <https://www.gov.uk/government/publications/autism-self-assessment-framework-exercise/autism-self-assessment-exercise-2016-introduction>

- Can we measure unmet need for working age adults?

There were specific comments on the employment measures that aren't very helpful as people have to have a care management assessment in order to be included in the data and this doesn't actually reflect the people who move from a care setting into formal employment. It is an important area of policy and practice, but the current measures don't capture it. – We received the following from organisations who work with people who are helped into employment:

We had a discussion about ASCOF indicators 1E and 1F which everyone is having trouble with.

It's clear to us that there are 2 issues raised: the indicators themselves and how LAs collect the data. It seems that each LA collects data in their own way; some using fixed census points and others collecting data throughout the year. It's also apparent that some are much better than others about getting information on outcomes from voluntary sector partners who support people into work. There also appear to be variations about how someone is entered on to the SALT register or not.

In terms of the definitions, we've received different views but overall, we think that they could be amended as follows:

Indicator 1E - *the problem is the defining of "known to the Council". Currently this requires a person to be included in the SALT register because of a learning disability. The problems started with this new definition in 2015 as it misses too many people out. We recommend going back to the pre-2015 definition: The definition of individuals 'known to the council' is restricted to those adults with a learning disability (with a primary client group of LD) who have been assessed or reviewed by the council during the year (irrespective of whether or not they receive a service) or who should have been reviewed but were not.*

This earlier definition is what is being used by DWP in their Supported Employment proof of concept and everyone's much happier with it as it picks up school leavers and we don't have individuals taken off the indicator because council's believe that supported employment isn't long-term support as defined by SALT.

Indicator 1F - *the issue with this indicator is similar in that people may have extensive experience of using secondary mental health services but then get supported long-term by primary care. Their needs for specialist employment support remain the same though. We recommend that the definition of "known to secondary health services" should change to: "Adults "known to secondary mental health services' is defined as those aged 18 to 69 who are receiving, or have received, secondary mental health services and who are, or have been, on the Care Programme Approach (CPA)"*

Again, this would tie in with the cohort definition used by DWP on the Supported Employment proof of concept.

- The current measures for delayed transfers of care from acute hospital (DToC) are seen as limited as they focus too much on the process measures and not enough on the outcomes for people who have been helped post hospital.
- The place where a person lives is very important but under the current measures too much is covered under the blanket provision of “living in their own home or with family”. This covers a wide range of very different settings and services. It is suggested that more distinction needs to be made between them.
- New admissions to residential care may be an output from the current system but overall rates of long-term admissions also need to be considered as lengths of stay in residential care may also be a helpful outcome measure. There is evidence that for some people they are prematurely and inappropriately assessed as needing residential care (particularly from hospital).
- We need to capture the contribution that Occupational Therapists make in local authorities. ASCOF 2D ‘outcome of short-term services – sequel to service’ is based on people that receive a short-term service (home support/short term tenancy/residential) that then require an ongoing service. It does not capture those where OT intervention and/or assistive equipment has been provided – these interventions are not considered a short-term service under the definition. There is value in retaining an indicator that provides an ‘effectiveness of reablement/promoting independence’ measure but a broadening of the definition to include incidences where OT input and equipment could encourage social care to consider how it can achieve reablement/promoting independence through interventions other than care services.

2.5 Challenge to the scope of this review

There was a wide range of local authority representatives and some stakeholders who thought that if we are looking at a performance framework for individuals this should cover the whole of the health and care system and that the review should include NHS Outcome Frameworks⁹ and Public Health Frameworks¹⁰ as well as the current ASCOF. There was a strong sense that limiting this work only to the outcomes for adult social care did not help look forward to future requirements. This view was extended by some to suggest that we should focus on the well-being of populations rather than solely on what council adult social care currently offered.

In their written response to the engagement process, the LGA state their view in this area:

⁹ <https://digital.nhs.uk/data-and-information/publications/clinical-indicators/nhs-outcomes-framework#>

¹⁰ <https://fingertips.phe.org.uk/profile/public-health-outcomes-framework>

“... our ultimate aim is to develop a single over-arching outcomes framework to cover adult social care, health, public health and children and young people’s health in order to reflect the place-based, population health and wellbeing approach promoted by the LGA to support the development of common objectives and a system-wide approach to measuring progress. The Department of Health and Social Care, NHS England/Improvement and Public Health England have a stated aim of reducing the number of indicators in the outcome frameworks and should welcome proposals for a single framework.”

They go on to state:

“The adult social care indicators in the single framework would help local systems assess their effectiveness and understand the extent to which local people get the care and support they need, when they need it to:

- *help prevent or delay people developing needs for care and support*
- *prevent people’s care needs from becoming more serious and help people regain skills, resilience and independence, for instance after a spell in hospital*
- *help to keep people well and independent*
- *ensure that all care and support is of high quality.*

We, therefore, recommend to ADASS that the revised set of performance indicators for adult social care should be part of a broader review of all the national outcome frameworks, with a view to bringing them together in a simplified, single outcome framework for the health, care and public health system for children and adults”

2.6 General comments from stakeholders about ASCOF

The following points summarises feedback offered at the workshops about the overall ‘usefulness’ of ASCOF as a reporting tool:

- *“Timeliness of report not helpful – too late, benchmarking difficult*
- *Not good enough to benchmark*
- *Definitions not sufficiently clear and open to some interpretation*
- *Framework doesn’t help manage demand or transformation*
- *Too much reliance on survey data, doesn’t capture use of resources or efficiencies*
- *We don’t look at the survey*
- *Doesn’t talk about quality*
- *Currently out of step with BCF*
- *Social workers don’t see this as fit for purpose as it doesn’t ‘speak to them’ about their work*

- *It currently reports in silos*
- *Whose story are we telling – our service users, or the council's?*
- *Why don't community health services have a similar outcome framework?"*

2.7 Office for Statistics Regulation

While the consultation for ASCOF was being undertaken the Office for Statistics Regulation published a report¹¹ with the following conclusions:

"The need for good data to support delivery of adult social care should not be underestimated. While there is rightly a focus on delivery, a scarcity of funding has led to under investment in data and analysis, making it harder for individuals and organisations to make informed decisions.

"This needs to be addressed. The need for information is increasing as society evolves and the demands on social care services over coming years look set to increase. Improved data matters in solving problems, supporting efficiency and maximising outcomes. It is also important to inform decisions made by individuals about the care they receive or provide for themselves and their families

Our review highlighted three main areas for attention:

- *Better leadership and collaboration across the many different organisations involved in the process of publishing official statistics on social care, that enables working across boundaries to join-up government departments, local authorities and between public and private sector providers;*
- *Gaps in available data as most information available comes from local authorities with responsibilities for adult social services and does not cover private household expenditure, privately funded care or the value of unpaid care causing limited knowledge of individuals care journeys and outcomes; and*
- *Improving existing official statistics through accessibility, coherence, quality, timeliness and granularity of the data to provide insight and allow existing data to better meet user needs."*

IPC echo the recommendations made in the report – especially where it overlaps with our findings (see below) around the need for more granular data to help build the best possible picture of what is happening.

¹¹ Office for Statistics Regulation (January 2020) Adult Social Care Statistics in England

2.8 Draft Report - DHSC Social Care Analysis Review of trend reported in ASCOF

During the process of reporting comments and feedback from stakeholders, IPC received a draft copy of a review undertaken by DHSC Social Care Analysts of ASCOF performance trends reported by councils. Notwithstanding the current draft status of the report their early findings are worth noting in this report therefore an extract of the paper is shown below. In essence, their findings suggest that the narrow margins of changes in the performance in these areas year on year provides limited value for the commentary at a national level however, the indicators do provide some interesting insights of where changes have occurred at a local authority area:

“This paper aims to provide background information about ASCOF and to examine the challenge that its measures show little change over time. There are plans to refresh ASCOF, so insights from this paper can help inform this work. It will examine the change and variation over time at the local authority level in five key ASCOF indicators:

- *Indicator 1A: Social care-related quality of life score*
- *Indicator 1B: The proportion of people who use services who have control over their daily life*
- *Indicator 1D: Carer-reported quality of life score*
- *Indicator 3A: Overall satisfaction of people who use services with their care and support*
- *Indicator 3B: Overall satisfaction of carers with social services*

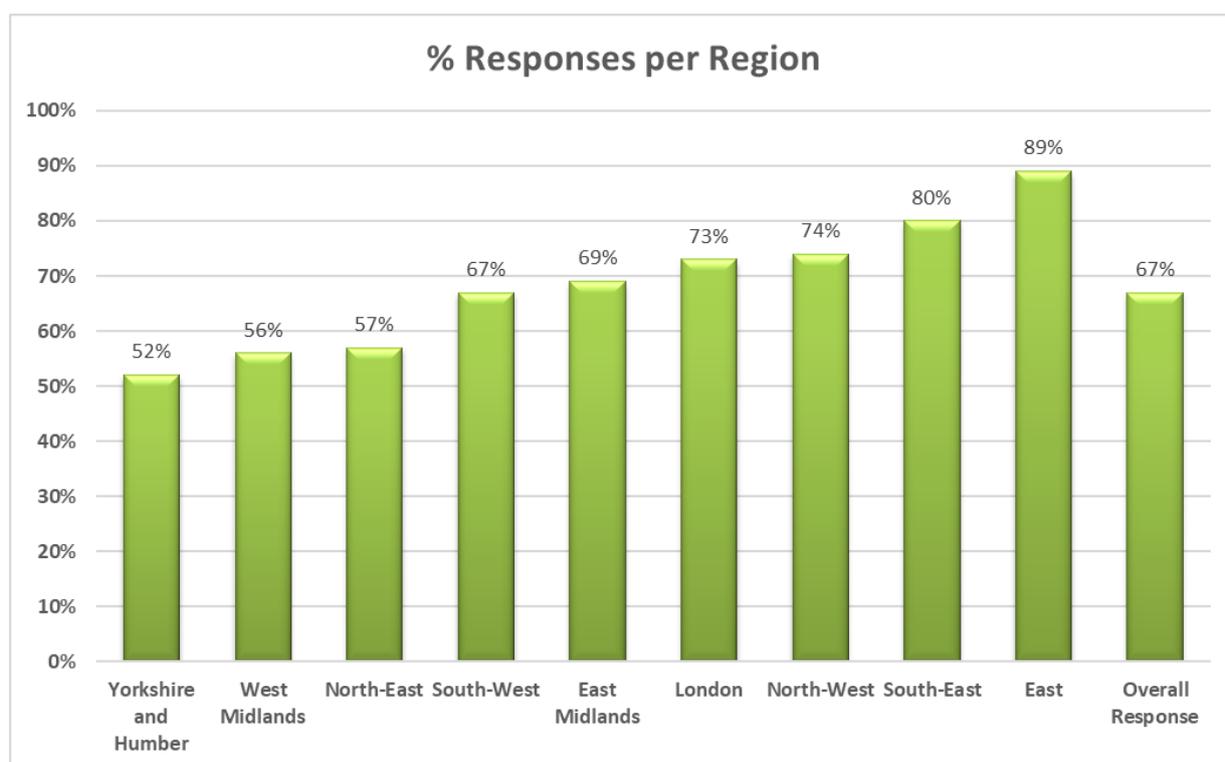
Conclusion

At the national level, all five indicators show either a small amount of change from 2014/15 to 2018/19 or no change. There is variation within indicators at the local authority level, but this variation occupies a small portion of the potential range of each indicator, especially for indicator 1A. At the local authority level, there is variation in the magnitude and direction of change in ASCOF indicators; however, this is too confined to quite a small range. For some indicators, local authorities are diverging in indicator scores, which may not be reflected in national averages.

3 Reviewing the Current ASCOF - Survey Results

An electronic survey was sent out to every local authority on 10th December 2019 for completion by 31st January 2020. A copy of the survey can be seen in Appendix 2.

The survey was completed by 67% of all councils.



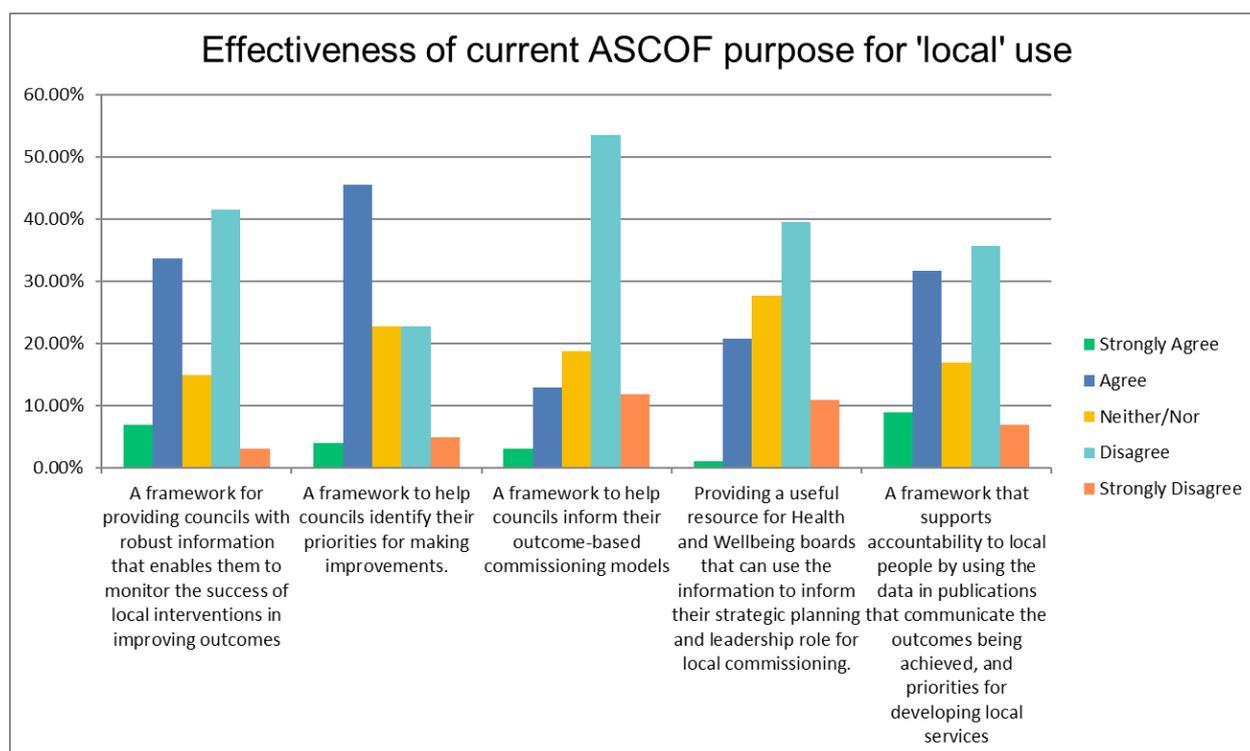
The ASCOF aims to give an indication of the strengths and weaknesses of adult social care in delivering better outcomes for people who use services and is used both locally and nationally to set priorities for care and support, measure progress and strengthen transparency and accountability. Local authorities were asked in the survey to rate the effectiveness of using the framework in a local, regional and national context.

3.1 Use of the framework locally

At a local level, the purpose of the framework is:

- To provide councils with robust information that enables them to monitor the success of local interventions in improving outcomes, and to identify their priorities for making improvements. Local Authorities can also use ASCOF to inform outcome-based commissioning models.
- To provide a useful resource for Health and Wellbeing boards that can use the information to inform their strategic planning and leadership role for local commissioning.

- Strengthen accountability to local people. By fostering greater transparency on the outcomes delivered by care and support services, it enables local people to hold their council to account for the quality of the services that they provide, commission or arrange. Local authorities are also using the ASCOF to develop and publish local accounts to communicate directly with local communities on the outcomes that are being achieved, and their priorities for developing local services.



Overall, survey respondents do not see the current ASCOF as providing an effective framework for monitoring and reporting their performance. The exception to this overall trend is that **45% of councils said they “Agree”** that it helps them to identify their priorities for making improvements.

53% of councils “Disagree” that the framework helps them to inform their outcome-based commissioning models.

A selection of comments:

- The ASCOF framework helps measure local interventions in terms of numbers but does not measure outcomes for individuals consistently. For example, ASCOF 2b tells us if someone is back at home following rehab but not whether that is due to our interventions*
- The range of performance indicators informs Health & Well Being boards and help scrutinise authorities but don’t necessarily identify how to improve this*
- It can be useful when merged with other data (e.g. Use of resources)*

-
- *ASCOF is not used to assist with strategic planning because the measures are not easily aligned with local priorities*
 - *A key test is whether the general public would look at ASCOF and understand it*
 - *Due to the nature of the data collection the information is not received in a timely way and often changes that impact the data have already been put in place.*
 - *ASCOF not published to communicate outcomes to local people as it's difficult to engage with in its current form.*
 - *ASCOF framework provides limited use in any areas defined above. Local Authorities have significantly more locally developed indicators which look at the demand, prevention/early intervention, short term care, long term care, finance and outcomes on a journey that inform in a more comprehensive way*
 - *The ASCOF framework is used by the authority to help form the business as usual performance reporting as well as its statutory duties. The framework is currently outdated due to changes at both a national and local level, however for regional challenges and benchmarking the framework is vital when comparing the authorities outturns with near neighbours. Using the current framework allows the authority to see where we currently sit and what local challenges are potentially having an impact on performance outturns.*
 - *The ASCOF has provided a framework and been used for the above purposes but it is only partial.*
 - *ASCOF does not fully reflect the service we offer to our service users and also it is not in line with our local/ national strategy and demands*
 - *For local people the measures, wording, definitions are not easily understandable, nor the variations in performance linked to different interpretations of guidance and measures.*
 - *The ASCOF framework is used in Devon as: - Central to our local adult social care performance framework; - The evidence base for our annual report, budget setting and strategy and planning; - A component of our local health and care system outcomes framework; - Key to regional working and sector-led improvement. But it is also supplemented by local indicators, whether to give additional insight, or to fill gaps in the current framework.*
 - *Locally our information is connected to our strength-based practice, integration with other organisations and systems. We are focussed on prevention, signposting, managing demand and market capacity. The current framework is short sighted in this respect, there is a lot of focus around operational areas but none around commissioning or system performance and any new framework would ideally cross reference to health, housing and employment, assistive technology and developing communities.*
 - *As a nationally recognised outcomes framework we use ASCOF to report to the Health and Wellbeing Board, as well as Council Member's. However local*

outcomes, commissioning and priorities are monitored further by local data and KPI's.

- *Enables the Council to monitor areas of underperformance and areas of improvement, alongside promoting and sharing good practice. Provides the benchmarks and initial starting points for internal targets and KPIs Has had little use and impact in improving accountability, commissioning and ownership of Health and Well Being.*
- *The framework is used locally to identify areas where improvements may be needed and to monitor the impact of any transformation and service improvement on outcomes. We have seen the outcome change as a result of local transformation work. The framework forms a significant part of performance monitoring locally*
- *ASCOF is more of a strategic tool and does not have the level of detail or frequency / timeliness of reporting that would be required to support understanding of the impact of multiple local interventions*
- *ASCOF generally doesn't provide Commissioners with the intelligence they need especially without a mix of good cost, volume, efficiency and quality measures.*
- *Many of the questions are old fashioned and are based on pathways that may no longer Locally ASCOF allows us to monitor outcomes and interventions for those areas covered within the indicators – although there are some gaps, notably around flow between social care and hospital systems.*
- *ASCOF data is used by partners in Health and Wellbeing Boards and other forums, although the limitations of some of the indicators (for example around reablement effectiveness) under-values the impact of social care interventions.*
- *Some indicators are helpful and genuinely outcome measures, many are not. The public will not readily understand the definitions and issues behind what appear to be fairly straightforward indicators.*
- *ASCOF at present doesn't define what success looks like locally or how outcomes have been improved. The measures are limited by generalising 'care and support', safety and choice/control.*
- *The ASCOF framework is possibly more beneficial to Health and Wellbeing Boards who are able to use the information to monitor interfaces with Adult Social Care via their own reporting frameworks*
- *The ASCOF should be the principal tool in capturing the efficacy and efficiency of the local systems behind ASC service provision. The ASCOF measures currently have a use in providing some level of council accountability and transparency to local people. To some extent, they are also a helpful addition to internal performance reports as well as local publications.*
- *The ASCOF provides some performance information that can enable the Council to identify where improvements can be made. The ASCOF is also used in Thurrock to some extent to communicate outcomes to local people. However, in the main the*

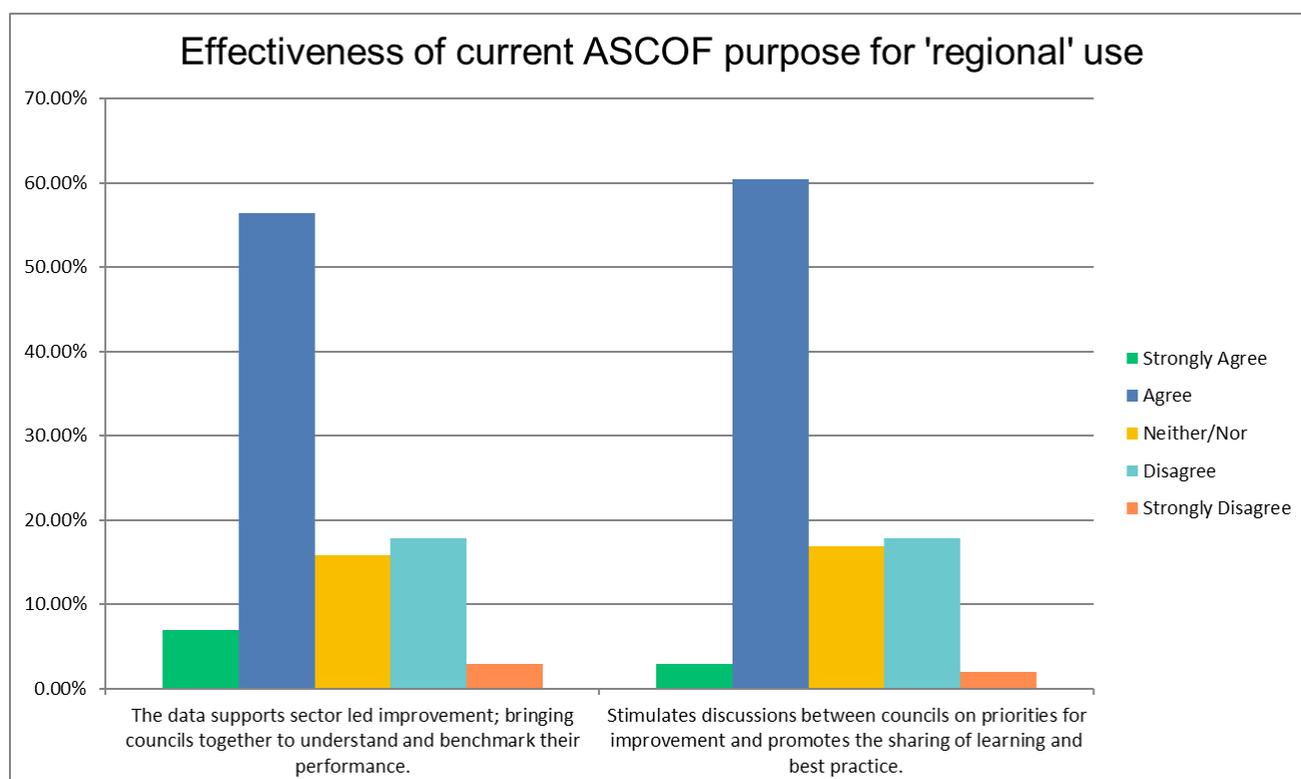
ASCOF is outdated and some of the indicators (such as the reablement indicators) do not give an accurate picture of outcomes for individuals.

- *The ASCOF measures don't provide a real focus on outcomes for individuals and therefore locally are not seen as a robust tool or measure to inform our commissioning intentions, unfortunately key ones tend to end up being the focus such as DToC*
- *The current ASCOF process provides robust independent publicly available information. This is used from a local perspective for setting internal targets and performance measures.*
- *I would much rather have a clear and accessible benchmark for what local people are saying about Council support and its impact on their lives (ie what we have now) than any focus on outcomes or feeding back to HWB that turns out to be complex and inaccessible*

3.2 Use of framework regionally

At a regional level, the purpose of the framework is:

- To support sector led improvement; bringing councils together to understand and benchmark their performance. This, in turn, stimulates discussions between councils on priorities for improvement, and promotes the sharing of learning and best practice.



Overall, councils “Agree” that the framework is effective to benchmark and understand effective practice across their regions.

A selection of comments:

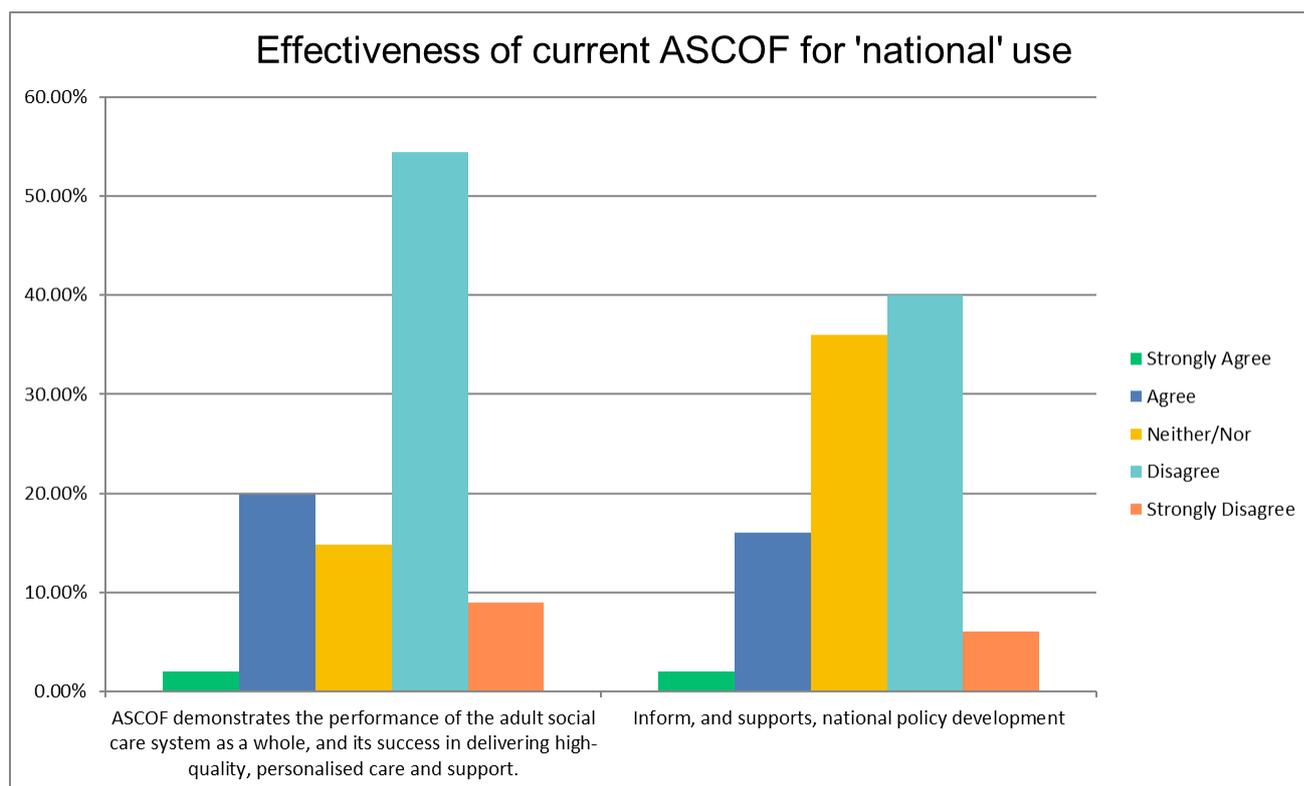
- *On a positive note, the historic trends can be helpful to some extent to track changes. However, they don't take into account local changes in processes or implementations of new systems.*
- *The degree of sharing / benchmarking depends on the culture within individual Councils. The current ASCOF measures are clear and accessible enough to make this more likely rather than less likely.*
- *Data on some of the activity and volume can be also useful. Framework can help identify priorities for improvement by allowing comparison to other authorities and own trends. We need to try to avoid snapshot based measures that can easily distort performance where performance is uneven through the year.*
- *The ASCOF measures when benchmarked are an overall valuable tool to see where locally we differ from other areas. Though taking this further involves considerable time to understand local data definitions*
- *The framework does provide a vehicle for benchmarking between local authorities and can be used to stimulate debate on results, but I am less confident that it promotes the development of best practice.*
- *CQC and DToC is helpful regionally*
- *Benchmarking data in particular enables us to identify priorities for improvement, identifying areas where there is clear room for improvement.*
- *ASCOF can promote and support discussion around best practice.*
- *We agree that the ASCOF data has supported sector led improvement.*
- *From previous experience solely using the ASCOF measures for benchmarking purposes normally results in conversations that are more focused on how the data capture varies between LAs, rather than on the best practice and outcomes.*
- *As a region, we recognised that the ASCOF did not contain the correct measures to drive sector led improvement, as such we have used the ‘Six Steps’ to facilitate this.*
- *Regionally, discussions and comparisons focus mainly on DToC performance across the local area – however, as above, it is difficult to consistently measure performance when there are different integration arrangements across health and social care.*
- *When the SALT was first introduced it was described as something that could not be benchmarked. Yet the ASCOF measures that come from it are constantly benchmarked.*

- *In the North West we have a strong performance leads group that enables us to effectively benchmark all the indicators measured by ASCOF on a quarterly basis.*
- *London councils don't tend to measure ASCOF measures against one another and in London we also have a suite of 'Regional Indicators' that are monitored on a quarterly basis. However individual councils may well choose to use the results from the ASCOF framework to inform their own performance monitoring and to support improvement across individual service areas*
- *Councils are not always comparing 'like with like' in the ASCOF measures, often this is due to internal processes rather than anything else.*
- *Differences and limitations around interpretations and operating models can make direct comparisons difficult and misleading*
- *The framework is not collecting key volume information relating to managing demand, prevention, use of resources, and strengths-based practice. This information would help with sector led improvement.*
- *There are regional intelligence groups where statutory returns and performance frameworks are discussed, however because all authorities in the eastern region aren't using the same software provider it means performance data is sometimes only reported once a year, as opposed to routinely monitored on a quarterly basis.*
- *No guidance what is good or bad. Crude league table not the answer*
- *The current measures do not reflect current national and regional priorities*
- *We have to use other sources such as SALT and Regional data to benchmark outside of the relevant ASCOF measures.*
- *There is still significant variation on the way LA's capture and report KPI's devaluing benchmarking and comparisons.*
- *The non-survey ASCOF measures are benchmarked regionally on a quarterly basis and sub-regionally on a monthly basis. It's this local frequent reporting that makes the measures meaningful at a local level.*

3.3 Use of framework nationally

At a national level, the purpose of the framework is to:

- Demonstrate the performance of the adult social care system as a whole, and its success in delivering high-quality, personalised care and support. Meanwhile, the framework supports Ministers in discharging their accountability to the public and Parliament for the adult social care system, and continues to inform, and support, national policy development.



Overall, councils “Disagree” that the framework provides an effective vehicle that demonstrates the performance of adult social care or informs the development of national policy.

A selection of comments

- *ASCOF is useful in its current format. However, there is definitely room to review existing indicator logic and to develop indicators that better monitor outcome based commissioning and integration with Health. As well as greater focus on prevention and wider signposting, or safeguarding outcomes such as Making Safeguarding Personal.*
- *While it can assist to some extent it, does not capture enough around the effectiveness of the whole of ASC. This has the potential to mislead prioritisation*
- *Whilst the overarching outcomes are on the whole sound, the measures can be difficult to link to specific support and interventions*
- *Adult social care should not be judged through the lens of health*
- *Any narrative about adult social care needs to draw on all or several of these sources as well as other contextual data. Narratives not based in such a range of evidence can oversimplify*
- *The purpose of ASCOF is generally confused – is it a means of communicating national priorities/policy drivers (e.g. LD in employment, Direct Payments), outcomes measurement (were peoples' outcomes achieved), or compliance with the Care Act?*

- *The ASCOF framework is a national measurement that unfortunately does not provide the granularity of the recording consistency across all authorities taking into account their differing local requirements.*
- *The ASCOF doesn't focus on the system as a whole, the vast majority of measures are focussed on local authorities.*
- *I do not think this is a quality measure. It is quantitative in nature. What national policy developments has it informed and supported?*
- *Data is submitted nationally in a number of separate statutory returns. Only some of the data from the statutory returns is used for ASCOF. This means that ASCOF can only tell part of the story and this makes it harder at a national level to weave together a compelling narrative about the impact of adult social care on people's lives or to use it to inform and support national policy development.*
- *It does provide data to support the achievements of the sector but does not have the credibility to inform national policy development.*
- *ASCOF does not cover those customers who are ineligible for care and support or who are self-funders or users of universal services. There is a lack of whole system approach and little focus on quality.*
- *The measures within ASCOF do not provide a system wide view of pathways, interactions, customer journey, outcomes, demand and finance. All of which are affected by the system rather than any one part of it*
- *The methodology behind reporting is perhaps not robust enough and variation can be a result of different practices rather than performance issues. Different areas face different pressures, evidence provided by different data sources can complement the data and put it into context.*
- *We believe whilst ASCOF is outdated and it doesn't demonstrate performance of the adult social care system as a whole, however it is still used to inform, and supports, national policy development.*
- *Should be looking at a health and Care system as a whole, not social care in isolation.*
- *ASCOF does provide national information, but does not take into account geography, local demands, recording practices and data quality. Little emphasis is placed on integrated Care/ joined up working and demand management and therefore even though it may support national development it is not representative of demand.*
- *Taking England's results as a whole, ASCOF does say something useful about the state of adult social care, but it is unclear how this has led to changes in national policy since the Care Act.*
- *Data without narrative does not necessarily provide robust or reliable information on which to make policy decisions*
- *The limitation of ASCOF is that it aggregates what people think, without elucidating why they think it. This is fine - there is so much local variation because of conditions*

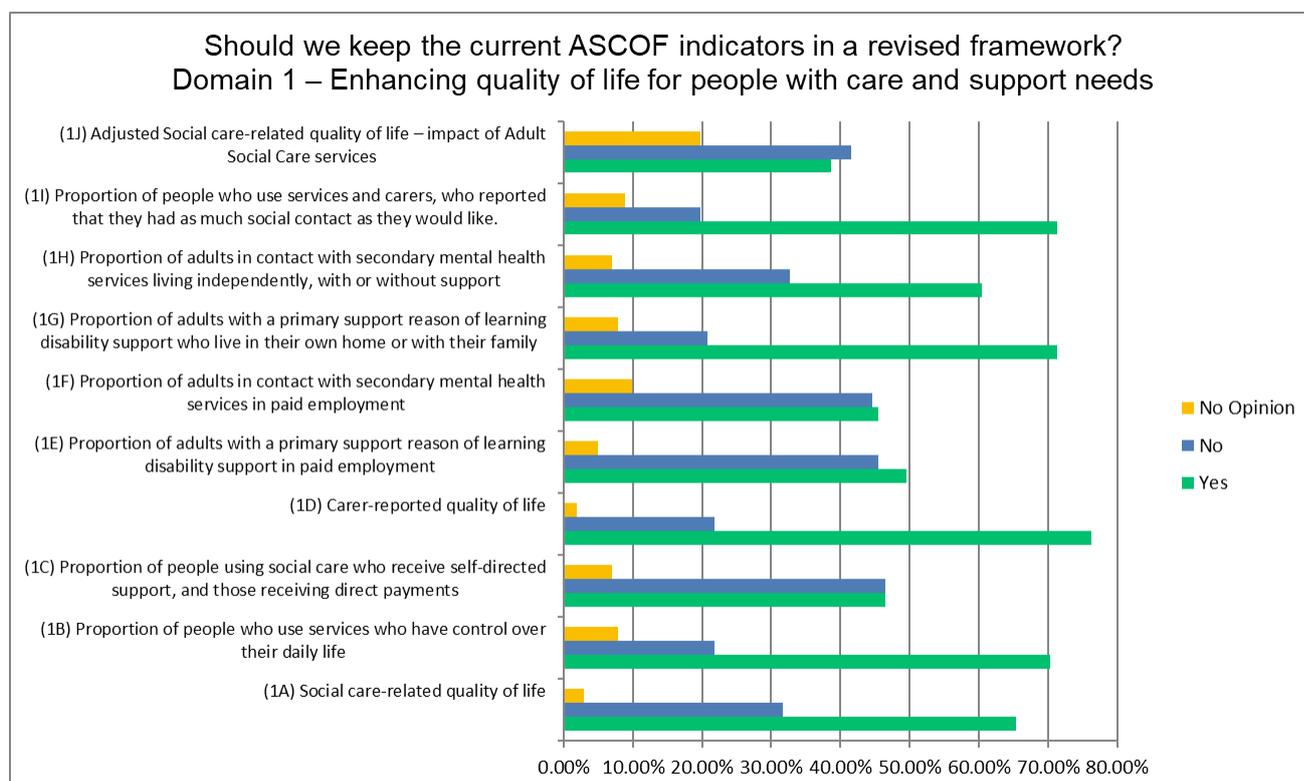
that are much broader than ASC. But on a national level it probably doesn't help inform policy development - that's not a reason to lose it though.

3.4 General comments on the usefulness of the framework

- *The framework doesn't take into consideration workforce – gaps can have an impact on a Local Authorities ability to deliver. Quality of the market is not assessed for example CQC performance in care homes The number of 'handbacks' would be a useful measure to include as it would also provide an indication of how well a market is delivering for that Authority.*
- *ASCOF does demonstrate the current social care system once a person is in the system. It does not include the wider preventative agenda or trying to access the social care system. As noted above, there is no measure of the strengths-based approach, so successes of the system are being missed.*
- *The ASCOF provides some indication of personalised care and support, for example through the direct payments indicator and some of the survey questions, however the indicators do not demonstrate whether services themselves good quality are.*
- *The ASCOF framework only loosely relates to a methodology that can support proper outcome based reporting and perhaps relies too heavily on surveying the service and carer populations supported by councils.*
- *The data set does not reflect the key care act duties and the move towards strength-based practice. It does not support or encourage rights-based practice*
- *Missing Safeguarding measures, missing useful measures on transition services, missing consideration of funding issues for those without funds, care home capacity issues are not measured, and homecare provider capacity isn't measured.*
- *No measures are derived from the ASC-FR (finance return) or NMDS – SC (workforce return), SAC (safeguarding return) or DoLS (Deprivation of Liberty return) or DPA (deferred payment return)*
- *Focus on outcomes that matter to people: We need to see measures that demonstrate the value in and show the vital contribution of social care in order to change the narrative and measure the things that are important to local people (e.g., use of Think Local Act Personal / Making It Real Framework and Workforce Indicators in ASCOF).*
- *We report on S42 enquiries but we now need a broader analysis and should consider how we can better capture the outcomes from safeguarding. For example, Making Safeguarding Personal has been highlighted as good practice, which focuses 'up front' on the outcomes people want to achieve. We should consider the learning from this approach.*
- *The current framework is data driven as opposed to evidence-based intelligence on performance*

- *Whist we acknowledge the importance of the user’s voice and experience and would need to capture some of the information, we don’t believe that the survey continues to be effective in doing this*
- *The current set of measures all pre-date the Care Act. They are ASC Outcomes in name only, as very many of them do not look at outcomes at all. They are not person-centred, and too many of them are reliant on user surveys, which themselves have not been updated in many years. The level of response to the surveys clearly indicates survey fatigue is an ever-increasing factor.*
- *The ASCOF provided some initial benefit when first introduced. However, changes in legislation and policy (The Care Act 2014, Better Care Fund), changing models in social care practice and social care provision and increases in demand and pressures in funding, mean that priorities these indicators once represented have become displaced.*
- *Some helpful aspects but we are still collecting PAF style data - some of which is more meaningful*
- *The current ASCOF framework measures the wrong things in the wrong way*
- *ASCOF Data is not as relevant now: The Care Act 2014 has been implemented since ASCOF was introduced and some areas of activity are not being captured. For example, the importance of prevention and early intervention*

3.5 Domain 1 – Enhancing quality of life for people with care and support needs



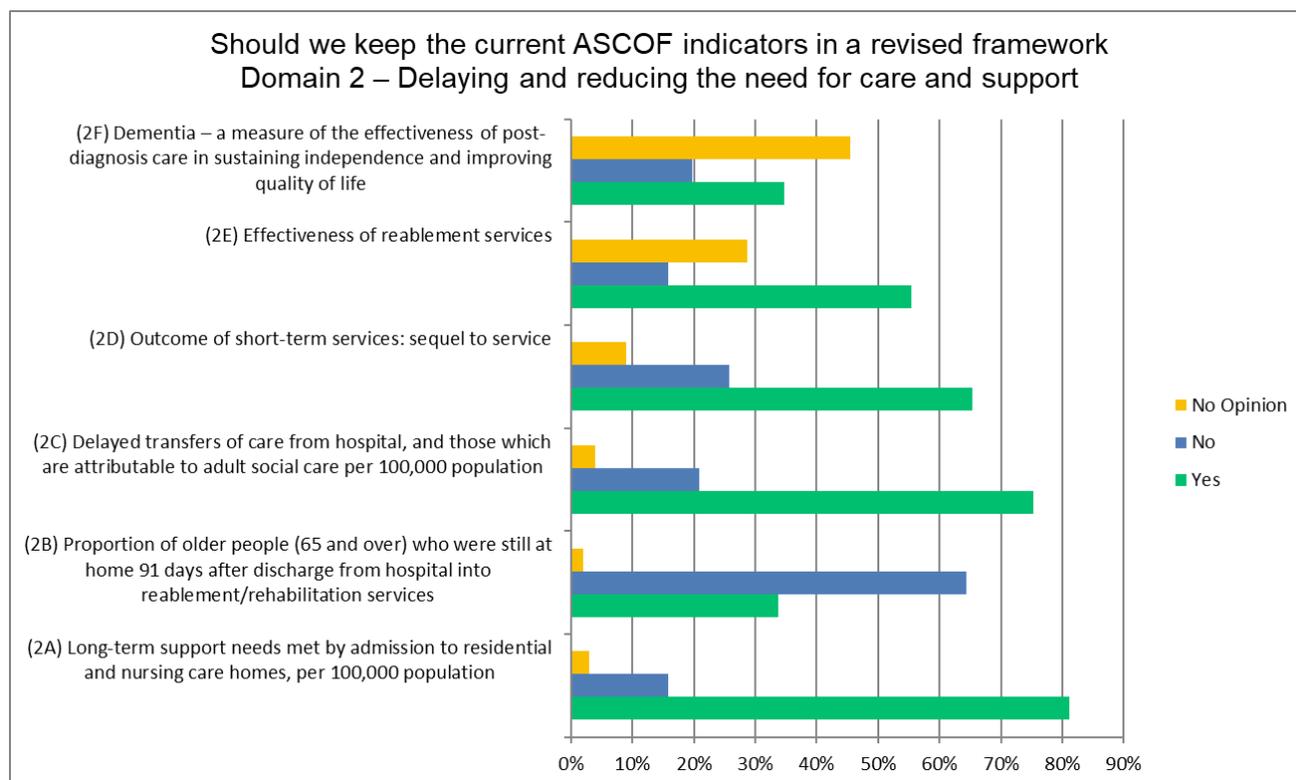
3.5.1 Summary of Comments

- **(1A) Social care-related quality of life** - 65% respondents support the use of this indicator however, there are a number of comments relating to the lack of meaning to the public. Comments also relate to the duplication of 1A and 1J which is “confusing”.
- **(1B) Proportion of people who use services who have control over their daily life** – 70% support for this indicator however, suggestions offered that would revise the question to – *“Proportion of people who use services who have more control over their daily life with the services they get”*. Or, include measures which capture the components of person-centred planning and care delivery
- **(1C) Proportion of people using social care who receive self-directed support, and those receiving direct payments** – 46% support retaining this indicator. This indicator received a significant number of comments which included support for retaining the measurement of direct payments (note that is an output measure, not an outcome), but to remove the measure of self-directed support as this is “redundant”, “meaningless” as most councils report a 100% response. Further comments are similar to 1B – to measure component parts of person-centred planning. However, one suggestion to revise the self-directed support element is - *“The proportion of people who receive direct payments and the number of people involved in their support plan”*
- **(1D) Carer-reported quality of life** – 76% of respondents wish to keep this indicator however there are a number of suggestions to how this should be constructed in the future, for example – *“QoL calculation is too complicated and while a quality of life measure is useful a simpler view which could be monitored more frequently to impact change”, “The indicators (including 1B and 1D) that captures information re. the views of service users via the Users’ or Carers survey are useful up to a point. However, for the majority of them, the questions that contribute to the ratings are either too vague i.e. not attributable to ASC, subject to interpretation i.e. feeling safe, or too old i.e. not relevant anymore as they no longer reflect the new pathways for ASC (pathways to independence).”*
- **(1E) Proportion of adults with a primary support reason of learning disability support in paid employment** – 49% support retaining the measure however, there are a significant number of comments suggesting that the current focus is limited. Comments to revise the measure include:
 - Ensure that the measure includes adults in full time education, training and voluntary employment
 - Include ‘new’ clients entering employment, education etc
 - Include those who have moved from education or voluntary employment into paid employment
 - Exclude young adults in full-time education from the cohort

- Combine 1E with 1F to cover both people with a learning disability and mental health illness
- In addition, a comment was made on the usefulness of this and 1F to benchmark with other councils – *“there are a number of significant factors impacting on the out turns of these measures such as the local economy, the demographic and the approach to promoting independence. It is therefore very difficult to effectively compare performance.”*
- **(1F) Proportion of adults in contact with secondary mental health services in paid employment** – 45% of respondents suggested that this measure should be retained. There are a number of suggestions to revise the measure which include:
 - *“Only includes current clients. Therefore, working with someone on a recovery pathway following a Section until their health improves to the point that you can discharge them would mean that if the former client was now fit for work, this success could not be reported.”*
 - *“No measure of ‘new’ clients supported. Voluntary work not taken into consideration. This is a wider social/council responsibility. Measure looks at CPA, the numbers of which are reducing over time.”*
 - *“1F (and 1H) are based on people using secondary MH services. There is anecdotal evidence within mental health services of an increasing tendency to manage people with complex and challenging behaviour in the community, rather than within inpatient provision. The increase in acuity of mental health presentations managed in the community is highly likely to impact negatively on current measures around employment and accommodation. These measures need a different basis.”*
- **(1G) Proportion of adults with a primary support reason of learning disability support who live in their own home or with their family** – 71% support retaining this indicator. There are a number of suggestions for revising the focus of indicator in the future, for example:
 - *“we need a sense of how people are progressing through the social care system.”*
 - *“This measure doesn't take client choice into account. Either rename the indicator (to “LD adults in permanent community-based accommodation” or, include residential care in “Settled accommodation””*
 - *“this needs to reflect newer approaches to providing care and the role that supported living is provided here”*
 - *“This makes an assumption that living with their family is the best option for the individual – this may not always be the case”*
- **(1H) Proportion of adults in contact with secondary mental health services living independently, with or without support** – 60% support to retain this measure.

- **(1I) Proportion of people who use services and carers, who reported that they had as much social contact as they would like** – 71% wish to retain this indicator
- **(1J) Adjusted Social care-related quality of life – impact of Adult Social Care services** – 38% suggested retaining this indicator. In addition to the comments made in 1A, the focus of suggestions relate to the complex nature of the calculation

3.6 Domain 2 – Delaying and reducing the need for care and support



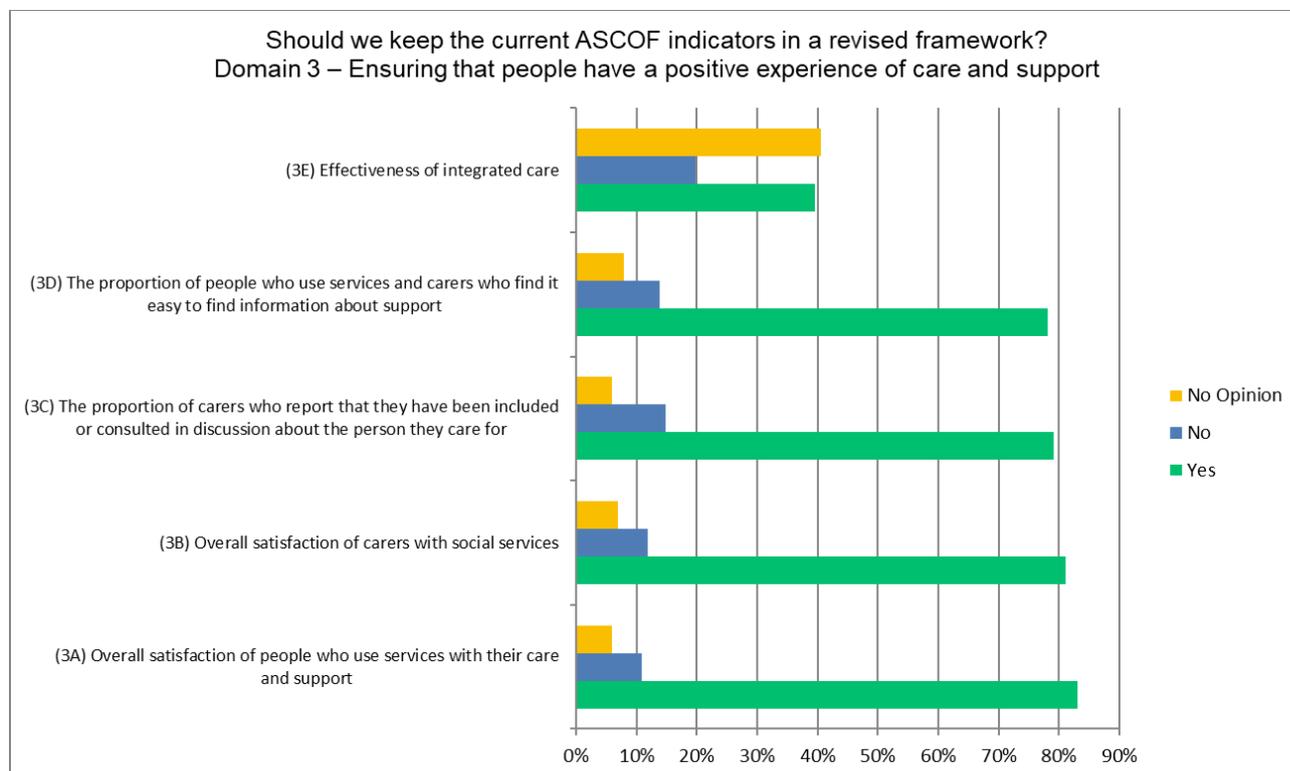
There is support to retain indicators 2A, 2C, 2D and 2E. There is a view that 2B should not be retained in its current format.

3.6.1 Summary of comments

- **(2A) Long-term support needs met by admission to residential and nursing care homes, per 100,000 population** – 81% suggest retaining the measure. There are a number of suggestions that offer alternatives for differentiating the cohorts and placements within this population, for example:
 - Appropriateness of placement, including views of client and families
 - Differentiate between residential and nursing admissions and include extra care
 - Count new long-term admissions
 - *“Number of Res/Nursing Admissions per 100,000 populations, as a % of LTS in community-based services”*
 - *“Number of long-term support needs of younger adults (aged 18-64) met by admission to residential and nursing care homes, per 100,000 population”*
 - Count the number of admissions due to depleted funds by previous self-funders
 - *“Average age at admission and length of placement”*

- **(2B) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services** – 33% of respondents suggested that this indicator should remain. This indicator provided the greatest number of comments and suggestions. In general, comments suggested that the current indicator does not report on outcomes and there are significant resources required to collect the information, but it does give a very limited snapshot of activity for a three-month period. The indicator is limited because:
 - It does not help to understand the effectiveness of the intervention or if it has met an individuals' needs
 - As each local system has a variety of 'reablement' models, the effectiveness of these models is difficult to benchmark
 - It does not reflect reablement following an A&E admission
- **(2C) Delayed transfers of care from hospital, and those which are attributable to adult social care per 100,000 population** – 75% have selected this indicator to remain. However, the comments in this area mainly relate to the view that this indicator perpetuates a health/social care "blame game" and the timeliness of reporting undermines the usefulness of this indicator.
- **(2D) Outcome of short-term services: sequel to service** – 65% of respondents wish to retain this indicator. Once again, there are a number of comments that the indicator has been helpful to highlight the importance of the pathway however, it does not measure reablement outcomes and is "overly complicated" to calculate. Suggestions to improve the indicator include the 'achievement' or reduction in on-going levels of need
- **(2E) Effectiveness of reablement services** – 55% said that the indicator should be retained
- **(2F) Dementia – a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life** – 34% respondents suggested this indicator should be retained, however 45% had no opinion. Suggestions for the revision of this indicator included:
 - *"2F is open to interpretation. Different types of dementia and trajectories need to be reflected as these will impact outcomes for people. This needs to give a narrative on what would be an indication of better outcomes or quality of life for an individual"*.
 - *"Can we develop more integrated measures using health and social care data by linking through NHS numbers? Like the ASCOF 2F Dementia measure which need to be developed further"*

3.7 Domain 3 – Ensuring that people have a positive experience of care and support



Responses in this domain provided the highest level of “yes” answers in the survey. Of the five measures in this domain, only 3E – Effectiveness of integrated care, does not suggest a consensus on its future suitability.

3.7.1 Summary of Comments

- **(3A) Overall satisfaction of people who use services with their care and support** – 83% agreed to keep this indicator
- **(3B) Overall satisfaction of carers with social services** – 81% agreed to keep this indicator

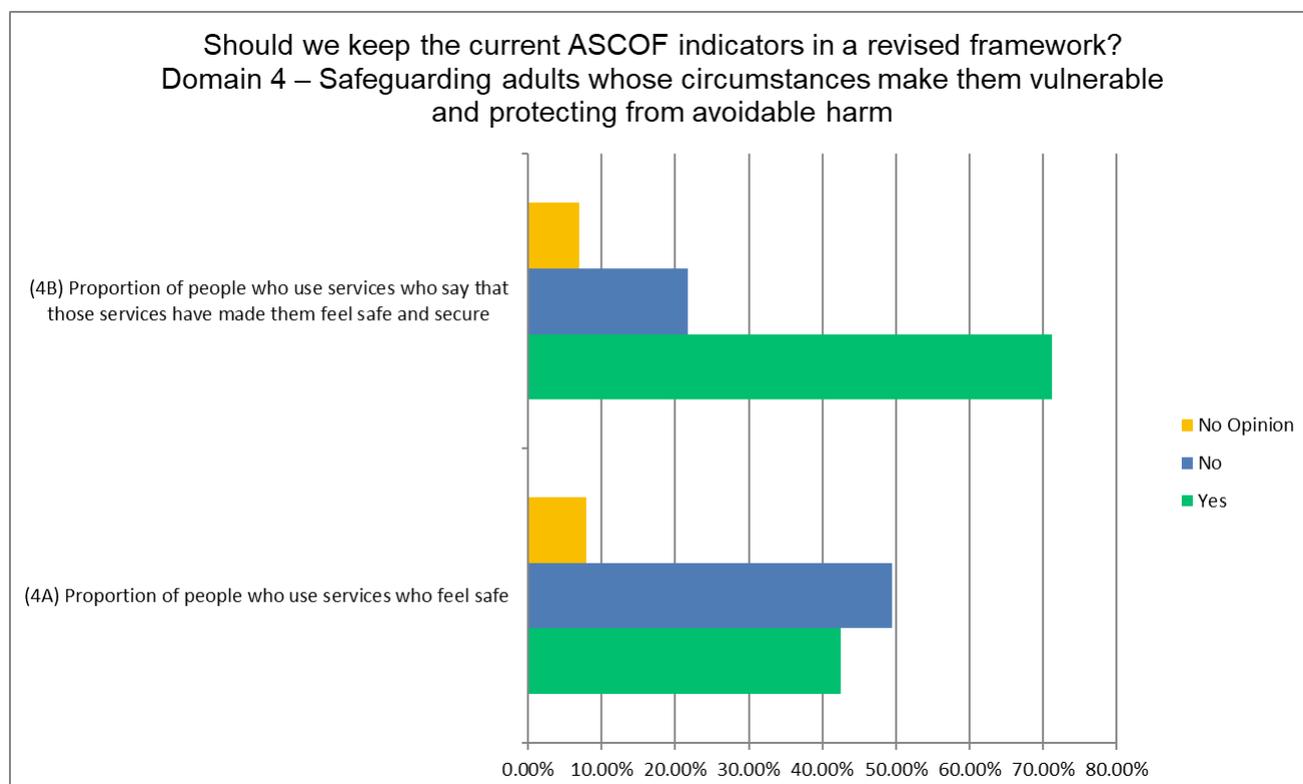
Comments relating to 3A and 3B:

- *“3A/3B – The response to this question often contradicts other replies in the survey – could this question be moved to the end of the PSS Survey?”*
- *“ASCOF 1B,1D, 3A, 3B, 3C, 3D - The indicators that captures information re. the views of service users via the Users’ or Carers survey are useful up to a point. However, for the majority of them, the questions that contribute to the ratings are either too vague i.e. not attributable to ASC, subject to interpretation*

i.e. feeling safe, or too old i.e. not relevant anymore as they no longer reflect the new pathways for ASC (pathways to independence)”.

- **(3C) The proportion of carers who report that they have been included or consulted in discussion about the person they care for** – 79% suggested that this indicator should be retained (see above comments)
- **(3D) The proportion of people who use services and carers who find it easy to find information about support** – 78% of respondents wish to retain this indicator (see above comments)
- **(3E) Effectiveness of integrated care** – 39% responded “yes” and 40% responded “no opinion” to this indicator. Two suggestions regarding this indicator are:
 - *“3E – Integrated care needs to be defined and will vary for individuals depending on their needs and across a wide range of services. People would need to be clear about what services are being included”.*
 - *“3E - an indicator that measures the effectiveness of integrated care is needed and we support its continued development. An indicator in this area is critical to oversight of developing Multi-Disciplinary Teams that are wrapped around Primary Care Networks”.*

3.8 Domain 4 – Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm



3.8.1 Summary of Comments

- **(4A) Proportion of people who use services who feel safe** – 42% responded “Yes” and 49% responded “No” to retaining this question. The overwhelming focus of comments relating to this indicator is that the question is ambiguous and open to interpretation – i.e. does the persons view on feeling safe appertain to the effectiveness of the support provided by adult social care or other external factors and support? Suggestions for revised indicators for 4A (and 4B) include measures from Making Safeguarding Personal: Proportion of those subject to a section 42 enquiry asked for a desired outcome (part 1); Proportion of those subject to a section 42 enquiry that felt their desired outcome(s) were achieved. A further suggestion is *“If these questions and overall satisfaction, accessing support, having contact etc. were collected within a review document, for example, there may be more of a qualitative measure, rather than just a series of numbers”* and *“In addition to the existing survey 4A, a sub indicator should be created to understand not only if people have safety concerns but what is causing that concern i.e. the reasons”*.
- **(4B) Proportion of people who use services who say that those services have made them feel safe and secure** – 71% of respondents suggested to retain this indicator. Many of the comments relating to 4A also relate to 4B however, there is one specific comment for this indicator: *“4B regarding safety and security, is assuring however does not allow, without looking locally at the data behind the measure as to what about the support provided supports safety and security.”*

3.9 Survey Suggestions for the future Framework

Part 2 of the survey included the following question:

What additional performance indicators, including those you have developed locally (including any that you have had to develop to meet Care Act requirements), would you suggest for inclusion in the revised ASCOF? These should include proposals for outcome measures that should be developed to measure what will be important in 5 to 10 years’ time.

In particular, ADASS are particularly interested to hear your thoughts or your local examples of indicators that explore the following:

- *Integration across health and social care, are there any performance measures that you think are key in measuring its impact?*
- *The Care Act duty to deliver a high quality, sustainable market, are there any performance measures that you think are key in measuring the impact of commissioning?*

- *Measuring the use of resources in adult social care, are there any performance measures that you think are key in measuring efficiency and effectiveness?*
- *Measures how well adult social care manages demand? What might key measures here be?*
- *The user and carer survey, what are the key measures that capture the experiences of users and carers?*

A summary of comments from the survey are shown below*¹²:

3.9.1 Integration

General Considerations:

- *More integration of health and social care indicators with potentially one integrated Outcomes Framework, particularly with regard to mental health.*
- *We agree that it is important to capture the impact of health and social care integration but in order to do this meaningfully, measures in any outcomes framework need to incorporate shared accountability as opposed to the current local authority focus and accountability. The SCIE offers, we think, a useful logic model as a starting point for measurement (see <https://www.scie.org.uk/files/integrated-care/measuring-evaluating/logic-model/integrated-care-logic-model.pdf>)*
- *Explore potential measures related to SCIE Integration Scorecard, based on the logic model*
- *Can we develop more integrated measures using health and social care data by linking through NHS numbers? Like the ASCOF 2F Dementia measure which need to be developed further.*
- *To be included in the ASCS survey*
- *Push for integrated datasets across health and Social Care to be mandatory to allow true performance reporting and demand management and demonstrate alliance with the care act.*
- *The perception of what integrated care means is different, therefore, a standard approach / definition should be developed. It should describe what people feel their experience of integrated care has been and how their outcomes have been met.*
- *We would not want this framework reviewed in isolation to the Better Care Fund and would like to consider some meaningful integration measures.*

Flow/Process Measures:

- *Continuing Health Care (CHC) interface – the number / percentage of users that have joint CHC funding*

¹² Suggestions with * are made from non-Council stakeholders

- *The only current measure relating to integration and improving the interface between health and care is that regarding Delayed Transfers of Care. As above, it could be supplemented with other flow measures derived from joined-up person level data.*
- *Destination on discharge; % of total LA and NHS spend on bed backed care (this will be harder in areas where there is no co-terminosity);*
- *Number of contacts that are signposted to third party, community-based services*
- *Flow measures including admissions avoidance*
- *Number of episodes of reablement or intermediate care intervention for clients aged 65+ (per 10,000 population)*
- *Some system flow indicators particularly across acute and community interface, collaboration of other providers*
- *Multi-disciplinary work e.g. % joint health/social care assessments, CHC joint funded packages, shared Patient Report Outcome Measures (PROMs)*
- *The time between one professional identifying the other's need for input and the date that input occurs*
- *Rapid and urgent community response, experience across the interface of care*
- *DTOC figures are closely monitored (although a challenge to report on monthly) and any increases or decreases reviewed to look at why.*
- *Repeat referral cases and STMAX reporting are reviewed monthly. We look at these KPIs to consider the effectiveness of support provided and to analysis why people are re-referred and whether this is something that was preventable or necessary.*
- *Referrals by source allow us to see where referrals are coming from and to target promotion or develop stronger connections to partner agencies if required.*

Impact Measures:

- *Surely our focus should be on how well people are discharged from hospital - not just how quick.*
- *% who receive long term care after a period of reablement (therapy led or domiciliary care)*
- *% of people discharged to a permanent residential bed without any opportunity for short term recovery.*
- *% of people who completed rehabilitative support who have a reduced level of long-term service or no long-term service*
- *Destinational outcome measures including after hospital discharge*
- *Survey measure of how joined up ASC and Health are, via the current survey. Some means of understanding someone's health and social care journey, and the impact of social care support on this.*

- *Something about keeping people at home longer and local.*
- *Should focus on reducing 'demand, duplication, need and pressures' across the system*

3.9.2 Sustainable Markets (Commissioning)

Activity/cost of provision

- *We can use our existing SALT/Finance data.*
- *CRiLL, LARA and CIPFA provided good measurements of commissioning activity across different LA, but again this has disappeared. Work is in progress on integrating CQC and Adult Social Care using PowerBI, starting in London with the results of the Bed-based Study to produce cost and quality data.*
- *Potential monitoring of off framework orders. % on framework and a % off framework*
- *no of care homes opening, closing, vacancies*
- *The regional ADASS dashboard tracks sustainable commissioning and demand management through measures such as recording market capacity, fee rates and service expenditure as well as overspend forecasted.*
- *Differing costs can explain differences in activity and spend and also indicate issues in the local market and its commissioning*
- *It is essential to assess both market capacity and utilisation*
- *The number of hand-backs would be a useful measure to include as it would also provide an indication of how well a market is delivering for that Authority.*
- *Average hourly rates for home support % of service users where their outcomes have been met to maintain independence*
- *Number of individuals with a Learning Disabilities who have a community based service*
- *Number of individuals who are receiving domiciliary care*
- *Capacity utilisation in care homes – LA funded residents in own LA as % of total available beds in LA area.*
- *The number of days from assessment to commissioned care beginning*
- *Average cost of packages (ie committed spend per quarter).*
- *Number of PAs.*
- *recording market capacity, fee rates and service expenditure as well as overspend forecasted.*
- *The cost of care and average volumes of support packages*
- *Level of market exists, thinking about LPS performance*
- *Average cost of services by category and client group (market assessment),*
- *average length of stay in residential and nursing placements by client group*

- *Monthly breakdown of provisioning by type supports an awareness of the demand on our framework providers/PAs and residential/nursing homes. Any significant changes in figures would be reported to our QA officer to monitor.*
- *Including a breakdown of PSR allows us to monitor demand on specific service i.e. LD provision.*
- *Services are considered by type as a way of monitoring demand on our commissioned support services which contributes to be aware of our local market, and to identify any potential gaps in service provisioning. We monitor all admissions into residential care (including property cases and depleted funds) as all are recognised as having impact of the service.*

Quality of provision.

- *% of Local Authority contracted providers with a CQC rating of Good or Outstanding. Note - this would need to be reported by the local authority and not taken directly from the CQC website. The CQC website will list all services in each LA boundary, however the LA would not necessarily be contracting with every service and may have stopped contracting with a service for reasons of a poor CQC rating.*
- *Need to be able to monitor and reflect the need and choice of the citizen - Measure the number of out of area placements / admission rates – identifying need and nature of the placement*
- *Placement to a good provider, not only measurable on the CQC rating*
- *Housing related: accommodation status for ALL social care users, and consideration of the quality/appropriateness of accommodation.*
- *Quality and location of provision eg. % LA funded clients receiving care out of county (boundary authority vs further away,*
- *% of people in good/outstanding homes or with good/outstanding providers.*
- *proportion of 'good' and 'outstanding' care homes and domiciliary care packages commissioned and present in the local market.*
- *Baseline indicator on availability of advocacy support**

Impact of services

- *2D (reablement success) measure has been used to improve the assessment pathway, manage provider performance and resulted in a more effective and efficient commissioning.*
- *It may be helpful to include more qualitative measures which would support how outcomes are met or how safety has been improved. A local or regional report which includes aggregate data and then a more individual response as to what measures show. This would support that any national report produced could showcase positive examples of commissioning, practice or models of support.*

- *More indicators that focus on the effectiveness of support and services, i.e. STMAX outcomes cross referenced with any re-referral data or information/advice sequels without referral within 12 months.*
- *A local measure used to measure effectiveness is based on the outcomes recorded on reviews, and the percentage of people that have a improved or consistent wellbeing scores.*
- *Outcomes of care and support provision are also included with the personalisation survey so any dissatisfaction with a commissioned service would be reviewed at this point.*
- *We are compliant with annual review timescales and so looking at the outcomes from review allows us to consider the effectiveness of the services provided to adults and has also helped with developing joint therapy and social care reviews as it was recognised that this would increase efficiency and the adults integrated experience with ASC.*

3.9.3 Use of Resources

- *The existing benchmarking on UoR facilitated by John Jackson is very useful. We need to utilise that better before building in more complexity. Timeliness is the one measure missing from current ASCOF that feels like it would be helpful.*
- *Measures that assess the proportion of people served, and at what cost per client. - These are derived and presented in the Local Government Association Use of Resources report*
- *The inclusion of some aspects of the ASC-Finance Return into ASCOF, such as unit costs, so we can better understand use of resources alongside performance and outcome data.*
- *Including some information from the ASC Finance Return on the use of resources into ASCOF will support local authorities to look at resources alongside performance and outcome data.*
- *Use of Resources and unit costs – based on NET not gross (ASC-FR does not gather the range of unit costs that PSS EX1 did – resurrect this?)*
- *We need a grip on length of stay and flow - from a customer perspective ie timeliness being a huge predictor of both prevention and quality*
- *There needs to be a greater focus on prevention and short term / low level support (especially technology)*
- *Spend on adult social care per adult 18+*
- *Spend on adult social care per adult 65+*
- *Spend on short-term care per adult 18+*
- *Spend on short-term care per adult 65+*
- *Spend on long-term care per adult 18+*
- *Spend on long-term care per adult 65+*

- *Unit cost of care homes placements for a person aged 18-64*
- *Unit cost of care homes placements for a person aged 65+*
- *Gross expenditure per person, % spent on (shifted to) low level support and prevention*
- *Referral to home assessment / Assessment to deployment of provision / E2E times from referral to needs met*
- *Unit costs of, as a minimum, domiciliary care, residential care and nursing care, but could also include other types of services such as extra care and supported living from the ASC Finance Return.*
- *Average caseloads and allocations/case closures by team are used as a basic measure of demand within the service. However, we acknowledge that case complexity is harder to evidence. The amount of assessments, SA Enquiries, mental capacity assessments and best interest assessments can however be used alongside this KPI to look at impact across the service at any given time.*
- *We monitor types of referral and assessment to look for any patterns/trends in demand from first point of contact and to ensure that any service development reflects any potential increase in demand.*
- *we now have national eligibility criteria (we didn't when ASCOF was originally introduced) - and so I think we need to use SaLT return to Capture variation in access and combination of SALT return and finance return to develop an effective use of resources PI.*

3.9.4 Demand Management

'Front Door'

- *Addition of measures around front door, demand management, community support and true outcomes for those supported by Adult social care*
- *Measures that assess the impact of prevention are lacking but best restricted to strengths-based practice at the front door e.g. a sampled follow-up survey of those offered information and advice. –*
- *adopt some of the measures in the 6 steps framework*
- *Repeat contacts and how effective our VCFS sector is*
- *People assessed who go on to receive a service;*
- *Impact of other preventative services.*
- *proportion of front door contacts resolved at first contact, proportion of care act assessments leading to no further action, reablement outcomes.*
- *Outcome measures about the prevention of admissions / re-admissions might be more relevant than the recent focus on DTOC reduction.*
- *Prevention on admission to hospital, Fall prevention*
- *Numbers of customers supported through early intervention/prevention,*

- *Indicators that measures prevention at the front door to adult social care e.g. % of contacts/referrals for adult social care that are resolved at the initial point of contact or through accessing universal services.*
- *What is coming into/through the front door?*
- *a sampled follow-up survey of those offered information and advice. - Measures that assess the reach and impact of short-term services need to be improved*
- *People assessed who go on to receive a service;*
- *Prevention metrics such as: community capacity, social connectedness.*
- *Metrics such as: proportion of front door contacts resolved at first contact, proportion of care act assessments leading to no further action,*
- *% of demand or rate of people who receive equipment only*
- *Numbers of people that requested a Care Act assessment but didn't get one **
- *Specific questions that would help understand and measure whether there are inequality issues that need to be addressed**

'People who receive short-term support'

- *% of NEW clients for whom their needs were addressed at the point of the request (i.e. only had one request in the year).*
- *Measures that assess the reach and impact of short-term services need to be improved.*
- *% new clients discharged from hospital offered Reablement or other forms of short-term support including more preventative support (i.e. the Wellbeing service in Lincolnshire).*
- *Repeat requests for care, conversion rates (e.g % requests leading to needs assessment, % clients eligible at assessment, and % of those for whom their needs were addressed without long term support,*
- *impact of reablement and not just about hospital discharge.*
- *Conversion rates from early help and prevention to long term support (already gathered in SALT)*
- *Locally for reablement we monitor responsiveness and effectiveness; urgent, priority, non priority (therapy); reduction in hours (care); outcomes following intervention - needs met (which we already have in ASCOF).*
- *reablement outcomes.*
- *The % of patients who at the point of discharge have received an appropriate service within 48 hours.*
- *The proportion of people in any week who are waiting for a service that has been agreed by the patient and the multi-disciplinary discharge team.*
- *The proportion of older people who are assessed as having care needs, who were offered a re-ablement based service.*

- *Length of time people waited from initial contact with ASC to having an assessment**

'People who receive long-term support'

- *% reviewed/assessed in last year – useful for benchmarking;*
- *Number of interventions tried before a long term support package has settled*
- *we are monitoring the number of new long term users starting services each week, as well as repeat requests for support*
- *% reviewed/assessed in last year*
- *The proportion of adults with a learning disability who should be offered a programme to assist them achieve a higher level of independence.*
- *The proportion of older people receiving longer term care whose care needs have decreased from their initial assessment/latest review.*
- *The proportion of younger adults receiving longer term care who care needs may have decreased from their last review*
- *The proportion of older people receiving longer term care whose needs have increased since their initial assessment or latest review?*
- *% of people with LTS (over 12months) with a completed annual review.*
- *Proportion of people in receipt of community mental health services who had an assessment of their care & support needs as per the Care Act; And family carers of those people under the same*.*
- *The effectiveness of palliative and end of life care in ensuring*:*
 - *People are enabled and supported to live as well as possible until they die, and*
 - *People who are dying in their own home or in residential/nursing care receive the care and support that enables them to experience high quality coordinated care (across health and social care)*
 - *Families and caregivers of people who are in their last year of life receive the support that enables them to care for the person but also acknowledges their own needs as a grieving carer.*

General comments

- *% of spend dedicated to prevention/short term/long term*
- *We should be using clearer definitions and consider using the John Bolton KPI's in a revised framework to enable performance to be measured and benchmarked in a meaningful way.*
- *Measures on timeliness of assessments and services provide intelligence on effective operations.*
- *Pathway predictions/trend profiling and trajectories*

- *Timeliness is the one measure missing from current ASCOF that feels like it would be helpful. We need a grip on length of stay and flow - from a customer perspective ie timeliness being a huge predictor of both prevention and quality*
- *The John Bolton 6 steps to measuring demand has assisted us in helping to understand the wider system performance*

3.9.5 User and Carers Survey

Current Survey - 'Positive' Comments

- *Indicators from surveys give the best measure of outcomes from perception of customers.*
- *The survey aspects of the ASCOF are tried and tested and a good resource for effective outcome reporting.*
- *The survey measures are helpful and quite a lot of ASCOF is survey-based. It does show that we are listening and responding (e.g., Carers' Survey indicators). The surveys allow consistent feedback from users themselves with the ability to add local questions if required*
- *Findings from the surveys can encourage authorities to seek good practice from those that get better results*
- *Questions from the Adult Social Care and Carer Survey have been consistent over time so that the results can be effectively benchmarked.*
- *The survey measures are the most useful as this gives us an opportunity to gain resident's opinions of how well we are doing.*
- *The Survey measures work well when %'s are used as it's easily understood and provides a good idea of customer satisfaction.*
- *Users and Carers Surveys are an excellent direct method to gauge satisfaction levels of these two important client groups.*
- *All survey KPIs should be retained and more should be introduced*
- *Some of the survey based indicators attempt to capture the impact of services on the quality of life of vulnerable people.*

Current Survey – 'Negative' Comments

- *The ASCOF framework only loosely relates to a methodology that can support proper outcome-based reporting and perhaps relies too heavily on surveying the service and carer populations supported by councils*
- *ASCOF currently relies on composite measures of quality of life using responses to survey questions, which have a fairly complex methodology and can be difficult to interpret*
- *Within the ASCOF framework there is a large dependency on both the adult social care survey and carer's survey. Whilst we acknowledge the importance of the*

user's voice and experience and would need to capture some of the information, we don't believe that the survey continues to be effective in doing this

- *The adults survey goes out to those adults receiving long term services (LTS001b) which means that results to the question around information and advice is not being asked of the people who are receiving the service at the front door and don't go on to receive a long-term service. That said it does also prove difficult to contact this cohort as we may never take ore details than their name.*
- *Resource intensive and can be costly to run. They also only hit a small proportion of the supported population (no short-term Adults)*
- *Survey is limited to people receiving a service not people who requested support or even wider population. For example self-funders that may have needed advice.*
- *Many of these services users will have conditions such as dementia which prohibits them from taking part in the survey. Therefore, over the last few years we have found it increasingly difficult to meet the targets set for this particular group.*
- *The level of response to the surveys clearly indicates survey fatigue is an ever-increasing factor*
- *ASCOF data derived from Users' and Carer's survey findings are not deemed to be very robust as some the questions within these surveys are vague, open to interpretation and have not changed for many years e.g. 'I feel safe' as the response could be related to local crime and not ASC. It has therefore been difficult to give credence to some of the ratings for these indicators*
- *Survey responses are influence by many external factors such as health, housing, community that it is difficult to understand social care impact.*
- *Differences in interpretation (of guidance) between councils, weaknesses of some of the definitions themselves and challenges in working out what leads to better or worse user and carer survey results has meant ASCOF itself has not been that useful for sector-led improvement*
- *Stated "No" to the indicators derived from the adult social care survey and carer's survey. However, we recognise there is a need to reflect the users experience and it is important to do so; however, we do not feel that the current survey methodology adequately does this. Year on year it becomes more difficult to achieve the required sample size.*
- *Some of the survey questions are open to interpretation (e.g. what do people using services think of when asked if they feel safe? We suspect it will not always be related to what we understand by a safeguarding issue).*
- *Surveys are too long and are very inflexible regarding how they can be administered. This places added burden on the Council's, and residents complain of survey fatigue.*
- *The survey data that feeds ASCOF is useful but only collected once a year and only for long term service users.*

- *Once a year is not often enough although we accept that an increase in frequency is unrealistic from survey based measures.*
- *(Carers) Bi-annually doesn't allow us to understand how well implemented policies and initiatives are working annually.*
- *The data from the surveys is a really helpful resource asking for user feedback but is this accessible to all? Are we still asking the right questions? Despite the caveats about the survey being independent and confidential do service users and carers feel able to give open responses about the care they receive?*
- *The survey indicators are not well phrased and are insensitive to change*
- *I have concerns about the survey indicators as the response rate is low and not sure a letter is the best way of gathering data*
- *There is an over reliance on surveys across the suite.*
- *Surveys don't reflect priorities or statutory duties. It also creates a large burden on local authorities to complete.*
- *ASC is more focused upon prevention and lower level/community-based support - these areas are not reflected by survey results currently.*
- *Many ASCOF measures rely on data from ASC Survey and Carers Survey. We are required to stratify our sample. We wanted to highlight that we are running out of people to survey. We have a high level of need, including where people lack capacity. This means that it is getting very difficult to develop the sample for the surveys (e.g., this is especially difficult to achieve in residential care where people may lack capacity).*
- *We are seeing the impact of survey fatigue, have very little change in results year on year and they take a large amount of staff time. The questions are vague and by the narrative that we see added to returned surveys the receivers often don't differentiate between who has been supporting them (ASC, GPs, Community Groups, etc)*
- *The measures from the surveys are based on Y/N answers and not outcome focussed.*
- *Survey results can be difficult to understand and are not helpful in identifying improvement actions. As each LA have different methods of collecting the survey, it does affect response rates and outcomes, each LA should have to follow the same process.*
- *There is a strong indication the current arrangements lead to results which are more of a reflection of how the questions have been constructed and how they are locally delivered (even recognising it is meant to be standardised) rather than genuinely capturing outcomes. However, the intention of the questions continue to be relevant so our challenge is how to reconstruct the survey approach to get more meaningful results.*
- *Feedback from commissioners is that the questions in the survey are too broad and it is not obvious what specific performance issues they need to address.*

The surveys questions themselves are ok, but the ASCOF measure for quality of life is a convoluted calculation based on the responses to 8 separate questions. The result is a score (between 0 and 24) which doesn't really mean much to anyone, but is a way of benchmarking results between councils

- *Remove survey*
- *There also issues with the sampling within the surveys i.e. the exclusion of individuals with DoLS within the surveys etc*

Suggestions for future design of the survey

- *Consideration should be given to NHS Digital undertaking the user/carers' experience surveys*
- *The satisfaction level surveys should be done more frequently to show emerging trends.*
- *The carer's survey should be undertaken annually.*
- *Change the frequency of the national surveys running the User and Carers alternative years and move away from paper collection for the survey.*
- *Instead of annual surveys can we use some sort of feedback collection at review (planned or unplanned) which helps to monitor the outcomes achieved for the customer.*
- *We would propose scrapping the current Survey programme and running a series of targeted local survey directly with our customers.*
- *The questions need to be updated to fully achieve this, and context (in the form of comments from individuals) needs to be added to every question so that we can analyse and interpret the results and better understand what we are doing well, and what we need to improve on.*
- *Is there a possibility of sharing data obtained by the CQC to reflect the user's experience?*
- *Other surveying approaches should be considered including being built into the assessment and review processes.*
- *If the survey could be moved online in future (there are pilots underway) the surveys could become more frequent.*
- *Perhaps this could involve all service users and be collected in a different way*
- *Qualitative data within the surveys, in the form of written narrative from service users/carers this offers a better insight into perceptions of the service and help identify themes for further investigation*
- *We feel that surveys are increasingly important to understand the impact of services on individual's lives, however we do feel that the surveys require more narrative on the reasons for individuals' answers so that we can better understand where improvements are needed.*

- *More must be done to engage hard to reach groups such as clients with LD and those across the spectrum with diminished mental capacity.*
- *Survey questions are quite general, and for better intelligence we need the direct link to support they receive and at a greater level of significance at different levels of aggregation – by age group, PSR, service type.*
- *Overall satisfaction should also incorporate individuals who are ‘quite satisfied’ according to the survey response*
- *The survey form needs to be streamlined to only a few critical questions (with narrative explanations*
- *The framework needs to reflect lived experience, though the surveys need to be adapted to allow for this*
- *To work with health colleagues to look at devising or modifying surveys to measure people’s experiences/outcomes in an integrated way.*
- *There needs to be a complete re-write of User Survey and Carers Survey. We need to be asking questions that provide insight into specific areas of experience rather than just overall satisfaction. E.g. what constitutes person centred planning and delivery (from a provider perspective as well as support planning). The surveys need to be much shorter in length.*
- *All questions in the surveys should be reviewed and reduced to just retain the most useful questions (such as ease of access to information and advice), to then inform those that would be most beneficial to include in a refreshed ASCOF*
- *In addition, rather than an annual survey, a different type of mechanism to gain feedback could be put in place. This could be for example a ‘trip adviser’ type portal for people to put general feedback on, or it could be Local Authorities implementing the capture of responses to a couple of key questions from all service users. These could be asked at the point of contact for people who only go on to receive universal services/signposting, at service end for short term services, and at review for long term services. If the questions were made mandatory for all Local Authorities benchmarking would be possible and results could be obtained more frequently throughout the year rather than annually. It would also be possible to compare results across different service types. Again, technical solutions, i.e. app/portal should be considered (purchased nationally) with LAs being given access to capture feedback through, for example, follow up text messages, user feedback by voting buttons via an app during face to face contact, links sent by e-mail following intervention etc.*
- *The surveys are comprehensive in the scope of their questions but under-utilised. - They could be complemented or replaced with surveys of desired and achieved outcomes through assessment and review. - They could also be complemented with more frequent, high volume, light-touch surveying of satisfaction.*

- *Would like to see standard refined survey as part of the review process and asked of everyone annually and related to what is important for individuals and their personal outcomes have been met.*
- *Survey measure of how joined up ASC and Health are, via the current survey.*
- *A survey covering reablement / intermediate care was expected but has not been fully developed and the placeholders in the ASCOF have been there for a considerable time without progressing.*
- *A metric to measure user experience of reablement would be desirable – maybe a rolling short survey collection at the end of a completed reablement episode.*
- *Survey indicators for universal service recipients – this could be rolling asking of set questions at the end of each / key contact events.*
- *For user and carer survey how quickly did you receive the support you felt you needed*
- *Survey Questions already in existence that we feel could be a useful ASCOF measure are:*
 - *1) Proportion of people who use services who say that those services have helped them to have a better quality of life,*
 - *2) Proportion of people who use services who say that they have enough choice over the care and support services they receive (currently only in community survey),*
 - *3) Proportion of carers who feel that they have encouragement and support in their caring role.*
 - *Potential new survey questions as ASCOF measures are:*
 - *4) Proportion of people who use services who say that those services have helped them to be more independent,*
 - *5) Proportion of people who use services who say that those services have improved their wellbeing,*
 - *6) Proportion of people who use services who say that those services have helped them to achieve the things that matter most to them,*
 - *7) Proportion of carers who use services who say that those services have helped the carer to maintain a good life.*
- *In relation to user and carer survey the language needs to reflect the shift to strengths based practice, we need to understand what is important to the person and their experience of their interaction with social care and what is important to them within their life, was that achieved, if not why not? It is not just about choice and feeling safe, language we use in the measures needs to reflect the language and aspirations of the Care Act and the social care that we want to see for the future that sees us shifting away from process and deficit models*

- *In addition to the existing survey KPI ASCOF 4A, a sub indicator should be created to understand not only if people have safety concerns but what is causing that concern i.e. the reasons.*
- *2B - just get rid of the 91 day indicator and replace with survey based indicator*

In addition to suggestions from councils, the following were offered from other stakeholders:

- *Specific questions around finance to expose whether people have had access to the right information to understand the financial assessment process and that they may have to make a financial contribution.*
- *Take a rights-based approach, one that is grounded in the wider context of people's lives. Asking people about 'social care related quality' of life for example does not allow an understanding of the impact of other factors on peoples experience of living life.*
- *Consider making ASCOF more than an annual exercise; colleagues envisaged an online portal that could be regularly updated with stories, blogs, etc and involve people in the co-production of their own lives and those of their communities. For example, Dudley Council are training Community Reporters to gather stories that contribute to the Local Account. Shropshire's Local Account tells the story of their experiences of co-producing new ways of working alongside people and communities.*
- *Co-design the revised ASCOF with people on a national level and local level with people and communities allowing people to talk openly about their experiences, in ways that makes sense to them. Invite the workforce to talk about their experiences too.*
- *Push boundaries by asking people who access services whether they feel their local authority trusts them to make their own decisions about their care. And if not, why not. Ask individuals what they like about where they live, what they don't like, and what would make it better (in the broadest sense) – Something that doesn't need to be repeated regularly but sets a great baseline for what needs to change locally.*

3.9.6 Other Themes

Safeguarding – the overwhelming call is to use the 'Making Safeguarding Personal Framework' indicators 1 – “Was the individual or individual's representative asked what their desired outcomes were?” and 2 – “Did the person or their representative feel that the desired outcomes were achieved?”

4 Appendix 1 – Stakeholder Engagement Activities

ADASS Regional Workshops:

- ADASS East
- ADASS East Midlands
- ADASS London
- ADASS London – Performance Leads
- ADASS North East
- ADASS North West – Performance Leads
- ADASS South East – Performance Leads
- ADASS South West – Performance Leads
- ADASS West Midlands
- ADASS Yorkshire and Humber

Representatives from:

- Association of Mental Health Providers
- BASE
- Better Care Fund
- British Association of Social Workers
- Care Quality Commission
- Carers UK
- Department of Health and Social Care
- Dr Adi Cooper – Care and Health Improvement Advisor (Adult Safeguarding Lead),
Local Government Association
- Innovations Network (SCIE)
- IPSOS MORI
- Kings Fund
- Local Government Association
- London School of Economics
- National Audit Office
- National Autism Society
- National Coproduction Advisory Group
- National Principal Social Worker Group representative
- Newton Europe
- Shared Lives
- Social Care Institute for Excellence
- Think Local Act Personal

5 Appendix 2 – ADASS Survey Questionnaire



“The right narrative” Help us to refresh the Adult Social Care Outcomes Framework

The Adult Social Care Outcomes Framework (ASCOF) is increasingly experienced by Directors of Adult Social Services as an outdated performance framework of adult social care, rather than an outcomes framework, whose metrics measure, to a certain degree at least, outmoded methods of adult social care delivery.

ADASS are working with The Institute of Public Care (IPC), Oxford Brookes University (subject to funding) to explore through a programme of discussions and engagement with sector stakeholders, the necessary revisions to ASCOF that will ensure that a new framework can:

- Better measure **what people value about Adult Social Care (ASC)** and its **impact on their lives in terms of independence and wellbeing - this includes which existing ASCOF PIs should be retained, which should be changed and which should be added.** This will include **proposals for outcome measures that should be developed to measure what will be important in 5 to 10 years' time.**
- Measure the **impact of the local authority ASC function** in meeting those **policy objectives of the Care Act** currently omitted from ASCOF, **e.g., the effectiveness of commissioning** in driving a high quality, sustainable care market, and how well a local authority **prevents the need for ASC, the escalation of people's needs (demand management) and wellbeing.**
- Include an **improved, more “balanced”, set of health and ASC interface indicators** which also measure **what happens to people before/when/after they leave hospital in addition to the DTOC targets, e.g. destinalional outcomes, hospital admission avoidance - to sit alongside work being undertaken in relation to the review of the BCF.**
- Measure the **efficiency and effectiveness of the use of resources by a local authority ASC function.**

Simply put, we are seeking the views of Directors of Social Services and their colleagues to better understand:

What measures do you want to keep?

What measures do you want to change?

What new measures do you want to introduce?

The closing date for this survey is 31st January

Data protection and confidentiality

Survey responses will be collected using SmartSurvey. For information on how and where your data will be stored, see the [IPC Privacy policy](#). All of the information you share with us will be stored safely for the duration of the evaluation and destroyed six months after it has finished. The information you give us will be anonymised and your comments will not be identifiable. Your consent for your data to be processed will be assumed from you starting the survey.

Name of your local authority (drop down mandatory)

Part 1 - Current ASCOF Framework

Q1. The statements below describe the purpose of the *current* ASCOF. For each statement please say if you ‘Strongly agree, agree, neither/nor, disagree, strongly disagree’ that ASCOF current address this purpose. **MANDATORY**

Locally:

Purpose	Strongly agree	agree	Neither / nor	disagree	Strongly disagree
A framework for providing councils with robust information that enables them to monitor the success of local interventions in improving outcomes					
A framework to help councils identify their priorities for making improvements.					
A framework to help councils inform their outcome-based commissioning models					
Providing a useful resource for Health and Wellbeing boards that can use the information to inform their strategic planning and leadership role for local commissioning.					
A framework that supports accountability to local people by using the data in publications that communicate the outcomes being achieved, and priorities for developing local services					

Comments (optional)

Regionally

Purpose	Strongly agree	agree	Neither / nor	disagree	Strongly disagree
The data supports sector led improvement; bringing councils together					

to understand and benchmark their performance.					
Stimulates discussions between councils on priorities for improvement and promotes the sharing of learning and best practice.					

Comments (optional)

Nationally

Purpose	Strongly agree	agree	Neither / nor	disagree	Strongly disagree
ASCOF demonstrates the performance of the adult social care system as a whole, and its success in delivering high-quality, personalised care and support.					
Inform, and supports, national policy development					

Comments (optional)

Q2. Please state if you would like to keep the following current ASCOF indicators in a revised framework: **MANDATORY**

Domain 1 – Enhancing quality of life for people with care and support needs	Yes	No	No opinion
(1A) Social care-related quality of life			
(1B) Proportion of people who use services who have control over their daily life			
(1C) Proportion of people using social care who receive self-directed support, and those receiving direct payments			
(1D) Carer-reported quality of life			
(1E) Proportion of adults with a primary support reason of learning disability support in paid employment			

(1F) Proportion of adults in contact with secondary mental health services in paid employment			
(1G) Proportion of adults with a primary support reason of learning disability support 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			
(1I) Proportion of people who use services and carers, who reported that they had as much social contact as they would like.			
(1J) Adjusted Social care-related quality of life – impact of Adult Social Care services			
Domain 2 – Delaying and reducing the need for care and support	Yes	No	No opinion
(2A) Long-term support needs met by admission to residential and nursing care homes, per 100,000 population			
(2B) Proportion of older people (65 and over) who were still at home 91 days after discharge from hospital into reablement/rehabilitation services			
(2C) Delayed transfers of care from hospital, and those which are attributable to adult social care per 100,000 population			
(2D) Outcome of short-term services: sequel to service			
(2E) Effectiveness of reablement services			
(2F) Dementia – a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life			
Domain 3 – Ensuring that people have a positive experience of care and support	Yes	No	No opinion
(3A) Overall satisfaction of people who use services with their care and support			
(3B) Overall satisfaction of carers with social services			
(3E) Effectiveness of integrated care			
(3C) The proportion of carers who report that they have been included or consulted in discussion about the person they care for			
(3D) The proportion of people who use services and carers who find it easy to find information about support			
Domain 4 – Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	Yes	No	No opinion
(4A) Proportion of people who use services who feel safe			
(4B) Proportion of people who use services who say that those services have made them feel safe and secure			

Q3 What do you find useful about the current ASCOF and in what way?

MANDATORY

Q4 What is NOT useful in the current ASCOF and why?

MANDATORY

Q5 How could this be improved?

MANDATORY

Part 2 – The Future Framework

Q6 What additional performance indicators, including those you have developed locally (including any that you have had to develop to meet Care Act requirements), would you suggest for inclusion in the revised ASCOF? *These should include proposals for outcome measures that should be developed to measure what will be important in 5 to 10 years' time.*

In particular, ADASS are particularly interested to hear your thoughts or your local examples of indicators that explore the following:

- **Integration across health and social care**, are there any performance measures that you think are key in measuring its impact?
- The Care Act duty to deliver a **high quality, sustainable market**, are there any performance measures that you think are key in measuring the impact of commissioning?
- Measuring the **use of resources** in adult social care, are there any performance measures that you think are key in measuring efficiency and effectiveness?
- Measures how well adult social care **manages demand**? What might key measures here be?
- The user and carer survey, what are the key measures that capture the **experiences of users and carers**?

optional

Q7 Why do you see these as being useful?

Mandatory if Q6 completed

Completed by

Name

Job title

Are you willing to be contacted by IPC to discuss your responses? If yes, please provide email and phone number

Thank you for taking time to complete the survey.

The closing date for the survey is 31st January 2020