S | P | R | U

RESEARCH TO DEVELOP NEW APPROACHES TO MEASURING AND UNDERSTANDING SOCIAL SERVICES OUTPUTS AND PRODUCTIVITY

Comments from Social Policy Research Unit, University of York, 25 March 2004

Caroline Glendinning

DHP 2053 December 2004

THE UNIVERSITY of York

Research to develop new approaches to measuring and understanding social services outputs and productivity

Comments from Social Policy Research Unit, University of York 25 March 2004

We have met with the team from the Centre for Health Economics, University of York, who are involved with NIESR in a parallel study to develop measures of NHS outputs and productivity and have discussed with them some of the issues involved in developing measures of social services productivity. The following note draws on the experiences of SPRU's research programme on social care outcomes and raises some questions which we think need to be taken into account in developing measures of PSS output and productivity.

The SPRU Outcomes programme

The DH-commissioned programme of research in SPRU over the past seven years has focused on the outcomes of social care for different groups of service users: working age disabled adults; frail older people; carers; and severely disabled children and their families. Projects have:

- Explored with service users the concept of social care 'outcomes' and defined those dimensions of outcomes that service users value and aspire to achieve;
- Examined a variety of ways in which information about desired service outcomes can be routinely communicated to service providers;
- Investigated different strategies for introducing outcome-related approaches into assessment, review and care planning activities.

The first of these areas of research – the conceptualisation of outcomes – has particular relevance for the proposed research on PSS productivity.

Dimensions of outcomes and their relationships to outputs

Extensive research at SPRU with a range of PSS user groups has identified the following dimensions of social care outcomes:

- Outcomes involving change – for example, improving self-confidence, self-care skills or the accessibility of the physical environment.
- Outcomes that maintain quality of life (or slow down in deterioration in quality of life) – for example, sustaining desired levels of personal comfort, social interaction and control over daily routines.

- Outcomes that are intrinsically associated with the **processes** of receiving services – feeling valued, respected and confident that individual needs and preferences are recognised.

This typology has a number of implications – in particular for the use of output measures as proxy outcome indicators:

- A very high proportion of PSS interventions and activities are aimed at maintenance, rather than change – but there is no evidence about the empirical balance between these two types of activity, and no normative debate about what the correct balance **should** be. Thus an approach to measuring outcomes that aims simply to detect improvements is on its own inadequate; the achievements of PSS may be substantially underestimated if the implicit model of outcome assumes an expectation of detecting improvements. The important question, therefore, is the counterfactual of what would have happened **without** the maintenance-oriented social care intervention.
- Even change-related outcomes may lack an appropriate baseline (or the baseline may be hypothetical) – as in the example of a previously independent older person receiving rehabilitation after a major stroke.
- Most importantly, any focus on activity and outputs risks ignoring crucial process-related outcomes. For the vulnerable groups of people who constitute the focus of PSS activities, process-related outcomes cannot be ignored, as they are critically important in contributing to overall outcomes. For example, an approach to measuring the productivity of home care services that takes into account only activity and outputs (hours of services provided, numbers of people supported) risks incentivising the quick completion of tasks for the maximum number of clients. It ignores the social interaction, the opportunities to exercise choice and control over how tasks are completed, and the (slower) enabling approaches that clients value as constituting high-quality services (and that are also more likely to lead to desired outcomes).

Underpinning this last point is the crucial distinction between outputs and outcomes. Outputs – service interventions and activities – may only partially contribute to desired outcomes. In the PSS context, the relationship between outputs and outcomes is arguably much more tenuous than in health care, where it may be assumed with a fairly high degree of certainty that a specific output or activity (for example hip replacement or cataract surgery) will lead to beneficial outcomes (improved mobility, reduced pain, improved vision) for patients.

In contrast, in PSS, a focus upon activities and outputs may actually reduce the chances of achieving desired outcomes. A classic example would be the reduction of risk and the provision of care in ways that reduce independence and create dependency and institutionalisation. Similar arguments currently arise in relation to

the provision of personal care in ways that are incompatible with ‘enablement’ and rehabilitation goals.

A major risk of measuring productivity through measures of activities or outputs, therefore, is that these – rather than desired outcomes - become the focus of evaluation and performance management. The wrong behaviours and activities are incentivised; outcomes are distorted; and productivity measures become counter-productive.

Social care is co-produced by services and users together

In contrast to health care, social care can be thought of as being co-produced. A medical model, in which a given set of signs and symptoms prescribe a routine ‘treatment’, is inappropriate. Social care assessment and review processes aim to identify the **individual** circumstances, needs and risks to which potential users are exposed. The thrust of policies for adults and older people over the past two decades has been to enable PSS to deliver individualised responses to those needs. To a far greater extent than in health care, therefore, users contribute to the specification of needs and the individualised package of services that are to be delivered in response through mechanisms such as care management. To the extent that those service activities are used in measurements of output and productivity, they will reflect substantial elements of user choice and preference.

Moreover, users themselves play a crucial role in the production of PSS outputs and outcomes. PSS may provide a paid carer to help with bathing and dressing, but the responses, feelings and valuation of the experience by the user make a critical contribution to the overall output and outcomes of the service. An emphasis on PSS activities alone risks marginalising the contributions of the service user to the overall output and outcomes of an intervention.

Furthermore, users make substantial contributions to the overall production of PSS in a very real material sense, through the fees and charges they pay. This is most significant in relation to residential and nursing home care, where significant numbers of older people pay the full market costs of their care and others make graduated contributions depending on their assets and incomes. Users also contribute to the production of home care, day care and other related services through means-tested charges.

It will be important to disaggregate these user contributions to overall PSS activity.

The role of other agencies in contribution to PSS productivity

Other welfare agencies also contribute to the productivity of PSS as well.

- The boundaries between health and social care are notoriously blurred, particularly in the complex areas of intermediate, continuing and long-term care. The NHS funds continuing care in nursing homes; and contributes to the

nursing care provided for self-funded and social services-funded nursing home residents. The productivity of PSS may arguably have been increased by the recent investment of additional NHS resources in short-term intermediate and rehabilitation services; as a result, more older people may require intensive support for a much shorter time than previously, thereby contributing to a greater throughput of clients.

- To the extent that social security benefits (particularly Disability Living Allowance and Attendance Allowance) are taken fully into account in means-tested assessments for social care service charges, the DWP budget is also, indirectly, contributing to PSS productivity.
- Housing agencies are also major providers of social care support, particularly for older people and people with learning disabilities. Current DH policy is to promote the development of very sheltered housing facilities as an alternative to residential care.

It will be important to disentangle the contributions of these other statutory agencies to overall PSS productivity.

The role of informal carers

The biggest contribution to the overall production of social care undoubtedly comes from informal and family carers. This has two consequences:

- First, global outcome measures (such as well-being, quality of life, or prevention of admission to institutional care) risk blurring the respective contributions of formal PSS and informal care and, as a result, incorrectly attributing to PSS the substantial practical and social support provided by carers.
- Secondly, an increasing amount of PSS activity is directed to the support of carers themselves. In turn, this may make a major contribution to the overall output of social care. This can be conceptualised as an **indirect** output of PSS activity. The challenges of measuring indirect outputs of this kind are considerable. It may of course be possible indirectly to increase PSS productivity by increasing the levels of PSS support to carers. However, there would be potential implications for other government agencies as well, particularly for DWP, if employment-related support and income replacement provision for carers were not also increased.

The role of independent sector provision

Substantial elements of PSS responsibilities are actually delivered by independent sector providers. This is particularly the case with residential care and increasingly the case with home care services as well. Independent sector providers also deliver services to self-funding users. It would be necessary to distinguish between independent sector services provided to the latter group; and those provided under contract to statutory PSS commissioners. The latter could reasonably be included in

measures of PSS productivity, to the extent that they reflect patterns of more or less efficient commissioning and contracting.

Practical challenges

It is unlikely that social services departments' information systems have the capacity to link data on assessments of need, service inputs, outcomes and costs; or to aggregate routine data about outcomes for individuals. Our experiences of supporting the implementation of an outcomes approach in PSS suggests that analyses of individual outcomes may best be undertaken through customised, one-off analyses rather than through routine data collection and analyses.

Although it would be a crude indicator, it is possible that some of the process-related outcomes discussed above might be reflected in user satisfaction surveys conducted by social services departments. However, routine user satisfaction surveys of PSS clients may fail to capture negative views, particularly on the process-related outcomes of PSS activity, if they are seen to be carried out by or on behalf of the PSS provider. Independent surveys would therefore seem to be essential.