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Identifying the impact of adult social care: Interpreting outcome data for use in the Adult Social Care Outcomes Framework

Plain English Summary

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The Policy Research Unit in Quality and Outcomes of person-centred care (QORU) is a collaboration involving researchers in health and social care from the Universities of Kent, Oxford and the London School of Economics (LSE), funded by the Department of Health.

Our aim is to improve the quality of health and social care of people with long-term conditions through generating high-quality evidence about need, quality and outcomes of person-centred care.

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Background

At the heart of health and social care policy is the aspiration to achieve world-class improvements in health and wellbeing of the population. England has embraced an ‘outcomes’ strategy in managing the work of the NHS, socal care and public health systems, meaning that the system should assess what it does in terms of the impact it makes on people’s quality and length of life.

To assess progress in this regard the Department of Health has developed three ‘Outcomes Frameworks’, for the NHS, for public health and for adult social care provided by local authorities (LAs). The health and wellbeing of the population is measured in the Outcome Frameworks using data collected in national surveys and other sources.

The Adult Social Care Outcomes Framework (ASCOF) aims is to assess how well the adult social care system, as operated by each local authority in England, is performing. People using care services are asked a set of eight specifically-designed multiple-choice questions by survey and their responses are converted into a numerical score representing their ‘social care-related quality of life’ (SCRQoL). The Adult Social Care Survey (ASCS) is used. All local authorities are required to undertake this survey. A similar approach is used to ask about the social care-related quality of life of people who are (unpaid) carers, with six questions being used to determine a numerical score. In this case the Survey of Adult Carers in England (SACE) (or just “the carers survey”) is used.

Collecting information about people’s quality of life is important because that is what really matters to most people. But understanding what this information is telling us about care services can be difficult. The problem is that many things influence the quality of people’s lives, not just what the social care system does. Other significant influences include, for example, the severity of their health conditions, their economic situation, their living environment, and their personal characteristics such as their age. These other influences are generally outside the control of local authority social care. It may therefore not be appropriate to judge how well the case system is doing be just using information about total quality of life.

Aims and methods of the study

The project aimed to develop a measure of ‘added value’ reflecting the impact of care support provided by local authorities on social care-related outcomes. A supplementary aim was to provide initial estimates of the value for money of (community-based) social care.

A person’s SCRQoL score can be considered as being the sum of all external influences plus the effects of social care. As such, if we are able to come up with a figure for the amount contributed by the external factors then we can also subtract this figure from the overall SCRQoL score. What is left is a number – which we call the ‘adjusted’ SCRQoL score – that is a better indicator of just the effect of social care, i.e. the part that local authorities are able to affect.

The project surveyed 546 people with physical or sensory impairment (PSI), 224 with mental health problems (MH) and 220 people with learning disabilities (LD). Also, data were collected from 387 (unpaid) carers who helped look after a subset of these care recipients. The set of eight questions on quality of life were used to measure SCRQoL. The questions assess aspects of people’s lives e.g. whether they feel safe, in control, occupied, approprialely fed and dressed. Peoples’ answers are converted into an overall score between 0 and 1, a calculation that accounts for the relative importance people place on different aspects of quality of life. The zero value represents having no quality of life (in theory it is defined where people would rate their quality of life as being so bad that it is no better than being dead). A value of one means ideal quality of life. This conversion is called ‘utility weighting’.

In the study, the mean value of SCRQoL was 0.74 for people in the PSI sample, 0.71 for the MH group, and 0.87 for the LD group. People reported that hypothetically without their care services their SCRQoL would be, on average: 0.31 for the PSI group, 0.41 for the MH group and 0.51 for the LD group.

We developed a method for calculating adjusted SCRQoL scores separately for cared-for people and for carers. First, an *adjustment factor* needs to be calculated. Second, the person’s SCRQoL is calculated by applying the *utility weighting* conversion. Third, these numbers are used in the following equation:

Adjusted SCRQoL = (utility-weighted) SCRQoL - adjustment factor.

The adjustment factor can be thought of as the person’s quality of life without services. If the adjustment factor takes a high value, the adjusted SCRQoL will be modest, indicating that services are only having a small impact in this case. If the adjustment factor is small, then the adjusted SCRQoL will be relatively large, indicating that services have a large effect.

Results

The study produced adjustment factors according to the primary reason people need help. For people with physical or sensory impairment, or mental health problems it is:

Adjustment factor =		0.5798
Age: if the person is over 65 years then add:	(+)	0.0473
Self-rated health: if the rating is ‘fair’ then subtract:	(−)	0.0148
Self-rated health: if the rating is ‘bad’ or ‘very bad’ then subtract:	(−)	0.1090
Count of activities of daily living (ADLs) that the person finds difficult or is unable to complete alone without help: subtract:	(−)	0.0202 × count
Design of home: if it ‘meets most needs’, subtract:	(−)	0.0308
Design of home: if it ‘meets some needs or inappropriate’ then subtract:	(−)	0.1250
Access to local environment: if ‘difficult to get to all places’, subtract:	(−)	0.0603
Access to local environment: if ‘unable to get to all places or do not leave home’, subtract	(−)	0.1100

Since this adjustment factor is calculated by adding each influence on quality of life (e.g age over 65), it is possible to not include some influences if that were preferred. This option might be relevant for those influences where we suspect that care services could have an effect.

We calculated a similar formula for people with LD. However, due to the more limited availability of data, this adjustment was less robust than the PSI+MH version.

A similar approach was used to calculate an adjusted care-related quality of life for (unpaid) carers. As with cared-for people, carers answer a set of specifically-designed multiple-choice questions and their responses are converted into an overall score, which we call carer-SCRQoL. In theory, this indicator should embody the effects of services as well as a range of external influences.

We therefore calculated an adjusted carer-SCRQoL by subtracting an adjustment factor, as before. For carers the study produced an adjustment factor which is calculated as follows:

Carers adjustment factor =		14.353
Care recipient: has ‘dementia’, then subtract:	(−)	1.820
Care recipient: has ‘mental health problem’, subtract:	(−)	0.703
Care recipient: has ‘sensory impairment’, subtract:	(−)	1.508
Carer: is 45+, then subtract:	(−)	1.807
Carer: is ‘male’, then add:	(+)	1.437
Carer: is ‘white’, then add:	(+)	0.634
Carer: is ‘employed full-time’, then subtract:	(−)	0.036
Carer: if the ‘carer lives with care recipient’, then subtract:	(−)	3.339
Carer: if the carer has a ‘physical problem’, then subtract:	(−)	2.401
Carer: if the carer has a ‘mental health problem’ then subtract:	(−)	1.419

A complication in this case is that the carer’s survey does not currently ask exactly the specified questions to generate carer-SCRQoL. Also, at present, the results of the questions asked about carer quality of life cannot be translated directly into a scale that accounts for the importance people place on each aspect of their quality of life, unlike the 0 to 1 scale for service users. As a result the project produced a formula for calculating carer-SCRQoL from the questions in the carer survey.

Discussion points

The adjusted score seeks to better indicate the impact of the care system. It is best used for comparisons between local authorities and/or changes over time.

There are some limitations to recognise. First, there needs to be agreement about what external influences are really beyond the control of LAs. Second, the study was unable to collect sufficient data to produce a robust adjustment for services to people with learning disabilities.

Nonetheless, our conclusions are: first, that is feasible and meaningful to calculate an adjusted care-related quality of life indicator given the data available (from the ASCS and carer national surveys). Second, that using an adjusted score is merited in principle, because otherwise the care system might be assessed by an indicator that is at least in part influenced by factors outside their control.