Demonstrating the Impact of Community Led Approaches

Using data to understand the impact of community led and preventative care and support

Community Led Support

an NDTi Programme

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Healthcare Improvement Scotland | ihub

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The author acknowledges the wonderful support given by colleagues in South Ayrshire HSCP. The experience, input, challenge and learning from Phil White, Steven Kelly and Kirsten Kirr, have allowed us to test how we might use our data differently to tell the story of their journey and the impacts of Community Led Strength Based practice.

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(ihub is part of Healthcare Improvement Scotland**).**

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Introduction and Context

Background & Introduction

Current measures across health and social care can provide a good understanding of demand and use of resources for current service models. This data is helpful in the formation of strategic plans and allows system leaders to respond to acute pressures in the systems as and when they arise. There is a question as to whether this data, and the information which it delivers, is optimal in the light of new drivers, behaviours, and desired impacts such as those outlined by the Independent Review of Adult Social Care[1] and the aims of a National Care Service.

Scotland has developed strong policy and accompanying legislation that seek to drive a more preventative approach to health and social care service provision. Local Health and Social Care Partnerships are increasingly describing practice that meets the aspirations of the policy and legislation and there is growing evidence of community led approaches and a clear focus on *What Matters*[2] to individuals.

In order to build confidence in these new and emerging models of care, we need to seek data and evidence that not only demonstrate the effect this approach has in supporting people to live well and to live independently, but also the effect this has on the health and social care system: In short, we seek to understand what works in these approaches to maximise health and wellbeing and the effect this additional health and wellbeing has in reducing or stabilising demand for acute health and social care services.

This report describes the approach and findings of a short and focussed piece of work with one Health and Social Care Partnership (HSCP) to explore the question:

How far can the current set of measurements across the Health and Social Care system, or the data underpinning these measures, be effective in capturing the impact of prevention through community-based interventions?

The details of this exploration and its findings are set out in the report and appendices below, so too are a number of caveats, conclusions, and recommendations. We hope this will be instructive in furthering the work to understand the links between the aspirations, strategies, practices and impacts of community-based preventative approaches; and to contribute to the process of building a growing evidence base of the value of strength-based, community led approaches in Health and Social Care.

[1] https://www.gov.scot/groups/independent-review-of-adult-social-care/

[2] "Why ask what matters? – What matters to you?

We acknowledge the generous support from colleagues in South Ayrshire HSCP, in the giving of their time, experience, and expertise to support and to test the thinking, approach and possibilities outlined here. Any errors, omissions, or misunderstandings contained here are entirely those of the author.

Caveats and Assumptions

It is important to recognise that an ageing and growing population, living longer with more complexity and comorbidity is likely to continue to drive demand across many health and social care services. It is also important to note that Health and Social Care is, and has been for many years, a system under pressure. This pressure means that the system is vulnerable: capacity which may be realised by new ways of working is susceptible to being taken up quickly by demand previously unknown or excluded from the system by virtue of the system being 'full' or at its capacity.

Many communities, families, staff groups and services have been hit hard by the effects of the global coronavirus pandemic. Going forward, many will likely be affected by a rise in the cost of living and other economic consequences which will no doubt have its own impact on people's health and wellbeing. For all these reason and others, it demonstrates that a focus exclusively on output data in a single part of the system - such as number of people in the services, demand, budget expenditure or use of care - are not in themselves adequate measures of the effectiveness of this work. The rising tide of complexity and demand, driven by multiple factors will raise all boats; our data must show we are managing our resources optimally through evidence-based approaches backed by good data and intelligence.

This work was completed within a relatively short period of time and as such has not had the luxury of exploring all the possibilities, opportunities, or potential of the current data. Irrespective of the success of the approach, or its scalability, we must dig deeper and use our current data and intelligence more creatively and effectively to see the changes in our use of this precious resource and the intended and unintended consequences in the delivery of greater wellbeing for the people and families in our communities.

Observable Impacts

In 2021 a report was compiled by NDTi based on a selection of the English Social Care data returns[3], which looked at whether there were any visible signs of change in the recorded outcomes and outputs for those Local Authorities in England where they had a track record of Community Based Approaches.

This report, entitled *Observable Impacts of Community Led Support: A summary of six opportunities and impacts of CLS Strength Based & Place Based working in Adult Social Care,* compared a cohort of early adopters of NDTi's Community Led Support Programme to the other English local authorities in a number of areas which were deemed susceptible to the positive impacts of Community Based Approaches.

Purely on the basis of the data, a number of positive markers were evident in both outcomes and outputs for a cohort of early adopters of Community Based Approaches. The relationship between these positive markers and the local authorities use of resources, practice and focus was tested through conversations with senior leaders.

The data appeared to show that the early adopters demonstrated differences in the output and outcome data markers around both the proportions of contacts received from their communities and the ability to find resolutions to the early requests for support from within these same communities. The report highlighted consistent and sustained increases in self-reported quality of life, choice and control and increased social contact.

The *Observable Impacts* report concluded that something 'different' appears to be happening when the principles of community led support, and by extension Strength Based Community Approaches, are applied consistently in the area of care and support. Those differences are centred around a quicker, community-based approaches which supported wellbeing and were realising measurable improvements in quality of life.

It is hoped that the content and approach demonstrated here is this report can help to take this thinking another step forward. In an information rich world such as health and social care we must continue to search for the link between practice and outcomes, outcomes and wellbeing, wellbeing and resilience and resilience and sustainability in our services.

[3] Short and Long Term Care Activity Data (SALT) and ASCOF data.

Approach and Methodology

General Approach

In order to start to explore the data, an approach was needed to understand the purpose and activities, the problems to be solved and the solutions employed by the new ways of working. NDTi's Community Led Support (CLS) Programme[4] employs a *Staged Approach* within its Measurement Evaluation and Learning offer, which it employs with local authorities across the United Kingdom to surface Strategic Intent and Systems thinking. This approach sets out to deliberately expose the system and any assumptions and identify potential new or additional measures to support learning (Tab1).

Stage	Description
Stage 1 Strategic Intent	I. Discuss and identify mission, vision & strategy and agree upon the focus area of Community Led Support in the business.
Stage 2 Introducing the Measures & Logic Modelling	I. Articulate a logic model of the application of Community Led Support in the agreed area. II. Identify and agree upon measures - financial and nonfinancial - against scorecard areas to show balance of experiential, process & economic.
Stage 3 Baselining, analysis and Strategy / Delivery Mapping	I. Collect retrospective scorecard data over an extended period to show current position (baseline) and trajectory. II. Analyse for connections correlation and causation between data. III. Convert Logic Model into a Strategy/Delivery Map.
Stage 4 Framework delivery	I. Update financial and nonfinancial measures in scorecard format as necessary. II. Agree and create data and report with timings and formats suitable for staff at each organisational level to communicate progress, enhance delivery, improve practice and performance and support learning.
Stage 5 Communication	I. Communicate the mission, vision & strategy to all stakeholders, showing the learning and evidence that shows how practice and behaviours link to key outcomes and desired strategic impacts. II. Communicate the expectations around engagement with the data and the framework in terms of learning and improvement.

Figure 1: Community Led Support Staged Approach to Measurement Evaluation and Learning (NDTi).

[4] https://www.ndti.org.uk/change-and-development/community-led-support

This methodology was adapted to match the timescales and scope of this work, working with an identified HSCP though the first 2 stages of the process and partially through the 3rd stage. The work concluded at Stage 3.2 as further parts of the approach focussed on practical delivery of data delivery and changes, which is out of scope of this report.

Stage 3 itself was adapted to look both at how locally available data might be employed differently, and also looked at some of the current national data returns to see how far they might support measurement and learning around impact and effects in their current formats.

Specific HSPC Approach and Outputs:

Stage 1 (I): Strategic Intent

Conversations were held with key individuals at the HSCP about the community led and preventative approaches. The purpose was to explore the nature of the work, why this approach was chosen and broadly what sorts of impacts, gains or changes were expected.

This conversation confirmed that the approach was a whole system intent to maintain independence, wellbeing, and Quality-of-Life for as long as possible through building and supporting better community networks for all. It was articulated that the use of community assets and opportunities and the signposting and prescribing of these at certain key points in people's life would help maintain wellbeing and as such keep people out of formal care for longer.

Current examples, such as different chronological aging of people from different socio-economic backgrounds were brought forward to show the link between opportunities and decline in health and wellbeing. The evidence for this is already available and seen locally and nationally in the data from different places, where people living in poorer regions and neighbourhoods were displaying poorer health and care outcomes and, as a result, requiring earlier and more pronounced formal intervention to support them.

This thinking was articulated in the form of a *Health and Quality-of-Life curve* (fig.2 below), which describes a trend over time of declining health and quality of life. At a given point in the curve (determined by need or eligibility) formal services will be required to intervene to offer support to bridge the gap between what people need to be able to achieve and what they can do for themselves.

The graph was populated with two curves: one optimal (green) showing a desired trajectory of maintaining health and Quality-of-Life for as long as possible, with the inevitable decline happening later, and one sub-optimal (red) showing an earlier decline.

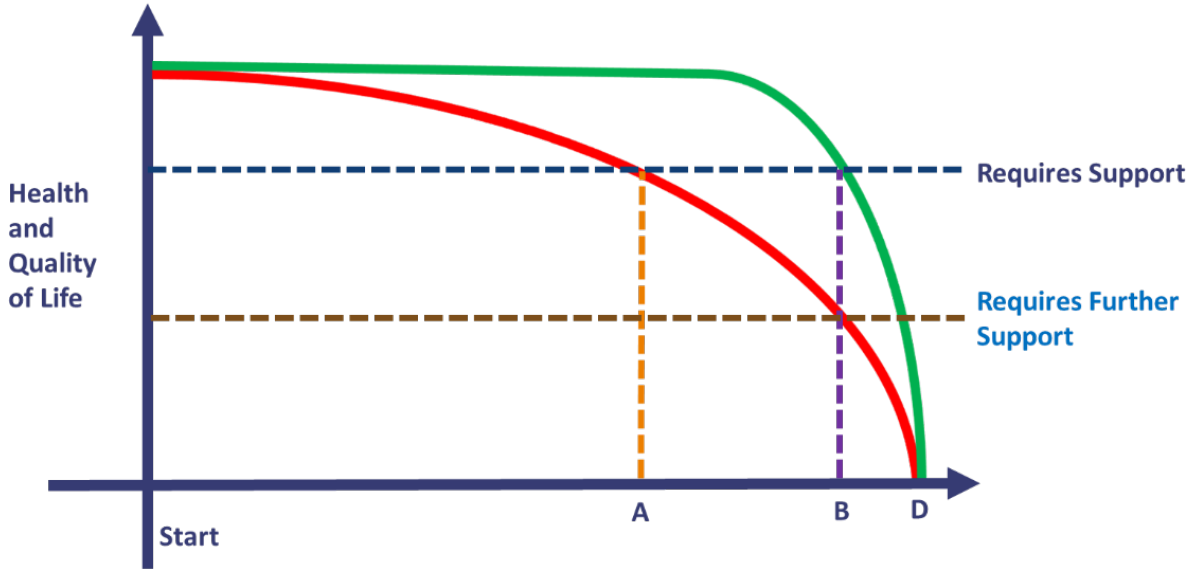

Figure 2: Health and Quality-of-Life Curve (unannotated).

Community Asset Based approaches and preventative measures could be seen to be included in the interventions (and investments) in the north of the graph, being approaches which seek to maintain health and Quality-of-Life outside formal services.

Equally, strength-based and outcomes-focussed practice (which includes Community-based Asset Based Approaches in concert with formal care) could equally be seen in the south of the graph after people have crossed any threshold that leads them into formal care, the use of which supports the ongoing trajectory of their health and Quality-of-Life at an optimal level.

Stage 2 (I): Articulating Logic Models

The conversation with the HSCP showed they had a clear delivery strategy for their Community Asset Based Approaches, an excellent understanding of coverage, of where and how resources were deployed and 'what good looks like' in the practice and delivery.

Previous work in this area has given us some simple logic modelling that applies to the north and south of the *Health and Quality-of-Life curve Graph,* specifically in the operational expectations of how this work seeks to delay or prevent the need for formal services and, where formal services are required, the ongoing use of Community-based Assets could support people to maintain good lives, what matters to them and how this might mitigate the need for care due to avoidable decline in health and independence.

Simplified Logic	Inputs (what happens)	Outputs (the difference)	Outcomes (the result)	*System impact*

	Community hubs enable strengths based early conversations in the community Joined up working across partners on the ground streamlining process	More people seen more quickly in community or in response to a request for support via customer services.	More people connected with community supports & activities Issues resolved for people in a timely and effective way Reduced isolation	*Reduced use of resources involved in assessment & planning* *Fewer crisis responses* *Reduced numbers in system* *Increased Quality-of-Life reported*
	There is a link between this activity and the use of residential care and use of social care following hospital discharge. Note, there is no direct link with a reduction in the use of homecare at this point.			

Figure 3: Simplified Model of hub Conversations / Joint Working on the cusp of care (Prevention / Prior to Formal Care).

	Inputs (what happens)	Outputs (the difference)	Outcomes (the result)	*System impact*
Simplified Logic Model	Strengths based conversations happen as part of assessment, support planning and review activity.	More people achieving outcomes without recourse to paid support or with a mix of natural and paid support. 'Smart' reviewing is proportionate to complexity and cost of package.	Increased community connections, resilience and quality of life. Targeted use of resources in planning and review. Strength-based practice is embedded in community teams.	*Increased reported quality of life* *Reduced demand on paid support to achieve outcomes.* Connecting plans with quality and efficacy of provision
	This approach is supported by Strengths based practice frameworks but is less supported by current case management system configuration. The connections between plan and outcomes are essential to inform quality			

Figure 4: Simplified Model of Strength-based practice (maintaining Community options to meet outcomes with Formal care).

Stage 2 (II): Identification and agreement of relevant measures

The combination of the *Health and Quality-of-Life curve* and the two logic models displayed a number of potential areas of effect that are demonstrable and measurable to test if these were visible from within the data. It also highlighted areas which may not be measurable from within the existing data but were likely to show the effects of this method of working.

A long list of these measures was created (*See Fig. 5 Long list of Measures arising from Strategic Overview and Logic Modelling conversations)*

Effect / Impact	Potential Evidence / Measures

Wider Prevention Opportunities and Strength-based Approaches with Community connections should successfully drive up no further action at first request to ASC. A secondary measure of this effectiveness could be seen in the number of people who, following a strength-based intervention that led to signposting or no further action from ASC, return to request further formal support.	Number of "No Further action" or signposting at front door. Number of immediate repeat requests for support (Within 6 weeks?) Economic value of delay to formal services / economic costs of community alternatives.
While overall entry to the system may rise, due to rising complexity and aging populations requiring formal support of ASC, it is plausible to assume that enhanced prevention and opportunity would delay the onset age of demand. A system that seeks sustainability would need to seek to narrow the gap between an overall trend in rising life expectancy vs. a stagnation in the age of entry to services. A system that seeks equity and equality would look to narrow the gap between differences in this age for different economic areas, ethnic groups, genders etc.	Mean Age at entry into system. Economic value of delay to formal services / economic costs of community alternatives. Sustainability within the system shown through narrowing the gap between life expectancy and system entry . Narrowing the gap between wards / postcodes / lower-level super output areas, ethnicity, etc. entry ages.
While overall use of care may continue to rise, due to rising complexity and aging populations requiring formal support of ASC, it is plausible to assume that enhanced prevention and opportunity would influence the volume of care provided at first entry to the system.	Mean Entry package of care size (hours).
During the term of any package of care, the overall trend in volume of formal care will inevitably be upwards as age, frailty, and complexity rise. The impact of our work, through the blend in formal services a clear focus on outcomes that prevent crises, maximise independence and support Quality-of-Life should influence this profile.	Rate of growth in care over time (hours/input). The economic value of difference in use of care between observed and baseline / counterfactual.
A strength-based and outcomes-focused approach should lead to a clearer understanding of when and how to review cases based on their cost and complexity. Clarity around the human and systemic costs of crises avoidance should lead organisations to behave in a way that puts resource to use for maximum effect not a one size fits all approach.	Cost and complexity in review / planned and unplanned reviews, and consequences. A reduction in unplanned (crisis) reviews as well as increase in planned reviews is economical in terms of use of professional time and care. Links to rate of growth in package of care (above).
One of the observed effects of a change in the distribution of formal and information support and service, coupled to the slowing rate of change in formal provision, is a shifting of the mean age into more acute modes of support.	Mean age at care change of location due to crisis or condition (e.g., end of life pathway, palliative care, Nursing and residential).
A focus on people's outcomes, their wellbeing and better connections should lead to a shift in the self-reported Quality-of-Life for those who present to the system. Beyond the obvious benefits of the individual, increases to Quality-of-Life is linked higher levels of resilience and engagement in community, and ultimately to reduced use of health and care services.	Quality-of-Life indicators Self-reported improvements in safety, connectiveness, wellbeing, ability. Potential economic value of use of services.

Figure 5: Long list of Measures arising from Strategic Overview and Logic Modelling conversations

Stage 3 (I) & (II): Baselining and Analysis

Based on the developed long list of possible measures, a shortlist of measures was created based on known available data in the local HSCP system. This was put forward to test the capacity of the local HSCP to surface, analyse and report on whether these were viable measures, and what they were indicating.

Potential Evidence / Measures	Data analysis thinking	Data Source / Potential Data Sources
Repeat request for support and No Further action at front door.	**How far can we see that the targeting of the conversations is having the effect of successful Demand management?** How far can data show us that we avoid repeat conversations either due to quality of conversation (practice) or quality of signposted options (commissioning)? Is there a statistically significant correlation between hub coverage and demand management geographically?	Data from the hubs. Data from Entry to Support Planning . Services.
Mean Age at entry into system.	While overall entry to the system may rise, due to rising complexity and aging populations requiring formal support of ASC, it is plausible to assume that enhanced prevention and opportunity would **delay the onset age of demand.** Comparison of current local Mean Age at entry into system to: Previous (baseline) Mean Age at entry into system (local data only) Current Mean Age at entry into system vs. Location of Hubs (historical and present) Other similar authorities (where known).	Date of Birth Date of First Time Entry to Social Care system.
Mean Entry package of care size (hours).	While overall use of care may continue to rise, due to rising complexity and aging populations requiring formal support of ASC, it is plausible to assume that enhanced prevention and opportunity would **influence the volume of care provided at first entry to the system.** Comparison of current local Mean Entry package of care size (hours) to: Previous (baseline) Mean Entry package of care size (hours) local data only) Current Mean Entry package of care size (hours). Location of Hubs (historical and present).	Date of Birth Date of First Time Entry to Social Care system. Size of initial package of care (formal in hours).
Rate of growth in care over time (hours/input).	During the term of any package of care, the overall trend in volume of formal care will inevitably be upwards as age, frailty, and complexity rise. The impact of our work, through the blend in formal services a clear focus on outcomes that prevent crises, maximise independence and support Quality-of-Life should influence this profile.	Date of Birth Date of First Time Entry to Social Care system. Size of initial package of care (formal in hours).

	Comparison of the rate of change (R squared) of packaged of care for each group of demographics to Previous (baseline R squared).	Size of package of care (annual)
Cost and complexity in review / planned and unplanned reviews, and consequences.	A strength-based and outcomes-focused approach should lead to a clearer understanding of **when and how to review cases based on their cost and complexity.** This should allow a clearer view of cases which need closer attention and avoid unnecessary crises which can have significant personal consequences and require more resource to unpick or manage longer term.	Proportion of Planned vs unplanned reviews. Sequalae to planned and unplanned reviews re: change of location, or greater use of care. Reason for unplanned reviews.
Mean age at care change of location due to crisis or condition (e.g., end of life pathway, palliative care, Nursing and residential).	One of the observed effects of a change in the distribution of formal and information support and service, coupled to the slowing rate of change in formal provision, is a **shifting of the mean age into more acute modes of support.**	Date of Birth Date of Change of Location to more acute care.

Figure 6: Short List of Local Data analysis opportunities.

In additional to the local shortlist, a separate list was created that had the potential to reviewed or analysed against the national data provided by the HSCP on an annual or biennial basis which may have potential to extend our learning about the effects of Community Asset based and Strength-based practice.

Potential Evidence / Measures	Data analysis thinking	Data Source / Potential Data Sources
Self-Reported Quality-of-Life Measures.	A focus on people's outcomes, their wellbeing and better connections should lead to a shift in the self-reported Quality-of-Life for those who present to the system.	Health and Social Care Experience Survey
System wide demand.	Beyond the obvious benefits of the individual, increases to Quality-of-Life is linked higher levels of resilience and engagement in community, and ultimately to reduced use of health and care services.	

Figure 7: Short List of National Data analysis opportunities.

Findings and Learnings

As learning from implementation is shared we anticipate further information about local learning and insights to follow in due course.

National Data Source Meta Analysis:

A review was undertaken of the file specifications for the local authority national returns and a meta-analysis of the opportunities to derive learning was undertaken. It was not possible to undertake an analysis of the data beyond what was outlined at the local HSCP data analysis level; however, this meta- analysis looks to see how much of this can be replicated locally for all HSCP from the returns, and what can be replicated and analysed nationally at the centre to learn about community asset and strength-based effects on demand and quality of life.

The focus of this meta-analysis was on:

- The SC2 Returns; and
- The Health and Social Care Experience Survey.

The SC2 Returns

The SC2 returns are submitted to the SC2 data by each HSCP / Local Authority on a quarterly basis. The SC2 submission contains 7 files:

1. DEMOGRAPHIC: Demographic information for clients who started to receive social care since the previous submission, i.e., the information has not been submitted previously for the client.
2. CLIENT: The Client Information for the period specified.
3. SDS: The self-directed support selected during the period specified.
4. HOMECARE: The home care and reablement given during the period specified.
5. EQUIPMENT: The community alarm or telecare service active during the period specified.
6. CAREHOME: Care given in a care home during the period specified
7. IORN: The Indicator of relative Need group(s) of the client during the period specified.

A full description of the formats for file exchange and the contents are available via the ISD Scotland website (see references) and will not be reproduced here.

The following meta-analysis shows that its is possible to create a data set from the SC2 returns that can establish a source data set to replicate many of the areas identified as important when looking for the effects of community-based approaches and strength-based prevention.

Data Item	Description	Analysis / Data Use	SC2 File Origin
Social Care ID	The identifier used within the Local Authority to uniquely identify a client. Must be the same ID as used for the Social Care Survey.	Exists in all files and acts a primary key to connect all files. Creates an individual count	ALL
CHI Number	The identifier used by NHS Scotland to uniquely identify a patient.	Allows potential links to other data files ion the system to track wider system usage over time.	Demographic
Postcode	The client's postcode of residence.	Supports analysis and targeting to improve equality of outcomes.	Demographic
Date of Birth	The client's full date of birth.	Coupled with Service entry date, data of death etc. gives life expectancy and mean age of entry / exit from services.	Demographic
Gender	The gender of the client, e.g., 1 = Male, 2 = Female See the Social Care Dataset Definitions and Recording Guidance for valid codes.	Supports analysis and targeting to improve equality of outcomes.	Demographic
Ethnic Group	The client's ethnic group. See the Social Care Dataset Definitions and Recording Guidance for valid codes.	Supports analysis and targeting to improve equality of outcomes.	Demographic
Financial Year	The financial year the quarter recorded belongs to, e.g., 2016 will be submitted for the financial year 2016/2017.	Coupled with DOB can establish mean age of change in status dependent on file.	ALL
Financial Quarter	The financial quarter being reported. Must not be recorded when the period type is financial year.	Coupled with DOB can establish mean age of change in status dependent on file.	ALL
Primary NEED (Details of each recorded in CLIENT FILE)	Indicates if the client belongs to a specific 'need' related client/service user group. The value can be 0 or 1 where 1 indicates that the client belongs to that client/service user group.	Supports analysis and targeting to improve equality of outcomes.	CLIENT
SDS Options	Indicates which SDS option was selected for the care package.	Supports analysis and targeting to improve equality of outcomes.	SDS
SDS Start Date	The self-directed support start date of the care package.	Coupled with Service entry date, data of death etc. gives life expectancy and mean age of entry / exit from services.	SDS

	The support may have started prior to the quarter being reported.		
SDS End Date	The self-directed support end date of the care package. This can be null if the support has not yet finished.	Coupled with Service entry date, data of death etc. gives life expectancy and mean age of entry / exit from services.	SDS
SDS Needs	Indicates which SDS is needed for personal care for the care package.	Coupled with Service entry date, data of death etc. gives life expectancy and mean age of entry / exit from services.	SDS
SDS Support Mechanism	Indicates what the SDS support mechanism for the care package is.	Coupled with DOB can establish mean age of change in status dependent on file. Coupled with Service entry date, data of death etc. gives life expectancy and mean age of entry / exit from services.	SDS
SDS Net & Gross Values	The SDS value for SDS for the care package delivered during the reporting period specified. Valid to two decimal places.	Allows tracking of rising costs and values.	SDS
Home Care Service Start Date	The date the home care service started. The home care may have started prior to the period being reported.	Coupled with Service entry date, data of death etc. gives life expectancy and mean age of entry / exit from services.	HOME CARE
Home Care Service End Date	The date the home care service ended. This can be null if the client is still receiving the home care.	Coupled with Service entry date, data of death etc. gives life expectancy and mean age of entry / exit from services.	HOME CARE
Home Care Hours	The number of hours of the home care service the client received or was planned to receive during the period specified. Valid to two decimal places.	Tracked over time gives information about rate of change in need.	HOME CARE
Care Home Admission Date	The date the client was admitted to the care home. The client may have been admitted prior to the period being reported.	Date	CARE HOME
Care Home Discharge Date	The date the client was discharged from the care home. This can be null if the client is still in the care home at the end of the period.	Coupled with Service entry date, data of death etc. gives life expectancy and mean age of entry / exit from services.	CARE HOME
Nursing Care Provision	Indicates if the client needs nursing care. The value can be 0 or 1 where 1 indicates that nursing care is required.	Coupled with Service entry date, data of death etc. gives life expectancy and mean age of entry / exit from services.	CARE HOME
Funding Type	The funding type received by clients who self-fund their care home placement, e.g., Free nursing care.	Supports analysis and targeting to improve equality of outcomes.	CARE HOME

	See the Social Care Dataset Definitions and Recording Guidance for valid codes.		
IoRN Group	The Indicator of Relative Need (IoRN) group assigned to the client. See the Social Care Dataset Definitions and Recording Guidance for valid codes.	Coupled with DOB can establish mean age of change in status dependent on file. Coupled with Service entry date, data of death etc. gives life expectancy and mean age of entry / exit from services.	IoRN
IoRN Group Date	Date of IoRN group allocation.	Coupled with DOB can establish mean age of change in status dependent on file. Coupled with Service entry date, data of death etc. gives life expectancy and mean age of entry / exit from services.	IoRN

Figure 8: Data analysis opportunities from SC2 Return.

It is believed that over time and across all areas, an analysis of this data set would allow a tracking of the expected changes described for any single HSCP and also allow comparisons between HSCP areas.

The Health and Social Care Experience Survey

The Health & Care Experience Survey is part of a suite of national surveys which aim to provide local and national information on the quality of health and care services from the perspective of those who are using them. The Health & Care Experience Survey itself covers GP services, Out of Hours care, social care and caring responsibilities and is undertaken every two years.

The survey contains five themed areas:

- *The GP Practice,*
- *Treatment or Advice from the GP practice,*
- *Out of Hours Health Care,*
- *Care Support and Help with Everyday Living, and*
- *Caring Responsibilities.*

Our work focussed on the last two of the five areas: *Care Support and Help with Everyday Living,* and *Caring Responsibilities and in particular these questions:*

Care Support and Help with Everyday Living	*Caring Responsibilities*
I was aware of the help, care, and support options available to me	I have a good balance between caring and other things in my life
had a say in how my help, care or support was provided	Caring has had a negative impact on my health and wellbeing
People took account of the things that mattered to me	I have a say in services provided for the person(s) I look after

was treated with compassion and understanding	Local services are well coordinated for the person(s) I look after
felt safe	I feel supported to continue caring
was supported to live as independently as possible	
My health, support and care services seemed to be well coordinated	
The help, care or support improved or maintained my quality of life	
Overall, how would you rate your help, care, or support services? Please exclude the care and help you get from friends and family.	

Data and analysis from these returns is available[5] and will not be reproduced here. The sample methodology stated is: *"PHS selected names and addresses at random from all those who are registered with a GP Practice in Scotland, live at a Scottish address and are aged 17 and over"* (Health & Care Experience Survey 2021 Privacy Notice)

The questions within the survey have a clear connection to the work that is described within the Health and Wellbeing Life Curve and the subsequent areas of Community-based Asset work. The questions arising are:

- Whether these questions could be used to formulate a Social Care Related Quality-of-Life measure?
- Whether those individuals randomly selected to receive the survey as part of the sample will have direct experience of the practices and behaviours of Community Asset Based approaches or Strength-based Practice which contains Community options?
- Whether enough people with experience of the practices and behaviours of Community Asset Based approaches or Strength-based Practice which contains Community options are selected to draw statistically significant and comparable data?
- Whether, with lawful and appropriate adaptations to the sampling methodology, more value can be realised from this exercise by deliberately targeting people who give their consent or are known to have received Community Asset Based approaches or Strength-based Practice which contains Community options?

[5] https://publichealthscotland.scot/publications/health-and-care-experience-survey/health-and-care-experience-survey-2020/introduction/

Gap Analysis

Areas of opportunity will be outlined in the report's *Opportunities, Conclusions & Recommendations* section, however the process has shown there some gaps in the data. Some of these gaps have the potential to be bridged, while others may need a view as to how they might be bridged without overkill or overloading of the system in the creation of unwieldy data collections. These areas are as follows:

Understanding the targeting and reach of early intervention and prevention (process level). Given that recording of details for people really only happens when they cross the threshold into formal services – for good reason - it can be difficult to see how early conversations are assured that both the practice and opportunities are optimal at an operational level. It is not necessarily desirable to create administration to track prevention and good conversations, and the proxy measure might be enough to determine whether these are broadly effective.

Understanding the impact of Intervention and prevention on Quality-of-Life Outcomes. As outlined above the nature of sampling for the Health and Care Experience Survey may not, at this moment in time, be able to track Quality-of-Life gains that are related to this practice. If specific sampling is undertaken and the data is able to be disaggregated the data after it is collected this would be able to do this. There may also be the potential to include some Quality-of-Life questions or statements in the care review processes to connect specific plans, interventions, approaches and services more closely to Quality-of-Life gains.

Opportunities, Conclusions & Recommendations

This work has been limited in its scope by the virtue of the time pressures but has shown that there is significant potential in the current data to evidence the impact of work in prevention, community asset-based approaches and strength-based practices. The data and information collected and used in our organisations is a hugely valuable and yet underutilised resource. When aligned properly it can support, empower, and drive practice improvement, learning and change. Where data is underused or not aligned and understood properly it can also frustrate and block innovation and creativity, limit learning around resource, behaviours and impacts, and even result in perverse behaviours in pursuit of targets.

Transformational change is especially vulnerable to the effects of misaligned data measures. This is because new ways of working require a balance of favourable organisational factors for success: a trinity of good leadership, cultural change within the workforce and better use of data. Data and information designed to support old ways of working will often require revisiting and reworking to tell a story of the impacts of new ways of working. Our work has exposed barriers around the use of data at a local level.

As we understand the value of data and its potential to become information and organisational intelligence, there is a need to invest in the capacity and skills in the local systems. Empowering staff and local leaders to take control and be confident in the use and analysis of data is also a vital part of this equation. Practice leaders can use the information and insights that come from this work to improve delivery and focus on experience and quality in relations to outcomes. Improvement leads can seek to close the gaps between optimal and sub-optimal outcomes and resource use through coproduction and collaboration with stakeholders and other system leaders. Operational and Strategic managers can make decisions about allocation of scarce resources to best effect.

Systems thinkers and data support become an essential element of the local resource for both frontline staff and system leadership: The process of identifying impacts and practice in a complex, dynamic and quickly changing environment such as health and social care is best supported by curious and skilled system thinkers working alongside the business, supporting strategic leaders and operational delivery to give the best chance of learning and sustaining an evidenced based approach.

The fact that client level data is collated locally and utilised nationally and therefore can be connected across services is extremely powerful and holds enormous potential to monitor impacts on the entire health and social care system. It is an excellent foundation which, with the right investment in shaping and understanding the data, will allow National leaders as well as Strategic system leaders to evaluate new ways of working and new models of delivery in terms of their impact on the whole system.

While measurement through process and financial data alone cannot and should not be the sole arbitrator of success in this field, and if we are to conclude that a focus on outcomes and wellbeing can drive the broader picture of health and resilience, better use of the outcomes data must be made.

The opportunities shown in this work would suggest that it is time for a broader, deeper, and more detailed conversation with all systems partners to identify all potential opportunities and impacts of the new ways of working for People, Workforce and Organisations. Something similar to the approach outlined here can be used to drive out assumptions, connection, and opportunities to measure, evidence, learn and communicate. Data and information should be used to support learning about what works and why, rather than being seen as a systemic 'end in itself'.

The following are key recommendations and conclusions arising from the work so far to realise opportunities and potential to connect data to the goals of outcomes, improvement and sustainability:

1. **There should be investment made in order to realise the potential of data at a Local level:**

   To support strategic managers, system leaders and frontline staff, an investment must be made in the capacity and skills at a local level to shape the wealth of currently available data into information and intelligence. Our work has shown that there is enormous potential to tell the story of this work and connect the golden thread of causations from strategy to practice, but that this needs the time and effort and constant engagement of technical capable system thinkers who work hand in glove with, rather than at arm's length from, the health and social care delivery partners.

2. **Opportunity should be taken to connect and expand current National data to explore what works across the whole system, and this learning should be shared widely:**

   Within any complex system such as health and social care, changes in one part of the system inevitably impact other either for good or ill. The structure of data at a client level puts the Scottish HSPCs in an enviable position to work collaboratively and intelligently to gauge the effects of new models, prevention, demand management and improved outcomes across much larger system boundary. As data and evidence emerges at this level, effective decisions can be made to support use of resources across the system.

3. **More must be made of the reported Outcomes data:**

As described above, as a central part of national strategy as well as a fundamental element of the wellbeing that drives sustainability, consideration should be given to the current use of outcomes data for social care. Specifically, could existing questions and data used to formulate a Social Care Related Quality-of-Life measure? Could sampling be altered to ensure individuals with direct experience of the practices and behaviours of Community Asset Based approaches be included? Whether social care reviews could be sensitively designed to include simple questions about how care and support help individuals achieve their desired outcomes?

4. **Information on 'what works' should be part of Quality and Improvement locally and nationally:**

   Outcomes, Experiential, and Quality-of-Life data, such as that captured in the Health and Care Experience Survey has the potential to be used to triangulate and enhance the learning for HSCPs engaged in this work. The Person level data captured across the system has huge potential to tell a story of equity and improvement. It has the potential to target those most in need and to close the gap between those with the best outcomes and those who are left behind. Wherever possible, the information that HSPCs are able to show about what drives better outcomes should be part of all relevant Quality Improvement and Inspection Criteria.

5. **There must be a focus on Measurement for Learning:**

   While recognising the importance of data in our journey for evidence, innovation, and improvement, we must ensure that we do not focus on these to the exclusion of everything else, but rather on the practice and quality factors that drive these measures. Organisations should be supported to be curious about their data and involve their staff in investigating the real causes and linkages between behaviours and impacts. Such an approach would support real learning and progression in these areas.

Appendix 1: References

Item	Further details
What matters to you?	Why ask what matters? – What matters to you?
National health and wellbeing outcomes framework	https://www.gov.scot/publications/national-health-wellbeing-outcomes-framework/pages/5/
National health and wellbeing outcomes framework (Overview documents)	https://www.gov.scot/publications/national-health-wellbeing-outcomes-framework/documents/
Independent Review of Adult Social Care	https://www.gov.scot/publications/independent-review-adult-social-care-scotland/pages/1/
SC2 Data Mart File Specification	https://www.isdscotland.org/Health-Topics/Health-and-Social-Community-Care/Health-and-Social-Care-Integration/Dataset/_docs/Source-SC2-Data-Specification-v1-0.pdf
English National Returns Data	Adult Social Care Activity and Finance Report, England - 2020-21 - NHS Digital
Observable Impacts of Community Led Support	https://www.ndti.org.uk/resources/publication/observable-impacts-of-community-led-support