Creating National Performance Framework (NPF) Outcomes and Indicators for Care;
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Published: 26/06/2023

Citation for published version (APA):
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Title: Creating National Performance Framework (NPF) Outcomes and Indicators for Care; The Scottish Case and Experience

Abstract

The COVID-19 pandemic has, in many developed economies, highlighted the longstanding social care crisis. This is also true for the UK where the need for thorough and sustained change in the entire policy domain of care – understood to include paid care workers, including childcare workers, and unpaid carers and those experiencing care – is clear. To achieve such change, the prominence and visibility of care as a key policy issue needs to increase. One way in which this may be possible is through having an outcome for care anchored in an outcomes-based performance measurement framework. A number of countries, regions or municipalities use such frameworks, for example in relation to health, the environment, or inequality, and often in the guise of ‘wellbeing frameworks’.

This article presents a proposal for a blueprint for an outcome on care tailored towards Scotland’s National Performance Framework. The blueprint was developed on the basis of a policy review and interviews following participatory action research principles.

It is suggested that the blueprint can serve discussions on how to firmly embed care as an important domain for governmental and public agendas in and beyond Scotland. It argues that performance framework outcomes offer levers for a visible celebration of success and the easier identification of barriers to improvement and that they can provide a positive focus over time to sustain systemic and positive change in order to create ‘countries that care’.

Keywords: Care regimes; performance framework; wellbeing framework; social care

Introduction

The COVID-19 pandemic has, in many developed economies, highlighted not only shortcomings in health care systems and deficiencies in the capacities of public health systems to deal with crises
of this order, but also the inability of social care systems to cope with a pandemic (Dowling, 2021) and the insufficient communication between both systems (Bottery, 2020). In the United Kingdom (UK), long-term care homes were one element of the complex and diverse social care system that was frequently reported on during the pandemic. This was because of the many care home deaths, including the fatalities from among care home staff, due to the coronavirus (McGilton et al., 2020) and because care homes were perceived by many in the UK as being treated as a ‘poor relation’ to the National Health Service regarding the provision of, for example, personal protective equipment and official guidelines (Pautz and Gibb, 2020; Gibb and Pautz, 2022; Daly, 2021; Gray et al., 2022).

The pandemic served to bring to public attention, yet again, the UK’s long-standing ‘social care crisis’ (Bunting, 2020; STUC, 2019). Key elements of this crisis are the understaffing of care homes, the low pay of adult social care and childcare workers in combination with the disproportionately gendered make-up of the workforce, problems around the quality of care, and the lacking integration of health care and social care. The pandemic too shone some light on the situation of unpaid carers (Pautz ed., 2020; Maclean and Hay, 2021; Whitley et al., 2023; Power, 2020) who already before COVID-19 had been disproportionately affected by poverty, to name just one key issue (ONS, 2016; Vizard, 2019).

The social care crisis across the UK carries features known to many societies. The International Labour Organisation has summed up the globally existing challenges around care in its ‘Five Rs’. It argues that care, paid and unpaid, needs to be recognised more widely as a key social and economic activity, that unpaid care work should be reduced and redistributed, that paid care work needs to be better rewarded, and that paid care workers ought to obtain better representation (Addati et al., 2018). More specific to the UK, a better integration of health care with social care is seen as key (Hendry et al., 2021; Miller et al., 2021; Evans and Forbes, 2009), while many economies struggle to recruit into the social care workforce and retain staff (Skills for Care, 2022). Moreover, the governance of the social care sector is characterised by severe policy implementation problems (Coleman et al., 2021).

There is stagnation across the UK when it comes to care. Prior to the pandemic, policy makers across the UK proposed and promised action to resolve the social care crisis (e.g. Labour, 2019; Johnson, 2019; Scottish Government, 2019; Dilnot, 2011). Arguably, too little has been achieved,
and it seems that since the ‘end’ of the pandemic in 2022/23, care has been displaced as a key concern by other issues. At the same time, there is unprecedented dissatisfaction with social care (Morris et al., 2023). For this reason, this article argues that care – understood as a domain that includes paid care workers, including childcare workers, and unpaid carers and those experiencing care – is too important to not be a central focus of policy makers. Care is, after all, a key employment field; it generates considerable contributions to the economy; unpaid care affects the incomes and mental and physical health of millions, and it is something that most people will, at one point in their lives, need.

Because care is so important, the article argues for two things. First, it makes the case for the outcome-focused ‘performance measurement framework’ as a useful policy tool that can increase the visibility of key policy issues, keep policy makers’ attention focussed on them, and can serve the public as an instrument to hold government to account. Outcomes can be defined, in simple terms, as the changes resulting from specific services or interventions (e.g. Glendinning et al., 2006) and are, in such frameworks, often formulated as normative desiderata on where a society ‘wants to be’ with regards to equality, poverty, the environment, or health. Most of these frameworks adopt a ‘dashboard approach’ with easy-to-understand indicators, sometimes coupled with a ‘traffic light system’ to indicate progress. Second, the article makes the case that the domain of care should be an explicit part of such a framework and presents a ‘blueprint’ of an outcome on care for Scotland’s National Performance Framework (NPF). The proposed outcome is, so we argue, not only of use for Scotland but can also inform debates in other countries.

In the remainder of this article, this blueprint and its developmental path are presented. Following a brief description of performance measurement frameworks in the context of the ‘wellbeing economy’ and after an outline of the methodology underpinning the development of the outcome, the results of a policy review are discussed with regards to how existing policies in the UK and elsewhere have provided the basis for the development of the outcome blueprint for Scotland. Then it will be shown how interview data was used to shape the blueprint further.

**Performance measurement, wellbeing frameworks, and care**

Performance measurement frameworks exist in a range of countries, but also regions or cities, across the world. They differ in how far they ‘cover’ the many different policy domains and in
which indicators are chosen and how they are presented. All are inspired by the notion of ‘evidenced-based’ or ‘evidence-informed’ policy making (Boaz et al., 2000) and are rooted in the New Public Management paradigm with its outcome and target-oriented approach and its focus on quantitative measuring (Bovaird and Davies, 2011; Lapuente and Van de Walle, 2020; Borgonovi et al., 2018).

Scotland is one example of a country with a wellbeing-focused performance measurement framework. Inspired by the US state of Virginia’s performance framework (Wallace and Schmuecker, 2012; SNP, 2007) and by methods such as Mark Friedman’s ‘outcome-based accountability’ approach (Friedman, 2005; Cook, 2017), in 2007 the Scottish Government introduced the National Performance Framework (NPF) with (today) eleven National Outcomes and 81 indicators (Scottish Government, 2021a). According to Cook, the NPF was developed with the ‘explicit purpose of signalling priorities whilst enabling local areas to respond flexibly to meet need and enabling the people of Scotland to hold the Government to account’ (2017: 9). To give one example of an outcome, the outcome statement on poverty declares that ‘We tackle poverty by sharing opportunities, wealth and power more equally’. Progress with respect to the ambition described in each outcome is measured by between five and ten indicators. Indicator data are presented in relatively simple ways and are accessible online. Following a review, the term ‘wellbeing’ was added to the NPF in 2018 (Wallace, 2019; Heins and Pautz, 2021) so that, today, positive developments towards attaining the outcomes would result in Scotland becoming a ‘wellbeing economy’ characterised by ‘inclusive economic growth’ (Scottish Government, 2021a).

None of the outcomes in the NPF have an explicit focus on the care provided by unpaid carers, adult social care workers or childcare workers, nor do any of the outcomes look at how care is experienced by those who need it. Such relative silence regarding care is indicative of the longstanding undervaluation of care in Scotland. If Scotland wishes to maintain its position as one of the ‘wellbeing world beaters’ (Fischer, 2019), as reflected by its leadership role within the Wellbeing Economy Governments initiative (Scottish Government, 2021b), and live up to the NPF’s underlying value of ‘treat[ing] all of our people with kindness, compassion and dignity’ (Scottish Government, 2021a), the inclusion of care in the NPF is a necessary and urgent step and can serve as an example for governments elsewhere.
Methodology

To develop the new outcome and its indicators, two data generation approaches were used. First, a policy review was conducted. The goal was to establish an understanding of how care may be included in performance frameworks or similar instruments elsewhere in the UK and internationally. The review allowed the identification of a ‘pilot list’ of indicators which could be used to measure whether progress is made towards a new outcome on care and helped in the formulation of a draft outcome statement itself.

Second, interviews were conducted with people with experience of receiving or providing care, or working within organisations in the care sector. This approach was informed by the principles of participatory action research (McIntyre, 2008). Participatory action research seeks to produce knowledge from the perspective of the people that are being researched and emphasises the stimulation of social justice-oriented change through the research (Cahill, 2007). Participatory action research encompasses all research practices that ‘place the researcher in the position of co-learner and put a heavy accent on community participation and the translation of research findings into action for education and change’ (Minkler, 2000: 192). With regards to its application to policy research, the approach ‘produces research with community members for the purpose of informing policy and countering inequality’ (Stoudt et al, 2023: 23).

The interviewees included four unpaid carers (parents and carers of siblings, spouses or older relatives), three care workers (working in care homes), and three people experiencing care. Researchers also interviewed eleven representatives of organisations – private, third sector, and public – involved in providing, financing, or monitoring care or supporting care recipients or providers. Lastly, via a focus group discussion the views of four independent academic experts were sought. Altogether, 25 people were interviewed.

The interviewees were identified based on their role, position and interest in relation to the domain of care. Interviews took place online via Zoom and lasted between 45 and 90 minutes. Interviewees consented to their participation under the condition of anonymity. Given the small number of interviews, no claim is made that the views captured are representative of the organisations or demographic groups interviewees came from. Nonetheless, despite the non-representative sample of interviewees the involvement of stakeholders in the formulation of outcome and indicators was
deemed to be key to the development of a practicable outcome with credibility in the care community and true to the principles of participatory action research.

Interviewees were first asked their opinions on a pre-formulated outcome statement and were asked to offer alternative formulations. Then they were requested to identify what to them were the most important aspects that should be measured to ascertain how policy is performing in relation to care. These first steps enabled interviewees to highlight the issues and aspects of care that were most important to them. Then the ‘pilot list’ of indicators put together by the researchers was presented to the interviewees for comment. The responses to both interview stages were combined into the outcome blueprint presented below.

**Policy review**

To inform the proposed outcome on care and its indicators, a review of policies on national and international developments in health performance frameworks, wellbeing frameworks, care policy, and care quality measurements was undertaken. The rationale for including health and wellbeing frameworks in this review was that such frameworks sometimes have elements of social care embedded within them. Care policy and quality measurements of care were included in the review to identify existing measurements for indicators.

Amongst the relatively few countries which have adopted multi-dimensional approaches to measuring wellbeing is New Zealand. The Ministry of Social Development (2016) identified ten domains of wellbeing (health; knowledge and skills; paid work; economic standard of living; civil and political rights; cultural identity; leisure and recreation; safety; social connectedness; and life satisfaction). While care is absent from these instruments, aspects such as life satisfaction and health are of relevance to carers, care workers and those experiencing care.

Just like New Zealand, the Netherlands started looking at societal wellbeing early. However, despite a rich tradition in ‘social monitoring’ – for example, the Life Situation Index has been looking at health, housing, social participation, leisure activities, sport, mobility, ownership of consumer durables and holidays since the 1970s (Boelhouwer, 2010) – this monitoring has not yet translated into a governmental performance framework. In response to this lacuna, academics have used the OECD’s Better Life Index as a basis for a new ‘composite hybrid’ wellbeing index in the
hope that the Dutch government adopts it. Here, Rijpma et al. (2017) included eleven dimensions of wellbeing (subjective wellbeing; health; work-life balance; education; housing; environment; safety; income; jobs; community; and civic engagement).

Under the impressions of the ‘post-GDP’ debate after the financial crisis, the German federal parliament set up a commission in 2010 to develop a new way of understanding and measuring ‘growth, prosperity and quality of life’ (Deutscher Bundestag, 2010). Indicators included in the commission’s report were traditional ones such as GDP, but also those measuring social participation, education, health and freedom (Strunk, 2015). A few years later, the federal government started developing a wellbeing framework using some of the commission’s proposals. The first report, published in 2017, with a performance measurement system under the title ‘Wellbeing in Germany’, did not feature an outcome on care. Only one indicator among 46 acknowledged care by measuring ‘reduced working hours for care responsibilities’. The framework was underpinned by twelve dimensions of wellbeing: healthy throughout life; good work and equitable participation; equal educational opportunities for all; having time for work and family; a secure income; living a life in security and freedom; acting with global responsibility and securing peace; living freely and equal before the law; preserving nature, protecting the environment; strengthening the economy, investing in the future; standing together in family and society; at home in urban and rural areas (Bundesregierung, 2017a). While this framework was abandoned two years later, some of its indicators could be used to inform a performance framework outcome on care.

England saw, in 2010, the beginnings of the measurement of national wellbeing. The Office of National Statistics was put in charge to pull GDP measures with instruments that captured social and environmental aspects of society, including subjective wellbeing. The following domains, underpinned by 43 indicators, were identified as being significant to people in England: personal wellbeing; our relationships; health; what we do; where we live; personal finance; economy; education and skills; governance; and environment (ONS, 2011). While there is little specifically on care, indicators such as personal wellbeing and personal finance should have a role to play in an outcome on care.

So far, the review has shown that wellbeing performance frameworks have not – or only cursorily – included the domain of care as outcomes and feature only few indicators specifically on care.
However, there are some exceptions. Wales’s 2019 National Outcomes Framework for People who Need Care and Support (Welsh Government, 2019) is part of Wales’s wellbeing strategy and uses outcome indicators clustered under eight tenets of wellbeing (rights and entitlements; physical and mental health and emotional well-being; protection from abuse and neglect; education, training and recreation; domestic, family and personal relationships; contribution made to society; social and economic well-being; suitability of living accommodation). While the Welsh model omits care workers from its considerations, it explicitly considers unpaid carers and those experiencing care.

In England too some steps have been taken to measure care outcomes through a performance management approach. One development was the adoption of the Adult Social Care Outcome Toolkit (ASCOT; Netten et al. 2012) into the Adult Social Care Survey for England (Department of Health, 2017). The approach being developed in Northern Ireland to measuring outcomes could be instructive for an outcome on care for Scotland and beyond. In 2018, the Outcomes Delivery Plan with twelve outcomes and 49 indicators was published. One outcome explicitly addresses care, but with a sole focus on those using care: ‘We care for others and we help those in need’ (NICS, 2018). Following a revision the framework now features six indicators for assessing how well the country meets this outcome (poverty; mental health; quality of life for people with disabilities and their families; supply of suitable housing; support for looked after children; and support for adults with care needs) (Northern Ireland Executive, 2021). If adopted, Northern Ireland may become the first country to include a specific outcome on care within their national wellbeing framework. However, beyond criticism of the conceptual underpinnings of the framework (Gray and Birrell, 2018; Orme, 2021), the proposed outcome does not consider those providing care.

**Developing the outcome and its indicators**

With the policy review in mind, an outcome statement was developed that was to be developed further through the interviews: ‘We value those needing care and those giving care’. Interviewees suggested that the words ‘needing’ and ‘giving’ were problematic as they denoted a specific power relation. One said that “Giving care” makes it [care] sound like a gift, rather than it being essential’ (Stakeholder interviewee), while a person experiencing care stated that ‘I don’t like the word “needing”… I think it’s disempowering for disabled people – like we can’t do anything on our
own’ (Person experiencing care). The term ‘value’ received mixed opinions, too. On the one hand, it was seen by many interviewees as a positive term to include within the outcome statement. A person experiencing care said:

‘I really like the word “value”. I think a lot of the time disabled people can feel like a nuisance. It [the wording of the pilot statement] makes you feel valuable to society (Person experiencing care).

However, others saw the term ‘value’ as too weak. The outcome statement is ‘not strong enough. It needs words like “support”, “commit”, or “invest” – active words that ask for action’ (Stakeholder interviewee). The interviews led to a reformulation of the initial statement into ‘We fully value and invest in those experiencing care and all those providing it’.

Based on the insights from the policy review, a list of pilot indicators (Table 1) was developed and taken to the interviews for feedback and further development based thereon. Before this pilot list of indicators was presented to interviewees, they were asked how they thought the outcome should be measured so that an initial list of indicators already emerged then.

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<th>Funding levels</th>
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<tr>
<td>Voice of carers, care workers and those cared-for</td>
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<td>Quality of life</td>
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<td>Quality of care</td>
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<td>Financial wellbeing</td>
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<td>Safety</td>
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<td>Life-care balance (time for one-self)</td>
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<td>Social connections</td>
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Gender pay gap

Education and skills development

Fair Work and fair pay

Professionalisation

Suitable housing

Table 1: Pilot list of indicators as used in interviews

During the development of the pilot list, one problem arose out of the complexity of the domain of care – there are many arenas where care is provided, and the care workforce is as diverse as the groups of unpaid carers and those using care – which needs to be reflected in the indicators. The number of indicators used for existing outcomes in the NPF average at seven. As the list of indicators for care grew with the interviews, it soon became clear that a different approach was needed. The decision was to establish seven ‘beacon indicators’, each underpinned by a set of sub-indicators, to account for the complexity of care. The sub-indicators would be key to determining whether progress is made against the outcome statement as it is the data from the sub-indicators which will generate an assessment of whether the beacon indicator is ‘maintaining’, ‘improving’ or ‘worsening’. In the following, some interviews excerpts are used to describe how the blueprint (Table 2) was arrived at.

During the interviews, quality of life – for carers, care workers and those experiencing care – emerged as a key beacon indicator. As also the policy review showed, it is central to many wellbeing frameworks:

‘I think quality of life is most important. People need to be mentally well, feel supported, healthy, able to do things that they want to do… feel at least okay’ (Unpaid Carer).

In this context, mental health was seen as key to quality of life:
‘I suppose mental wellbeing isn’t mentioned here, or stress and depression. Caring can be quite overwhelming, so stress and depression can be quite difficult, and it is quite a challenging role’ (Unpaid carer).

For the beacon indicator ‘quality of life’, five sub-indicators emerged out of the interviews and the policy review. These are life chances of young carers; mental wellbeing; social connections; life-care balance; and respite availability. Unsurprisingly, quality of care emerged as a key indicator for an outcome statement:

‘Quality of care is really important because you might technically be receiving support or care, but if it’s not enough time or not appropriate or not done well…then it’s not really helping properly’ (Person experiencing care).

The policy review and the interviews suggested four sub-indicators: access and affordability of support; adequacy of care; support for unpaid carers; and safety of all involved in care. As demonstrated in the policy review, wellbeing frameworks consistently have a measure around financial wellbeing. The interviews supported how important this indicator is:

‘Many of the care staff come from deprived areas and live in situations of poverty and debt. The low pay makes it difficult for them to escape from these situations’ (Paid care worker).

Given that much paid and unpaid care work is conducted by women, it is important to capture how gender impacts patterns of financial wellbeing. The concept of the ‘lifetime earnings gap’ was suggested as a good way of capturing gendered differences.

The beacon indicator ‘financial wellbeing’ could have five sub-indicators: cost of care as a percentage of household income; percentage of unpaid carers and care workers and those experiencing care living in poverty; life-time earnings gap; the length and level of maternity and
paternity financial support; and unpaid carers are supported in remaining in decent paid work or in returning to decent paid work.

A fourth beacon indicator should revolve around voice and influence of carers, care workers and those experiencing care. This would measure the opportunities which carers, care workers and those experiencing care have to inform and influence the parameters which structure their care/care providing experience at both the policy and delivery levels:

‘It’s really important that carers and those receiving care are listened to rather than decisions made for them’ (Person experiencing care).

Another theme here was choice. Interviewees suggested that this is highly important, but often overlooked in relation to those providing care on an unpaid basis:

‘Do unpaid carers have a choice in their care situation? We need to get to a place where they can choose to care, and also choose time where they are not caring because the services are there to enable them to do so’ (Stakeholder interviewee).

This beacon indicator could have sub-indicators: choice over the nature of care and how it is delivered; unpaid carers’ choice over the care they provide; care workers feel their employers listen to them; and carers and those experiencing care have influence over care policy and public spending decisions.

A fifth indicator revolves around access to education and training. Interviewees suggested that there are gaps in carers’ knowledge and skills:

‘We are given the training that we are legally required to, but if you are providing good support to complex needs there can never be enough training or too much education, and there is a lot missing. We need upskilling so we can achieve better outcomes for those we care for’ (Care worker)
In addition to discussing care-related education and training, interviewees also spoke about the importance of access opportunities for unpaid carers to formal education and paid work:

‘Better support for student carers would be good, too. We always have to make sure someone is at home, so, when I am at home I try to keep him [the child] occupied with colouring in or put the TV on for him and I try study’ (Unpaid carer).

This beacon indicator has four sub-indicators: percentage of people experiencing care in education; percentage of care workers in vocational training; percentage of unpaid carers in education; and percentage of unpaid carers who have received care-based training.

A sixth indicator should address the job quality of those who work in care. Care workers often report a range of issues affecting their job quality, such as long hours, unpredictable shift patterns, difficulty accessing sick pay, insecure contracts, and poor relationships with management (Pautz et al., 2020). These issues were mirrored in our interviews with care workers:

‘It’s difficult to say ‘No’ to overtime, but it’s also difficult to accommodate it when you are working 12 days in a row […]. Sometimes our shifts are 33 hours long […]. It’s difficult to find routine staff with [temping agencies] companies paying less holiday pay, sick and pension’ (Care worker).

This beacon indicator has four sub-indicators: pay levels; job satisfaction; unpaid overtime worked; and holiday entitlement.

The funding of care, be it delivered by paid or unpaid workers, is important in context to all previously discussed indicators. Whilst no wellbeing framework currently measures the funding of care, many governments do measure the funding of health, or ‘health and social care’. The inclusion of this indicator would allow highlighting differences in how certain policy areas are financed and would allow drawing links between the quality of care and investment into care:
‘The care system needs to be properly resourced so that care workers can consistently deliver compassionate and dignified care. This would mean care workers not being rushed, so enough funding to pay for adequate staff’ (Stakeholder interview).

The beacon indicator ‘adequacy of funding for care’ has three sub-indicators; level of funded childcare; percentage of GDP of spending on social care; and level of funding committed to social security entitlements for those with a disability and unpaid carers (for adults and children) per recipient.

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<tr>
<th>Beacon Indicator</th>
<th>Sub-indicators</th>
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<tr>
<td>1. Quality of life of care workers, carers and those experiencing care</td>
<td>Life chances of young carers</td>
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<td>Mental wellbeing</td>
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<td>Respite availability</td>
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<td>2. Quality of care for all</td>
<td>Access and affordability of social care and childcare</td>
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<td>Adequacy of the quality of care experienced</td>
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<td>Safety</td>
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<td>Support for unpaid carers</td>
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<td>3. Financial wellbeing of care workers, carers and those experiencing care</td>
<td>Percentage of unpaid carers and care workers and those experiencing care living in poverty</td>
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<tr>
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<td>Cost of care as a percentage of household income</td>
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<td>Lifetime earnings gap</td>
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| 4. Voice and influence of care workers, carers and those experiencing care | The length and level of paid maternity and paternity leave  
percentage of unpaid carers who feel supported towards and within decent work |
|---|---|
| 5. Access to education and training | Choice over the nature of the care and how it is delivered (people experiencing care and, in the case of children, their parents/guardians)  
Unpaid carers’ choice over the care they provide  
Care workers feel their employers listen to them  
Carers and those experiencing care have influence over care policy and spending |
| 6. Adequacy of funding for care | % of people experiencing care in education  
% of care workers in vocational training  
% of unpaid carers in education  
% of unpaid carers who have received care-based training |
| 7. Job quality of social care and childcare workers | Level of funded Early Learning and Childcare hours  
% of spending on social care of GDP  
Level of funding committed to social security entitlements for those with a disability, and unpaid carers for adults or children per recipient  
Pay levels for care and childcare workers |
Conclusion

The crisis that affects the domain of care across the UK pre-dates the COVID-19 pandemic. However, the pandemic’s disproportionately stark consequences for carers, care workers and those experiencing care demonstrated that those experiencing care and those providing care require a concerted approach that addresses the challenges they face as a result either of their care needs or their care responsibilities. In this article, one potential element of such an approach was presented in the form of a blueprint for a performance framework outcome on care, complete with indicators, that can measure progress or otherwise in attaining the outcome. While the proposal is tailored to the Scottish context, it can also be adapted for contexts beyond Scotland.

No doubt, the proposed approach is complex. First, it is important to acknowledge that measuring outcomes generally is not easy. As this article demonstrated, establishing a list of indicators to measure success or failure of policy requires making choices on which indicators to include and which to exclude. Second, to measure the impact of policy interventions can involve potentially costly methods such as regular large-scale surveys and interviews, control groups and longitudinal follow-ups. However, in many developed economies most of this data exist or data generation instruments in place already can be expanded. Where data does not yet exist, an argument can be made to develop it, qualitative or quantitative.

It is clear that outcome approaches do not automatically lead to performance improvements (Wimbush, 2011). In fact, ‘within the literature on performance management there has long been concern that an undue focus on measures and targets drives organisations to focus on meeting the targets as opposed to improving public services’ (Cooke 2017: 14). But research examining outcomes-based processes has identified a range of benefits from focussing on outcomes (e.g. Perrin, 2006; Shorr, 1995; Plantz et al., 1997). For example, performance frameworks offer

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Table 2: Proposed outcome beacon indicators with sub-indicators
opportunities to celebrate policy success and can help identify policy shortcomings, including around joined-up strategic planning. Their outcomes can provide a focus over time to attain long-term systemic positive change through cross-sectoral collaboration and co-production. Outcomes information can be used to communicate policy successes and failures and increase transparency and accountability. Lastly, a focus on outcomes can minimise the need for centralised bureaucratic management and make space for local innovation.

While an outcome on care cannot address the social care crisis alone and certainly not overnight, it can set a context for policy and spending decisions and enhance public scrutiny of the progress achieved. It locks in a commitment to working towards, in this case, a ‘country that cares’ or a ‘culture of care’. An outcome on care could also make navigating further current and future disruptions, such as the cost-of-living crisis, less likely to lead to adverse impact on care.

A final word on the methodology underlying the development of an outcome. The policy review shone a light on what is done with regards to measuring outcomes on care and related domains. It made clear that the domain of care is not usually a policy priority and always sits underneath health care. While the review allowed the development of an outcome statement and a pilot list of useful indicators and underlined the complexity of the domain of care the interviews, informed by the principle of participatory action research, provided useful feedback on what the researchers developed on the basis of the review and had a significant impact on the shape of the eventual blueprint as presented here.

References


