DRAFT Regional Integrated Community Service Outcomes Framework –

1.0 Rationale & Context

There are three important factors that inform this framework.

Firstly, population ageing and the increased prevalence of long term limiting conditions (LLTC)/ multi morbidity and associated frailty has long been recognised as compromising the sustainability of our organisations. This is expected to increase further over the next 20 years. The prevalence of LLTC's increases with age so the number of people with LLTC's will increase as a direct consequence of population ageing.

Secondly, we miss opportunities in all areas of care and support, regardless of who is providing it, to integrate to maintain and maximise the health, wellbeing, happiness and independence of people in our region, including that of carers. The pathways related to the care and support of older people, particularly those who are frail and those with complex and/or additional needs are the ones most under pressure in our system. There is a growing knowledge that too many older people are admitted to hospital or long term care unnecessarily; evidence suggest 20-30% of unplanned admissions to hospital in those over 75 years old could be avoided. For older people, admission to an acute hospital can lead to loss of function that is irreversible as evidence demonstrates immobilisation is a common feature of acute care. From a systems perspective, not only are people's lives damaged by losing life skills and independence, but the consequential cost to both the NHS and social care are significant.

Thirdly, our current system has a heavy bias towards condition specific measurement, the measure of performance not outcomes and measurement of performance primarily focussing on secondary/ acute care, which constitutes a very small part of the system as a whole. There is little measurement of population outcomes and a lack of robust data outside of the hospital system and across organisational and service interfaces.

Social Services & Wellbeing (Wales) Act 2014 (SSWBA)

The SSWBA provides for a regional mechanism to bring together health, social care, the third sector and other partners to take forward effective delivery of integrated services in Wales. The purpose is to improve outcomes and well-being of people with care and support needs, and their carers within West Wales. The Integrated Care Fund (ICF) is a mechanism to support delivery of the requirements of the Act and there is a duty placed upon organisations to ensure efficiency and effectiveness of service delivery both at population & organisational level.

2.0 Ambition & Aims

This outcomes framework has been developed in response to the need to improve population health at individual and organisational level and specifically address the factors mentioned above and those affecting carers. Whilst development of the framework has focussed around Older People & Frail Adults, measures for Adults with Learning Disabilities, Children with Complex needs and Carers are currently under development.

The ambition is to produce a blended suite of outcomes, indicators, performance measures, care standards and an 'offer' across a range of integrated pathways informed by the work at National level though a range of relevant programmes and groups, including the National Programme for Unscheduled Care and Ministerial Advisory Group for Carers. The framework is an iterative document, which will be adapted and improved in response to need.

The purpose of this Framework is to give a clear and concise guide to:

- Our key objectives and priorities
- Our priorities for delivering a good service
- How we will use performance measures to continually improve and inform whole system impact on organisations objectives and population wellbeing
- How we will evaluate the impact of Intermediate Care & ICF revenue funded projects
- How we evidence programmes that address health inequality

We have developed our approach around population outcomes as this can only be delivered through a collaborative coalition of equal partners; no one service can be responsible for achieving the outcome for a whole population, but individual services can be held responsible for what they contribute to the individuals they serve. This approach will ensure we balance the relationship between service demands, prudent allocation of resources and outcomes for people across the whole system. We will use a blend of measures across the whole system and its interfaces, to ensure we do the right thing and drive continuous improvement within the region.

3.0 Principles

- Measure only what is important. Too much data means that we "can't see the wood for the trees". Drill down for more data only if performance is not acceptable.
- Identify and measure against base-line data.
- Use a number of different performance indicators to build up the overall picture and narrative about the service.
- Use that information to identify where the focus of service improvement should be.
- Encourage behaviour that is driven by doing the right thing for the people.
- Develop greater understanding of the reciprocal relationship between community and secondary care. Not just what community can do to support hospitals, but also by co-producing solutions with the community, to achieve better outcomes for the population of the region.

4.0 What does a good service look like for the region?

An overarching outcome for the framework is proposed which recognises the outcome for Community Services emerging at National Level:

> People in West Wales will enjoy optimal health, well-being and independence.

Aligns with those articulated in the Welsh Government National Outcomes Framework:

Citizens understand what care, support and opportunities are available and use these to help them achieve their well-being
Citizens access the right information, when it's needed, in the way they want it and use this to manage and improve their well-being
Citizen's voices are heard and listened to
Citizen's individual circumstances are considered
Citizens speak for themselves and contribute to the decisions that affect their life, or have someone who can do it for them
Citizens get the right care and support, as early as possible
Citizens contribute towards their social life and can be with the people that they choose.
Citizens engage and make a contribution to their community
Citizens get care and support through the Welsh language if they want it
Citizens live in a home that best supports them to achieve their well-being

Three key themes have been identified to describe the aspirations for service delivery which seek to deliver on the overarching outcome:

1. Staying Well & Independent in the Community

- Promoting general health and wellbeing
- Supporting people to live independently in a suitable home setting
- Improving individual and community connections

2. Timely intervention to prevent crisis

- Rapid response to an episode or crisis; assessing, treating and or supporting people at home wherever possible, working closely with partners
- Enabling people to be as independent as possible through providing services and support that are proportionate to need

3. Maximising people's time spent in their home of choice

- Integrated planning processes that avoid unnecessary delays
- Prudent use of resources
- Targeted support that assists people to maintain or regain independence

How do we know we are delivering against the overarching outcome?

By agreeing a balanced and meaningful basket of measures and by focussing on and adopting a population outcomes approach to measurement. This includes:

- Measures of numbers such as how much and how many – this will help us understand demand and activity
- Measures of quality – how well we do something and the difference our services make.
- Measures of controlling resources – how well we manage the relationship between the demand for our services and the impact of decisions on our resources

5.0 Draft Measures

THEME 1: Staying Well & Independent In The Community (IPOP COMPONENTS 1, 2 & 3)

Services which support people to:

- Live at home independently
- Access Information, Advice and Assistance
- Manage or improve health and well-being
- Access 'Self Care' programmes
- Access Care Closer to Home
- Live in care homes or extra care settings

Measures (Must include measurement of quality also)

- Number/percentage of people referred to social prescribers
- Number/percentage of enquires per quarter per locality to IAA
- Number/percentage of additional entries or updates onto Dewis and Info Engine quarterly per locality
- Number/percentage of hits on Dewis website
- Number/percentage of user led organisations, CICs and social enterprises developed/supported per locality
- Number/percentage of carers identified
- Number/percentage of carers supported
- Number/ percentage of carers signposted

THEME 2: Timely intervention to prevent crisis (IPOP COMPONENTS 4&5)

Services which:

- Assess, treat and support people at home or in the community
- Provide a rapid response to a crisis
- Help to avoid an admission to hospital

Measures (Must include measurement of quality also)

- Number/percentage of supported turnaround at the front door of acute hospitals
- Number/percentage of people supported by Intermediate Care pathway / rapid access service
- Number/percentage of people supported by a reablement service
- Number/percentage of people referred to intermediate care beds
- Median LOS in Intermediate Care beds
- % bed occupancy in Intermediate Care beds
- Number/percentage of interventions by user led organisations, CICs & social enterprises

THEME 3: Maximising people's time spent in their home of choice (IPOP COMPONENTS 6 & 7)

Services which support people to:

- Take a frailty approach to preserve function and reduce length of stay
- Make the transition from hospital to community
- Prevent re-admission to hospital
- Enable people to be discharged quickly and with the appropriate service
- Ensure prudent use of resources on discharge
- Manage demand and capacity, recognising budget constraints (efficient use of finite long term social or nursing care resource; both domiciliary and residential)

Measures (Must include measurement of quality also)

- Median length of stay in inpatient bed by cluster
- Number/percentage referred to IAA & community prevention services from hospital
- Number/percentage of commissioned hours of domiciliary care