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7<sup>th</sup> February 2011.

**Plymouth LINK's response to proposals contained in the  
Consultation *Transparency in Outcomes: a framework for adult  
social care***

Plymouth LINK supports the proposals contained in this consultation in principle. This response is based on feedback themes of the Plymouth LINK and on comments from two individual members of our Stewardship Group (the latter are in yellow boxes, shown as A and B). An addendum is also from Respondent A, responding to the consultation in a more general way - rather than to individual questions

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

Plymouth LINK recommends that existing users of adult social care (ASC) services be the first port of call for identifying what quality means in ASC to develop the standards. LINKs can also add information and feedback to support a wider public view of quality in services.

There should not be a great difference (and therefore a need to balance), between guidance, outcomes and what matters to people. Service user experience is heavily reflected in CQC's regulated outcomes and standards for services. What matters to people should inform outcome expectations, guidance to services and be looked at cost effectively. If what matters to people leads the way for Quality Standards, then services commissioned in the future will be more effective and sustainable and the system will become more cost effective, delivering what people want.

A: LINKs would be best placed; only by true democratic transparency; representation on Doctor's consortiums can holistic accounting and holistic representation be deemed 'best practice'. Carers and sufferers are the centralised concern; without planning and involvement in the delivery service then Quality Standards becomes professionalised provision and accountability. Quality Standards in its present proposal becomes target driven towards elusive best practice within fiscal restraints.

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

Experience of Plymouth LINK shows that where Quality Standards are applied to services or conditions mean that many people will fall through the net. Quality Standards need to be over-

arching and applicable to all services and conditions. Feedback to the Plymouth LINK highlights common issues of staff attitudes, accessibility and being listened to/patient involvement (rarely the service itself). Basing Quality Standards on these areas as suggestions for the first set of topics will benefit all service users in all services.

A: Standards will always fall if not patient/carer achievable; it is therefore essential that through LINKs groups have input; not consultative but representable.

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

Basing Quality Standards on these areas will be more accessible to service users, commissioning services and will quickly highlight the good services from the bad. Service users need to be able to see how potential services are rated as per the Quality Standards. This rating can come from self assessment, CQC assessment and service-user experiences.

A: LINKs

Question 4: *Do you agree with proposals for a single data set for adult social care, supported by a single collection and publication portal?*

Plymouth LINK supports the idea of one port of information for ASC; however, unless this information and the system used is compatible with the proposed system for health, then the difficulties experienced by patients falling between health and social care will continue. Information (even if it looks different) needs to be able to be shared between services at the touch of a button.

A: Yes

Question 5: *Do you support the case for a set of consistent outcome-focused measures, which combine the best available data on social care outcomes?*

Plymouth LINK agrees that outcome focused measures need to be consistent, especially where these measures reflect patient involvement and a patient-centred service. A natural single data set will enable a smooth transition for patients between services and geographical areas and a choice for people, as highlighted by the feedback we receive.

A: No

Question 6: *Do the four domains and outcome statements proposed adequately capture the breadth of outcomes which are relevant at the highest level to adult social care?*

The four domains and outcome statements seem positive in capturing and improving the experience of adult social care services and reflect the areas of concern and feedback that Plymouth LINK has been made aware of.

However, ASC commissioners and services may not see these as 'new' outcomes and could argue they are already working towards these outcomes.

The new system, therefore, has to be clear about how (and by whom) these will be measured, how services will be accountable to them and provide clear, smart measures for each of them.

Plymouth LINK would also recommend that progress against these outcomes are judged by service users and that services involve service-users in their day-to-day work to build a picture of the quality of services. Achieving these outcomes should also tie the services to using independent voices and groups, such as HealthWatch, to offer an independent view and arms-length evaluation of service users' experiences.

These outcomes also need to tie in with regulation of ASC services to enforce accountability.

A: Yes

Question 7: *Do you have any further views on how adult social care should align with other sectors to support integrated working? How might this be put into practice?*

Partnership with other sectors and services is vital to ensure a positive pathway of care. Plymouth LINK receives feedback that highlights that transitions between services is not easy or smooth and often services are not aware of others that can improve a client's health and care.

It therefore seems odd that this is not an outcome in its own right. Plymouth LINK recommends that under Domain 3 - '*ensuring a positive experience of care and support*' - that another outcome statement be included to cover the transition between services and the experience of the patient of services working together. This will encourage ASC services to work more closely with their partners in social care and health.

A: Representation/respect and acknowledging all social and health issues pertaining to individual circumstances, not diagnostic models.

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

Plymouth LINK would like to see local people having a louder voice in improving services and therefore agrees with the principles of including local views (ULO, HealthWatch, etc.). However, replacing an independent regulatory system (CQC) with an internal self-assessment raises some concerns. How will ASC commissioning be externally regulated, making them accountable to achieving set standards and outcomes? What will happen if local people (through ULOs or HealthWatch) can't sign off/assume the accounts (either through lack of knowledge/ understanding or even without qualification)? There needs to be a clear process for signing off accounts and what happens if the above occurs? If accounts could be signed off without HealthWatch assurance and therefore a local voice, this does not show a commitment to local involvement and becomes a tick-box exercise.

In principle, Plymouth LINK supports the need for a public facing quality and outcome account, but has concerns about this being a solely self-assessment process – what is the incentive for the local authority to achieve?

We would assume that services will continue to be regulated as per existing practice.

A: Yes

Question 9: *Do you have any local examples and evidence of the benefits of a local account-type approach?*

Plymouth LINK is working with NHS Plymouth on their quality accounts, which has been a

positive process supporting the Trust to consider how it engages over the year to build a picture of local priorities to influence the focus for the next year. Plymouth LINK has supported this work through meetings with the Trust, consultation, setting priorities and advising on producing accessible accounts. The guidance for LINKs and Health in working together to produce quality accounts could form a basis for ASC local accounts. This does, however, not address the issue that accounts are reliant on the bodies/trusts themselves rating their performance.

A: LINKs

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

Learning from experience of setting up LINKs, it is recommended that a basic template be the start point for all accounts. It is fine to allow for local differences, but LINKs all reinvented the wheel using best practice from other LINKs to create similar documents in the absence of any guidance. Plymouth LINK recommends that a template will save valuable time and resources for ASC in producing the local accounts.

A: Strange wording balance? Does this interpret as LAs being able to report on proposed fiscal restraints as being within target met/or the true affect on service provision.

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

Service providers' contracts should reflect and show how they are contributing to working towards the accounts. Using expert service users as part of the process of monitoring council contracts and services will increase transparency and accountability – possibly through local HealthWatch.

A: Representation

Question 12: *Would you support an assurance role for the local HealthWatch in the production of accounts?*

Local HealthWatch, representing a wider local voice which will include service-users, will be an important voice but should be considered alongside the voices of others, including specifically service-users/groups. Strengthening the voice of local HealthWatch from that of LINKs may not be popular or easily achieved in different areas and should come with guidance for local authorities and HealthWatch so that there is a consistent approach. HealthWatch needs to be involved throughout to have an informed voice, as per the example in Question 9 above, and not just as a 'signing-off' function.

A: Yes

Question 13: *We would also be keen to receive views on whether user and carer-led assessments could support transparency and empower local people?*

Plymouth LINK fully supports the idea for user/carers-led assessments as giving people a real say. Where LINK functions will continue into local HealthWatch, this could be a role for the 'Enter & View' function as we move forward.

A: LINKs accountable to the public through volunteers at all levels.

Question 14: *What role is there for financial incentives on providers or commissioners at a national level to support the focus on quality and outcomes?*

In a climate of less funding, this may raise questions and concerns from local people, but prove a compelling incentive for providers. Where Plymouth LINK receives feedback about service quality and provision in different areas of ASC services, it seems important to encourage services to embrace a culture of continuous improvement. Financial incentives, combined with registration against CQC standards and local quality accounts will only increase the opportunities for improved services in the city.

A: There is no role for reward for best results; results rewards should be improving those services that are not considered 'best practice'. I reward my dog for achievement<sup>6</sup> and encourage not punish delivery of less acceptable practice. Rewards encourage and maintain division in service provision.

B: I believe that with all the furore around bankers bonuses, the public would not accept use of public funds to reward councils, service providers, etc., for basically doing their job. This section needs a serious re-wording, and 100% of public money needs to be distilled into services and not bonuses or rewards.

Question 15: *How should the Care Quality Commission ensure that future service inspections are risk-based and proportionate?*

No Response

A: Consultation

Question 16: *Does the regulatory model of registration, compliance and inspection provide sufficient safeguards for ensuring minimum Quality Standards across adult social care?*

Yes, the model supports the idea that standards are achieved over time. However, in order to prevent the opportunity for services to only show standards in response to compliance checks, it may be better to make these *ad hoc*.

A: No

Question 17: *How best might independent monitoring of local council arrangements for managing services be secured?*

No response

A: LINKs

Question 18: *Are these the most appropriate criteria for assessing measures? Should other areas be considered?*

Where Plymouth LINK has received feedback about the problems experienced by local people where services are not working together effectively, it would be good to build in that a criterion for measures is that they include partnership with other services as needed, also that they can/will be evidenced/measured by service users and carers and local people.

Question 19: *Throughout the outcome domains, we would be grateful for your views on the particular measures proposed, in particular:*

- *Their fit within the relevant domain and how they effect the balance of the set of measures as a whole;*
- *How they support joint working with the NHS and other partners;*
- *What interventions you think contribute towards the improvement in outcomes in this domain, and what evidence there may be locally on their cost-effectiveness; and,*
- *What further proposals which may be available from 2011/12.*

As mentioned previously the need to improve partnership working between ASC and other services has been a feature for Plymouth LINK, including a specific outcome under the domain of 'ensuring a positive experience of care and support' will embed joint working into the measures and support this more proactively than the existing measures.

Question 20: *What are your views on the proposal to repeat the Carers' Survey every two years to provide a more regular comparable source of data on outcomes for this group?*

Plymouth LINK receives much feedback from carers as a priority area of work and supports the continuation of the carers' survey biannually.

Question 21: *What are your views on designing common models for capturing outcome information at the local level, which would be adopted on a standard basis?*

As previously suggested, use of HealthWatch as an independent voice could strongly support the outcome measures and use of the 'Enter & View' function could add the 'experiential' subjective and rich stories that add weight to general information and surveys. Plymouth LINK also supports new and more innovative ways to include service users and carers in measuring and assessing services against outcomes, creating a more user-centred approach from services.

## **Addendum**

General comments on the consultation form Respondent A, a member of the Plymouth LINK Stewardship Group:

I get concerned when asked to assess an article to a pre-prepared set of pre-determined outcomes.

To be a true consultative exercise then democratic transparency must be to permit and encourage debate. The article relates to 'best practice' and 'rewards'; what is required is a patient/individual based response to a set of circumstances that are unique to that person.

Achievement can only be produced by a social service system overhauled at every level; particularly at ground force level that is not target driven but patient/carer led; direct payments led. Change would incorporate the ability to 'shop around' also gather from informed knowledge that the best 'outcomes' for the individual is either a central point of service or a series of providers that give 'best practice'. Power of own choice and accountability to the budget holder; individual/carer would ensure only the 'best practice' would survive.

Social services (adults) would then be enabled to be more pro-active in provision; early intervention and identification of need, support and advice in partnership with the individual or carers. At present the system is diagnostic criteria; not permitting a concrete assessment of both present and previous social/family/care support.

My wife is a carer and her experiences with Plymouth Social Services has been dualistic; support; respite and advice has been exceptional; BUT; with the increasing costs both emotionally, time and financial is now evidently differentially affecting on her standard of life. As dementia goes ever forward the strain of caring increases, being a dual carer is pushing her resources (mentally) to the limit. It becomes essential that carers are recognised within that care package.

As the strain of an increasing elderly population and the demands on the general finances on individuals/families increase; the service is and could be at breaking points; the idealistic outcome would be full fiscal freedom to address the issues. Any cuts now in this climate of cuts must have a dramatic reduction of affordable 'best practice'; what in reality is a system under extreme fiscal and employment pressures will impact on provision of service; already in affect; !

LINks role will be the monitoring of the proposals; we must use this opportunity however minimalistic to highlight the present shortfalls; target driven or best practice driven amounts to 'outcomes' based on financial not patient/care led.