Cwm Taf Morgannwg

Health and Social Care

Regional Integration Fund

Outcomes and Performance Framework

0.1	**Initial Document**	**September 2021**	**Geraint Evans**
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2. Summary

This report has been prepared to provide an overview of the Performance and Outcome Framework (Framework) that has been developed to support the introduction of the new Health and Social Care Regional Integration Fund across Cwm Taf Morgannwg (CTM). The Framework has been developed to support the closer alignment of the projects and programmes commissioned from the grant and to align existing programmes currently commissioned from the following funds:

- Health and Social Care Regional Integration Fund

The Framework should allow those responsible for commissioning service to**:**

- Strengthen alignment between projects/programmes.
- Align service delivery with the aims of the Regional Partnership Board.
- Support the improved coordination of different departments, agencies and key stakeholders in relation to health and social care.
- Focus resources on activity that has been shown to have a positive impact on reducing the escalation of need and/or its effects.
- Enable agencies to monitor progress and strengthen transparency and accountability, and
- Inform action taken to secure further improvement.

A Venn diagram visualising the relationships between the funding programmes and the Framework can be seen in appendix 1.

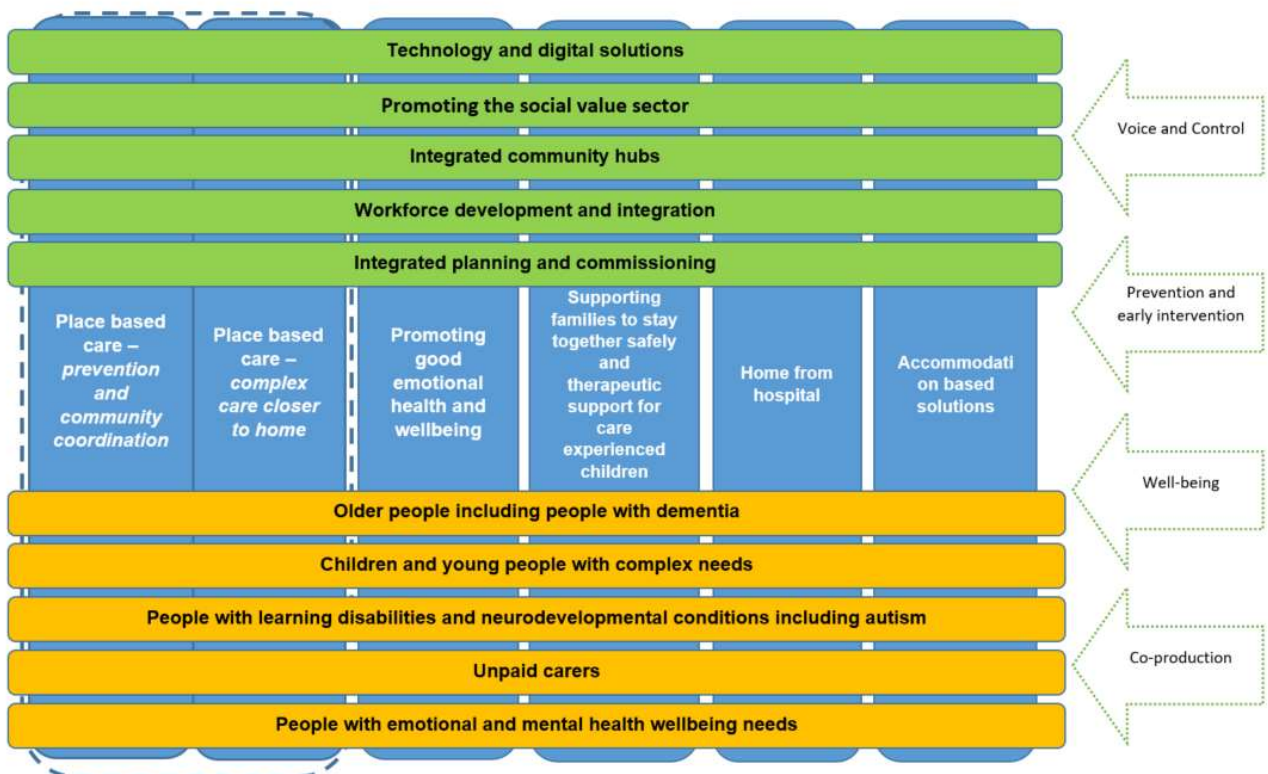
3. Background

Following the commencement of the new RIF on the 1st April 2022, there was a requirement to introduce an outcomes and performance framework across all commissioned services.

The new framework would ensure all services contributed towards the principles of the national guidance and provide a consistent suite of measures and indicators that supported the new models of care.

However, the Framework which will be presented in this report takes the principles from the national guidance and provides a more local focus based on the identified needs and requirements in CTM.

Regional Integration Fund – Models of Care



4. Aims and Objectives

The primary aims of the Outcomes Framework are:

- To identify and articulate the change we want to see, describe what success will look like and by doing so drive the actions of those involved.
- To support local commissioners and providers to adopt ways of working which optimise the combined impact of programme commissioned from the Health and Social Care Regional Integration Fund.
- To support the delivery of an outcomes focused programme of delivery, ensuring interventions are complementary and by doing so sustaining their success.

To support the achievement of these aims, a number of principles were agreed, they are:

- Outcomes-focused – the framework has to be centred around one or a small number of high-level outcomes, linked to our target populations and contribute towards the aims of the programme and the priorities of the Local Authorities, Health Board and their partners.
- Structured – the framework adopts a Results Based Accountability (RBA) methodology and structure as promoted by the model.
- Purposeful – previous frameworks developed to support the delivery of programmes have a high number of, sometimes meaningless, indicators and measures. To make this framework purposeful and functional the total number of indicators and measures are kept to a minimum.
- Accountable and actionable – Potential users, from providers to commissioners, should be able to identify where they contribute towards the framework and if required take action to address any

adverse outcome. This needs to be overseen within a context of clear accountability and governance.

- Applicable and useable to multiple stakeholders – The framework has to be user friendly and easy to understand at all levels.
- Proposed measures must meet an identified gap / pressure – all outcomes, indicators and measures within the framework have been identified and prioritised from the key messages highlighted in the Population Needs Assessment.
- Feasibility of information – to support the introduction of this framework all information needs to be robust and available on a timely basis.
- Realistic – This is in terms of the expectations placed on strategic and operational staff / providers to make a difference towards the measures within the framework.

5. What is the Outcomes Framework?

The Outcomes Framework is a collection of outcomes, indicators and measures brought together into a single, useable structure to improve the planning, development and monitoring of programmes funded from the Health and Social Care Regional Integration Fund.

It is structured around two primary population groups (adults and older people and children and young people) that have been expanded into a single, clearly defined outcome spanning the conditions of wellbeing the fund wishes to impact.

Sitting under the outcome, providing more of a focal point for organisations, are four delivery themes and subsequent priority areas. A small number of indicators for each priority enables us to measure the impact on a regional basis and completes the population accountability element of the framework.

This formal structure provides a consistent direction for all services and projects to identify their contribution towards our strategic outcome. The Framework also provides a suite of performance level (outcome) measures which will be the primary focus of all services. In addition we have included a small number of secondary performance measures that will identify and measure the journey of service users towards achieving the outcome and start to explore how we measure the social value of the projects.

This structure is intended to ensure consistency in reporting which will enable the collective performance of the programmes, across the region, to be collected, analysed and the full (combined) impact realised.

This Framework is intended to replace all existing frameworks from previous grants and provide a single structure for all services to be commissioned, monitored and evaluated.

It has been developed to ensure it is complementary with the existing systems as well as any national developments and where appropriate a number of the indicators and performance measures will be the same. Therefore, the importance of having a healthy, connected, informed and safe population is reflected throughout the Framework.

In essence this new Framework provides opportunities for multiple projects, programmes and providers to consider collaboratively what needs to change in order to realise the greatest impact for our most in need children, young people, adults, older people and their communities and how they can complement each other to achieve this. Whilst there will be outcomes, indicators and measures within the Framework that may not be applicable to all services, it will provide a clear picture of the scope that programmes have to align their work.

6. Benefits and expectations

The objective is that the Framework and subsequent monitoring information influences strategic management decisions, impacting actions at an operational level, leading to a planned programme of delivery avoiding duplication and optimising the impact of services.

It provides an opportunity for a collective consideration of what is working well and what needs to change through consistent data collection and the ability to intelligently analysis the data. Whilst there will be outcomes and measures that are not common, the Framework provide a clear picture of the remit that new and existing programmes must align their work.

The coherent picture provided should allow managers to learn lessons about effective practice and shape provision to ensure it is complementary. At an operational level, the clear expression of shared purpose in the Framework should support workers to plan and deliver services which avoid duplication and optimise their collective impact. To inform this the Framework must provide a clear and easily understood picture of what is most important.

The successful implementation should therefore realise the following benefits:

- Articulate the change we want to see, describe what success looks like and by doing so drive the actions of those involved.
- Avoid duplication and strengthen alignment between existing and new programmes (and wider).
- Increase the capacity and effectiveness of services through shared learning and shared resources.
- Complementary delivery of interventions which provides enhanced possibility of sustained success.

- Easier identification of gaps in provision and support decisions to fill those gaps.
- Align service planning and design so that a service might be commissioned once and accessed across multiple programmes. (joint commissioning)
- Take a shared approach to workforce development.
- Enable the effective monitoring of progress and strengthen transparency and accountability.

We expect operational and strategic planners to work together to develop methods for introducing this Framework, embed complementary monitoring procedures and periodically analyse the implementation of the framework and the data being presented.

This should help develop a comprehensive understanding of which services are most effective and where duplication can be avoided. Officers and Managers should develop an understanding of not only the data for their own service but also that of the other commissioned programmes. This understanding should facilitate recognition of expertise in their partners so that participants are referred to the best placed programme to meet needs, thereby optimising the common delivery of outcomes.

It is also important to remember that the programmes that form the basis of the Framework are not the only interventions which play a role in tackling health and social care needs across CTM. It is therefore essential that work continues to develop joint arrangements with other public services, voluntary sector, community partners etc.

7. The Outcomes Framework

As previously mentioned, the structure of the Framework follows the RBA methodology spanning from population accountability to performance accountability and identifying the contributory lines between each level.

7.1 Outcome

The starting point for development of this Framework was the identification and agreement of a single clearly defined and comprehensive outcome covering the whole target population; towards which all relevant programmes, providers and other stakeholders can direct their efforts.

To identify the most appropriate outcome information was utilised from numerous sources including:

- Information from grant guidance
- Population needs assessment
- Existing outcomes frameworks
- Information gathered from local partners
- Existing performance and monitoring arrangements

After reviewing and analysing this information the following high level outcomes were identified:

All people in Cwm Taf Morgannwg will:

- Enjoy good wellbeing
- Live safe and connected within their communities
- Be healthy
- Supported to live independently

7.2 Themes and priorities

Due to the wide-reaching nature of the outcome a number of service delivery themes and priority areas were included. These provide a more specific area of concentration and a focal point for organisations, departments and wider stakeholders when identifying their service contribution. They directly link to the outcome and support improved collaboration across providers when delivering support services.

<table>
<tr><td colspan="8">All people in Cwm Taf Morgannwg will:
• Enjoy good wellbeing
• Live safe and connected within their communities
• Be healthy
• Supported to live independently</td></tr>
<tr><td colspan="2">1. Safe and independent living.</td><td colspan="2">2. Connected with your communities</td><td colspan="2">3. Knowledge and information</td><td colspan="2">4. Healthy and good wellbeing</td></tr>
<tr><td>People live at home or close to home</td><td>People live in safe and secure homes</td><td>Knowledge of and access to community-based services</td><td>People feel part of their community</td><td>Access to information to make informed choices</td><td>Opportunities to be involved in decisions that impact your life</td><td>Good mental health and wellbeing</td><td>Healthy and active lifestyles</td></tr>
</table>

7.3 Indicators

For each priority up to five indicators have been identified. These will measure the collective impact of our commissioned services at a population level. Although there will be services outside of this funding that will also impact these indicators, the correlation between performance and population accountably will provide evidence of a services contribution.

To inform the identification of appropriate indicators a number of criteria was adopted to ensure they were relevant and measurable, these were:

- The indicators had to be focused and manageable.
- They had to align with the outcome, themes and priorities within the Framework.
- They related to an identified need from the Population Needs Assessment.
- They must be understood by a wide range of audiences.
- The data must of sufficient quality and available on a timely basis.

Details of all the indicators can be found in the full Framework in Appendix 1.

7.4 Performance Measures

Each priority has a corresponding set of appropriate performance measures that will enable the consistent collection of operational level data across all services funded from the Health and Social Care Regional Integration Fund.

The performance measures will describe the level of accountability for all commissioned services and enable robust performance management to be adopted.

These measures will provide the information to inform what difference is being made at a local or regional level and will directly contribute towards the indicators and outcome within the Framework.

For each of the priority between 3-7 performance measures have been suggested.

Although the performance measures align with their corresponding indicators, many projects will span more than one indicator. Where this is the case a combination of performance measures from across the whole Framework may be required to fully realise the impact of delivery.

7.5 Engagement/social value Performance Measures

Underpinning the Framework will be an engagement/social value framework. This will provide a suite of secondary measures that will identify and measure the outputs that enabled individuals to achieve the outcome focused performance measures (the journey) and begin to explore how we can measure the wider social value of a service.

These measures will provide additional, important information about the journey of individuals towards the achievements of the outcomes and any wider social impact. These are vital when attempting to understand the story behind the scenes of activity.

This information will also recognise and measure the effort put in by projects that enable the service users to achieve the primary performance measures/ outcomes, which can often take a much longer period of time.

These softer outputs include:

- Community engagement
- Participant engagement levels
- Awareness raising of specific subjects
- Capacity building
- Volunteering
- Softer outcomes (confidence, self esteem etc.)
- Referrals and signposting

A copy of the full framework including the Engagement/social value element can be found in appendix 1 of this report

8. Standardised report cards

To improve the standardisation of outcome and reporting processes the Framework proposes a single process for reporting information on performance.

These report cards also follow the RBA model and incorporate all the relevant elements of the Framework. They are therefore compatible with the whole process and ensure that all potential users can see the direct contribution between performance and population accountability.

An example of the report card can be seen in Appendix 2 of this report.

Appendix 1 – Health and Social Care Integration Fund - Outcome's and performance framework

Cwm Taf Morgannwg

Single overarching strategic outcome.	All people in Cwm Taf Morgannwg will: • Enjoy good wellbeing • Live safe and connected within their communities • Be healthy • Supported to live independently							
Service delivery themes	1. Safe and independent living.		2. Connected with your communities		3. Knowledge and information		4. Healthy and good wellbeing	
Priorities	People live at home or close to home	People live in safe and secure homes	Knowledge of and access to community-based services	People feel part of their community	Access to information to make informed choices	Opportunities to be involved in decisions that impact your life	Good mental health and wellbeing	Healthy and active lifestyles

Population accountability

The outcomes/performance framework has the following elements:

1. Clearly defined outcomes:
The starting point for development of this outcomes/performance framework was to identify a small set of comprehensive outcomes towards which programmes, departments and other stakeholders can direct their efforts.
One high level strategic outcome:

Outcome
People across CTM will be supported to:

- Enjoy good wellbeing
- Live safe and connected within their communities
- Be healthy
- Supported to live independently

2. Service delivery themes and priorities:
Additional tiers below the outcome and used to as a development aide to support the identification of appropriate priorities and provide a focal point for organisations, departments and wider stakeholders when identifying where their services contribute.

3. A set of indicators for each priority:
For each priority, up to 5 indicators have been proposed. All indicators within the framework must meet the following criteria:

- They must relate to the priorities and themes.
- They must be understood by a wide range of audiences.
- The data must of sufficient quality and available on a timely basis.

The indicators used will measure the level of success realised at a population level and must therefore be focused and manageable, align with the priorities and outcome and identified as areas of need across the region (using the PNA).

For these reasons the number of indicators used have purposely been kept to a minimum, which will keep the framework manageable and focus effort.

Performance accountability

4. A set of primary performance measures

Each indicator will have a set of appropriate performance measures that will ensure consistent collection of operational level data across all services commissioned from the RIF (or wider).
The performance measures will be used to provide a level of accountability to all commissioned services and enable a robust performance management process to be adopted.
These measures will provide the information to inform what is being impacted on a delivery level and will have a direct contribution towards the population level indicators within the framework.

It is suggested that between 4-6 primary performance measures should be identified for each service or project commissioned.

A suite of secondary performance measures (engagement / social value)

The secondary measures provide additional, important information that informs the journey towards achieving the outcome focused primary measures. This is important when attempting to understand the story behind the delivery and will begin to measure the total effort put in by services, as the primary performance measures can often take a longer period of time to realise.

It is suggested that no more than 2 additional secondary measures should be identified for each service or project commissioned.
The table below provides an overview of the service delivery themes mapped against the RIF pillars.

The Framework below provide the measures across all commissioned and are structured against each of the 8 priorities listed above.

Priority 1: Live at home or close to home

Population indicators:	
Indicator 1.1	No of hospital bed days freed up
Indicator 1.2	No of days spent in institutions
Indicator 1.3	% of people discharged within 48hours of being fit
Indicator 1.4	No/% of children place out of county

Performance measures (For targeted interventions where a need has been identified)	
No of step-up step-down (SUSD) admissions	No of people supported to move back home, with support if required (within 48 hours after being declared fit, if available)
No of conveyances to hospital avoided (where a service has been provided that would have otherwise required a visit to hospital)	No of people supported to live independently (with support if required)
No of children supported to be reunified with their family/carer	No of placements supported that do not breakdown
No of children/people supported who are placed within the county	

Priority customer groups include:	
	• People awaiting discharge from hospital • People fit to stay at home with support • Children becoming looked after

Priority 2: Live in a safe and secure homes

Population indicators:	
Indicator 2.1	Unscheduled care medical admissions for residents aged 65+ (per 1,000)
Indicator 2.2	No of Falls Risk Assessment Tool (FRAT) referrals
Indicator 2.3	Children looked after
Indicator 2.4	Child protection register
Indicator 2.5	Incidents of crime and anti-social behaviour

Performance measures (For targeted interventions where a need has been identified)	
No of people starting a telecare package	No of people admitted to hospital following a fall (prevention)
No of people receiving aids and adaptions to remain safe at home and independent	No/% of people who felt services have supported them to stay safe at home (carer/family of individual if unable to communicate answer)
No of families/individuals recording increased resilience	No/% of families/individuals supported that do not step up to statutory services (did not escalate to care and support or higher)

Priority customer groups include:	
	• People at risk of falling at home • People with dementia • People with chronic conditions • Children at risk of becoming known to statutory services

Priority 3: Knowledge of and access to community-based services

Population indicators:	
Indicator 3.1	Access to the appropriate health and care information
Indicator 3.2	% of people who feel they are able to do things that are important to them (National Indicator)

Performance measures (For targeted interventions where a need has been identified)	
No of new opportunities to engage with the local community (new developments)	No of people supported to access locally available support (referrals)
No of people with increased knowledge of the services available to them (locally)	No of people prescribed access to local services (social prescribing)
Priority customer groups include:	• People isolated at home • People with mobility issues • People living alone • People recently discharged from hospital

Priority 4: Feeling part of their community

Population indicators:	
Indicator 4.1	% of people who feel they belong in their local area (National survey for Wales)
Indicator 4.2	% of people feel people from different backgrounds get on (National survey for Wales)
Indicator 4.3	% of people who feel that they are able to influence decisions that affect them (National survey for Wales)

Performance measures (For targeted interventions where a need has been identified)	
No of people feeling more connected with their communities (less isolated)	No of people reporting increased social connections (inc. clubs, activities, groups etc.)
No of people who feel they can influence decisions that affect them (have a say in how they receive services/interventions)	No of new local services developed using a co-production approach
Priority customer groups include:	• People isolated at home • People with mobility issues • People living alone • People recently discharged from hospital

Priority 5: Access to information to make informed choices		
Population indicators:		
Indicator 5.1	Access to services (Welsh Index of Multiple Deprivation (WIMD))	
Indicator 5.2	% of people who have access to the internet	
Indicator 5.3	% of people who have access to appropriate health and care information	
Performance measures		
No of people reporting improved awareness of local/regional support services	No of people reporting they have access to the information, advice and guidance they need (specific or general)	
No of people supported to improve their internet skills to access information and advice		
Priority customer groups include:	• Older people • Frail / disabled people • Vulnerable groups •	

Priority 6: Opportunity to be involved in decisions that impact your life		
Population indicators:		
Indicator 6.1	% of people who felt involved in decisions about their care and support	
Indicator 6.2		
Indicator 6.3		
Performance measures		
No and % of people receiving what matters discussions	No of people with improved satisfaction with local/regional support services	
No of local co-production opportunities (provide opportunities to be involved)	No of people (or their families) satisfied that they are (appropriately) involved in decisions that impact their life	
Priority customer groups include:	• Older people • Frail / disabled people • Vulnerable groups •	

Priority 7: Good mental health and wellbeing

Population indicators:	
Indicator 7.1	% of people who are lonely (National survey for Wales)
Indicator 7.2	% of people claiming ESA/IB due to mental health issues (NOMIS)
Indicator 7.3	CAMHS referral rate
Indicator 7.4	Numbers referred for school-based counselling

Performance measures (For targeted interventions where a need has been identified)	
No of people reporting feeling less isolated	No of people attending specific/specialist groups (mental health and wellbeing)
No of people with improvements in their mental health or emotional wellbeing (using a mental health measuring tool)	No of people reporting they live in a home that best supports them to achieve good wellbeing

Priority customer groups include:	
	• People who are isolated • People who are immobile • Older people aged 65+ • People with dementia (and their carers)

Priority 8: Healthy and active lifestyles

Population indicators:	
Indicator 8.1	Obesity rate
Indicator 8.2	% of people reporting fewer than 2 unhealthy behaviours (National survey for Wales)

Performance measures (For targeted interventions where a need has been identified)	
No of people living a more physically active lifestyle (reported by self or professionals)	No of people attending local specific/specialist groups (healthy and active lifestyles)
No of people supported to lose weight	No of people supported to reduce/cease an unhealthy behaviour

Priority customer groups include:	
	• People who are isolated • People who are immobile • People who are overweight •

Engagement / Social Value Framework

Secondary performance measures (list not exhaustive)	
No of people accessing the service	No of people signposted to additional / relevant services
No of people progressing within the programme	No of people with increased confidence (self-esteem)
No of people supported to access support / advice / services	No of people more positive about their futures
No of people completing a programme / intervention	No of people participating in personal and social development opportunities
No of people with increased engagement in positive activity	No of people reporting improved wellbeing (self-reported)
No of people with increased knowledge/skills of: • IT • Volunteering opportunities • Development opportunities • Healthy lifestyles • Budgeting • Support available • Parenting strategies	No of people more aware of volunteering opportunities
No of people supported to make new friends / improve their social networks	No of partners engaging with the delivery of the service (multi agency delivery)
No of professionals reporting an increase in specialist knowledge (defined by the programme)	No of people supported to improve finances / access benefits (not sure which priority this fits)

Appendix 2 – RBA project card (population)

Outcome, Priorities and indicators

Baselines and causes

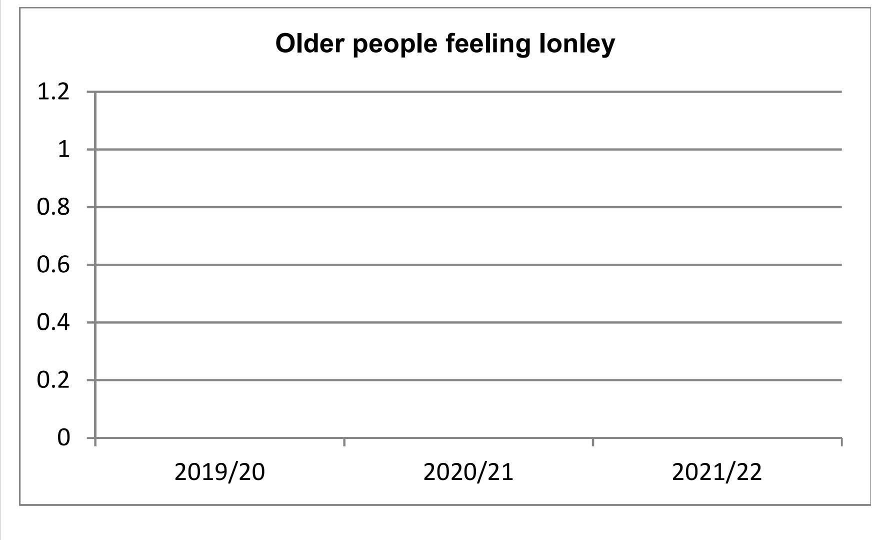
Programme Information

Target population
Older people

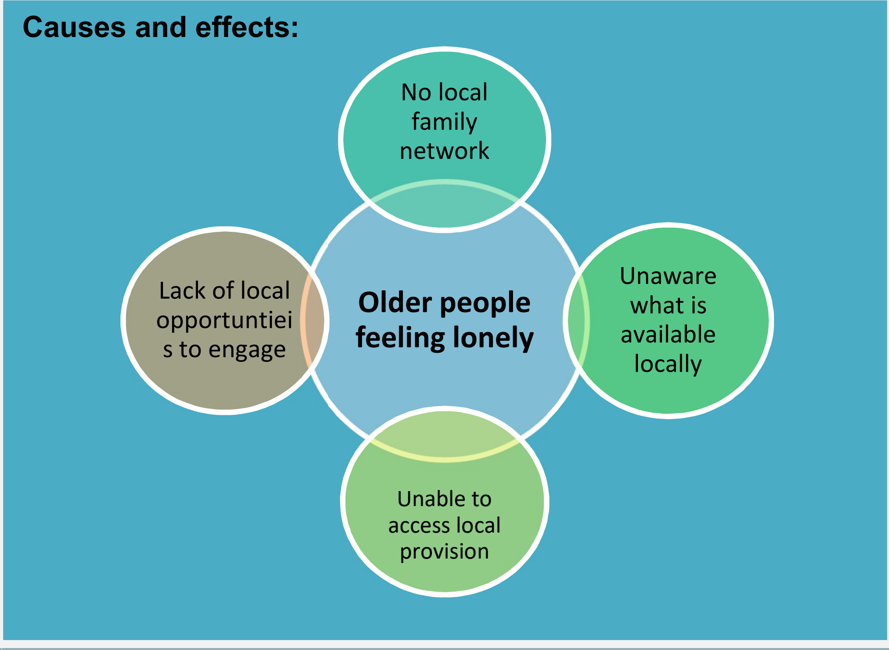
Priorities
Healthy and good wellbeing

Indicators
People feeling lonely

Performance measures
- No of older people supported
- No of people reporting feeling less isolated
- People supported to attend specific/specialist group activities



Causes and effects:



Story behind the baseline:

Project/programme description:

Key partners	Role

Financial implications: £
Annual funding received from the

RBA report card (performance)

Indicator and performance measures | Baselines and performance | Additional Information

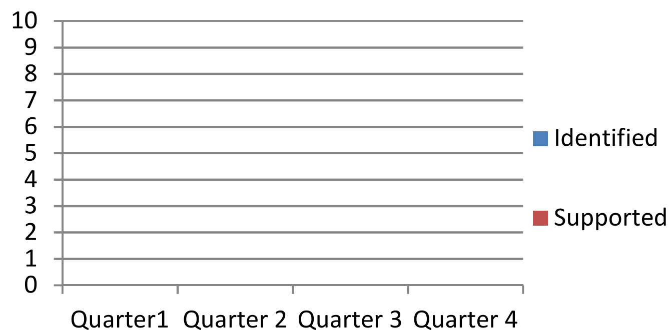
Indicator
People feeling lonely

Performance measures

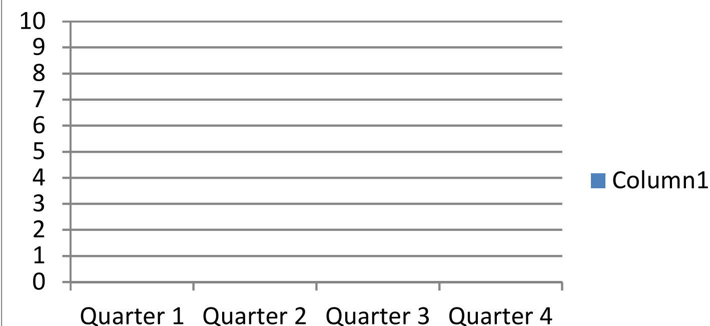
- No of older people supported
- No of people reporting feeling less isolated
- No of people supported to attend group activities

Project title and description:
Older people befriending service

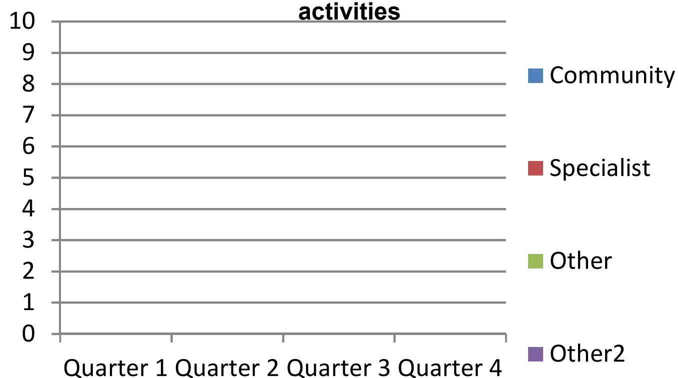
Performance measure 1



Performance measure 2



Performance measure 3



Additional information:

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