

Department of Health Consultation on proposals
Transparency in outcomes: a framework for adult social care
Response from members and participants of Coventry LINK

About Coventry LINK and this response

Coventry Local Involvement Network is an independent network of local people and voluntary and community groups working for the improvement of NHS and adult social care services. Coventry LINK is a network made up of **173 members**. Coventry LINK carries out extensive community engagement work as well as specific work to look at issues with NHS and adult social care. The people who took part in this consultation were individual local citizens, service users, and carers plus representatives from voluntary sector organisations, which provide support to different groups of service users for example older people, people with long term conditions, and people with learning disabilities.

Comments on the proposals

Coventry LINK supports the statement below and considers that getting this right is the key to Personalisation within Adult Social Care being a true success.

“We need to focus on outcomes because a truly personalised approach means placing those outcomes that matter to people at the heart of what we do.”

Coventry LINK agrees with the definition of Quality to mean:

Quality can be described as a composite of four factors:

Effectiveness – *getting it right the first time;*

Experience – *a positive experience of care and support;*

Safety – *protecting vulnerable people;*

Efficiency – *ensuring value for money*

Build the evidence base

1. How should Quality Standards in social care balance guidance on service practice, cost effectiveness, what matters to people and outcome expectations?

The commissioning process should encourage a wide range of providers thereby providing choice both to meet the needs and aspirations while allowing people to make choices on care packages that may have cost implications on them.

Quality standards have to be desirable, achievable and measurable. Starting at the desirability point and working backwards to see what is involved operationally to achieve that desired outcome and adding some unit of cost and a minimum standard was viewed as the way forward.

At citizen level – Everyone cannot be given everything they desire, a suggestion was that there could be a matrix assembled to include costs so that a person can apportion their personal budget in line with their ‘wish list’. There could be a desirability scale for outcomes and for each outcome a person can prioritise which is the most important for them to feel that they have made a choice and experience good social care. E.g. Person can put in order of importance different required outcomes such as personal care, transport, social networking, hobbies etc. It was commented “If citizens are vocalising what they want and it is known how much it costs then guidance on service provision can be formalized. This process will be truly bottom up and not top down”.

It is good that the ‘One size fits all’ is recognised as not being sufficient, Quality Standards should have clear and concise definitions as to the type of care that can be given as a right/free of charge and those where payments are made by the service users.

Many service users, carers and local people will have no experience of the role of commissioning. Clear and accessible information and guidelines will need to be in place.

Service Users own expectation of service is usually based on very personal and individual need therefore Quality Standards based on service level agreements will often be at variance to expectation particularly when there are more than one area of care required.

Quality Standards will need to ensure where a carer is involved they are treated with respect, are listened to and given appropriate support as and when require in their changing roles to carer partners.

Questions raised:

2:2. what does ‘be employed in building pathways to deliver this and ensuring dissemination happens across all areas of social care’ mean?

2:3. how will any conflict between NHS, Social Care and service users resolved? Decisions based on National pointers may not necessarily reflect local experiences or population implications.

2:7. how will people access information about buying services? And what will be the 'best service', who will judge it to be the best service? Cost will have a bigger impact on service user's choice than previously, so how will Social Care managers be assured that outcomes are being realised?

2. How can we categorise Quality Standards in adult social care, and what should be the topics for the first Quality Standards?

Comments included:

“Appropriate trained staff who understand care issues involved with individual”

“Diagnosis for the person or their carer in a form that they are able to understand the condition and any treatment needed, along with support to identify any care/support options they may need in their local area”.

“Assessments agreed by health and social care and addresses individual needs”.

“Carers assessments also in place and acted upon”.

“People’s specialist requirements are identified”.

It was suggested that categories could be based on a model like Maslow’s Hierarchy of needs.

Below is an example of topics that were considered to be a good starting point for Quality Standards. It was considered of high importance to build timeframes into the Quality Standards as it is thought that for people who need support through an adult social care provision that having a clear understanding of response time avoided disappointment and potential complaint and alleviated some associated anxiety.

Category	Topic	Standard	Outcome	On-going evaluation
Physical needs	Poor mobility	Citizen has information to enable choice for Provision and maintenance of optimum mobility by appropriate resource allocation within one month of support request	Person has equipment / hands on support needed to be as mobile as possible within one month of requesting support.	Feedback quarterly on whether support is still appropriate
Social needs	Loneliness	Provision of resource to enable citizen to join, carry out, or attend	Person has enough money to secure activities of	Feedback after three months to ascertain whether

		social activity of his/her choice within one month of request	his/her choice within one month of request.	outcome is still meeting need
Safety needs	Unable to conduct own affairs due to lack of capacity	Provision of Advocate under Mental Capacity Act to have information to enable request for necessary care package	Advocacy has enabled citizen to receive care according to local guidelines	Feedback quarterly on quality and appropriateness of care package

3. How can Quality Standards be developed to support service users as commissioners and local people in their role to hold councils to account?

Quality standards should be simple to understand, be readily available and should receive regular feedback by citizens who use services. Providers who do not deliver expected standard of care to be investigated by commissioners

A data set should be instigated to collect data that matters to citizens. For instance, on service providers – who they are, what other people’s experience of their service is, their reliability, their administration costs, their service provision etc.

It was considered very important to provide clear information on what is meant by outcome focus measures and personalisation.

“Ensure information is based on local data and up to date”.

“Independent bodies or organisations are able to ensure that accountability will be demonstrated to local people”.

Demonstrate Progress

Questions raised

3:18. who will decide within councils and what if cost if it is a cost based decision and what would be the procedure for any appeal?

3:27. who or what will ensure that the new transparency framework (3:35) will work for the public in this connection?

Support Transparency

It was fully supported that the key to adult social care was public accountability as this allows the use of expertise that is already informed and involved. It will also helps in maintaining good working relationship with local independent providers who may already be working their own standards of service level care allowing them to share good practice.

It was commented that 4.2 identified “good recognition of basic need”. However this will only be of use if the data and information is up to date and current.

It was highlighted that figures and facts often no longer apply to current situations and usage, or are used to forecast impact in the future. For service users that are receiving 'short term' social care it will not provide sufficient information to give them a 'yardstick'.

8. Do you support the proposal to replace annual assessments of councils conducted by the regulator with public facings local accounts on quality and outcomes in adult social care?

This proposal is supported as it is considered that local people are best placed to understand how their needs can be met. Those that receive services should be regulating it - giving them the power to change.

Accounts should also apply to the provider: There should be a mechanism of collecting data of both good and bad services where the service user feels "safe" to be honest about their personal experience –this can only drive up standards. It was commented that "Poor service providers and specific carers should be named and shamed".

9. Do you have any examples and evidence of the benefits of a local account type of approach?

Coventry LINK is involved in looking at Quality Accounts for University Hospital Coventry and Warwickshire, this relationship is still developing and is considered to be of great local value.

10. What is your view on the balance between requiring standard elements in reports and allowing freedom to fit to local circumstances?

Allowing freedom to fit local circumstances is a good idea as every locality will have different specific local issues. However there must be some way of collating this data to use a comparator for peer review and national review to avoid post code lottery situations.

There is a need for some set standards from the top. Service user's input is valuable, but it is often the same people that turn up to these groups who may not be representative of all service users. There is also the risk of these people having their own agendas. It is ensuring that *all* voices are heard, mechanisms like local Health Watch are best placed for this

A problem with any online reporting is that it is not inclusive and many people do not use a computer so other forms of distributing data should be sought alongside anything that is web-based.

11. The proposed accounts would only apply to council commissioners. What further actions, if any, might be considered to promote transparency amongst service providers?

Local reports should be available to all citizens as well as commissioners. This way commissioners would be open to challenge as to why they still allow poor performing service providers to remain on the registered list of providers.

12. Would you support an assurance role for the Local Health Watch in the production of the accounts?

It was considered very important that local citizens contribute to the Quality Assurance process; Health Watch is the ideal vehicle to do this. HealthWatch must retain the wide inclusivity of local people and organizations that LINk has. This will ensure that a diversity of viewpoints and perspectives are balanced in order that no one organisation gets the 'lion's share' of the 'voice' on what are whole community services.

There needs to be a mechanism to ensure objectivity. One suggested method is that there is a turn around of all of the people that sit on panels who are part of this process and they can assess each other between local areas.

13. We would also be keen to receive views on whether user and carer led assessments could support transparency and empower local people

It is considered important that people using the service must give feedback and this feedback data should be reportable.

It was thought that as 'shoppers' we use our feet to 'voice' our choice and do not use a shop if it does not meet our values. Service users must have some way to use their 'voice' to choose which service provider to buy services from using their personal budget. There are no shops for them to walk round and view what is for sale so it is important that robust, clear, user friendly, and on-going real-time reports on all service providers are available and accessible to enable user choice. Reports possibly could include:

1. Service providers' (SP) process – is it user friendly?
2. SP's response times and guarantees
3. SP's QAs including: risk assessment register, standards, data collection/reporting systems
4. Contingency planning
5. Complaints procedure

Reward and Incentive

14. What role is there for 'payments by results' or other financial incentives on providers or commissioners at a national level to support the focus on quality and outcomes?

Financial incentive was not generally viewed as being a positive thing. Incentives should come for reputation and customer base. If good reputation is present more purchasing of services will happen. Quality care givers will retain their customers. It is considered that Incentives distort outcomes.

It was commented, “could be used for driving down as well as driving up standards”. It was commented “Poor quality care givers will lose their customer base if the reporting and monitoring do their job”.

Feedback and evaluation are a much better way of maintaining high quality.

Question: Will there be an available list of accredited service providers who have already achieved a minimum level of service provision via SLAs?

Question: What is best practice? By what/whose criteria is a service considered best practice if, as this document seems to be saying there is no evidence base yet?

The terminology ‘best practice’ is not informative to anyone unless there is a comprehensive table for comparison of all service provision. What works well in one location may not work in another and it is not always practicable to transfer practice from one location to another.

Ratings with levels such as basic, good and excellent with appropriate clearly written standards provide a better value-laden choice for users. For instance, someone may choose a basic standard for one part of their care and an excellent service for another part of their care, depending on their personal priorities.

If it is agreed that reward and incentive of a financial nature is supported the incentive should be ring fenced to be used for non profit activity e.g. training and development

Secure the Foundations

15. How should the CQC ensure that future service inspections are risk based and proportionate?

CQC could implement a risk assessment model of practice to be split into sections: a general risk assessment across the sector to include categories such as Service contingency, HR issues etc. This could potentially be inspected before registration/accreditation and inspected perhaps 5 yearly or unless monitoring system throws up a potential problem

And

a specific care group risk based assessment for each service provider to be inspected yearly, or earlier again if monitoring system throws up a potential problem It was considered that “Making robust inspections based on agreed criteria for risk and safeguarding” was very important

16. Does the regulatory model of registration, compliance and inspection provide sufficient safeguards for ensuring minimum quality standards across adult social care?

It is considered that it may be better to call in accreditation rather than registration. The former has more value-meaning in that it implies some one has met certain standards/criteria. Registration merely implies being put on a list

It was felt strongly that there should also be complete transparency that a SP who falls below the minimum standard will be de-registered (de-accredited) and therefore not allowed to offer service in the City again until compliance can be seen, not promised. Having failed once there should be no interim whilst they sort things out. No-one should be allowed to give sub-optimal care provision even for a short while. A poor performing SP will have breached minimum required standard of care. It was strongly viewed that vulnerable people should not have to be subjected to below minimum standards of care. It was considered that the commissioners are their advocates in this instance and are also gatekeepers to make sure that poor SPs do not exist.

17. How might independent monitoring of local council arrangements for managing services be secured?

Accountability at local and national levels with financial liability to ensure that management of services procedures are adhered to.

An interesting model that was suggested was:

A 'Carestat' system could be instigated. This idea comes from the original 'Citistat' (see www.baltimorecity.gov/Government/AgenciesDepartments/citistat) idea in the New York Police Dept. It was taken up by the Mayor of Baltimore to see how service delivery was in the town. A much simpler system could be developed for use in this instance. The main tenants of this system are:

- real time data has to be sent to the **statistician** before each meeting
- Heads of Depts. (commissioners) or their representatives come before regular meetings of involved stakeholders, ie Health Watch, service users, service providers
- Results from the top ten (or another number) set of priorities is discussed.

This ongoing regular process (which can be delivered fortnightly or monthly) will give:

- Organisation 'memory'.
- help to sort problems out quickly because most of the stakeholders will be represented
- Trigger CQC response to poor quality or new potential risk

A real benefit to it is that it can be efficiently and effectively monitored if it is done in 'real-time' rather than retrospectively as evaluation often happens.

Additional Comments

Annex A Table 1
Promoting personalisation

General agreement of the list of indicators was supported although some concern was raised for both people with learning disabilities and people with mental illness. This was that employment is seen as such a vital enhancement of quality of life.

It was viewed that meaningful occupation helps in people's feeling of worth and place in society, but for people within these groups, full time employment, especially for people with learning disability, will be an aspiration rather than a reality. Part time employment may be possible but often only if support can be offered as and when required. Too much emphasis in this may even hold back people from trying to achieve improvements in their quality of life and compound feelings of inadequacy.

Louise Stratton
LINK Project Officer
On behalf of Coventry LINK
Coventry LINK is an Independent Network Hosted by
Voluntary Action Coventry
3 Castle Yard
Hay lane
Coventry
CV1 5RF
Tel: 024 7622 0381
Email: coventrylink@vacoventry.org.uk