

Developing and Implementing a Local Performance Measurement System in Older People's Services

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Abstract

This paper summarises work in developing and implementing a local performance measurement system within older people's services. Difficulties in developing such systems include central government demands for data that are not always appropriate to local concerns, technological problems and problems with interpretation. The work attempted to confront these difficulties by outlining a model of the most important domains for monitoring, devising a suite of indicators to comment on organisational objectives and using comparative analysis to formulate questions concerning key areas of variation. The system offers a number of benefits and focussed implementation can overcome difficulties and increase co-operation from staff.

Introduction

The current performance agenda has generated enormous demands upon social services authorities to justify and monitor their practice in a manner unparalleled in previous periods. Since the social services reform programme set out the performance measurement approach in late 1998 (Cm 4169, 1998), there has been a proliferation of documents, requests for information and data definitions, all intended to assist in measuring performance. The Performance Assessment Framework (PAF), which was intended to provide an integrated source of data to judge the practice of social services authorities, has changed in the three years since its inception (Department of Health, 1999). New returns, such as those of the Referrals Assessments and Packages of Care (RAP), have been added (Department of Health, 2001a). The validity and reliability of much of the information collected have been increasingly questioned (Miller, 2002). All this activity and debate have created confusion locally. Social services departments are currently struggling with new demands for information as well as facing difficulties in implementing their own performance management systems.

A number of problems characterise the current view of performance measurement within social services. Firstly, local management is so focussed upon collecting information for the purposes of central returns that attention is diverted from the kinds of information useful in monitoring local practice. Secondly, the information technology infrastructure available within social services authorities is often insufficient to support the development of reliable indicators. Thirdly, there are serious problems with the interpretation of some indicators and confusion over the measurement terms offered. Fourthly, the modernisation agenda has created so many

overlapping areas of action that efforts at devising locally based performance systems are often diluted. There are also questions of ownership and utilisation of information and often, as a result, practitioner based resistance to the monitoring of performance. What is needed is a model of best practice that can guide the design of locally based systems within social care. This paper puts forward such an approach with reference to work conducted before the implementation of the current performance agenda. The approach is evaluated using information derived from interviews with senior staff who played key roles in the planning, development and implementation of a performance system in a social services department. From this, suggestions are offered more widely for the future implementation of performance systems within social services authorities.

One concern within social services authorities is the extensive range of data currently mandated by the DoH and the difficulty authorities have in collecting this. In some cases, there are difficulties in providing accurate data particularly on costs. Computerised systems may be unable to integrate and analyse the data once it is collected. There also seems to be a lack of structure to the available information. The national PAF data is modelled around important government concerns with the consistency of service provision across the country. It is largely *descriptive*. There are only limited attempts to link data together in order to comment on important dimensions of performance such as efficiency. Against this background, it is difficult for individual authorities to measure success against their own local objectives. Commentators have already argued against the particularly centralised nature of the managerialist agenda in social care (Sheldon, 2001) and it is worth noting the way in which the current indicator set has reflected this. Monitoring local concerns and

reconciling these against the demands for information from central government are now of immediate relevance to most social services managers.

This paper draws on work undertaken by the Personal Social Services Research Unit (PSSRU), University of Manchester in developing a performance measurement system within a large county social services department. It focuses on developing a system for older people's services although many of the principles can be applied to other user groups such as mental health (Clarkson and Challis, 2002). The development work began when the performance agenda was in its infancy, but it is hoped that the framework and measurement issues described can inform current attempts at implementing such systems. The first section describes the background to the work including the emergence of the DoH policy initiatives directed at monitoring social care performance. The framework used to structure the work is then presented and is followed by an outline of the development work undertaken in the authority. Examples drawn from the suite of indicators recommended to the authority are then presented. The paper ends with a discussion of some of the measurement issues raised by the work and an outline of guidelines to assist those charged with implementing such systems.

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Background

The work was commissioned in late 1995, before the reforms set out in the Modernising Social Services White Paper (Cm 4169, 1998) made the monitoring of performance a mandatory requirement. Although, at that time, social services departments were not subject to central government performance monitoring to the same extent as at present, they nevertheless saw a need to monitor their activity more closely. In this context, the PSSRU was asked by Cheshire Social Services Department to recommend and then help to implement and monitor a set of performance indicators for its services to older people. The department already had a well-established county-wide computerised information system which held data concerning service provision and finance. At that time, the data available for authorities to monitor their performance were drawn from the

Department of Health's Key Indicators, originally set out as a demonstration package in December 1988 (Warburton, 1988). In addition, routine information covering primarily service and expenditure data were returned to the Audit Commission (see Audit Commission, 1986) and CIPFA (Chartered Institute of Public Finance and Accountancy) (CIPFA, 1999). These indicators were, to a large degree, the only detailed resources to which social services had access. However, they were used predominantly to compare one local authority with another. Departments had begun to see the merits in collecting their own information for internal use, particularly in the light of the reforms of community care and care management in 1993 (Cm 849, 1989; Hoyes et al, 1992). However, they struggled to respond to pressures to monitor local markets, as potentially useful information was often unavailable. In this respect, the nature of the available data had come under increasing criticism. Financial information was over-represented to the exclusion of other information detailing the way in which services were provided. Information was also prone to error and, particularly cost data, ignored some basic 'rules of thumb' in collection (Miller, 1986; Duncan and Warburton, 1987; Knapp, 1987). Departmental returns to the DoH and organisations such as the Audit Commission and CIPFA were not always taken seriously and, already, there was resistance to the closer monitoring of performance particularly amongst front-line staff who generated the necessary data itself.

The modernisation agenda was intended to introduce performance monitoring in a structured way so that the PAF indicators, introduced in the White Paper Modernising Social Services (Cm 4169, 1998), could provide a more integrated structure to the available information. Local social services departments were mandated to monitor performance within the Best Value regime (Cm 4014, 1998), which meant that authority wide objectives and indicators needed to be developed. It was within this context that pressures to devise reliable and useable measures were emerging. The work described below sought not only to address these concerns but also, by developing a suite of indicators built on a causal model, aimed to provide a means by which such central government demands could be integrated with the needs of

local managers and professionals. In so doing, it provides what we consider to be a logical and systematic approach to the use of indicators and techniques for measuring social care performance. The first stage of the work involved the construction of a model within which to devise relevant indicators. This was presented to a range of staff, from senior managers to team leaders and practitioners. The second stage comprised a number of workshops where performance principles, relevant data needs and measurement techniques were identified. The third stage moved on to highlight the uses of performance information within the department. Lastly, incentives to implementation that may aid future approaches to monitoring and performance measurement were identified.

A Performance Model

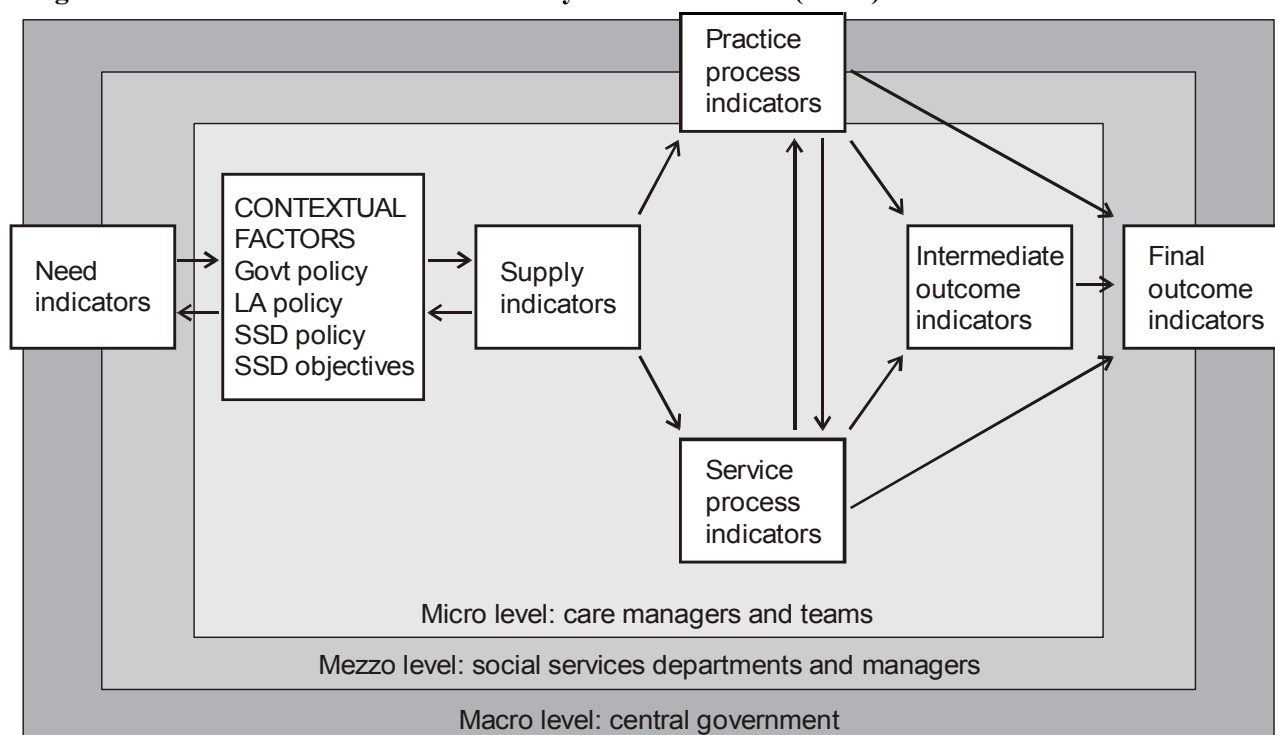
The apparent failure to locate indicators within a model that structures their design, collection and interpretation is one reason for current omissions in national collections. Indicators have been selected with little reference to research findings and practice from other areas, including other countries where performance methods are being implemented (Rosen et al, 1993; Department of Human Services, 1994; Kates et al, 2001). Although the PAF has been applauded as a performance framework, it nonetheless only provides a list of indicators within descriptive categories salient to current DOH concerns. The central focus is about aligning indicators to government objectives and concerns with regulation. To monitor performance locally demands that we focus instead upon analytical models, which mirror the way in which services are produced and delivered. Fortunately, examples of such 'logic models' (Westat Inc/US Administration on Aging, 1999) exist, from Donabedian's (1980) health care model of structure, process and outcome to the PSSRU's production of welfare model developed for social care (Challis and Davies, 1986). In beginning this work, a model of social care performance was articulated that could guide the collection of local indicators (Challis and Warburton, 1996). The Performance Indicator Analytical Framework (PIAF) links together indicators of need which, filtered through national and local policy, influence the supply of services.

Indicators of service process cover the ways in which services are allocated and practice process indicators cover the pattern of operation of services in relation to the core tasks of care management. Finally, intermediate outcome indicators reflect patterns of service output and final outcome indicators the health or social benefits of care.

The PIAF was presented to a representative group of staff in the social services department as an introduction to the development of relevant performance indicators within each domain. The framework was seen as important in that it could not only signal the types of indicators needed for local monitoring but also structure the available national indicators to more faithfully reflect the operation of social care. This was considered important in the present work where staff at all levels, from local management to senior practitioners and team leaders, were encouraged to see the PIAF as structuring relevant information at both a national and a local level (see Figure 1). It also permitted indicators to be related together to begin to test and identify causal processes and explanations of differences.

The development of such a model was thought to be a valuable tool in assisting staff to conceptualise their practice. It helped them move from a relatively simplistic conception of measurement (identifying a dimension of interest and searching for indicators with which to measure it) towards a model of the inter-connectedness of features (identifying domains of evaluation and devising potential indicators from these domains to judge performance along particular dimensions). The nature of the model permitted the ordering of information in a way that reflected the actual operation of service delivery in an authority. It provided an anchor for the subsequent development of indicators around local objectives. In this way, the model draws on and develops the Social Services Research Group's performance management framework described in 1988 (Barnes and Miller, 1988). At the time, this represented an improvement upon existing interpretations of the information needed to judge performance locally. However, in a post reform, increasingly outcomes orientated environment, a more analytic model is needed.

Figure 1: The Performance Indicator Analytical Framework (PIAF)



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Development Process

The process of developing the performance system was an iterative process between PSSRU researchers and staff in the department. Clarification of the measurement approach, along with a rehearsal of the potential strengths and weaknesses of sample indicators drawn from the PIAF, was outlined in a series of workshops. This provided an opportunity for a range of staff to familiarise themselves with the indicators and the underlying rationale for their development. Indicators were closely aligned to the department’s objectives for its services to older people. These and some examples of indicators recommended to the department within each domain of the PIAF are presented in Box 1. A series of intensive meetings was then convened in which each proposed indicator was considered in the light of feasibility of data collection, relevance, clarity of specification and means of standardisation. What emerged was a *suite* of potential indicators, structured according to the PIAF, from which measures for judging a particular objective could be selected. This approach draws upon best practice in designing performance systems in business and other areas of public sector activity

(see Kates et al, 2001). It contrasts with the current approach of the PAF, in which indicators are allied directly to policy concerns or other areas of interest. The difficulty in doing this is that new areas of practice, such as the emergence of integrated assessment approaches (Department of Health, 2002), may be overlooked. Consequently, additional indicators constantly have to be devised to monitor practice in these areas and this tends to dilute efforts at presenting and analysing existing information. PSSRU is currently engaged in developing the indicators recommended in this work, which number over 140, in order to represent a best practice suite aimed at assisting authorities to monitor performance locally.

With the indicators in place, the next stage of the process was to investigate whether these could be collected reliably and what procedures needed to be set up to check on the accuracy of the information. Dissemination of information was also a core task discussed in the workshops. There was a need to spread information, at different degrees of aggregation, across a wider range of staff than the core group of middle managers traditionally associated with planning such systems. This meant that staff at all levels were involved in the approach

Box 1: Local service objectives for older people and examples of associated indicators

| Objectives | Examples of indicators |
|---|---|
| Targeted - ensuring the right services go to the right people at the right time, with a focus on high dependency groups and the use of 'promotional' funding to enable other agencies to provide appropriate care. | Practice Process: Proportion of cases allocated to each priority category after screening. |
| Timely - referring to the need for assessment and service processes to support care through timely actions and responses. | Practice Process: Time between initial contact/referral and first response by priority category. |
| Efficient - referring to the best use of resources and the need to ensure that: spending is appropriate to the current resource position; spending decisions are continually reviewed; and unit costs are kept at reasonable levels. | Service Process: Total average weekly costs to social services department of care packages in the community in cost bands by dependency. |
| Diversion - means diverting older users from institutional care to community-based care, striking a balance between what is desirable and what is possible. | Supply: Number of older people receiving intensive personal care on a daily basis. |
| Individual - within a context of diversion, referring to non-institutionalised services tailored to individual needs, the range of care plans, the diversity of care packages, and service flexibility. | Supply: Percentage of home care hours purchased by social services department for older people provided in evenings and at weekends by sector |
| Involved - including users' and carers' involvement in assessment, care management, and related decision making. | Need: Proportion of older people who self refer or who are referred for screening by others. |
| Choice - covering the range of services available to users and carers, and the number of options actually offered to them. | Intermediate Outcome: Proportion of users falling into main reasons for admissions to care homes defined by the department. |

and this increased effective participation. The approach chosen was to take forward a limited number of indicators for which data could be reliably collected in a planned and focussed way. After design and measurement issues associated with these indicators had been discussed and resolved, it was then seen as reasonable to widen the scope and include a larger group of indicators that could comment on more peripheral issues. Key areas of debate at this time concerned the role

of proxy indicators (designed to comment indirectly on a dimension of interest), and whether modes of recording and definitions were accurate. For example, a practice process indicator designed to comment on a timely response in care management procedures - the time taken to complete an assessment, stimulated debate as to when assessment begins and ends, when care planning begins and implementation commences. Such debates need to inform the design of

information systems supporting the collection of these kinds of data.

After the indicators had been reliably collected, the workshops moved on to consider the interpretation of the outputs from them. This focussed on the presentation of data from indicators chosen for each objective, shown on a comparative basis by district against the average for the County as a whole. This comparative approach was deliberately designed so that staff could begin to examine the reasons behind variations across districts and consider whether remedial action was required. Other levels of aggregation could also be used for analysis. For instance, similarities and difference in service response between teams could be compared. Even variations between individuals within teams could be compared against variations between teams. Again, performance, particularly financial performance, could be compared over time. Finally, comparison of actual performance could be compared against expected performance. The interpretation of data is dependent on the benchmark chosen, so that if the comparator is the departmental average, analysis will be different than if the comparator is by year or against some external standard, drawn from research or best practice approaches.

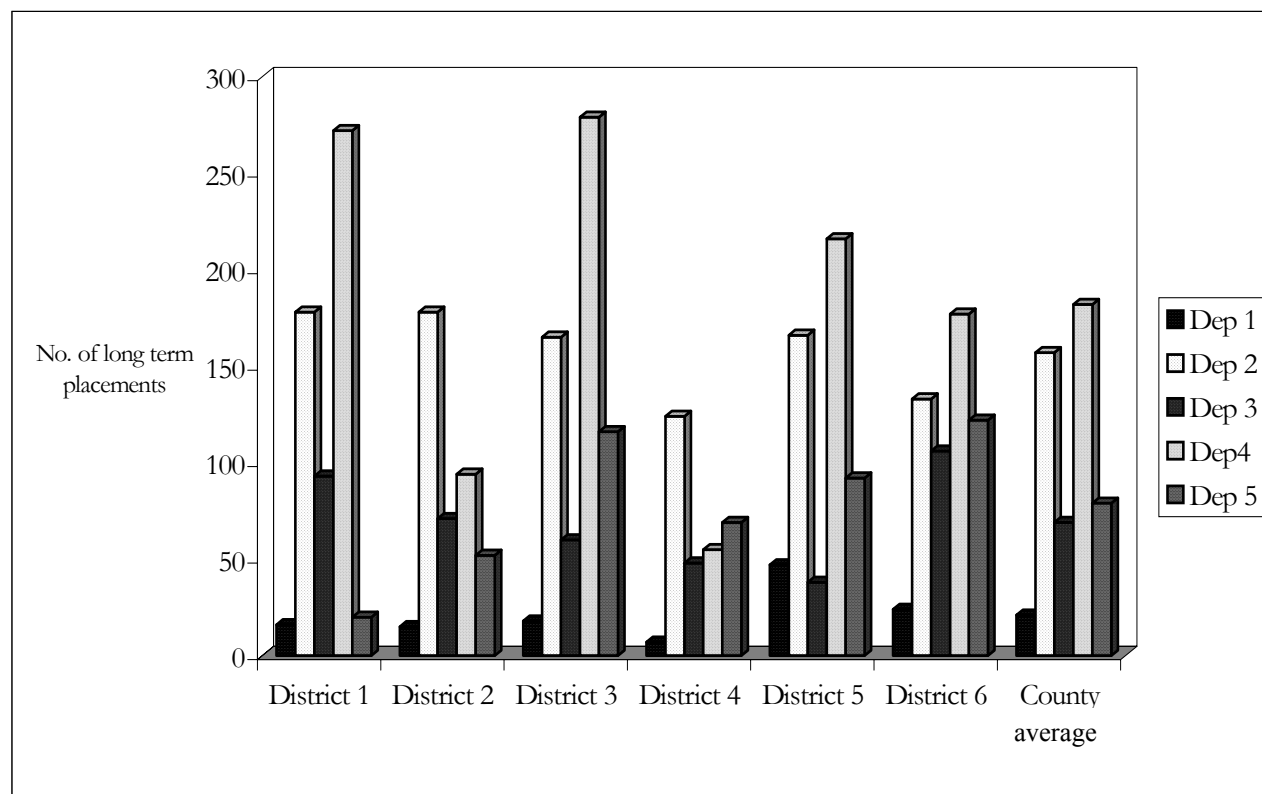
Examples of the Approach

Included in the workshops were presentations by staff led by the management group who were present at the work's inception. These would commence with an outline of comparative data from particular indicators and proceed to an interpretation of the relevance of any variance from the county average. For example, the objective of *targeted* services was set to focus priorities for service delivery on the most vulnerable elderly. Initially, the achievement of this objective was difficult to measure. A standardised measure of dependency was needed that could be integrated into the assessment process in order to signal those cases who were most vulnerable and in need of more intensive care. A dependency scale was thus developed for use in all assessments where residential or nursing home care might be considered. The scale relied on professional judgement as to a person's functional ability in domains such as personal hygiene, mobility, night

attention, continence, memory and mood. In addition to covering many of the criteria required for an assessment tool (Stewart et al, 1999), the scale was intended to inform care managers' judgements and provide consistency across workers and teams. Dependency scores from the scale were aggregated into five 'bandings' that were also used to assist with payments for residential and nursing home care. Inspection of indicators relating to both home care and placement activity by dependency bands was thus used to comment on the targeting objective. Figure 2 outlines output on one indicator examining the distribution of current long-term placements of older people by dependency bands. This intermediate outcome indicator measured the prevalence of placements in both residential and nursing home care at the end of each month. An interesting difference occurred in the distribution of care banding across districts. The highest dependency placements (Dependency 5) were the most expensive for the department to fund but one district, District 1, had fewer proportionately than other districts. Management enquiry found several reasons why this might be so. Of most importance was the existence of health practitioners within care management teams in the district. This had the effect of moderating nursing assessments and identifying more accessible health service provision in the area, both factors that reduced the need for high dependency nursing home admission in the district. The dependency profile of placements across the county did not show a smooth gradient of placements against dependency. Further action was therefore required in order to target resources more precisely, in particular domiciliary services, towards the more vulnerable elderly. Of special note were the high numbers of placements in particular districts in Dependency Band 2, which reflected those older people needing a high level of assistance or supervision that could, nevertheless, be provided at home. The characteristics of such cases warranted further attention and, in this way, the system was seen as useful in directing attention to areas of concern.

The department's *efficiency* objective was measured in a number of ways. Firstly, efficiency relates to the best use of resources and to ensuring that spending decisions are continually reviewed in light of the current resource position. Therefore,

Figure 2: Intermediate outcome indicator - distribution of current long-term placements by dependency bands (one month figure 1997/98)

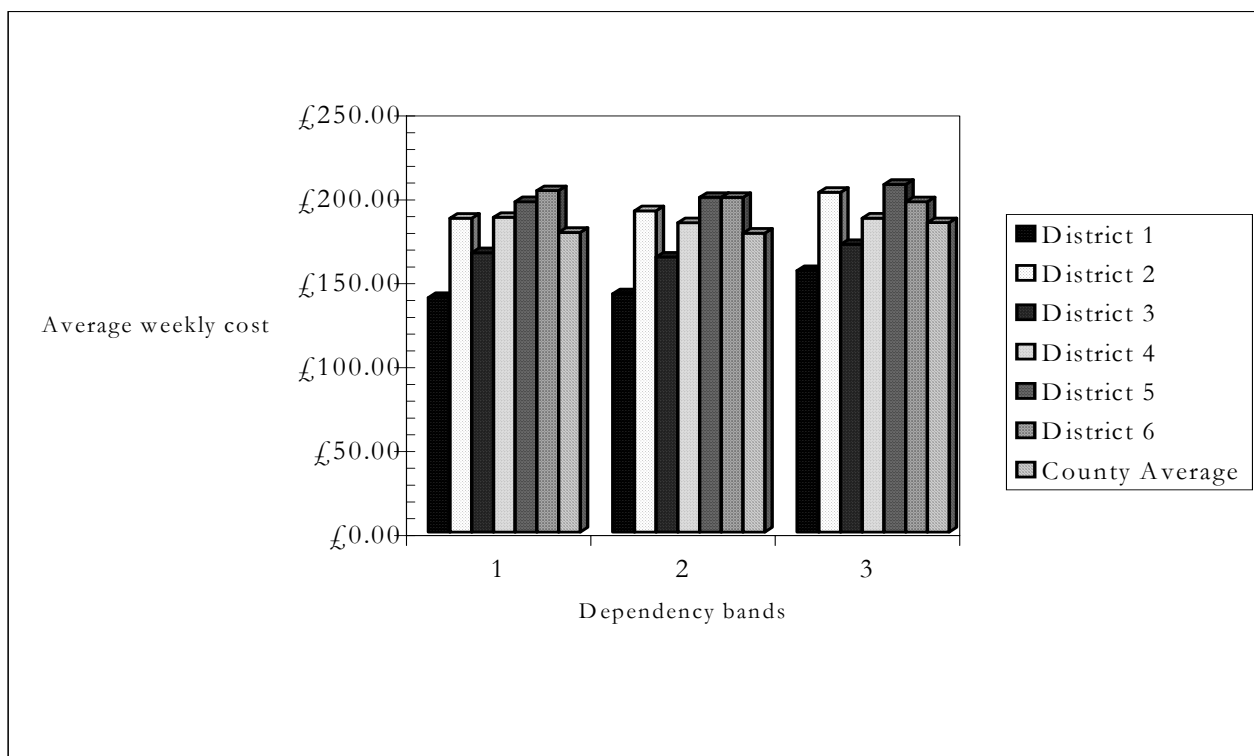


appropriate indicators to measure the success of this objective were those relating to cost and particularly the cost of care packages, with a reference point being the limit on care packages at home (£185 per week at the time of the study). Care packages costing more than this were signalled for special attention from team leaders and management. In order to monitor the overall efficiency of home care, a service process indicator was devised showing the total average weekly costs of care packages by dependency (see Figure 3). This indicated more variation of costs across districts than across dependency levels.

At one point, the department set targets for a five per cent reduction in costs overall with a ten per cent reduction in the costs of high cost packages. Increases in income collection through charges were also planned to achieve this objective. The information in Figure 3 enabled managers to see the variation across districts in the cost of care packages compared with the County average. The average cost of care packages differed across districts although within districts this average cost

was consistent over time. Two districts whose care package costs were consistently lower than others, Districts 1 and 3, were signalled for special attention. It was found that their staffing levels were similar, as were their purchasing patterns. In both districts, most care packages costing less than £100 per week were composed of single services, such as home care. Certain factors were seen as contributing to these purchasing patterns: both districts had a larger supply of day care in their localities and were smaller geographic areas, leading to efficiencies in travel costs of home care staff. Similarly, the consistently high average cost of care packages in District 6 was thought to be attributable to the greater over 85 plus population in this district. Further analysis was undertaken (not shown), plotting the average cost of care packages by age band where a clear gradient of costs by age was found. However, a similar relationship was found in other districts. It was considered that further analyses were required in order to seek explanations for these variations and that these would have to involve appropriate statistical analysis. An optimal statistical model

Figure 3: Service process indicator - total average weekly costs of care packages by dependency bands (1-3) (annual figure 1997/98)



would have to be a multivariate one rather than an analysis along single indicators. This would help to explain to what extent dependency was a determinant of cost variation as opposed to other sources such as levels of supply, the influence of local hospitals or health care providers, or factors such as rurality and population across districts.

Another strand to the efficiency argument was the need to demonstrate that in-house home care was cost effective in comparison with the independent sector. Indicators of unit cost were therefore employed to examine differences between the two sectors. It was found that the cost of in-house home care appeared to be expensive. Drawing on these comparisons, efficiencies in in-house home care were made in a variety of ways. Firstly, by the use of appropriate technology such as teleshopping for those clients requiring this type of assistance. Secondly, a reduction in travel costs by home care staff by the location of teams nearer to the clients served. Thirdly, through the introduction of flexible working practices to respond to a rapid rise in packages that required frequent short visits throughout the day and night.

In these ways, the management information produced by the department was beginning to show benefits in terms of monitoring costs and outputs in a more detailed fashion. The more precise measurement of unit costs was essential to this process. At the time of implementing the approach, efficiency was very much linked to the current policy concern of consistency (Cm 4169, 1998): examining the costs of services across districts and across clients with similar dependency profiles in order to learn from these possible sources of variation.

Such examples of output from the indicators developed in the department may be compared with the current indicators now required to monitor performance nationally (Department of Health, 2001b). This enables local management to see how the information used to judge progress on a particular objective complies with or differs from that required nationally to support the regulatory concerns of central government. Table 1 compares a selection of indicators devised as part of the local work considered here with national indicators around the performance area of efficiency. This

Table 1: Comparison of local indicators around PIAF domains with national indicators required for central government monitoring

| Performance area | Selected PSSRU locally devised indicators (PIAF domain) | Selected national indicators (source) ¹ |
|---|--|--|
| <p>Efficiency:</p> <p>National Extent to which local social services provide cost effective and efficient services</p> <p>Local The best use of resources. The need to ensure that: spending is appropriate to the current resource position; spending decisions are continually reviewed; and unit costs are kept at reasonable levels.</p> | Expenditure on home care per 1000 pop 75 plus (Supply) | Gross expenditure on home support per 1000 pop 75 plus (KIGS EX26) |
| | Expenditure on residential care placements per 1000 pop 75 plus (Supply) | Gross expenditure on residential care per 1000 pop 75 plus (KIGS EX22) |
| | Unit cost of SSD home help hour (Supply) | Gross hourly cost for home help/care (PAF B17 Cost and Efficiency) |
| | No. of ongoing cases per 1000 pop 75 plus in different user categories (visual and auditory impairment, cognitive impairment, depression and physical impairment) (Practice Process) <i>against</i> No. of screenings per 1000 pop 75 plus in different user categories (Need) | None |
| | Total average weekly costs to the SSD of care packages in the community by dependency (Service Process) | None |
| | Units of different services provided as a proportion of units purchased (Service Process) | None |
| | For closed cases in each quarter, reasons for closure (Intermediate outcome) | None |

¹ From *Key Indicators Graphical Package (KIGS)* (Department of Health, 2001b)

comparison highlights the differences between national and local foci and the information used to support this particular performance area. The PIAF model adopted here enables indicators to be devised which encompass the full range of

information relevant to measuring this dimension. In contrast, comparable information is often unavailable nationally which would permit such concerns to be measured comprehensively.

Measurement Issues

As the work progressed, these examples of output from the system began to be seen as limited. Building on the model developed in the department, measuring social care performance was seen as more complex than originally supposed. The comparative information produced so far related to individual indicators chosen for their salience to important organisational objectives with the benchmark chosen as the county average. At first, this approach was seen as essential in terms of building competence in examining data and in developing an information culture within the organisation. However, it was increasingly seen as important to employ external benchmarks derived from research or good practice. It was also realised that to monitor performance in a more detailed and sophisticated fashion required combinations of indicators and statistical techniques that could examine when differences between areas were of sufficient magnitude to be worthy of investigation. In this respect, links with an academic environment were seen as crucial in aiding staff attempts at monitoring performance in a more faithful way than perhaps current national collections, such as the PAF, allow.

For instance, current techniques of efficiency measurement, which examine unit costs between units of organisation and seek to control costs through manipulation of commissioning practices (Department of Health, 2000), necessarily concentrate on only one aspect of efficiency, namely *technical efficiency*. In social care, a consideration of *allocative efficiency* is just as important. This refers to how service outputs relate to need and demand. For example, are there sufficient levels of home care to fulfil the needs of certain user groups? Is the range of provision adequate in relation to specific levels of disability? Are services being targeted correctly to those who need them? Two concepts articulated in previous PSSRU research (Davies and Challis, 1986) attempt to measure the degree of allocative efficiency that exists. Horizontal Target Efficiency (HTE) refers to the extent to which those for whom a particular service is deemed appropriate actually receive it - 'do those who need it get it?' According to the model advanced here, measuring HTE requires need indicators to be combined with

intermediate outcome indicators to investigate the proportion of each target group who actually receive services. Need indicators, focussing on the numbers of older people with designated disabilities such as visual or cognitive impairment, depression or physical frailty could be compared against referral rates or service receipt. Appropriate case finding or screening techniques can improve HTE, including attempts at identifying undetected morbidity for which an appropriate service response exists (Bowns et al., 1991). Vertical Target Efficiency (VTE), on the other hand, looks at the distribution of services and to what extent those in need actually receive them - 'do those who get it need it?' VTE is a measure of the proportion of actual users who are in the target group. Measuring VTE would focus on the distribution of service receipt as against categories of need. Appropriate need indicators can be devised where their relationship to risk or morbidity is known. For example, categories of need could be defined by the numbers of those at risk of entering residential care, such as the very old or frail, those living alone, or those having particular conditions such as dementia. Service receipt data, plotted against these criteria, would indicate the spread of services over defined client populations. If services were spread too thinly over these priority groups, this could indicate poor VTE and the need to define more appropriately the populations for different forms of intervention. VTE can be improved by the establishment of clear eligibility criteria for service rather than attempting to spread a universal service over a larger number of clients (Bebbington, 1979; Ferlie et al., 1989). The measurement of these aspects requires data that may be difficult to collect in some authorities and which is largely unavailable in national collections.

The process of formulating relevant questions also led staff to consider the need for more complex multivariate techniques for examining particular aspects of performance. For example, in considering the average costs of care packages, staff commonly identified other factors that could have been important in explaining the variation across districts. In order to control for these factors, multivariate procedures could be used to assist managers to judge which factors contributed most to costs and which did not. Multivariate

procedures used in some research studies examining performance information within social services departments have much to offer work at this level (Gibbs and Smith, 1989; Llewellyn, 1994). However, these methods rely on extensive and good quality data and it may be some time before the right conditions for analysing such data are available within authorities.

Guidelines for Implementation

From our discussions with staff involved in developing the system, a number of principles emerged that can act as a guide to implementing performance indicators and systems in other authorities.

Implementation is as important as design

Although initial debates focussed on the design of measures and the technical requirements of the system, these issues are only one element in the whole process. Implementing performance systems is as much a management issue as a technology issue (Warburton, 1999). In addition to improvements in technology to collect and produce the right information, there also needs to be a shift in culture and attitudes on the part of staff. Managing this process of change needs to take account of the existing values of staff, some of whom may be resistant to the use of information (Leigh, 1988). In this study, a strategy was developed to work with staff on the use of information and what this information meant for their day to day work. This included the use of workshops where staff at all levels were able to collect and use information in a 'bottom up' manner. This ensured that everyone in the organisation owned the product and could perceive potential benefits for them.

Phasing is crucial

In beginning the work, views were expressed as to what would constitute the most effective means of implementing indicators within the department. There was the classic debate between 'big bang' versus 'stockade' modes of implementation. The former would consist of attempting to make the entire system operational on a particular date in the future with the concomitant risk of poor data and insufficient staff understanding but the advantage of scale of effect. The later strategy, chosen in this

case, was to take forward a limited number of indicators derived from reliable data that could be digested by staff and seen as immediately relevant. This brought with it the risk that implementing the larger suite of indicators would be postponed for a long period due to technical and organisational factors. However, phasing implementation in this manner gives direction and a feeling that the whole organisation is buying in to the enterprise.

Involvement is important

The importance of senior management support and staff involvement are seen as key issues for successful implementation in the management literature (Walsham, 1993). The support of senior management is seen as providing the contextual elements of a shared vision and authority for the dissemination of information (Leigh, 1988). Over and above this, other staff-centred objectives need to be identified and heeded. The involvement of all staff in the department was seen as central in making performance measurement work. The mechanisms for involving a wide range of staff included the way in which the indicators themselves were designed. Drawing from each domain of the PIAF and linking into each of the department's policy objectives meant that the indicators had relevance to staff at different levels of responsibility. Practitioners as well as managers were therefore included in the process, from its initial development through to the design of indicators and their eventual dissemination throughout the department. This approach gave real feedback to staff about how their actions fed into the process and helped them to feel included in the work. Interestingly, existing central government indicator sets are mostly concerned with aspects of immediate concern to middle management, such as the commissioning and monitoring of services. In contrast, the approach adopted in this work sought to devise indicators of relevance to the full range of staff who might need to judge and produce changes in service delivery. The method of dissemination was also important: the tailoring of the workshops in response to the views expressed by participants was one reason for the high level of involvement amongst staff.

Conclusion

This study, which was conducted before the current performance agenda took hold, attempted to promote a focussed strategy for implementing performance measurement within a social services department. The approach adopted could assist other departments who are having difficulties developing their own indicators and systems, particularly in the light of current demands for information from central government. The approach argues for a model to be developed with which to guide the design of measures, for measures to be drawn from a suite of potential indicators and for analysis to take place against appropriate standards.

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Monitoring social care performance raises complex issues of design and measurement. Current national indicators often fail to tackle these issues. It is important for departments to monitor their own performance locally as faithfully as possible, whilst bearing in mind that certain aspects may not be measurable in the short term. A planned, focussed and phased method of implementation, involving all levels of the organisation, is a way of avoiding some of the pitfalls in developing performance systems whilst also bringing about benefits in terms of increased co-operation from staff.

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