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 development. It takes a population-based, person-centred approach to service provision. It is driven by 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.
- Service provision is spread across all four levels of the population (level 1(universal), level/tier 2 (targeted), and levels/tiers 3 & 4 (individual), requiring a robust skill mix to manage complex relationships 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 framework provides a strong strategy that encompasses person-centred leadership and practice that changed the environment of relationships everywhere to support integrated, outcomes-driven, strength-based decision-making to build resilience.
- Over 1000 services/teams and some 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, fundamentally changing the power imbalance in the traditional models of care.

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 is an outcomes-centred approach, so focuses on the reasons for intervention before the type or amount of input delivered.
- 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 equips them to lead the process of achieving their personal outcomes.
- It promotes self-help and personal responsibility.
- It prioritises persons for individualised intervention by considering both the impact of their disorder and the likely effectiveness of intervention.
- It is a powerful framework for reflective practice; thus, it helps evidence effectiveness/intervention outcome and supports line of sight and professional accountability
- It focuses on continuous learning and provides organisational intelligence that comes from the people who are closest to the challenges

How does the Care Aims approach work?

It uses a population-based consultative approach. The main objectives at the universal and targeted levels include health education, health promotion & prevention, identification & signposting, and involve reassurance, support and capacity-building. Specialist practitioners work at level 1 (universal) with commissioners and service leads in health promotion and prevention activities, including collaboration with referrers, commissioners, senior managers and the public around the relative risk, the scope of 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 relationships and environments. This includes open-dialogue, coaching and consultation for the workforce and the public, with target groups being determined by the demographics of the population and epidemiology where known.

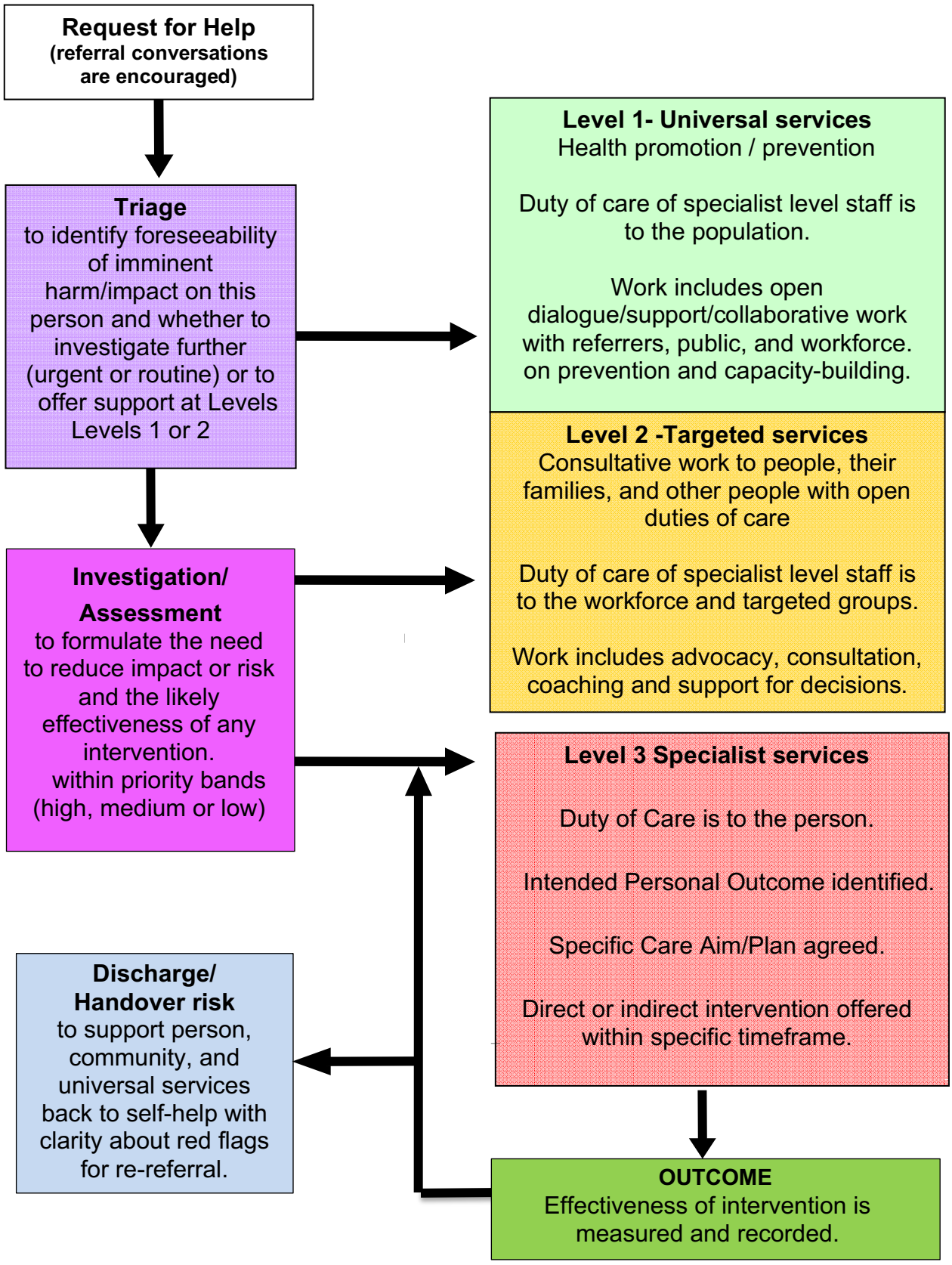
When a member of the public is referred for individual help (level 3), a decision has to be made as to whether intervention will be most effective at this level. If the most effective approach is assessed to be a specific intervention for the referred person, then they are offered a time-specific package of care. A Care Aim is allocated to this care to clarify the intended outcome. The effectiveness of intervention is measured using a **variety of clinical outcome measures** selected according to the Care Aim.

The Care Aims Intended Outcomes Framework

Collaborative Decision-making for Well-being

Care Aims Pathway

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



The Care Aims Intended Outcomes Framework

Collaborative Decision-making for Well-being

Triage decisions centre around the concerns of the referrer and their view of foreseeable harm/impact and consideration is given to:

Table 1

Capability and Capacity: (strengths and challenges)
Impact on them and perceived the impact the person they are referring, their family, carers, and/or community.
Impact of the context and environment (s) of the concerned person on their ability to address their concern.
Congruency of **anxiety and insight** shown by person/carers/educators/others.
Timing: evidence available that suggests delaying care may cause irreversible harm.

Scored as *urgent*, *routine* or *not necessary* to admit for further investigation or direct help now.

Assessment decisions centre around formulation of need and likely effectiveness of level 3 intervention by that service/practitioner. Consideration is given to:

Table 2

Understanding of Personal Outcomes: What matter to person (family/carers) and their participation in finding a way of meeting their outcome
Likely outcome: the evidence for, or previous response to treatment, indicating a good enough prognosis
Stability of the situation: (in relation to the likely effectiveness of care)
Level of help the person is already receiving: from other services, and the person's response to this (in relation to risk of psychological dependency.)

Scored as a *high*, *medium* or *low* priority, for treatment or management.

Individual intervention

Each Care Aim clarifies why the practitioner is intervening at Level 3 and helps to identify the predicted outcome of a specific episode of care.

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, Visual analogue scales etc).

Involvement can require more than one episode and thus a Care Pathway is described in terms of episodes, care aims and clinical outcomes.

The Care Aims Intended Outcomes Framework

Collaborative Decision-making for Well-being

Table 3. Definitions

June 2009

CARE AIMS DEFINITIONS

(Original Care Aims Labels are in brackets)

CARE AIM	PRIMARY PREDICTED OUTCOME OF THIS EPISODE OF CARE FOR THIS PERSON *What is my Duty NOW?*
INVESTIGATON (Assessment)	I will have an understanding of the **functional impact/future impact** of the presenting problem/situation or condition. I will know **if** I have a **duty of care** to this service user and I will know the **Care Aim.**
PREVENTION (Anticipatory)	The **risk** of **future harm** (where predicted harm/functional impact has not yet happened) will have decreased and/or any **anticipated** difficulties/complications or impacts will have been **prevented**.
STABILISATION (Maintenance)	Where **functional impact/harm** is currently unstable or deteriorating, this will have **stabilised** *but not improved*, or deterioration/ loss of function will have **slowed down.** *This care aim does not apply to stable situations.*
PARTICIPATION (Enabling)	The **functional impact/harm** caused by the presenting problem/difficulty/situation or condition will have **decreased** or will be **absent** and the service user will be **participating** more in his/her daily life.
RESOLUTION (Curative)	The **condition** will be **healing**, **problem resolving** and/or **skills** will be moving towards **normal limits** (pre-morbid/age-appropriate levels) but I am not expecting a change in **functional impact** (participation) ***yet.***
IMPROVEMENT (Rehabilitative)	The **condition** will have **improved**, **problem** will have **diminished** and/or **skills** will have **increased**, but these will be unlikely to reach normal limits in the future. I am ***not*** expecting a change in **functional impact** ***yet.***
ADJUSTMENT (Supportive)	**Readiness for change and/or acceptance** of the current situation/condition/impact will have increased as a result of a change in feelings, attitudes and/or insight. I am ***not*** expecting a change in function or impact ***yet.***
COMFORT (Palliative)	**Comfort** will have increased and/or **pain** will have diminished but the condition/problem or overall impact of these is unlikely to have changed *(i.e. the service user will not be participating more actively in daily life.)*

© Kate Malcomess, June 2009

Table 4: Person-centred outcomes pathway relates to where the person is in their journey towards recovery and current level of impact/trauma for them.

POSSIBLE PERSON-CENTRED OUTCOMES PATHWAY © Kate Malcomess, 2015

Primary Prevention		
At risk populations and their community are aware of foreseeable harm and asking for help when they identify an increase in risk	The public and health and social care colleagues will know who and when to ask for help when they identify risk	Population will understand how to maintain health and well-being, will remain self-managing as long as possible and return to self-management as quickly as possible

TRAUMA and Acute Outcomes				
I /my family feel safer and my physical health is stable	I/my family feel understood and listened to	I /my family have been able to explore my/their feelings about what has happened	I and my family/loved ones will be able to support and engage in any further intervention process, where necessary	I and my family/loved ones will be exerting reasonable control over immediate choices

Re/habilitation Outcomes					
I /my family feel respected and have a sense of self worth/ presence	I /my family am/are connected with the level of community I want	I/my family have a greater sense of hope about the future and are feeling more in control of immediate choices	My/my family feel in control of my needs in relation to privacy and recreation wanted	I /my family can think about my meaning and purpose and life plan	I /my family am financially and functionally able to sustain life and well-being

Transition				
I am as independent as I can be – sense of competence/ capability	My family/community understand my life plan and support me in this	I/my family am working towards specific self-determined, person-centred clear goals around increased competence	I /my family have co-produced a clear plan to achieve these goals	I /my family/my community are able to manage my risk and access services as needed (retrigger)

Reintegration/Self Management			
I /my family have clear personal goals related to my meaning and purpose and status in the community and have co-produced a clear plan to achieve these	I /my family have as much control as possible over the key decisions and choices for my life (to the extent of my capacity)	I/my family are feeling competent and confident to problem solve and ask for help when I/we need it	I /my family are feeling part of a community of my/my family's choosing

Secondary Prevention		
Person and community aware of foreseeable harm and asking for help when an increase in risk is identified	Risk of complications and recurrence will be managed – continuing to meet well-being needs independently	Person and proximal people will be aware of self-management strategies that build resilience

The Care Aims Intended Outcomes Framework

Collaborative Decision-making for Well-being

Table 5: Specialist service resources are spread across all four levels of risk management. The type of work and the skills required are different at each level as described below:

Level of risk	Type of Clinical work	Skill mix in Health	Example person / work
Level 1 **Universal**	**Health Promotion / prevention** work with **services** and **commissioners:-** • Informing commissioners about population risks • Supporting for self-help • Equipping and building the capability of the workforce to manage risk as close to the person as possible	Mostly bands 7 and 6, supported by bands 5 and 4 to gain experience.	• Collaborative work with referral agencies • Coaching/mentoring of colleagues in universal and primary services • Support for third sector services • Educating referrers, general public and other agencies about red flags, scope of practice
Level 2 **Targeted**	**Consultative** work with **the public** and **workforce:-** • Working on managing foreseeable impact on targeted population by changing attitudes, relationships, environments and opportunities in specific places / people • Working alongside other professionals / parents /carers/educators, etc. • **Being available at the referral boundary for conversations and support**	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.	• Target groups of the general population where demographics signal these groups are at risk of future harm, via screening, demographics etc. For example, ○ Social prescribing ○ Narrative projects ○ Open dialogue • Offer training. • Work with specific providers on improving access, environment and relationships.
Levels 3 & 4 **Individual & Regional** There is a clinical risk *and* the professional has a duty of care	**Individual Intervention:** • Working with **person** (as well as family, community and workforce) • Working on **participation/skills/ attitude/condition** (where managing the risk or impact of the difficulty on the person cannot be achieved only through changes in opportunities, others' attitude, or the environment) • **Care Aim** used to define the reason for intervention and to set short term goals and monitor effectiveness. • **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** Recommended proportion of time working at level 3 for each Band is 90% of B3,4,5 80% of B6 60% of B7 40% of B8 (varies according to demographic)	• Formulation that intervention is likely to change the impact of the problem and help the person to reach their potential now • Care Aim agreed, timescale set for evaluation and care plane agreed • Outcome of intervention recorded and formulation of need updated

The Care Aims Intended Outcomes Framework

Collaborative Decision-making for Well-being