The Care Aims Intended Outcomes Framework

Collaborative Decision-making for Well-being

What is the Care Aims Framework and how does it relate to Public Services?

- The Malcomess Care Aims approach is a powerful framework for service improvement. It is a population-based, person-centred approach to provision based on the fundamental ethical principal that all public services have a duty to do the most good and least harm for the most number of people in the populations they serve, within the resources they have available. It proposes that the only equitable way of doing this is by working out which people in the population are most at risk of not reaching their potential/being harmed and which of **these** risks/impacts would be reduced by the provision of one or more services.
- Service provision is spread across all four levels of the population (level 1(universal), level/tier 2 (targeted), and levels/tiers 3 & 4 (specialist), requiring a robust skill mix to manage complex cases and undertake sophisticated decision making and negotiation. The aim is ultimately to create a competent population that can be supported to manage their own lives.
- The Care Aims approach provides a strong strategy that encompasses managing a service, informing the population, empowering the workforce around the service user, and supporting the person and their family to manage their own lives wherever possible.
- Over 150 services/teams and organisations across the UK are using this way of evidencing practice in a wide variety of contexts.
- It is a person-centred, rather than a problem-centred, approach. It requires practitioners to ask "can I help change the impact of this problem on this person's life, and am I the best person to offer this help?" rather than "what is wrong and can I change the problem?"

What are the benefits of the Care Aims approach?

- It is a population-based approach that manages demand by managing the referral boundary and supporting public / workforce responsibility.
- It ensures capacity management decisions remain faithful to the ethical core principles of justice/fairness.
- It provides transparency of decision-making about professional input/allocation of resources
- It provides high quality services, value for money, and efficient services which empower the public and involve them as partners in achieving outcomes.
- It promotes self help and personal responsibility
- It prioritises clients for specialist intervention by considering the impact of a problem/disorder/ situation and the risk of them not reaching their potential, not on the severity of their disorder.
- It focuses on continual quality improvement and is professionally led.
- It is a powerful framework for reflective practice in professional decision making, thus it helps evidence effectiveness and supports professional reasoning
- It is an outcomes-centred approach, so focuses on the reasons for intervention rather than on the type or amount of input delivered.
- It is much more than simply a way of measuring outcomes

Implementation of the Care Aims approach involves:-

Organisations considering adopting this approach will need to develop a strong project process that encompasses a clear strategic steer and considerable tolerance for service redesign as follows:

- Redeployment of specialist staff to support all levels of risk management (universal, targeted and specialist)
- Re-defining relationships at the referral boundary to enable collaboration and helping relationships
- Re-focus of admission and discharge criteria at level 3
- Validation of current caseloads and waiting lists at level 3 to support capacity decisions
- Review of skill mix with a bias towards highly skilled practitioners working more as consultants and advisors at all levels
- A minimum of 4 days training for each member of staff over a 12 – 18 month period.
- Involvement of all partners to support consistency of message and approach
- Systems to record clinical and service outcomes with easy access to this information at all levels

- Involvement of service users in designing and reviewing service design and care packages and care plans
- Support from the organisation for service leaders to ensure implementation results in consistent change in practice across the whole staff group.
- The training of in-house trainers to support and sustain the use of the model in practice and with new staff.

How does the Care Aims approach work? (see table 4)

For the general population, specialist practitioners work at level 1 (universal) with commissioners and service leads in health promotion and prevention activities, including education of referrers and the public in the risks relating to a variety of disorders and difficulties, the scope of the help available and how to access services.

For targeted sub-populations, specialist practitioners work at level 2 (targeted) with the workforce and the public on managing the impact of identified problems by changing attitudes and opportunities and by creating supportive and effective environments. This includes training courses for groups of professionals or the public, with target groups being determined by the need and demographics of the population.

Therefore work at level 1& 2 is a population-based consultative model. The main objectives at levels 1 & 2 include health promotion & prevention, identification & signposting, and include reassurance, support and education.

When a member of the public is referred for specialist help (level 3), a decision has to be made as to whether intervention will be most effective at this level. If the most effective approach is assessed to be direct input to the referred client (direct treatment) then the client is offered a time-specific package of care. A Care Aim is allocated to this care to clarify the intended outcome and, thus, effectiveness of intervention is measured using a variety of clinical outcome measures according to the Care Aim allocated. Outcomes relate to the impact of the presenting problem rather than the condition/problem.

The person's journey (see diagram 1)

Following a request for help, support or advice, a triage decision is made on whether the impact of the problem can be managed at levels 1 & 2 by signposting and supporting universal or targeted services, or whether to admit the person for further assessment at level 3.

If further assessment is indicated a duty to assess is opened. The level of harm or future harm (in relation to illness/impairment, psychological well-being and day-to-day functioning) will suggest a level of urgency for assessment which considers the degree to which the person is impacted now in their daily life and the risk of future impact if their difficulties are not addressed. The over-riding consideration in deciding whether to admit a client for treatment will relate to the degree to which the practitioner can predict a reduction of the identified harm/impact as a result of their intervention.

If the decision is made to admit the client for intervention at level 3 service, a duty of care is opened and one of 7 'care aims' is selected, to clearly define foreseeable outcome for the first phase/episode of intervention. Before a package of care is provided, an episode goal is set and a baseline is taken against which the outcome can be measured. Intervention at level 3 may be direct or indirect, in a variety of locations, and is set for specified episodes. Each episode is followed by re-assessment of the impact of the problem to determine whether to open another episode and set another Care Aim or whether to close the case and signpost the person back to universal or targeted services.

If the client needs to access help at Level 4, practitioners working at this level would also use Care Aims to evidence their practice.

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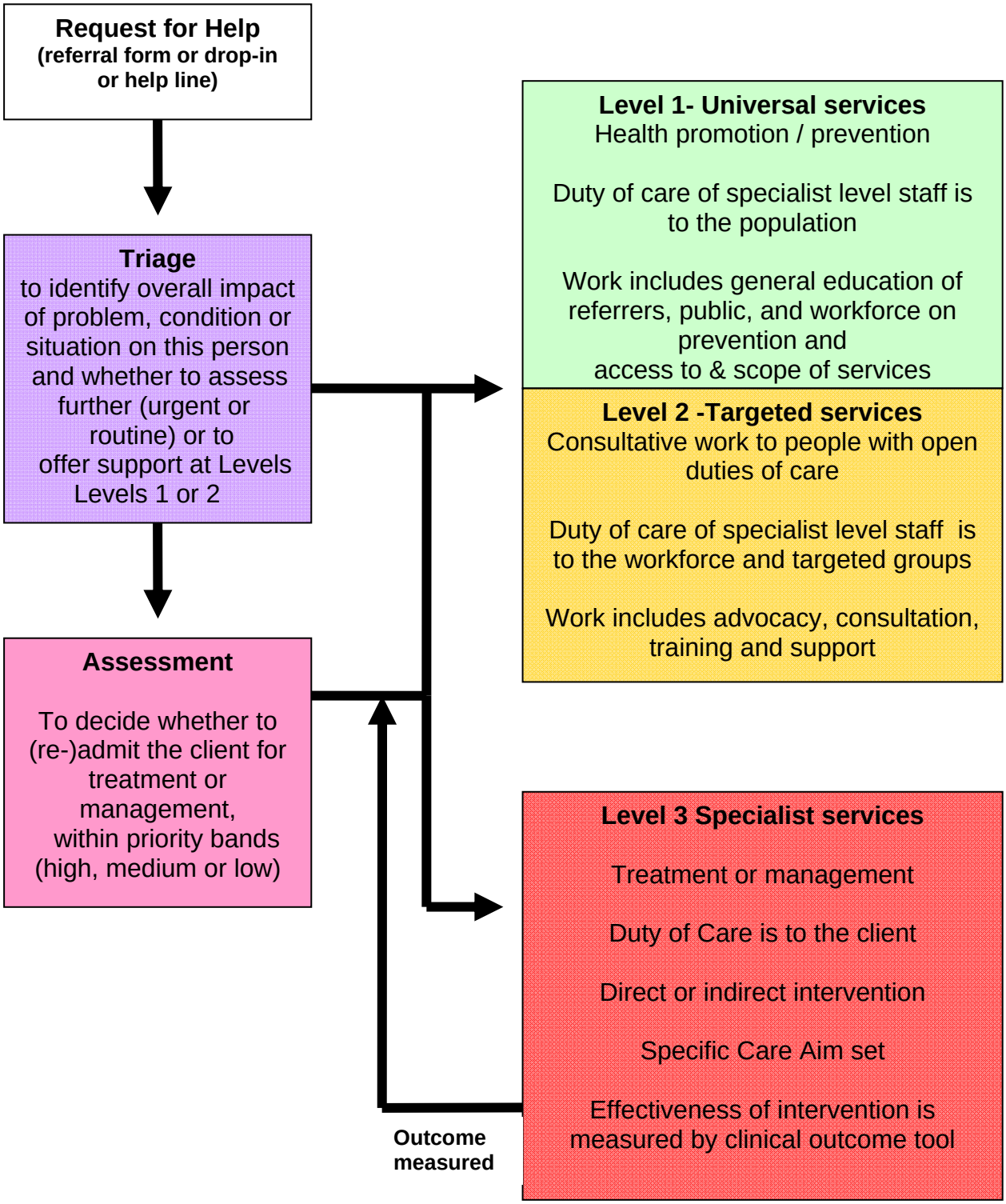
Please Diagrams and Tables below

Care Aims Pathway (Diagram 1)

Based on the **impact** of the problem on the person and on his/her day-to-day life, and how much **loss of potential** or **harm** this is causing.



Triage is based on the following guidelines:-

Table 1

Functional ability (level of disability resulting from the problem)
Impact of the disability on daily life and the burden of care on the carers / educators
Impact of the environment (s) on the client's ability to live their chosen life
Level of **anxiety and insight** shown by client/carers/educators/others
Timing: evidence available that suggests delaying care has an impact on the outcome

Scored as *urgent*, *routine* or *not necessary* to admit for further assessment / investigation

Prediction of Effectiveness at level 3 is based on the following guidelines:-

Table 2

Motivation: the client's (or carer's) likely engagement in and responsibility for treatment
Likely outcome: the evidence for, or previous response to treatment indicating, a good prognosis
Stability of the impact / situation (in relation to the likely effectiveness of care)
Level of help the client is already receiving from other services, and the client's response to this (in relation to prognosis)

Scored as a *high*, *medium* or *low* priority, for admission to level 3 treatment or management.

Level 3: Direct Professional Intervention

Each Care Aim clarifies why the practitioner is intervening at Level 3, and helps to identify the intended outcome for the first episode of care. A SMART episode gaol and a set short term goals are agreed.

At the end of each episode, the effectiveness of input can be measured, according to the Care Aim used and against the baseline taken at the start, using one of several Professional Outcome measures (such as COPM, TOMS, EKOS, Visual analogue scales, etc). The measure will match the intention.

Involvement with many clients requires more than one episode and thus a Care Pathway is described in terms of episodes, care aims and clinical outcomes.

Table 3.

Care Aim	Intention of Interv	examples of possible outcome measures
Investigation (Assessment)	To determine the nature and impact of the presenting problem, condition or situation.	Assessment protocols.
Prevention (Anticipatory)	To anticipate and prevent or reduce the chance of any future difficulties.	Risk scales.
Stabilisation (Maintenance)	To slow down or stabilise a deteriorating functional impact or situation.	Standardised measures.
Participation (Enabling)	To reduce the impact of the problem / condition / situation, and increase functioning, thus enabling the person to take part more in his/her daily life	Tallies of current functioning; video recordings; reports from client or other in their environment.
Resolution (Curative)	To resolve the problem, or improve the client's skills and facilitate lasting change in these to within normal limits (increased participation is not expected at this stage)	Standardised measures; published outcome measures.
Improvement (Rehabilitation)	To reduce the problem, or improve skills, though they are unlikely to reach normal limits (increased participation is not expected at this stage)	Standardised measures; published outcome measures
Adjustment (Supportive)	To facilitate change in feelings, attitudes and insight about care and/or the presenting problem.	Attitudinal scales; visual analogue scales.
Comfort (Palliative)	To increase comfort (where no other change is possible or appropriate) although the impact of the problem / condition and the impact on daily life remains the same	Visual analogue scales , pain scales

Resources are spread across all four population levels. The type of work and the skills required are different at each level as described below in table 4.

Table 4.

Level of risk	Type of Clinical work	Skill mix in Health	Example client / work
Level 1 **Universal**	**Health Promotion / prevention** work with **services** and **commissioners:-** • Informing commissioners about population risks • Support for self-help • Education and training of workforce	Mostly bands 7 and 6, supported by bands 5 and 4 to gain experience.	• Training trainers • General advice on environments, training packages etc • Leaflets, websites etc • Educating referrers, general public and other agencies about access, impact of problems and scope of work
Level 2 **Targeted**	**Consultative** work with **the public** and **workforce:-** • Working on managing impact of the problem on the targeted population by changing attitudes, environment and opportunities in specific places / people • Training other professionals / parents /carers/educators, etc.	Bands 8 and 7 involved in training the specialist workforce and complex consultation where sophisticated decision making and negotiation is needed. Other Training and consultation planned and delivered mainly by bands 7 & 6, with band 5 to gain experience.	• To target groups of the general population where demographics signal these target groups are at risk of not reaching their full potential, via screening, disorder, demographics etc. For example:- o Parenting groups o Narrative projects • Training packages delivered • Advice to specific places on improving access and environment and reducing risk
Levels 3 & 4 **Specialist & Regional** There is a clinical risk *and* the professional has a duty of care	**Treatment:-** • Working with **client** (as well as family and workforce) • Working on **skills/client attitude/condition** (where managing the impact of the difficulty on the client cannot be achieved only through changes in opportunities, others' attitude, or the environment) • **Care Aims** used to define the reason for intervention and to set short term goals and monitor effectiveness • Clinical effectiveness measured by **clinical outcomes** related to each care aim	Mostly bands 3, 4, 5 & 6 to consolidate skills, and develop specialist skills. Bands 7 & 8 to work with complex cases, and offer support and second opinions. **Skill Mix** Proportion of time working at level 3 by band is recommended to be **approx:** 90% of B3,4,5 80% of B6 60% of B7 40% of B8 (varies according to demographic)	• Where clinical intervention is likely to change the impact of the problem and help the client to reach their potential • Care packages and pathways agreed • Care Plans agreed and evaluated