SCOTTISH EXECUTIVE

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Chief Executives, Local Authorities
Chief Executives, NHS Boards
General Managers, Community Health Partnerships
Directors of Social Work/Chief Social Work Officers
Directors of Finance, Local Authorities
Directors of Finance, NHS Boards
Directors of Housing, Local Authorities
Chief Executive, Communities Scotland
Relevant professional, voluntary and other organisations
Joint Future Managers

Dear Colleague

JOINT PERFORMANCE INFORMATION AND ASSESSMENT FRAMEWORK (JPIAF) FOR 2006-07

Introduction

1. This circular sets out the national partners' expectations for assessing performance in JPIAF 2006-07 and lays the foundations for 2007-08. In recognition of the direction of travel of the Outcomes Group, JPIAF 2006-07 will, for the information relating to 2006-07, have a similar form and focus to JPIAF 2005-06 but will focus solely on reporting joint performance over 2006-07. **No information will be sought at this stage on LITs for 2007-08, pending the results of the Outcomes Group**. (The likelihood is that local partnerships will be invited to draw up LITs for 2007-08 from October 2007, but partnerships may not be required to submit these to the Executive.)

Context

JPIAF 2005-06

2. Joint performance in 2005-06 has improved over that for 2004-05. Although there is still room for improvement in some areas, partnerships generally showed better understanding of whole systems working and outcomes. The national picture shows that about one third of partnerships demonstrated **good progress** in joint working. More than half of partnerships are now making **steady progress** and only a small number were evaluated as **improvement required**. While progress is being made, it is not felt to be fast enough and more consistency is needed, as indicated below.

3. The outcomes approach is now at the centre of Joint Future. While Local Improvement Targets have been the key driver of progress towards the outcomes focus in Community Care, the national partnership is concerned at the level of progress and the lack of consistency on performance between partnerships. The Joint Implementation and Advisory Group therefore established a National Outcomes Project to develop on outcomes approach that will deliver improved results. The Project Board, chaired by Tim Davison (Chief Executive, NHS Lanarkshire), is tasked with taking the outcomes approach to a new level and with examining the scope to reduce the reporting burdens more generally.

4. The National Outcomes Project Board commissioned Aspiren, a firm of management consultants, to work with the NHS and local authorities, and other stakeholders to develop on a fast track basis a performance framework for all community care groups. This is likely to comprise 4 national outcomes, about 20 high level national performance measures and a number of national targets, based on the visions in *Delivering for Health*, *Changing Lives and Joint Future*. The consultation is taking place at the moment – and can be accessed at http://jf.aspiren.com/forums2/.

5. It is envisaged that Local Improvement Targets will continue to underpin that national perspective, but may need to be re focussed. It is intended that the new outcomes arrangements will be implemented in a staged way, with initial reporting in 2007-08.

JPIAF 2006-07

6. We are aiming to link the current arrangements with the expected direction of travel on outcomes - so JPIAF 2006-07 is more about current than future performance, while maintaining a consistent direction and providing some of the information for future needs. The scope of JPIAF 2006-07 is influenced by:

- the arrangements for JPIAF 2005-06;
- discussions about the content of individual indicators;
- the developing outcomes approach.

7. JPIAF 2006-07 is therefore a bridge between the full coverage in JPIAF 2005-06 and the new reporting arrangements on outcomes likely to start in 2007-08. JPIAF 2006-07 is less extensive than JPIAF 2005-06 (no LITs for 2007-08) and indicators 6 and 8 have been changed in the light of the emerging outcomes approach and other factors. 2007-08 will also be a transitional year, being the start of the emerging outcomes approach focusing on national outcomes, performance measures and targets. We will be working with partnerships to help them make the transition from existing reporting streams (including JPIAF) to new forms of reporting joint performance.

8. For the most part, JPIAF 2006-07 will take on the form of JPIAF 2005-06. The exception will be that there is no requirement at this stage to submit LITs for 2007-08, as described above. That obviously impacts for the moment on the intention to extend Local Improvement Targets to cover all community care groups from 2007/08. The developing outcomes agenda has cut across that for the time being, but we expect to return to it when the Outcomes Group reports in March. There are also changes within Indicators 6, 8 and 10. In short:

- JPIAF 6 is refocused on waiting times, and the reporting period will be October-December 2006.
- JPIAF 8 is refocused on access to a small number of key services.
- JPIAF 10 covers the same broad areas, but will incorporate for the first time a self-assessment dimension.
- JPIAF 11 will focus only on performance against targets for 2006-07.

9. We continue to expect partnerships to demonstrate a holistic view, with strong links between JPIAF 10 and local action (usually in LITs), and between JPIAF 6, 8 and LITs).

10. The guidance for each indicator has been reviewed and updated. In addition:

- Each JPIAF indicator again includes a reporting template and evaluation criteria;

- Partnerships are asked to provide focused information, using the templates, with a minimum of supporting information. Concentrating on specific data and reducing the volume of information is intended to reduce the reporting burden on partnerships and to help them focus their reports;

- Partnerships should contact the Joint Future Unit for support and clarification, as required.

Reporting Timeframe

11. Last year we extended the date for final submission of the performance indicators, which was welcomed by partnerships. The later submission date will therefore be maintained. **Partnerships should therefore return the information required for JPIAF 2006-07 to Judith.King@scotland.gsi.gov.uk or Stephen.Young@scotland.gsi.gov.uk at the Joint Future Unit no later than 18 May 2007.** Please note that submissions should be by e-mail only and that no extension to this submission date will be possible.

JPIAF 2006-07: Performance Indicators

12. JPIAF 2006-07 aims to continue the progress made towards developing the whole systems and outcomes approach in joint working. It should continue to build on the development and implementation of Community Health Partnerships (CHPs), and should underpin NHS Local Delivery Plans and the work of the Social Work Inspection Agency.

13. JPIAF 2006-07 will consist of 4 performance indicators. The annexes to this circular set out the information required, guidance notes, and the templates which local partnerships must use for reporting on each indicator:-

Annex A	• JPIAF 10	Whole System Indicator
Annex B	• JPIAF 11	Performance against Local Improvement Targets (LITs) for 2006-07
Annex C	• JPIAF 6	Single Shared Assessment (SSA): waiting times
Annex D	• JPIAF 8	Access to resources, following SSA, across agency boundaries
Annex E		Named contacts for the JPIAF Indicators

JPIAF 10 (Whole Systems Indicator)

14. JPIAF 10 is a key part of the outcomes approach. At a seminar in November, it was agreed that JPIAF 10 should continue in its current form for the time being, pending development of the outcomes approach generally. If it remains, refinement will be expected. Meanwhile the seminar in November agreed to introduce self-assessment in 2006-07.

15. The principles which underpin JPIAF 10 remain. Partnerships will be asked to demonstrate their understanding of whole systems working and their application of that to strategic developments. The Whole Systems Indicator Working Group recognises the need to refine further the input data of JPIAF 10. Annex A sets out detailed guidance for partnerships: they are not expected to provide extensive evidence, but rather a short and focused self assessment template setting out their understanding of holistic working and its application strategically. We are drawing up a self-assessment template that we expect to issue by the end of the month, with the data for JPAF 10. Partnerships should demonstrate the link to local actions, usually through their Local Improvement Targets, illustrate how their development of joint services under the Joint Services Framework *Better Outcomes for Older People* is improving outcomes in their areas, and how JPIAF 10 forms part of their wider performance framework.

16. We will provide the underlying data on JPIAF 10 shortly. We have already asked partnerships to validate the data on which JPIAF 10 will be based.

17. For the longer term, the intention is that the whole systems approach should be extended to the other community care groups. Once the outcomes approach is clearer, decisions on these aspects can be made.

JPIAF 11 (Local Improvement Targets)

18. The evaluation of JPIAF 11 in 2006-07 will focus only on partnerships' performance against their targets for 2006-07. Reporting on LITs will continue to focus principally therefore on measuring improvements in outcomes in services for older people.

19. The current template for LITs is retained and is to be found at Annex B. We have however included updated guidance and information on the criteria which will be used to evaluate the core target areas for older people. We would be most grateful if partnerships would complete the template as intended.

20. As noted above, 2006-07 is a period of transition. So too will be 2007-08. We expect to provide further information on the development of and reporting on LITs in 2007-08 in the coming months. In the meantime, if partnerships wish to draw up LITs in 2007-08 for their own purposes, that is for them to decide.

Partnerships should therefore report in JPIAF 11 only progress against their Local Improvement Targets for 2006-07.

JPIAF 6 (Community Care Assessment)

21. Two factors influence the information we are seeking on JPIAF 6. Firstly, in terms of the developing outcomes agenda, the direction of travel is towards waiting times. Secondly, that direction also emerged as part of the discussions with a number of interests about the level of detail on SSA sought previously. As a consequence, we have decided to reduce the information required on numbers and spread of SSAs, and to focus on waiting times. But because the data for 2005-06 showed such variations between partnerships, particularly at the extremes of the waiting times spectrum, there needs to be a better understanding of what is happening at these two areas. **Partnerships are therefore asked to provide a breakdown of those services which are provided within 6 days and also the reasons for waits longer than 56 days**. The reporting period will be October–December 2006, returns should include information on the whole partnership area (not a geographic sample) and this indicator will continue to apply to all client groups. This arrangement has been agreed with Audit Scotland and will be included in the SPI's for local authorities. Further guidance on JPIAF 6 is to be found in Annex C.

JPIAF 8 (Direct Access to Resources)

22. Faster access to services remains a key goal for Ministers. JPIAF 8 provides information on the extent to which that is facilitated. There are issues, however, about how best to measure that. In the light of discussions with partnerships, we have decided that for 2006-07 partnerships should report on the **level of access by lead assessors from another agency for a number of key services, (as opposed to all services as previously). This will link more effectively to other indicators and should provide a clearer view of practice across the partnership. Information in JPIAF 8 is again for all client groups. The template in Annex D identifies the key services.**

Enquiries

23. Enquiries about the general content of this circular should be addressed to Judy King, Joint Future Unit at Judith.King@scotland.gsi.gov.uk (or telephone 0131-244 4041). Enquiries about particular indicators should be taken up with the contacts identified for the individual indicators. Further copies of this circular are available by telephoning Stephen Young, Joint Future Unit (tel: 0131-244 5424). This circular is also available on the Scottish Health website at www.show.scot.nhs.uk/sehd/ccd.asp and the Joint Future website at www.scotland.gov.uk/jointfuture

Conclusion

24. This circular reflects the national partners' desire for continuous improvement in the outcomes for individuals and their carers from health, housing and social care services. JPIAF is the means of demonstrating joint progress within local partnerships and, in aggregate, nationally. Its precise scope is being reshaped to reflect the changing agenda on outcomes generally, to improve the quality of information reported and its meaningfulness to the partners locally and nationally. The extent to which JPIAF continues under the new outcomes agenda from 2007-08 onwards will be determined in the coming months.

Yours sincerely

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ACTION NOTE	TIMEFRAME
Guidance for JPIAF 2006-07 issued	12 February 2007
JPIAF 10 data and self assessment checklist issued	Late February 2007
Development of national outcomes, performance measures and targets	Late March 2007
Submission of JPIAF 2006-07: To include: Reports on • **JPIAF 10** - (for older people's services, including development of Joint Services Framework). • **JPIAF 11** – progress report only on LITs for 2006-07*).* • **JPIAF 6** (for all client groups) • **JPIAF 8** (for all client groups)	**18 May 2007** 18 May 2007 18 May 2007 18 May 2007 18 May 2007

ANNEX A

JPIAF 10 2006-07: GUIDANCE NOTES FOR WHOLE SYSTEMS INDICATOR 2006-07

Requirements for 2006-07

1. On the advice of the Whole Systems Indicator Working Group (WSIWG) and the seminar in November 2006, there will be no material change to the substance of the whole systems indicator for 2006-07. **There was, however, agreement that partnerships should report through self assessment templates, instead of providing a free standing report, which partnerships would self score**. **JFU would then assess the self-assessment**. The checklist, together with the model, will be issued shortly. This approach reflects the importance of whole systems thinking but recognises the direction of travel on outcomes more generally. If JPIAF 10 continues, the WSIWG recognises that refinement and improvement will be required.

2. We plan to send out the latest model in the next few weeks. The 'strike date' for the data will be March 2006. To ensure the model's accuracy, however, the Analytical and Statistical Division of the Health Department (ASD) has already sent out the input data for a data check. Our aim is to ensure, as far as possible, that the information in the model is an accurate reflection of activity in each partnership. Behind that, however, lies a need for partnerships to provide robust data in the first instance, especially as the uses of data are now much more sophisticated – as in JPIAF 10.

3. The Joint Services Framework, "*Better Outcomes for Older People*" suggested developing a new indicator in JPIAF for joint services. Due to the increasing focus in JPIAF generally on outcomes there was little support for another "process" indicator. **Instead, partnerships are asked to demonstrate in their response to JPIAF 10 how joint services are improving outcomes for older people. They are also invited to describe their performance framework, how it works and the difference it makes, and where JPIAF 10 fits in.**

4. The current model uses the best information available. It is not perfect, but is fit for purpose. To improve its content and to make it more meaningful to partnerships; the WSIWG will address the substantive issues which partnerships raised at the seminar on 20 November 2006. These fall into 3 categories:

- extending the model generally (eg adding new indicators for finance, primary care, etc);
- extending the JPIAF 10 approach to the rest of community care (eg mental health, learning disabilities, etc individually) ; and
- technical/sensitivity issues (eg refining the contents of indicators).

The last of these covers a wide range of issues drawn from partnerships' management responses and other sources. The WSIWG will consider these tasks once the outcomes position is clearer.

What JPIAF 10 aims to do

5. JPIAF 10 invites partnerships to consider in a whole systems way the relationship between its sub-indicators and to reflect particularly on the balance of care. It invites them specifically to identify the causes and effects that impact on individual indicators, and between them. The evaluation of JPIAF 10 is at three levels:

- how the model of relative performance places partnerships (basically how far they are from the average).

- how partnerships demonstrate holistic working and their understanding of their causes and effects locally.

- how partnerships translate that understanding and holistic approach into strategic action in the medium term and ultimately into their Local Improvement Targets.

6. There is therefore a powerful link between the performance data and the analysis derived from JPIAF 10, and local action usually through LITs. JPIAF 10 is a tool to drive continuous improvement, and year on year movement is the key to that.

7. The sub indicators in the model use existing data sources as proxies. For example, emergency and multiple admissions are a proxy for avoidable admissions. The model asks questions of partnerships on what influences the outcomes in their area.

8. Partnerships should therefore use the indicator as a broad measure of whole systems working. For comparison purposes, they may wish to benchmark with similar partnerships. Nationally, we read across between the results in the model and partnerships' responses on their understanding and application of whole systems working. In time, perhaps a more refined model may emerge. But while partnerships are still developing their whole systems approaches and the model is itself being refined, we will continue with the current arrangements.

Evaluation criteria

9. Partnerships' performance on the model - as measured by the distance from the average - falls into 3 categories;

- above average
- average
- below average

10. The bandwidths are to some extent influenced by performances overall, but are likely to revolve around rates of dispersion of greater than +1.0, 1.0 to -1.0, and more than -1.0 respectively. The WSIWG has been examining alternatives to the current presentations in the model. It has identified some possibilities, such as 'radar charts' but these are not sufficiently advanced for incorporating in this JPIAF round. So the previous arrangements remain in place for the time being. As regards the evaluation of partnerships' understanding and application of whole systems working, our expectations are set out in the Appendix. As indicated earlier, **we will convert these into a self-assessment checklist, so that partnerships can plot for themselves their assessment of their progress. Their aggregate score will determine the level of progress and hence the resultant evaluations. The checklist to be issued shortly with the data set for JPIAF 10 will set this out in more detail.**

Frequently asked questions

11. Some partnerships suggest that JPIAF 10 is not sufficiently sophisticated to assess effectively holistic working and to manage the balance of care. JPIAF 10 is constrained by a number of factors. It uses only existing data sources, it uses proxies for its intended coverage, and the individual indicators might be more comprehensive. But most partnerships recognise the value of what it seeks

to do: it changes fundamentally the way we use data and invites partnerships to challenge their own understanding of what drives performance locally. Over the piece, most partnerships regard JPIAF 10 positively, as a useful tool to analyse their performance and shape future direction.

12. A number of partnerships have suggested that the range of indicators is too limited and focus only on particular parts of the system, eg particularly on services for people with more intensive needs (and then not comprehensively). Some partnerships indicate that they have 'parallel' services (eg community hospitals) which have the same effect as those in the indicators but which are not currently counted. The focus on intensive activity in the 'services' indicators reflects that this group is more likely to feature in inappropriate admissions and delayed discharges, making the model reasonably internally consistent. The WSIWG is looking into these issues. In the meantime, **we encourage partnerships to set out in their responses how their "parallel" services contribute to better outcomes. We will have regard to that in our evaluation of their holistic approach; but it will not affect the model itself.**

13. A number of partnerships are not clear as to why there is a 75:25 weighting for substantive performance and in-year change respectively. Their concerns focus on the "change" factor. The change weighting reflects the national partners' desire to inject a dynamic into the model. Under it, partnerships that make positive steps year on year – as part of the continuous improvement cycle - are 'rewarded'. Because material change takes time – say 4/5 years – a 25% weighting corresponds to that rate of improvement.

14. A number of partnerships would also like to see the population aged 65+ weighted to reflect particular "drivers" such as the level of deprivation/rurality in the area. The WSIWG has noted these concerns but not acted on them, principally because the level of resource provided to partnerships allows specifically for the effects of deprivation and other similar drivers. The objective in JPIAF 10 is to establish whether partnerships understand and respond appropriately to their local circumstances (ie what are the causes and effects, of which these drivers are part). The other aspect, of course, is how partnerships manage their circumstances through effective systems and services. Both are equally relevant in the evaluation.

What is sought in respect of the understanding of holistic working and its application

15. In short, the Executive is looking for partnerships to describe broadly and concisely (a) their understanding of whole systems working and their analysis of the individual indicators and their inter-relationship, and (b) how they translate that understanding into jointly agreed actions in the short to medium term and, at least for 2006-07, into local action, usually through LITs.

Annex A Appendix 1

The substance of this appendix remains the core of the evaluation for JPIAF 10. It will, however, be converted to a self-assessment checklist – and issued shortly.

Areas for evaluation in JPIAF 10	**Information to be provided**
The extent to which partnerships have performed on the key sub-indicators and over all (the comparative model).	A brief summary of the trends in each of the key indicators: Emergency and multiple admissions Delayed discharges – total Delayed discharges – more than 6 weeks NHS geriatric long-stay bed use Persons supported in care homes Persons with more than 10 hours home care weekly Single Shared Assessments The partnership may want to 'benchmark' with immediate comparators.
How well partnerships demonstrate a holistic approach; and……..	Partnerships should demonstrate their understanding of the causes and effects within each indicator and the inter-relationship between indicators and on service provision. Balance of care is a key element. That should include: Emergency and multiple admissions - a proxy for inappropriate admissions. Delayed discharges - a combination of both systems and services that is a measure of joint working in a key priority area. Service levels - a measure of the partnership's total joint investment for people with more intensive care needs (the kind of person who may emerge as an inappropriate admission or a delayed discharge). The level/percentage of home care - a proxy for the totality of community based services for people with more intensive care needs) as a key part of the balance of care. Single Shared Assessments - a further proxy for joint working that are pivotal to changing the balance of care etc. The partners should describe how these key issues are brought together with others as described below. Looking at that in more detail, partners should demonstrate what the key drivers of current performance are, what are the pressure points in the system, and how do they plan to address them. How do services and systems combine to improve results? For example, how are admissions affected by demography/health, by GPs' referral patterns, by the availability of intermediate care/step up/step down services and by out of hours services? What arrangements and strategies are in place for other 'manageables', in particular around falls prevention and long term conditions management. Within this analysis, partnerships should also

	refer to the part played by service provision generally, and by the voluntary and independent sectors. Just as important is the inter-relationship of indicators. We are interested, for example, in how delayed discharges are influenced by the flow from admissions, by effective inter-agency systems, by appropriate levels of services, by specific responses such as step up/down services including rehabilitation, by factors such as rurality, etc. A number of partnerships cite having services that are not counted in the model (eg community hospitals) but are central to delivery, as part of the whole system. The partnership should report them here as part of demonstrating its holistic approach – but they will not count in the model itself.
….how partnerships translate the results of their performance and their understanding of the holistic approach and its application.	Partnerships need to demonstrate how they have applied their understanding of whole systems to the delivery of results. This can be looked at a number of levels. They should describe broadly how their joint strategies and plans (eg care group strategies, balance of care studies, commissioning strategies, capacity plans, etc), drive change and address local issues/weaknesses/ interrelationships between indicators that require practical action(s). The result should be partners' broad action plan with timescales. From that analysis partners should identify their specific practical actions in the short term (usually directly translated into LITs, at least for 2006-07) to deliver better joint services and better outcomes. This will call for clear timescales and explicit funding commitments in a joint financial plan. In addition, partnerships should illustrate how their development of joint services under the Joint Services Framework, *Better Outcomes for Older People*, is improving outcomes in their area. Then partners should show how their approach fits into or alongside their wider performance assessment arrangements. Guidance on the next steps in the outcomes approach – issued in January 2006 – makes that a priority. Partnerships should set out concisely their view of their current baseline (i.e: where they are at currently) and where they would wish to be in the medium to longer term

Partnerships can also view an **illustration** of the kind of root cause analysis in this area on the Joint Future website. http://www.scotland.gov.uk/Topics/Health/care/JointFuture/JPIAF10RCIv

ANNEX B

JPIAF 11 2006-07: GUIDANCE NOTES FOR LOCAL IMPROVEMENT TARGETS

Introduction

1. Local improvement targets (LITs) are the centre of the outcomes approach in community care and are integral to continuous improvement under Joint Future. LITs are the principal driver of results locally. They should translate into actions flowing from the analysis in JPIAF 10 and from JPIAF 6 and 8.

2. The information to be provided for JPIAF 11 is that outlined in Circular CCD9/2004, the guidance on Local Improvement Targets, which can be accessed on either of the following websites - www.show.scot.nhs.uk/sehd/ccd.asp or www.scotland.gov.uk/jointfuture. A revised template is attached to this annex. It is important that partnerships complete the template as intended – for their own and assessors' benefits.

LITs 2006-07

3. Partnerships have already set LITs for 2006-07 as part of JPIAF 2005-06. JPIAF 2006-07 should include a full year's progress report against their targets for 2006-07. Some partnerships will want to have regard to the comments on their targets for 2006-07 set out in the Final Evaluations for JPIAF 2005-06. Where they have changed their targets from the original, could they please make that clear.

LITS 2007-08

4. **In the light of the developing outcomes agenda, partnerships are not required to draw up and submit LITs of 2007-08 as part of JPIAF 2006-07**. They may, of course, for their own purposes want to continue the current arrangements – but there is no requirement nationally at this stage to do so. If the current direction on outcomes prevails, partnerships will be invited to draw up LITs to support the new outcomes picture by, say, October; but it is unlikely that they will be asked to report on them nationally. Recognising the period of transition, we invite partnerships to consider continuing to set LITs for areas that they want to manage by that means; and also to consider setting LITs for areas covered by the emerging outcomes approach (some of which are already reported on in other streams). This should assist with continuity during this transitional year, and provide a basis for effective local performance management in 2007-08.

Evaluation of Progress against LITs 2006-07

5. Partnerships will receive an evaluation of how they have progressed towards their targets for 2006-07 and on whether they have implemented effective systems to evidence this progress. The report on their full year's progress against targets will indicate whether the performance of each partnership:

- More than meets their targets
- Meets or is close to meeting their targets
- Falls short of their targets
- Falls well short of their targets
- Lacks information to measure their performance

We will, however, comment on whether the target, if not amended, was “insufficient” or “requiring development”.

The reporting template includes a column for partnerships to list remedial actions where they are falling well short of their targets, or where they are unable to evidence performance.

REPORTING TEMPLATE FOR LOCAL IMPROVEMENT TARGETS

1. National Outcome.	**2. Local Improvement Targets.**	**3. The baseline.**	**4. The definition of How your targets are being measured.**	**5. Performance against target**	**Action required**
Eg. Supporting more people at home, as an alternative to residential and nursing care.	Local Improvement Target, set within context of national target where appropriate.	Details of baseline against which each LIT is set.	These figures will be measured against the baseline figures in column 3 to determine percentage improvement. You should include how your Local Improvement Targets are being monitored/reported eg. *Progress on targets will be reported to the Joint Future Management Group on a quarterly basis.* Full year reports to be sent to the Scottish Executive by 18 May 2007.	Partnerships should record their performance against each separate LIT	Where the partnership is falling well short of the LIT, or where there is insufficient data to report on performance, this column should list the action planned by the partnership to resolve the problem.

MEASURING PERFORMANCE AGAINST TARGETS FOR 2006-07

Delayed Discharge (National Target)

6. Partnerships were advised of the revised targets for delayed discharge on 23 February 2006. The targets in 2006-07 are as follows:

- to reduce all delays over 6 weeks by 50%;
- to free up 50% of all beds occupied by delayed patients in short-stay beds;

7. On delays over 6 weeks, the starting position for each partnership will be set against performance in relation to the April 2005 target. This means that those who met the target will have fewer reductions to make in 2006-07. But partnerships that missed the April 2005 target will have to make up lost ground.

8. The starting position in relation to those delayed in short-stay beds will be based on the results of the April census. The targets for 2007-08 are:

- to reduce to zero patients delayed over 6 weeks; and
- to reduce to zero those delayed in short-stay beds.

Reducing Emergency Admissions (National Target)

9. This target is longer term: by 2008-09, to reduce the proportion of older people (aged 65+) who are admitted as an emergency patient two or more times in a single year by 20%, compared with 2004-05; and to reduce by 10% emergency in patient days for people aged 65 and over by 2008. Emergency admissions are defined as emergency or urgent inpatient admissions, excluding transfers. The only assessment in JPIAF 2006-07 will be progress against the incremental target(s) set for that year.

Intensive Home Care (National Target):

10. This aims to enable more older people to live and be cared for in their own home. This too, is a longer term target, to increase by 2008 the number of older people receiving intensive home care to 30% of all people receiving long-term care.

11. *Definitions*

Older people are people aged 65 and over.

Intensive home care is defined to be a home care package of more than 10 hours per week. At this level of service clients are more likely to need personal care (help with washing, dressing, feeding, etc) rather than just help with domestic tasks.

A care package is a range of services provided to meet an individual's assessed needs. The Social Work (Scotland) Act 1968 provides for a local authority to carry out an assessment of need and to arrange appropriate Community Care services.

Care home places are places in residential care homes or in private nursing homes. From 1 April 2002, with the introduction of the Care Commission, the distinction between residential care homes and nursing homes was removed and all homes are now registered as 'Care Homes'.

People receiving long term care is defined as older people receiving an intensive home care service, residents in Care Homes for older people and long stay geriatric residents in hospitals.

12. The only evaluation in JPIAF 2006-07 will be progress against the incremental target(s) in 2006-07.

Rapid Response Services (Local target(s))

13. In 2001, as part of the initiative to strengthen care at home, funding was provided to enable every partnership to develop comprehensive rapid response services to provide short term interventions, possibly intensively, to sustain people at home. The key aim of Rapid Response services is to prevent emergency and unscheduled admissions and to facilitate early supported discharge.

14. This is a purely local target which partnerships will set in line with local service pressures. In 2006-07, the assessment will be confined to progress against the target(s) for that year.

Single Shared Assessment: (Local Target(s))

15. This target aims to ensure that people receive an improved quality of care through faster access to services and better quality services.

16. The only evaluation in JPIAF 2006-07 will be progress against the target(s) for that year.

Better Involvement and Support of Carers (Local Target(s))

17. Carers' status as key partners in the delivery of care makes carers' assessments and respite important areas for service delivery. With carers' assessments being a significant gateway to support for carers, the numbers of assessments, levels of awareness and waiting times should be a continuing priority. Respite continues to be top of the carers' agenda in terms of practical support to enable them to continue caring.

18. They only evaluation in JPIAF 2006-07 will be against the target(s) for that year.

Equipment and Adaptations (Local Target(s))

19. The guidance on LITs for equipment and adaptations was set out in section 3 of Adam Rennie's letter of 29 March 2006 – see link below - http://www.scotland.gov.uk/Topics/Health/care/JointFuture/GuidanceonLITS. In common with the rest of JPIAF, we are not asking for new targets for 2007-08, but partnerships should report progress against their targets for 2006-07. We are conscious that most partnerships were unable to provide initially robust targets for this area in 2006-07 but request that, nevertheless, you report progress against the targets you have developed. If you have changed your initial target following the Evaluation Statement for 2005-06, please show clearly where this is the case. Please show clearly any changes to your initial (or draft) targets following the Evaluation Statement for 2005-06.

ANNEX C

JPIAF 6 2006-07: GUIDANCE NOTES FOR COMMUNITY CARE ASSESSMENTS 2006-07

Introduction

1. For JPIAF 2006-07, the reporting requirements have been reduced to focus only on waiting times (which was previously the second indicator in JPIAF 6). The requirements for reporting on waiting times are set out in Circular No CCD7/2004, http://www.scotland.gov.uk/Resource/doc/1095/0001855.pdf of 9 June 2004. The reporting period is October–December 2006.

What JPIAF 6 aims to do?

2. JPIAF 6, by focusing on waiting times, becomes more of an outcomes indicator. The indicator reports the partnership's speed of response (and also the total number of assessments). Additionally, however, we are asking partnerships to provide a breakdown of those services which are provided within 6 days and also the reasons for waits longer than 56 days, so that we can understand better reported performance. A template is attached.

3. The focus on waiting times – as part of more extensive coverage of SSA - is likely to be carried over into the performance measures in the developing Outcomes agenda for community care. Current thinking is that in future similar information should be collected for carers. Partnerships will therefore want to be aware of the likelihood of their systems having to capture the required information next year. (Meanwhile, we will assess under LITs, partnerships' performance in 2006-07 against their targets for carers' assessments and respite services.)

How will it be used?

4. The JPIAF Annual Evaluation Team, which has representatives from Audit Scotland, JFU and the Scottish Executive will analyse the information with a view to establishing if waiting times for services following assessment are improving year on year.

Technical Annex

5. The technical annex for JPIAF 6 is to be found in Appendix 1 to this Annex. Please ensure that the officers responsible for reporting on this indicator have the full suite of guidance to assist them in this process.

6. Any enquiries about this indicator should be addressed to Winona Samet, Joint Future Unit at Winona.Samet@scotland.gsi.gov.uk or telephone 0131-244 5317.

TIME INTERVALS FOR COMMUNITY CARE ASSESSMENTS

PI: Number of persons with completed community care assessments by time interval from first identification date to first service start, and service user group.

	1	2	3	4	5	6	7	8	9
	Up to 3 days	**4 to 6 days**	**7 to 27 days**	**28 to 55 days**	**Over 56 days**	**Total with service**	**Average (median)**	**No service provided**	**GRAND TOTAL (6+8)**
a) Older people aged 65+ without dementia									
b) Older people aged 65+ with dementia									
c) People aged 18-64 with mental health problems									
d) People aged 18-64 with physical disabilities									
e) People aged 18-64 with learning disabilities									
f) People aged 18-64 with drug/ alcohol abuse problems									
g) Other and service user group not known aged - 18-64									
TOTAL PERSONS									

Partnerships are asked to provide a breakdown of those services which are provided within 6 days and also the reasons for waits longer than 56 days. The reporting period will be October–December 2006, returns should include information on the whole partnership area (not a geographic sample) and this indicator will continue to apply to all client groups. This arrangement has been agreed with Audit Scotland and will be included in the SPI's for local authorities. Further guidance on JPIAF 6, is included in Annex C.

NOTES:

- The reporting period will be the three months from 1st October 2006 to 31st December 2006. Assessment completed date must fall on or within these dates.
- Do **not** count reviews or reassessments.
- **Count each person only once**, unless they change client group during the reporting period.
- **Exclude** anyone already in receipt of an ongoing community care service at the point of identification for the purposes of this table.
- Where no first identification date is available, use **Assessment Start Date** (eg where health has initiated an assessment use the date that it was across to SW to be lead assessor).

- As the reporting dates are October 2006 to December 2006, do not retrieve the data to populate the table until the **end of March** in order that Column 5 can be completed as far as possible. If there is no service by end of March, count into Column 8 (No service).
- Service start date **can** fall later than the reporting period.
- Criteria for Column 8:

    - People who have refused service(s).
    - People who were assessed as not eligible for service(s).
    - Any person whose needs cannot be met.
    - No community care service is provided (eg if after an assessment only a health service was required and provided).

For the purposes of reporting **Audit Scotland's Statutory Performance Indicator Number 1** for 2006-07 the data is the 'Total Persons' row at column 6.

Calculating the median:

To calculate the median you need to use the raw data before it has been processed and placed in the table. It is not possible to calculate the median from the data in the table itself. Calculate the median as follows:

a) List all the people counted in columns 1-5 of the relevant row of the table.
b) Sort these into order according to time interval, i.e. the person with the lowest time interval should be first and the person with the highest time interval last.
c) Do you have an odd or even number of people?
    I. **Odd**: Go to step d
    II. **Even**: Go to step e
d) The median is simply the time interval associated with the middle person in the ordered list
e) There is no middle record. Take the time intervals of the 2 'middle people', add them together and divide by 2.

For example,

a) If you had 6 people in columns 1-5 of row c of the table with time intervals of 3,80,4,1,12, and 10.
b) Sorted into order this would be: 1,3,4,10,12,80
c) There are an even number of people (6 people)
e) There is no middle record. The two 'middle people' are the 3rd and 4th person so we add together 4 (the time interval for the 3rd person) and 10 (the time interval for the 4th person) to give 14 and then divide by 2 to give 7. The median is therefore 7 days.

Repeat this for each row of the table, including the relevant people each time.

In practice you might use a spreadsheet to do this calculation. Some spreadsheet packages include a MEDIAN function which will calculate the median for you for a given range of cells.

WAITING TIMES OF LESS THAN 6 DAYS AND MORE THAN 56 DAYS				
SERVICES PROVIDED IN LESS THAN 6 DAYS		**WAITING FOR MORE THAN 56 DAYS**		
SERVICE	NUMBER *	SERVICE	REASON	NUMBER*

Approximate numbers of recipients of the relevant services will suffice. The scale is more important than accuracy.

JPIAF 6 2006-07 COMMUNITY CARE ASSESSMENT TECHNICAL ANNEX

Processing Rules for Table

This guidance covers not only the data requested in the waiting times indicator, but also the source assessment data that it is derived from.

Within SSA Partnerships, it is the responsibility of the Social Work Department to submit the JPIAF 6 return. The return includes persons with community care assessments for which the lead agency was not the Social Work Department itself. Where the lead agency was Health or Housing, the assessment information will only fall within the scope of the return if it has been shared with Social Work, so that all the information necessary to complete the return should be available somewhere within Social Work records. But shared information may have been communicated to Social Work in a number of different ways – eg on paper, through the use of e-mail or fax, or even verbally. It will be important to ensure that all these sorts of information sharing are captured centrally through some form of electronic record, and that all the details required for the JPIAF 6 return are itemised within this record.

The following processing rules make the assumption that any shared assessment information is appropriately shared (i.e. in accordance with the local information sharing protocol). Where assessment information has been shared inappropriately, there is likely to be no practicable way of excluding such cases from the count.

Where a person has more than one community care assessment within the reporting period, the earliest assessment should be taken first. Process as follows.

1. Has the person been counted already (i.e. in respect of an earlier assessment) for this reporting period? **[See Note A]**

If Yes	Do not count
No	Go to 2

2. Is the assessment an "eligible" assessment (i.e. not a screening assessment, a self-assessment or a review)? **[See Note B]**

If Yes	Go to 3
No	Do not count

3. Has the assessment been completed? **[See Note C]**

If Yes	Go to 4
No	Do not count

4. Does the completion date fall within the reporting period? **[See Note C]**

If Yes	Go to 5
No	Do not count

5. Was the person already a community care service user at the time of the event or contact that triggered a community care assessment? **[See Note D]**

If Yes Go to 6
No Go to 7

6. Person an existing service user - was the person assessed under a new service user group (i.e. a different group from that under which s/he was previously receiving community care services)? **[See Notes D and E]**

If Yes Go to 7
No Do not count

7. At the time of the assessment, was the person being assessed outwith their home area (i.e. another area was paying for assessments done or services provided)? **[See Note F]**

If Yes Do not count
No Go to 8

8. Who was the lead agency for the assessment?
If Health or Housing
Go to 9
If Social Work or Voluntary Organisation
Go to 10
If Joint Agency
Go to 11

9. Lead agency Health or Housing - was assessment information shared with Social Work?

If Yes Default for First Identification Date is Assessment Start Date **[See Note G]**
Go to 12
No Do not count

10. Lead agency Social Work or Voluntary Organisation - was the person already a community care service user (being assessed under a new service user group) at the time of the event or contact that triggered this assessment?

If Yes Default for First Identification Date is Date of Referral or (if no Date of Referral) Assessment Start Date **[See Note G]**
Go to 12
No Default for First Identification Date is Date of Referral
Go to 12

11. Lead agency Joint Agency - was the person already a service user through the Joint Agency at the time of the event or contact that triggered this assessment?

If Yes Default for First Identification Date is Date of Referral or (if no Date of Referral) Assessment Start Date **[See Note G]**
Go to 12
No Default for First Identification Date is Date of Referral
Go to 12

12. All cases - is there at least one relevant service start date such that Service Start Date >= First Identification Date AND Service Start Date <= Reporting Period End Date? **[See Note H]**

If Yes	First Service State Date is the earliest such Service Start Date Compute Time Interval = First Service Start Date – First Identification Date Count in appropriate column (i.e. 1 to 5)
No	Count in column 8

Notes to Processing Rules

A. No person should be counted more than once within the same reporting period. If a person has more than one completed community care assessment within the reporting period, the details for the return (i.e. Lead Agency, Assessment Type, Service User Group, First Identification Date, First Service Start Date) should be those relevant to the first such assessment.

This rule applies in the case where a person has an earlier community care assessment for which the lead agency is eg Health and a later community care assessment for which the lead agency is eg Social Work. The second assessment should be ignored. ***The need to avoid double-counting means that recording systems must be able to match a person across assessments undertaken by different agencies.***

B. For the person to be counted, the assessment must (a) encompass more than simply "screening activity" and (b) be more than just a self-assessment. Reviews and re-assessments of need are also excluded, with the exception of the case where someone has previously been receiving a community care service in respect of needs that fall under one head (eg learning disability) and is now assessed for needs under another head (eg mental health). Further guidance is given in the main JPIAF 6 guidance document.

C. For the person to be counted, the assessment must have been "completed" within the reporting period (though it may have been started before the reporting period). This means that all the components of the assessment of need must have been completed (including any specialist assessment) and the assessment form must have been signed off. For this purpose, a financial assessment does not count as part of the assessment of need and does not have to be finished for the assessment to be "completed". Nor does a care plan have to have been agreed.

Where an assessment is suspended or ended prematurely (eg because the person has moved or died), it does not count as a completed assessment. If the recording system puts an end date against such an assessment, it may be helpful to introduce a "completed" status to distinguish those assessments that have been "completed" for purposes of JPIAF 6 from those that have been "ended" but not "completed".

D. For a person to be counted, one of two circumstances must apply –

(a) The person was not in receipt of a community care service in the period immediately before the event or contact that led to a community care assessment. This does not rule out people who had received an assessment or services or equipment at some time in the past, so long as they were not receiving a service currently. Nor does it rule out people who had been receiving visits from eg a community nurse for a medical or nursing reason, or a housing worker for a housing reason, where the nurse or housing worker now decides that they require a community care assessment.

(b) The person had been in receipt of community care services in respect of needs that fall under the head of one "service user group", but then received a community care assessment where the main focus is a different "service user group". For example, a person might have been attending a day centre by reason of a learning disability, but then receives a community care assessment where the main focus is alcohol abuse. Or again, an older person might have been receiving a home help service, but is then assessed in relation to possible dementia. In both these cases, the assessment reflects a shift from one "service user group" to another "service user group", so the person ***is*** counted for purposes of JPIAF 6. In other cases, where an existing service user receives a re-assessment of needs under their existing "service user group", they are ***not*** counted for purposes of JPIAF 6. For more on "service user groups", see **Note E** below.

E. Where a person was over 18 but under 65 on the day that the assessment was completed, they should be allocated to one of five "service user groups" –

- People with mental health problems;
- People with physical disabilities;
- People with learning disabilities;
- People with drug / alcohol abuse problems;
- Other / not known.

Clearly many people have problems or difficulties of more than one sort. If this is the case, choose the group which best reflects the main focus of the assessment of their needs through which they fall to be counted. Further guidance is given in the main JPIAF 6 guidance document.

Where a person was 65 or over on the day that the assessment was completed, only two "service user groups" are applicable –

- Older people aged 65+ without dementia;
- Older people aged 65+ with dementia.

For older people, other factors such as learning disabilities or alcohol abuse problems are ignored for purposes of JPIAF 6.

For JPIAF 6 purposes, an older person should be placed in the "with dementia" group so long as the issue of dementia was a significant focus of their assessment (even if it turned out on investigation that their apparent confusion was caused by eg over-medication rather than dementia as such). In other words, a final diagnosis of dementia is not required.

F. See the main JPIAF 6 guidance document for guidance on assessments that take place outwith a person's "home area".

G. the "time interval" starts with the "first identification date". This is the date on which the person was first identified (in relation to this particular community care assessment) by Social Work, Health or Housing as possibly requiring an assessment of their community care needs.

The first identification date may be recorded as such within Social Work records. If the first identification date was not recorded as such, then (dependent on the circumstances) either the referral date or the assessment start date may be substituted.

- If the lead agency is Social Work, a Voluntary Organisation or a Joint Agency, and the person was not an existing community care service user, the "first identification date" may be equated with the referral date.
- If the lead agency is Health or Housing, the more likely situation is that a single shared assessment is carried out by a health or housing professional (e.g. a community nurse) in relation to a person with whom they have already had contact for other reasons, perhaps for a substantial period of time. The person may recently have developed community care needs that are not currently being met, causing the professional to carry out a single shared assessment. In this situation, the concept of a "referral date" is not really applicable. If no earlier "identification date" is recorded, the first identification date may be equated with the assessment start date.
- Where the person is an existing community care service user who has received a new assessment of needs under a different "service user group", there may or may not have been some form of internal referral within Social Work (or between Social Work and a Joint Agency). If there has been an internal referral, the first identification date may be equated with the referral date. If there has not been an internal referral, it may be equated with the assessment start date.

H. The "time interval" ends with the start date for provision of the first relevant new service. To be relevant, the "first service" must be a ***community care*** service response to those client needs that are the subject of assessment. It could be part of the care plan that resulted from the assessment, but it could also be an interim or emergency response that was put in place before the assessment was completed (or indeed started). It cannot be a service that was already being provided (at the same level) before the first identification date, but it could on occasion be a service that was provided on an emergency basis on the same day that the need of a community care assessment was identified (so that the time interval would then be zero).

Where a previous service (e.g. home care) is enhanced in response to increased need, this could be regarded as a "first service" for the present purpose – the "start date" being the date at which the service is first provided at the higher level. In the case of equipment or other one-off services, the start date is the date of provision. Direct payments count as a provision of service; the start date is then the date of payment.

The "first service" does not include provision of an information leaflet. Activities that are part of the assessment of needs also do not count as a first service response. "Professional support" can be included as a first service response only if it is a discrete service response by professional staff and goes beyond the support normally provided as part of the assessment of needs. For this purpose it needs to be "face to face", and provide direct support to the individual.

Note that some older service users may be subject to a Care Assessment Data Summary return as well as the JPIAF 6 return. The CADS return asks for information about 19 types of services. With three exceptions, any of these services can be regarded as qualifying community care services for purposes of the JPIAF 6 "first service start" – the three exceptions being "General information and advice", "Home-based nursing care" and "Admission to hospital".

Note also that other services that are not on the CADS list may also qualify as community care services for purposes of JPIAF 6 – whether other services for older people or services for other "service user groups" (such as people with mental health problems or people with substance abuse problems). But services that are normally provided through the NHS (e.g. physiotherapy or podiatry) should *not* be counted as community care services for this purpose.

ANNEX D

JPIAF 8 2006-07 - DIRECT ACCESS/DIRECT REFERRAL TO RESOURCES ACROSS AGENCIES BY LEAD ASSESSORS

Introduction

1. Faster access to services remains a key goal for Ministers. JPIAF 8 provides information on the extent to which that is facilitated. For 2006-07, the information sought focuses on access by local assessors to a number of key services.

What JPIAF 8 Aims to do?

2. JPIAF 8 counts the waiting times for these key services. There are issues, however, about how best to measure that. In the light of discussions with partnerships, we have decided that for 2006-07 partnerships should report on the **number of lead assessors from each agency who can directly access and or directly refer to a number of key services. Previously, we asked for information on all services. The key services are identified in the table below. This will link more effectively to other indicators and should provide a clearer view of practice across partnerships. Blank rows have been included in the table should you wish to add other services.**

How will it be used?

3. The assessors are looking for continuous improvement in the levels of access to resources. Evaluation will be on the basis of the levels of access provided.

4. Contact: Winona Samet, Joint Future Unit, Winona.Samet@scotland.gsi.gov.uk

Service Type	Budget Allocated (£000)	Number of lead assessors / key workers in each agency who can access services in column 1				
		Social Care	Housing	Health Care		Total
Total number of lead assessors / key workers in agency						
Home care						
Rapid response (include services which provide an element of emergency response)						
Equipment & adaptations • **LASW - equipment and [temporary/minor] adaptations for daily living** • **Health – nursing and walking equipment** • **Health – rehabilitation equipment** • **Public sector housing – [permanent/major] adaptations – local authority** • **Public sector housing – [permanent/major] adaptations – housing associations** • **Private sector housing – [permanent/major] adaptations**						

Table (Continued)

Admission to care home						
Community nursing						
Allied health professions						
Joint agency						
Independent						

Definitions:

1. **Direct access** is when the lead assessor can access the service without referring on for further assessment**.**

2. **Direct referral** means a referral to a service by the lead assessor and not through an intermediary such as a GP.

3. **Joint Agency** refers to services that are provided jointly by two or more of the local partners and that may be accessed by lead assessors.

4. **Independent sector** is where partners commission or purchase services that lead assessors from any agency can access.

5. The split required for **Equipment and Adaptations** reflects the range of provision across health, housing and social care. It uses language from current guidance that includes social work service equipment and [temporary/minor] adaptations for daily living [including sensory impairment], and health nursing and walking equipment [usually associated with primary care]. It includes health provision of rehabilitation equipment [environmental control systems, wheelchairs, and other mobility equipment], building adaptation and design across all tenures, and voluntary sector provision where this is on behalf of the local authority. It does not include anything that is invasive to the body, or that is used for medical treatment.

ANNEX E

NAMED CONTACTS FOR JPIAF INDICATORS FOR 2006-07

General Enquiries	Judy King (Judith.King@scotland.gsi.gov.uk) tel: 0131 244 4041
JPIAF 6&8	Single Shared Assessment Indicators Winona Samet (Winona.Samet@scotland.gsi.gov.uk) tel: 0131-244 5317
JPIAF 10	Whole System Indicator David Meikle (David.Meikle@scotland.gsi.gov.uk) tel: 0131-244 5453
JPIAF 11	Local Improvement Targets Linda Watters (Linda.Watters@scotland.gsi.gov.uk) tel: 0131-244 2374