Department of Health

# Transparency in outcomes: a framework for adult social care

*A consultation on proposals*

Social Care

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# Foreword

*A Vision for Adult Social Care: Capable Communities and Active Citizens* has set out a compelling case for the future. Across all the aims of this vision, one theme is consistent – ensuring the best outcomes are achieved for those needing social care, their families and carers, and the wider local community.

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.

Our goal is to improve not just outcomes for all people who use services, but to improve the quality of the services themselves by driving up standards in commissioning and provision, and to empower local people with a transparent local accountability over the councils who serve them. Quality is the factor which delivers the best outcomes, and public accountability is the safeguard.

Achieving this goal will require new approaches, and we are clear this is no time for 'business as usual'. Adult social care lives in changed times, with different expectations, roles and responsibilities – old mindsets of top-down programmes and performance management will not be enough. We will need a new partnership between national and local government, the social care sector, voluntary and community organisations, people who use services, and others such as the NHS.

This consultation document proposes a new strategy for transparency, quality and outcomes in adult social care. It sets out an enabling framework which aims to empower councils, local people and the wider social care sector to take new leadership roles. It provides a support to the critical link between adult social care and other local partners, such as the NHS, as well as demonstrating social care's important contribution to the Government's new Transparency Framework.

This agenda is not about top-down performance management where national Government directs and the sector follows, but about recasting this relationship for a new, more decentralised future. Throughout the document, we have thought about where the local government sector has said it can lead and the offer it has made to Government, and therefore what the balance of the remaining national role should be. We have listened to what councils have told us, and have described the where the sector itself can take charge and innovate, where local communities can provide more of the checks and balances, and how we, at national level, can support and facilitate.

This is only a start, and we will all need to work together to design a framework which meets the aims above.  One of our commitments is that the response to this consultation is a co-produced and co-badged document between national Government and the local government and adult social care sectors.

This is not a strategy document where Government presumes to know best, and councils are disenfranchised of a role in their own future. This is national Government's response to the localism agenda in adult social care – thinking first about where we should step back and allow local government and citizens to take control, and where else a national supporting role can and should continue.

This document marks the start of a conversation on how social care should approach quality as a sector, and how it should seek to account for outcomes to local people. Through your feedback, we will co-produce a new approach which puts the people, and the sector, in control.

**Rt Hon Andrew Lansley MP CBE**

Secretary of State for Health

**Paul Burstow MP**

Minister of State for Care Services

# 1. Introduction

## Our offer to local government

1.1. This consultation is published amidst both challenges and opportunities for adult social care. As *A Vision for Adult Social Care: Capable Communities and Active Citizens* sets out, achieving our aspirations whilst providing more efficient services in a financially constrained environment will require new approaches and different ways of thinking, both nationally and locally.

1.2. At the same time, the balance of power is shifting dramatically – away from the centre and towards councils managing their own future, and empowered local communities holding them to account for the services they provide and their experience of those services. The Coalition's *Programme for Government* said that:

> *'Wherever possible, we want people to call the shots over the decisions that affect their lives…We will extend transparency to every area of public life…Our government will be a much smarter one, shunning the bureaucratic levers of the past and finding intelligent ways to encourage, support and enable people to make better choices for themselves.'*

1.3. In responding to the challenges we face, we can no longer rely on top-down programmes or performance management, but instead need to foster a permissive, collective approach. It should be 'permissive' because local organisations need the freedom to manage themselves outside of central control, and it should be 'collective' to fuse cross-sector improvement and a stronger role for local government in joining up commissioning, possibly through the Health and Wellbeing Board, with a stronger local voice and accountability through the proposals for the local HealthWatch. The national role in this approach should be to facilitate and support, not to dictate.

1.4. The Local Government Group has made an offer[1] to the centre to take more control over its own affairs in response for achieving greater efficiency. In adult social care, councils have set out their own priorities for the next steps for social care transformation in a new partnership agreement, *Think Local, Act Personal*[2]. We have listened to those voices, and we understand the need and desire to decentralise, break down barriers and remove the burdens which artificially constrain local organisations and get in the way of local accountability. This consultation marks an opportunity to discuss these issues and co-design Government's offer to adult social care in response: a new approach in which councils are in the lead, the role of the regulator is refocused, and Government Departments are enablers.

[1] The LG Group includes the Local Government Association, Local Government Improvement and Development, and the Local Government Leadership Centre. Their offer to Government is at: www.lga.gov.uk/lga/core/page.do?pageId=11328875

[2] Think Local, Act Personal: Next Steps for Transforming Adult Social Care is available at: www.puttingpeoplefirst.org.uk/ThinkLocalActPersonal

1.5. Through this offer, we commit to co-production of the agenda with local government. The proposals which are set out here are a summary of what local government has told us – and we will establish through consultation whether the balance is right. Although this consultation is published by the Department of Health, it is our intention that the documents which follow be jointly owned between national and local government, co-badged by national Government, the Local Government Group and the Association of Directors of Adult Social Services, and agreed in the best interests of people who receive services.

## The key themes

1.6. The strategy is composed of three interdependent themes: the **outcomes** which services achieve for people, the **quality** of services which underpins those outcomes, and the **transparency** of the system which allows for public accountability as the safeguard.

1.7. Outcomes are crucial – they are what should drive all effective services. Social care needs to focus on outcomes because a truly personalised approach means placing the outcomes that matter to people at its heart. Embedding outcomes throughout the social care system will help all levels to think about what the individual needs, and design services to meet those needs. Moreover, by describing the ends, not quantifying the means, we can meet our commitment to significantly reduce the burdens placed on local services by the centre.

1.8. The quality of services is a marker for the outcomes which can be achieved. But it is more than just that: it is also about the effectiveness and efficiency of the service and the way it is commissioned. Quality can be described as a composite of four factors:

- Effectiveness – *getting it right the first time*; the focus of services should be to achieve the best possible outcomes for individuals in their circumstances, whether they are service users receiving reablement to regain their independence after discharge from hospital, carers looking for support, or members of the public trying to navigate through the system;

- Experience – *a positive experience of care and support*; people should be treated with respect and involved in their care, and there should be an active role for users, carers and local people; the perspectives of individuals and local groups on how services were delivered and what they achieved should drive accountability and improvement;

- Safety – *protecting vulnerable people*; the basic principle of protecting the most vulnerable people from avoidable harm, ensuring risk and choice are balanced appropriately, and setting essential standards in provision to which all services should adhere; and,

- Efficiency – *ensuring value for money*; there will be financial constraints on social care over the coming years, and high quality services will be those which can

continue to achieve the best outcomes in tight times. This will include preventative services, early intervention and better integrated working with the NHS, for instance around reablement and intermediate care services. One crucial aspect of quality will be how it supports more efficient commissioning and provision.

1.9. The concept of 'quality' is not a central creation – success in councils has shown that quality comes from the bottom up, through the systems which they and providers put in place to track the outcomes and feedback of those who use services. There are many local, independent sources of information which drive quality improvement – scrutiny processes, case reviews, Local Involvement Networks (which are proposed to become HealthWatch), and contract monitoring arrangements between councils and providers. These are the bedrock, and the aim of this document is to build on them with the additional support that national approaches can provide to all places and their populations.

1.10. 'Quality' applies not just to service provision; it is equally about commissioning practice. The role of councils as the conveners and leaders of local public services will be critical. In previous times of financial difficulty, squeezing prices on care providers has led to a decline in the quality of the market, as higher quality provision often suffers most – quality of commissioning makes a difference. We must also recognise that with greater uptake of personal budgets, the people who use services become the commissioners themselves, and therefore the 'quality' of services becomes part of an individual choice. The strategy has to consider how to support these individuals with the right tools to identify and commission high quality services, and hold them to account.

## The aims of the approach

1.11. The strategy proposed is predicated on how to ensure that the best outcomes are being achieved for those needing social care, their families and carers. It means making sure people are safe, treated with compassion, dignity and respect and enabled to make independent choices about their care and take control over their lives.

1.12. The overarching goals of the quality and outcomes strategy are:

- *To empower local citizens and support transparency*. The focus of accountability will be local, with consistent evidence of improvement for local communities and support for holding organisations to account.

- *To improve outcomes for those with care and support needs*. This means building the evidence base on how to achieve the best outcomes in adult social care, and ensuring this underpins service design, commissioning and delivery. In doing so, the focus must be on what matters most to people and ensuring action to highlight and tackle inequalities.

- *To improve the quality of social care services*. This requires understanding what 'high quality' means in adult social care, and how it can be delivered efficiently and

effectively. Obstacles should be removed so that local organisations can focus on quality with proportionate safeguards, and a commitment to transparency to local communities.

1.13. In outlining these aims, it is clear that this strategy will share common goals and aspirations with the NHS, Public Health and other local services. We must ensure that these common goals support local services to work together in their shared aim of improving outcomes for their local population, and that the detail of different frameworks or approaches does not place barriers in the way of partnerships.

1.14. Adult social care does not sit alone, and it is not just the NHS and Public Health who will be the key partners for adult social care. There are many more partners within local government, the local public, private and mutual sectors and voluntary and community organisations who will play a part in achieving better outcomes for local people. Whilst this strategy is focused on adult social care, we must not follow a path that leads to silo-working or puts up barriers to effective local partnerships. This is one of the areas that we want to discuss as we co-produce the approach with the social care sector, voluntary organisations and people who use services.

## Introducing the proposals

1.15. In the past, previous Governments have relied on centrist models of performance management to improve quality, which have run the risk of acting as distractions from the real business of improving the lives of those needing care and support. The time for these approaches has passed, and we need to free the frontline from bureaucratic constraints, and support local organisations to focus more squarely on the quality of care and the outcomes achieved. Our offer to local government is to work together to co-design the way forward and co-produce the response to this consultation.

1.16. The strategy we envisage building with local government is an enabling framework which embeds the themes of transparency, quality and outcomes in adult social care. It is multi-faceted and involves different organisations acting together, reflecting the breadth and interdependence of the issues. In short, the agenda proposed is framed around five core elements:

1. **Build the evidence base** – being clear about what high quality looks like in adult social care, and building the supports for evidence-based best practice.

2. **Demonstrate progress** – agreeing a fair, consistent data set which supports councils and communities to understand progress and to hold their organisations to account through assured comparison.

3. **Support transparency** – making information on the quality of social care and outcomes achieved available for the public, service users, carers, commissioners and managers.

4. **Reward and incentivise** – promoting sector-led quality improvement and the role for stronger incentives for providers and commissioners.

5. **Secure the foundations** – ensuring that essential standards of quality and safety underpin service provision to protect the most vulnerable.

1.17. These elements often overlap, and the key themes of localism and transparency are present throughout. Across these areas, we are trying to find a balance between a locally-led social care service which manages the market and is accountable to local people; a sector-led focus on improvement in which councils support and challenge each other to achieve the best outcomes; and the role of national bodies to protect the most vulnerable people through a strengthened legal framework and provide the tools needed to facilitate the system.

1.18. The following sections of this document begin to set out our proposed approach, and the different elements where work will be needed to lay the foundations:

- The following sections outline the five elements of the strategy above, and the initial proposals for consideration in each;
- Annex A describes a set of available outcome measures for April 2011;
- Annex B provides technical detail on those measures;
- Annex C reproduces the consultation questions from the whole document; and,
- Annex D advises on the consultation process.

# 2. Build the evidence base

**A summary of the proposals in this section**

- The role of the National Institute for Health and Clinical Excellence (NICE) will be expanded, subject to legislation, to include adult social care from 2012/13.
- NICE will work through the social care sector to bring together the evidence on best practice and publish Quality Standards which can guide efficient and effective services and commissioning. The first Quality Standards for social care will be produced in 2012/13.
- Local government and the social care sector will have a new role in building the evidence base – working jointly to identify areas for Quality Standards, and leading across the agenda.

2.1 To build a transparent framework around quality and outcomes, we need to be clear about what the evidence tells us 'high quality' looks like in social care, and the type of outcomes that people may be able to achieve.

2.2 There has not been a consistent definition of what 'high quality' means in adult social care. When research or innovatory practice has taken place, it has often not been disseminated widely. However, if there is to be a consistent focus on quality amongst social care providers and commissioners, then more formal ways of describing best practice are needed.

2.3 In the NHS, 'Quality Standards' are the mechanism by which the available evidence on best practice is presented to inform service provision. A Quality Standard is a set of between five and ten specific, concise quality statements and associated measures that act as markers of high quality, cost-effective care across a pathway or clinical area. It is derived from the best available evidence from guidance and other accredited sources and is produced collaboratively with the NHS and social care professionals, along with their partners and service users.

2.4 NHS Quality Standards are produced and published by the National Institute for Health and Clinical Excellence (NICE), working with clinicians and Royal Colleges. They are not policy statements, nor produced by the Government. The potential power of quality standards to drive improvement stems from the collaborative, evidence-based process that NICE uses to develop them. One such NHS Quality Standard, published in June 2010, looks at quality in relation to services for dementia – an important cross-sector issue which has resonance for social care as well as healthcare services. The Quality

Standard for dementia gives an indication of the format of the quality statements and supporting guidance, and can be viewed via the NICE website[3].

2.5 *Equity and Excellence: Liberating the NHS*, said that 'we will expand the role of NICE to develop quality standards for social care'[4]. Defining the extent of this expanded remit and the role of NICE in relation to adult social care will be critical to our new approach.

2.6 The forthcoming Health Bill will propose legislation to enact the expansion of NICE to adult social care. Subject to parliamentary passage, this would allow NICE to begin a new independent role as the centre of social care evidence and Quality Standards, starting from 2012/13. This will be important as NICE begins to approach issues which cover the whole pathway between NHS and social care services.

2.7 Quality Standards in social care will support progress on outcomes. They will be authoritative statements which set out the conditions of high quality services, and the results which individuals might achieve through those services. Based on the latest evidence, they will be a key lever for use in buying the best services, whether for a council service manager or an individual commissioning their own services through a personal budget.

2.8 Quality Standards are not the same as the regulatory standards which service providers need to achieve for registration purposes. These 'essential standards' capture the minimum acceptable requirements for quality and safety, whilst the Quality Standard is intended to reflect best practice in striving for excellence, and support the achievement of the best outcomes. The section of this document on 'securing the foundations' deals with how basic standards should underpin all services.

2.9 Quality Standards are not intended as a prescriptive or directive model. Instead, the Quality Standard, and the package of information which supports it, will be a tool for use in commissioning adult social care, dependent on circumstances and in conjunction with professional judgment. They will also help local people hold commissioners to account and support the role of the HealthWatch as a consumer champion.

2.10 A 'one size fits all' approach to best practice in adult social care will not be enough. People receiving social care, and the circumstances within which they require care and support, are unique – caring for an individual with similar conditions may require tackling very different needs, and interventions which work in one case may not be as successful in another. One of the key questions in this consultation is how to ensure that Quality Standards are flexible enough to support the social care context.

2.11 Similarly, the medical model for Quality Standards which is operated in the NHS is not especially relevant to adult social care. Categorising Quality Standards according to clinical conditions, for instance, could miss the substantial proportion of those using services who have more than one condition (or none at all). Moreover, Quality

[3] See www.nice.org.uk/aboutnice/qualitystandards/dementia
[4] See www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_117353

Standards in social care need to recognise that with personalisation, the budget holders will often be commissioning services for themselves, and the evidence needs to be accessible enough to inform choice.

## New partnerships to lead the strategy

2.12 Getting the leadership right will be important, and there will be a need to build new partnerships to co-produce the strategy. This will not just be about central government inviting local bodies to join groups, but about a real shared endeavour which reflects localism. As we co-produce the response to this consultation, we will ask the sector to consider how best to achieve this partnership in their best interests. Quality Standards for social care give one example why this is important: under legislation, they will be formally commissioned by the Secretary of State for Health, who will take advice from a consultative body on the choice of topics and their prioritisation. Getting the governance structures right to support the decisions on Quality Standards will be critical to the focus and direction of the strategy as a whole.

2.13 There are different options for the type of group which might fulfil this consultative role, including some existing partnership bodies between national and local services. In any event, it will be important that this be a shared arrangement, including social care sector leaders and representatives of people who use services. We will discuss options as part of this consultation process and take on board proposed changes to the NHS, public health and local government arising from the White Paper *Equity and Excellence*.

**Consultation questions**

1. How should Quality Standards in social care balance guidance on service practice, cost-effectiveness, what matters to people and outcome expectations?
2. How can we categorise Quality Standards in adult social care, and what should be the topics for the first Quality Standards?
3. How can Quality Standards be developed to support service users as commissioners, and local people in their role to hold councils to account?

# 3. Demonstrate progress

**A summary of the proposals in this section**

- A single Quality and Outcomes Data Set, to bring together all routine social care data requirements shared between areas, on the basis that this information is useful to councils and local people. This data set will reduce the overall reporting burdens placed on councils.
- There will be no national performance management, no targets nor league tables, and the current annual assessment of councils as commissioners of adult social care will be replaced with a more proportionate, sector-led approach. The Care Quality Commission will continue to inspect services where concerns have been raised.
- A fundamental review of all data requirements placed upon councils which lays out a path to replacing all current data collections, and commits to further reducing burdens from April 2012 onwards.
- A set of outcome measures, drawn from the available data, as an additional support for councils to consider for benchmarking their results, and to help local people to judge progress. All measures will be agreed and owned by the sector.

3.1 For people and their councils to get a sense of whether high quality services are being delivered, and whether people are experiencing the best outcomes, there needs to be a robust and consistent way of measuring progress. Local accountability requires that the right information be shared with those who need it, to allow for scrutiny, analysis and comparison.

3.2 Good information starts from the local level, based on the interactions between services and those who use them, and the way in which councils collect and use local intelligence. It will be important for councils to have robust approaches in place to gather data about the experiences of people and their families and report this to the public, and much work is already underway locally. Alongside the Vision policy paper, a separate publication, *Personal budgets – checking the results*, brings together learning and good practice about how councils are checking that personal budgets are achieving better outcomes. As part of this work, a sector-led consortium, In Control and Lancaster University have launched an evaluation tool for personal budgets, which is available free to all councils[5].

[5] *Personal budgets – checking the results* and the evaluation tool are available at www.puttingpeoplefirst.org.uk.

3.3 These sorts of local resources will continue to be the foundation for demonstrating quality and outcomes to local communities. However, councils do want to be able to compare their progress between areas on a larger scale, and most take part in benchmarking exercises to share their own data in the spirit of collaboration and peer review. At the same time, citizens should be able to compare results objectively if they are to fulfil the role which local accountability envisages.

3.4 The proposals in this section deal with agreeing the small subset of local information which is shared between areas to help people make informed comparisons or drive choice, and which gives councils the basis to benchmark their results and share their practice.

3.5 In the past, the national collection of management information from councils has been too directed and burdensome. National data sets and indicators have been unable to measure what really matters, and of little value to local people and councils. The new local agenda requires a fundamental rethink about what information is shared between areas, how councils share it, and for what purpose.

3.6 In considering what information is collected, we should state the goals which drive our view on information. Based on what councils tell us, we think the following aims apply:

- Information should be **consistent**, to help local people make informed judgments. However, we must respect the balance between consistent information and other information which supports local-level analysis. Only that subset of information which is agreed to be of value for consistent comparison need be shared between areas.

- Information must be made **publicly available**, to support transparency, and should be easily accessible to people with a variety of care needs.

- Councils should lead in determining what service information is shared between areas to support their own **benchmarking** and improvement. There should be no role for national performance management.

- Information must reflect the voice of local people, through experience measures which track their views and outcomes which are **meaningful**.

- Alignment of the principles and approach with the NHS, Public Health and other partners will support **joint working** in the interest of service users and carers.

- All information should be constructed to allow for disaggregation and analysis, to flag up disparities and promote excellence and **equality**.

3.7 High quality information is critical for improved outcomes, and it will be important to align efforts to improve information across adult social care, the NHS and public health. The approach can draw on the direction set in the consultation document *An*

*Information Revolution*[6]. The aim for this future information strategy is to ensure a health and social care system in which people have the information they need stay healthy, take control of their care and are able to make the right choices for them, their carers and their family, and hold the system to account.

3.8 There are two key elements in our proposed approach:

i. The **Quality and Outcomes Data Set** – a single, agreed set of data requirements which encompasses all routine social care information derived from council sources.

ii. A set of **outcome-focused measures** that would allow councils and citizens to interpret the raw data and paint a picture of what social care is achieving locally.

## The Quality and Outcomes Data Set

3.9 To support the consistent interpretation of local accountability between places, there remains an important role for validated and comparable data on social care. A lack of robust, comparable data will undermine local accountability by denying citizens the ability to challenge local government. It will also stifle the type of peer review and challenge which councils themselves want to develop.

3.10 The Quality and Outcomes Data Set (QODS) is a means of supporting councils and citizens to access data to fit with their needs. It is also an opportunity to be clear about the amount and purpose of the information reported by local government. This data set will only be of real value if it is co-produced with councils themselves, and only then will it dramatically reduce the burden imposed by the existing data collections, and give a basis for comparison on the issues that matter to people.

3.11 The Government recently announced its intention to abolish the previous performance regime, replacing the National Indicator Set with a comprehensive list of the data requirements placed on local government[7]. Adult social care will be a core part of this local government list, and the QODS would provide a direct read-across from the data used by the social care sector to the broader context of information across all of local government.

3.12 Part of this announcement was a commitment to reduce the burdens placed on local councils – and the development of the QODS will be at the forefront of delivering on this commitment. The QODS will streamline the data requirements by bringing together all routine data on adult social care into one place. At present, different organisations place requirements on councils, and this is not only burdensome but runs the risk of duplication. Some of those requirements will end – the annual performance

[6] *An Information Revolution* was published on 18 October 2010 and the consultation runs until 14 January 2011. The consultation documents are available via www.dh.gov.uk/en/Consultations/Liveconsultations/DH_120080

[7] See letter to Local Authority Leaders from Secretary of State for Communities and Local Government post-Spending Review, at http://www.communities.gov.uk/documents/localgovernment/pdf/1745945.pdf

assessment of councils, which placed a large burden in information terms, will not be continued. However, the Care Quality Commission will continue to need robust data to highlight risks to safety and quality, and inform a proportionate inspection system (see the section on 'secure the foundations'). The QODS will need to balance the needs of the different partners, but will be based on what councils need themselves.

3.13 Based on what councils and voluntary organisations tell us, we believe that a co-produced and nationally applicable data set is the best vehicle for combining requirements in one place. Government should not dictate what is contained in the data set, but can support its co-production and maintenance. There remains a role for facilitation and assurance which national bodies are well placed to fulfil, as well as supporting functions such as collection, validation and publication, to allow councils to focus their resources elsewhere. The NHS Information Centre for Health and Social Care, already the expert organisation for social care data, could provide a number of these functions in collaboration with councils, with the rest of the information market providing analysis.

## Building the QODS

3.14 The first QODS will have to start on the basis of the information which is already available and shared between councils. Whilst we know that some of the existing social care data collections are in need of renewal, we think it better and more practical to manage a transition rather than to seek quick fixes. The social care data collections for 2010/11 have already been agreed[8] with a number of reductions and rationalisations in data, for instance halving the sample period for collection of reablement data – which is estimated to save £300,000 nationally compared to the previous year. Further reductions in data burdens from April 2011 have also been announced, including the deletion of the annual Self-Assessment for the Care Quality Commission which has been estimated to cost £750,000 nationally. Subject to those further reductions, this data set would become the first QODS, jointly published in response to this consultation.

3.15 In the medium-term, there needs to be a broad conversation on how to build a more robust and sustainable QODS, and the Association of Directors of Adult Social Services (ADASS), working with the NHS Information Centre, have already started a fundamental, 'zero-based' review of social care data to inform this. This strategic review will consult widely on what data should be shared between areas for the different purposes of accountability, benchmarking, information and choice. It is founded on the principle of reflecting what the sector itself wants to benchmark to support their own improvement, and what people need to drive local accountability. It will make proposals by March 2011. With the aim of replacing all current data requirements with more targeted, valuable collections, it could lead to significant development work for implementation from 2012/13. Further information on this

[8] See www.ic.nhs.uk/services/social-care/social-care-collections/collections-2011

important review, including opportunities to be involved in the engagement process, will be available soon through the Information Centre's website (www.ic.nhs.uk).

## Outcome-focused measures

3.16 The raw data alone cannot always tell the full story, and transparency of these data alone may not be sufficient for local accountability. Alongside the QODS, and in the absence of an annual assessment by the regulator, we believe that councils and citizens alike have expressed a need for tools which enable comparison and elicit greater meaning. This points to a need to contextualise the data into a series of robust, intelligible and outcome-focused measures, agreed by councils for use between areas.

3.17 A set of outcome-focused measures would describe both the picture of what social care-related outcomes are being achieved in every place, and how efficiently individual services are contributing towards those outcomes. To ensure no additional burdens are created, any such measures must be drawn from existing data sources – both from councils and elsewhere. We would expect that the overall number of any such measures would be smaller than under the previous regime.

3.18 An agreed set of outcome measures will not be 'priorities', and we must not replicate the approach of the previous National Indicator Set. The question of prioritisation is one for local partners to decide together. There will be no expectation on councils to use individual measures to evidence their own improvement – there will be no targets set against them; nor will they be used nationally for performance management. Instead, the measures would be an attempt to demonstrate outcomes and add greater intelligence and comparability to the raw data already publicly available. Like the QODS, the measures would be published annually, perhaps by the NHS Information Centre for Health and Social Care. There is a need to make it easy to access these measures, and reduce the pressure on councils by putting all the information on their peers in one place.

3.19 This consultation proposes a set of measures which have been developed over time with the social care sector. We recognise that publishing certain data as measures has, in the past, led to perverse incentives; that is why we commit to co-producing and jointly publishing the final set of measures with the social care sector, and with the people who use services and carers, to make sure that the information shared in this way is genuinely useful. If there is a clear argument that individual measures are not helpful, or run the risk of being misinterpreted, they will not be published as outcome measures in this way.

## Designing the outcome measures

3.20 To act successfully as a set of measures which demonstrates the effectiveness of social care services, the design of proposals needs to set out clearly the different areas of focus, and the relationship between contributory factors and activities. Reviewing the impact of previous frameworks with local government and the social care sector, we

have learned a number of lessons for how a set of measures should be constituted to make most sense to councils and local people. In particular, it will need to distinguish between outcomes across two variables:

- The **level** at which the outcome takes place – whether it is a more overarching population-level outcome, or more specific to a certain area or group, or part of the commissioning data which drive activity;

- The category, or **domain**, of outcome – the general theme it represents in the overall approach, to ensure that the right areas are covered adequately.

3.21 This distinction is important, since for the measures to be effective, they should clearly differentiate between those areas which are higher-level or whole-population, those which relate to more specific user or carer groups, and those which are within the direct control of service managers. Treating all measures the same causes perverse incentives and undermines the type of fair presentation which is needed for local accountability.

3.22 From a practical perspective, there are several different levels of information which should be distinguished:

- **Overarching measures** – some measures are very high-level, giving an overview of the outcomes to which adult social care contributes across the local population, and often including in the contribution of other services. These will be very small in number, and are likely to link to the overall national responsibilities of the Government.

- **Outcome measures** – other more specific outcomes measures will relate to the overall themes and be closer to individual groups or the impact of local services. They will include a combination of user or carer-reported outcome measures and more objective outcome measures.

- **Supporting quality data and measures** – some data will not specifically represent an individual outcome, but will demonstrate service quality or other factors which are important contributors towards outcomes. They can also be useful to provide a consistent basis to drive local commissioning, and analyse efficiency in meeting the outcomes in each domain. In time, this quality information will be supported by NICE Quality Standards for social care, other statutory guidance and any information arising from other sector-led initiatives which provide comparable data and where use of data is agreed for this purpose (for instance, the *Place-Based Productivity* programme led by the Local Government Association).

3.23 All of these types of information are available as a subset of the wider pool of locally-held management information. For the purposes of transparency and local accountability, we know that councils also collect and share further **locally-held information resources**, and will be able to supplement any agreed standard outcome measures, at their own discretion.

3.24 To cover the picture for social care, outcome measures will need to replicate the different types of information across each of number of outcome domains. These 'domains' are themed groups which aim to capture similar or related areas, to simplify the presentation and draw out the key messages. Together the domains should capture the key outcomes for adult social care.

3.25 The description of domains will be important. The NHS Outcomes Framework[9] has proposed five domains for this purpose, and although these domains are not all relevant to adult social care, there are some common themes, and in the interests of alignment, this provides a signal to build on in social care. Nonetheless, the approach must ensure that the domains make sense in their own right to service users, carers and practitioners.

3.26 The table below suggests headings for the social care domains, as well as a series of 'outcome statements' which serve to describe the aspects of each explicitly. These statements have been developed in consultation with expert service users and carers, as a means of articulating what is most important. They are intended to set a guide for the areas that outcome measures should try to follow. The table also maps the domains across to their closest partner in the NHS Outcomes Framework, to demonstrate how they will align thematically.

[9] *Transparency in Outcomes: a framework for the NHS* was published for consultation on 19 July 2010. A response to this consultation will be published in late 2010. The consultation document can be viewed at www.dh.gov.uk/en/Consultations/Liveconsultations/DH_117583

| Adult social care outcome domain | Adult social care outcome statements | Equivalent NHSOF domain |
|---|---|---|
| Promoting personalisation and enhancing quality of life for people with care and support needs | • People live their own lives to the full and can maintain their independence by accessing and receiving high quality support when they need it.<br>• Carers can balance their caring roles and maintain their desired quality of life.<br>• People have control and manage their own support so that they can design what, how and when support is delivered to match their needs.<br>• People engage socially as much as they wish to avoid loneliness or isolation. | Enhancing quality of life for people with long-term conditions |
| Preventing deterioration, delaying dependency and supporting recovery | • Everybody has the opportunity to have optimum health throughout their life and proactively manage their health and care needs with support and information.<br>• Earlier diagnosis and intervention means that people are less dependent on intensive services.<br>• When people become ill, recovery takes place in the most appropriate place, and enables people to regain their health and wellbeing and independence. | Helping people to recover from episodes of ill health or following injury |
| Ensuring a positive experience of care and support | • Social care users and carers are satisfied with their experience of care and support services.<br>• Carers feel that they are respected as equal partners throughout the care process.<br>• People know what choices are available to them locally, what they are entitled to, and who to contact when they need help.<br>• People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual. | Ensuring people have a positive experience of care |
| Protecting from avoidable harm and caring in a safe environment | • Everyone enjoys physical safety and feels secure. People are free from physical and emotional abuse, harassment, neglect and self-harm.<br>• People are protected as far as possible from avoidable deaths, disease and injuries. | Treating and caring for people in a safe environment and protecting them from avoidable harm |

3.27 'Efficiency' will clearly be an important angle for councils' analysis and needs to be explicit within every domain. Whilst there is no single measure which accurately demonstrates efficiency, our intention is that publishing outcome measures alongside relevant activity and financial information from the QODS will allow for an analysis at the local level of value for money and productivity, by comparing outcomes with the activities invested and their unit costs. Moreover, efficiency and productivity measures are being considered specifically by the Local Government Group, and as final

proposals are co-produced in response to this consultation, the learning from that process will be included at councils' discretion.

3.28 Whatever different measures are agreed in the four domains above, in the first instance they will need to be populated using existing national data sets. Whilst these will principally be drawn from council sources (i.e. the QODS), there are other available data sets, such as NHS hospital statistics, which could create robust, relevant measures which stand beside other social care measures, but which do not increase data requirements. National bodies could support local councils and citizens in making these data easily available.

3.29 The set of outcome-focused measures is intended to reflect an agreed position on the best measures available at a given point in time. They are dependent on the existing published data which support them, and as the data change, so the measures themselves may change. As the 'zero-based' review of social care data requirements changes the available data set, the outcome measures are likely to evolve. The approach should be iterative to ensure it always matches the most robust view of what information should be presented in this way – on the understanding that all future changes will be explicitly agreed by the social care sector as the ultimate 'owners' of the measures, and changes will not increase the overall data burden.

3.30 There are a number of potential outcome measures which are based on existing data and would be available to councils from the first year, 2011/12. Some of these have been used in the past; others have arisen from co-produced work to identify better ways to use current data. A selection of these measures is set out in **Annex A**, with some additional technical information included at **Annex B**. We would like to use these annexes as a starting point for working with the social care sector to agree what outcome measures could be used as suggested from April 2011. As noted above, our expectation is that the final agreed set of outcome measures will not be greater in number than those used in the past.

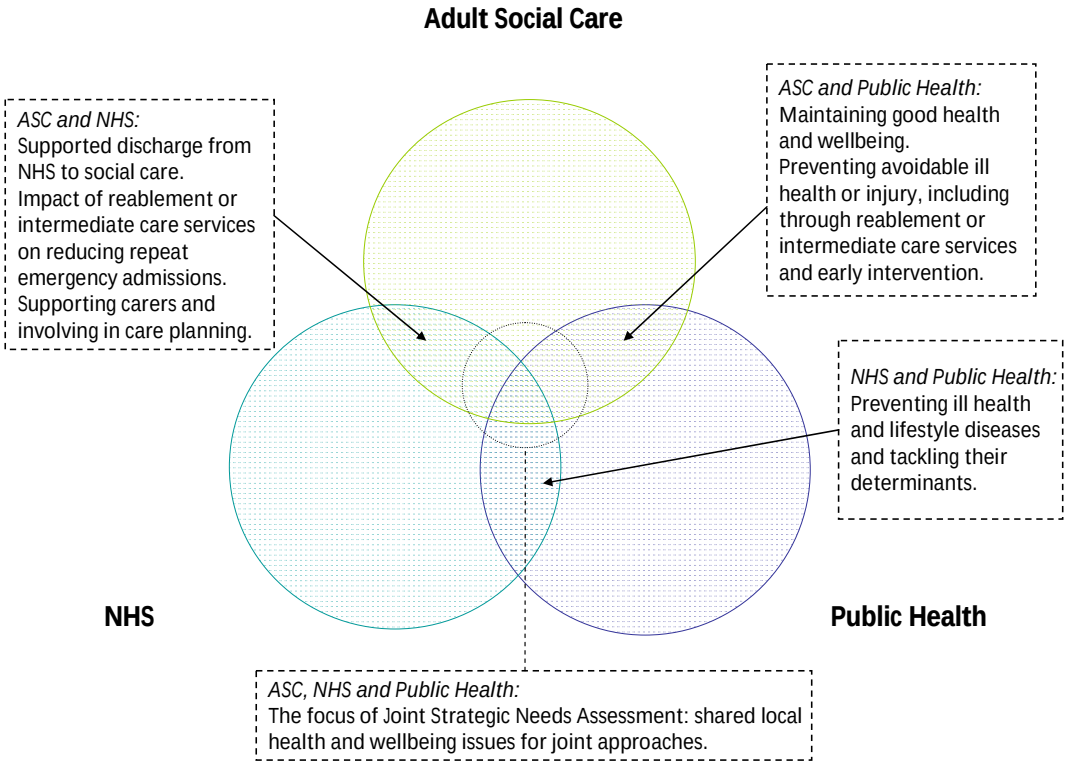
## Relationship with other outcome frameworks

3.31 As noted above, one of the most important aims of information will be to support local partners to work together where they share common outcome goals. To do so, it will be critical that alignment is built in with the partner frameworks for the NHS, Public Health and others from the outset, to not create barriers which will act against delivery. Feedback from consultation responses on the NHS Outcomes Framework has highlighted consistently the need for different approaches to support, not hinder, integrated working on a local level.

3.32 The diagram below shows how we might envisage the relationship between adult social care, the NHS and public health in terms of shared outcome focuses.

3.33 In this diagram, there would be some key areas of overlap, where local services share an interest and where a whole-systems approach could support both better outcomes and

increased productivity. By sharing the same or complementary measures between sectors, there could be a strong incentive for local services to work together and measure their progress on the same basis. The approaches of the three services to outcomes should not be separate entities but part of a single whole.




3.34 There are other local services which will be crucial to achieving outcomes, and which social care will work with in partnership – children's services, employment services, leisure and housing, for instance. Whilst this diagram does not yet include all the relevant areas of overlap and focus for all partners, the social care sector will want to consider how approaches from other areas can be aligned and synergies can be released. We would be grateful for views on how key areas for people such as transitions from children's to adults' services can be better reflected.

3.35 The Government has also announced a new Transparency Framework[10] as part of the Spending Review. Under the new framework, each Department will publish a Business Plan, including the reforms it will make and the key indicators on inputs (costs and activity) and impact (results achieved) by which the public can form their own judgment at the national level. Adult social care should play a part in that framework, with a clear link designed between the outcome measures for social care and the indicators in the Transparency Framework to reinforce a common view of the most important areas

[10] The Transparency Framework was announced as part of the Spending Review 2010. See the references at paragraph 1.84 and box 1.5 of the full document at http://cdn.hm-treasury.gov.uk/sr2010_completereport.pdf

shared nationally and locally. This is most likely to be at the level of 'overarching measures' relevant to adult social care, since these will be more nationally relevant.

**Consultation questions**

4. Do you agree with the proposal for a single data set for adult social care, supported by a single collection and publication portal?
5. Do you support the case for a set of consistent outcome-focused measures, which combine the best available data on social care outcomes?
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?
7. Do you have any further views on how adult social care outcomes should align with other sectors to support integrated working? How might this be put into practice?

# 4. Support transparency

**A summary of the proposals in this section**

- All agreed social care data and outcome-focused measures will be published in a consistent format and on an annual basis, through a single information portal.
- Councils will consider how to support those data with a published local account on their priorities for quality and outcomes in social care, as a key tool for transparent reporting to their local population.
- This local role for accounting will replace the Care Quality Commission's annual assessment of Councils as commissioners (including the former requirement for a Self-Assessment) from 2011/12.
- The local government sector, in consultation with other parties, plans to develop a system of peer review and challenge, through which councils can assure one another's results and support improvement.

4.1 Public accountability is key to adult social care, and the transparency of information is amongst the most important contributory factors. As we develop an approach which places local people in the lead role for holding organisations to account, we should consider how we can support them to exercise this new responsibility, for example the role that user-led, voluntary and charitable organisations might play to enable accountability. The broad aims here are twofold: to enable users and carers to make well-informed choices about their care and hold services to account, and to allow local providers and commissioners of services to judge their quality and that of others, to support their mutual improvement. In addition, the local HealthWatch will have the power to request the Care Quality Commission to undertake an inspection where it has grounds for concern.

4.2 Publishing a comparable, intelligible pool of quality and outcome information will clearly be an important asset, as will ensuring that validated data and measures are available and accessible. However, simply publishing information may not be enough for the genuine public engagement which underpins real transparency. Even the most relevant data and related measures will not always convey a sufficiently clear message. People tell us they need free access to both – the raw data if they feel they want to interrogate it themselves, and an interpretation for those not wanting to do their own analysis.

4.3 Part of our new approach to proportionate inspection of councils will be a refocusing of the role of the Care Quality Commission on essential standards, risk-based inspection

and thematic reviews. We need to consider the effect of these changes on public reporting, and where there is any 'gap' left behind, the principle of localism requires that it be up to the social care sector to fill it to the satisfaction of local people. We know that councils already use a variety of methods to communicate with their citizens which provide a basis, and that the local government sector more widely is considering how to develop a new programme of sector-led review, challenge and improvement in support. As with the other sections in this document, we are keen to establish what facilitating role could be played by Government to help councils achieve their ambitions.

## Local accounts

4.4 With the removal of annual regulatory assessments and an emphasis on localism, councils will be considering how they can best support transparency at the local level and communicate a narrative on their priorities, as well as the results they have achieved. There will be a role which could be filled by local accounts on quality and outcomes in adult social care, as many councils are already doing.

4.5 Local accounts, as the name suggests, would be self-assessed and published by the council – there would no national Government role in assurance. They would be based on an account of the quality and outcome priorities which the council has chosen, in consultation with its partners, and the progress it has made in achieving them during the past year. As well as drawing on the comparable information in the Quality and Outcomes Data Set and associated outcome measures, councils could supplement additional local data to support their narrative.

4.6 We have no plans to specify the content of a local account, and think the best organisation to decide how to engage citizens is the council themselves. Based on current best practice in different sectors, the account might include:

- A statement from the council's board, or the proposed Health and Wellbeing Board, on their quality and outcome priorities and how these have been taken forward over the year;
- A description of how the council is working with other partners locally in support of shared outcome priorities (for instance, in relation to cross-sector work on prevention and reablement with the NHS);
- A requirement that the account is signed off by the Local Involvement Network, or proposed HealthWatch[11], would provide an important local check and balance in the system. The local HealthWatch could sign off the local account either with or without qualification. They might include a statement on their perspective on the

[11] Local HealthWatch organisations were announced in *Equity and Excellence*, and are subject to parliamentary approval. See pages 19-20, www.dh.gov.uk/en/Healthcare/LiberatingtheNHS.

council's progress and the extent to which local people have been actively engaged in prioritisation and planning; and,

- A selection of data and measures which demonstrate the objectives chosen locally, and the progress made during the past year, in support of the overall narrative.

4.7 We know that many councils are already doing this sort of communication as a matter of course, and it is not our intention to distract or undermine their efforts. We also know that other local government sectors already have similar requirements (for instance, annual reporting on housing), and we see no reason why councils should not be able to choose to integrate these where they see benefit in doing so. Similarly, local partners may choose to tie reporting on social care with other public sector reports, such as NHS Quality Accounts, through the proposed Health and Wellbeing Boards, and we would want to promote, not discourage, such partnership approaches.

4.8 There are options for the extent of the requirements associated with such local accounts. Whilst greater consistency could be achieved by specifying particular content, we do not believe this will add enough value to balance the burden imposed, and there will be no new statutory duties. Our preferred route would be to encourage regular publications through work with the sector, based on what councils already do and their own priorities, and support this where possible with guidance on best practice and analytical tools for understanding data.

## Peer review

4.9 We believe that the best assurance of these accounts would be conducted between areas and by the social care sector itself. Sector leaders, including the Local Government Association (LGA) and Local Government Improvement and Development (LGID), are already developing a new system of peer-review through which councils will be able support each other to provide the most accurate and useful picture of social care. Through this mechanism, councils would be able to review one another's accounts, challenge poor practice and share expertise. This would also link to existing initiatives on sector-led improvement, by providing information on quality and outcomes that can be used to inform the direction, and is likely to take over some of the former responsibilities of the Care Quality Commission in relation to assessment. Government will offer to do what it can to support the organisations considering this new approach.

4.10 As part of these discussions on the next steps, we will also consider whether the local HealthWatch could have a more formal role in assuring the account or acting as a signatory, to make sure that the voice of local people is heard in the process.

## Assessments by those who use services

4.11 In keeping with the aims of local accountability, some councils have told us about how they are considering commissioning user- and carer-led organisations, as well as individuals themselves, to produce detailed assessments of their experience of adult

social services for publication locally. We think this could be a valuable means of interacting with local communities and supporting their voice to report on how they see the performance of the council. As well as manifestly encouraging transparency, it would provide important intelligence on local experience and expectations, and inform service commissioning as well as flag risks. It could supplement the sort of council-led account above, or the two could be integrated. We will work with councils testing this approach, to see how it could fit into the broader agenda.

4.12 People who use services can also share their feedback, rate their experience or provide more local intelligence through a growing resource of online service user and carer-generated information, such as *iWantGreatCare* www.iwantgreatcare.org and *Patient Opinion* www.patientopinion.org.uk, which inform choice but also can be used locally to demonstrate personal experiences and judge how services are achieving outcomes.

**Consultation questions**

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?
9. Do you have any local examples and evidence of the benefits of a local account-type approach?
10. What is your view on the balance between requiring standard elements in reports, and allowing freedom to fit to local circumstances?
11. The proposed accounts would only apply to council commissioners. What further actions, if any, might be considered to promote transparency amongst service providers?
12. Would you support an assurance role for the local HealthWatch in the production of accounts?
13. We would also be keen to receive views on whether user and carer-led assessments could support transparency and empower local people?

# 5. Reward and incentivise

**A summary of the proposals in this section**

- The new 'excellence' rating for social care providers, currently in development, will act as an accredited marker of best practice and high quality and an incentive for providers, as well as an important tool for supporting choice.
- We ask respondents to consider how financial incentives for providers based on rewarding quality improvement could be adopted by councils, including in partnership.

5.1 Success in embedding and improving quality and outcomes will be contingent on the right incentives being built in. Quality should become self-sustaining, where the objectives are at the heart of the local planning, commissioning and service provision, and best practice is recognised and rewarded.

5.2 This is not a question of coercion or punitive recourse, but of aligning different elements to support the overall direction, and of creating an approach in which quality and outcome improvements are sector-led and mutually reinforcing. We have already proposed a number of elements which will act as incentives in their own right: evidence-based guidance on best practice, transparent publication of data and associated measures, and self-reported accounts of council priorities and progress. There will be further structures to incentivise quality locally, such as independent sources of challenge like Overview and Scrutiny Committees and Local Involvement Networks/HealthWatches. However, there remains a question as to whether other appropriate and effective incentives could support our aims.

## Quality ratings for providers

5.3 Service providers will be at the forefront of improving quality and delivering better outcomes – they will have the most regular, often daily, contact with the service users and carers. All 30,000 social care providers have been registered by the Care Quality Commission, guaranteeing that essential standards have been met. These basic standards for quality and safety act as a bedrock from which improvement can be made towards the higher levels of practice and outcomes identified in the NICE Quality Standards for social care. To establish which providers are successfully going beyond those essential standards, and striving for excellence, a further assessment mechanism will be needed.

5.4 In the past, the Care Quality Commission has assessed providers and awarded a star rating based on their judgment. The star ratings (later replaced with quality ratings) have been a useful tool in a number of respects: supporting informed choice on the part of users, carers and their families, and assisting commissioners in judging the overall quality of the local care market. However, the old system does not fit with the registration requirements, and has already been targeted for reform.

5.5 The Care Quality Commission and the Social Care Institute for Excellence (SCIE) are already working to develop a new, bespoke method of assessing high quality practice in social care providers to replace the old ratings. The proposal is to create a new 'excellence' rating, the subject of an independent assessment of quality, as an important aid in distinguishing best practice. It is intended to replicate the positive elements of the former system, whilst providing a more proportionate approach to ratings overall.

5.6 The 'excellence' rating would be a key incentive for providers to improve quality, as well as a useful tool for commissioners, including those managing their own services, to support choice. It would be subject to an application from the provider, not a routine assessment, putting the onus on the provider to meet the standards. The methodology for awarding the rating would be developed to be closely linked into the broader strategy on quality and outcomes, reflecting the content of NICE Quality Standards when they are introduced in the future. Whilst the quality ratings in the past have been the preserve of the regulator, in the future there could be a role for a number of groups working with CQC on accreditation, including sector leaders, trade bodies, the local HealthWatch and people who use services.

## Supporting continuous improvement in quality and outcomes

5.7 As commissioners, councils will have a crucial role in promoting the focus on quality and outcomes across a diverse range of services. We want to support this vital function by providing effective levers that commissioners can use at local level to drive change and reward excellence.

5.8 Incentives for better commissioning are already built in to our proposals – the goal of achieving better value for money and greater efficiencies will be supported by Quality Standards which evidence best practice, and improved data which demonstrates progress. And locally, we know that most councils engage in some form of contract monitoring with service providers.

5.9 In addition to existing incentives, we are interested in considering whether more direct financial incentives for providers might support the focus on quality and outcomes at local level, encouraging a culture of continuous improvement and best practice. There are examples from other areas, such as the proposal to move to a 'payment by results' model for welfare-to-work providers which rewards achievement of specific outcomes. Taking the NHS as another example, we see how provider payments are now explicitly linked to quality through a number of mechanisms, most notably 'Commissioning for Quality and Innovation (CQUIN)', a framework for locally agreed quality schemes in

which achievement of ambitious quality improvement goals is linked to a small proportion of a provider's overall contract income.

5.10 Not all of the examples in other sectors will be relevant for adult social care, and any additional frameworks for incentives must allow adequately for local discretion. We want to work with councils to consider if and how 'payment by results' or other financial incentives could be used for adult social care. We would also be keen to hear about how councils are approaching these issues themselves to improve our understanding of models already in use.

5.11 The proposed new roles of GPs and of Directors of Public Health[12] in commissioning healthcare and public health services respectively will have an impact on the local economy and the relationships and processes needed for effective joint commissioning. It will be important that system architecture changes do not hinder partnership approaches and integrated working, and the role of the proposed Health and Wellbeing Board in aligning commissioning priorities will be in part to ensure a consistent focus on quality and outcomes.

**Consultation questions**

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

[12] Proposals on GP commissioning of healthcare services and public health reforms were announced in *Equity and Excellence*, and are subject to parliamentary approval.

# 6. Secure the foundations

**A summary of the proposals in this section**

- The role of the Care Quality Commission (CQC) will be strengthened and refocused as an effective quality inspectorate.
- CQC will assure alignment between the emerging strategy on quality and outcomes and their registration and compliance requirements, to provide a safeguard which is appropriate, balanced and transparent, in keeping with the regulator's primary accountability to the public.
- CQC will work with the local government sector to develop a new, risk-based system of inspection for councils, making a proportionate relationship between the burden imposed and the risks to safety. This will include HealthWatch having the right to request CQC undertake an inspection where it has grounds for concern.

6.1 A focus on 'high quality', exemplary practice and the best outcomes must never detract from our commitment to the basics. It is a core principle of public services to protect the most vulnerable in society, and the new approach must ensure this fundamental objective. Safety, safeguarding, dignity and quality are inextricably linked.

6.2 All those needing care and support should have full confidence in the quality of the services they receive, and be empowered and supported to challenge services when the quality falls short of what should be expected. The strategy, therefore, will be underpinned by a system which enshrines basic standards, promotes quality and balances risk effectively.

## Regulating for essential standards

6.3 The role of regulation will be critical throughout the strategy, and nowhere more so than in relation to essential standards for quality and safety in service provision and commissioning. The Care Quality Commission, as the independent regulator for adult social care, will be the most important organisation in this vital area.

6.4 The White Paper, *Equity and Excellence: Liberating the NHS*, stated that 'we will strengthen the role of the Care Quality Commission as an effective quality inspectorate across both health and social care.' The role of CQC, therefore, will be pre-eminent in underpinning quality in adult social care. The means through which the regulator will achieve this are through:

- **Registration**: The gateway to the social care market, through which all service provider organisations must achieve a series of essential standards to prove themselves fit for operation;

- **Compliance**: The process of ensuring the essential standards for service providers continue to be met over time, including periodic inspection of providers; and,

- **Inspection**: The mechanism for monitoring councils' ability to deliver effective safeguarding arrangements for the most vulnerable groups in their community.

6.5 The Care Quality Commission will continue to manage the registration process which controls access to the social care market for providers. This process ensures that all licensed care providers operate to agreed standards, setting the essential level of quality and safety to which all organisations must adhere.

6.6 Having met the standards required to operate, service providers must maintain them in the future. Compliance with the essential standards of quality and safety is monitored through a process of planned and responsive reviews, based on an assessment of the unique risk profile of each provider. By focusing on core duties such as safeguarding vulnerable people, the Commission can identify where standards are at risk of failing, and use powers to intervene where necessary.

6.7 Councils, as the major commissioners of local services, should have a significant influence on the quality and capacity of the local market for social care. Whilst regulating providers can cover some of the risks to safety, that alone may not always identify poor or dangerous practice. Independent monitoring of the council's arrangements for managing services locally could act as an additional lever, to reinforce public confidence in the quality and safety of services.

6.8 Regulation must be proportionate, and based on risk. In the past, CQC has assessed all councils annually and published their judgments, including standardised quality ratings. This has not been sufficiently risk-based, and has increased the burden on councils. In keeping with our principles of local accountability and proportionate regulation, we believe that that routine annual assessments should end after the last planned publications in November 2010. In the future, this will be replaced with a sector-led system of reporting, assurance and accounts which will be co-produced during this consultation.

6.9 Nonetheless, the regulator needs to be able to identify and respond to risks quickly to ensure the safety of vulnerable people, and we believe a strong case remains for targeted inspections of councils carried out by the Care Quality Commission. These inspections would take place where a significant risk had been identified through one of a number of triggers, for example information in the QODS and associated outcome measures, local intelligence or feedback from those who use services. As now, CQC will retain powers to request additional *ad hoc* information from councils to be used in judging risks to safety. CQC and sector organisations will work to develop new a model for

triggered inspections based on assured data, including feedback from users, carers and a role for the proposed local HealthWatch as described in this document.

**Consultation questions**

15. How should the Care Quality Commission ensure that future service inspections are risk-based and proportionate?
16. Does the regulatory model of registration, compliance and inspection provide sufficient safeguards for ensuring minimum quality standards across adult social care?
17. How best might independent monitoring of local council arrangements for managing services be secured?

# 7. Managing the transition

7.1 Developing the strategy on quality and outcomes in adult social care will be both revolutionary and evolutionary. It will be a markedly new approach to the way in which adult social care is held to account, and a move from the past which will require collective cultural change. At the same time, it is composed of a number of interrelated elements which will be developed and implemented over time, and subject to ongoing improvement as the evidence grows.

7.2 Not all of the proposals outlined before, even if accepted, would be achievable in the immediate term. Whilst April 2011 marks the start of our new approach, it will not be the end of our focus, and there will be a managed transition to the new arrangements.

7.3 Whilst we have yet to agree the proposals contained in the sections before, if all were implemented over the coming years of the next Spending Review period, we would need a staged approach to their introduction. The timeline below gives an indication of how different elements may be developed and implemented over that time:

## November 2010 to summer 2011: Consultation and development

- This will be an intensive period of consultation and engagement to ensure that the approach is genuinely co-produced with leaders in the social care sector, fits within the future policy and economic landscape, and is based on what matters most for people.
- The first stage, this consultation, will run until 9 February 2011, with the consultation response published by March 2011.
- Some elements will come into effect from April 2011: this phase will include the launch of the first Quality and Outcomes Data Set and supporting outcome-focused measures, effective from April 2011.
- Annual performance assessments of councils by the Care Quality Commission will end with the final 2010/11 assessments, published in November 2010. We would expect the first local accounts on quality and outcomes to take over and also come into effect in relation the 2011/12 year.
- Other longer-term elements of the strategy would not come into effect immediately. There will be further engagement in these areas over 2010, with the aim of including proposals on the approach, where relevant, in the Social Care White Paper, due by the end of 2011.
- The two relevant independent commissions, the Law Commission and the Commission on the Funding of Care and Support, will report in the spring and summer of 2011 respectively.

- The concurrent 'zero-based' review on social care data requirements will report in March 2011, and set out an agreed development programme for new data going forward.

### Late 2011 to March 2013: Implementation

- Following the engagement above, further proposals on the different elements of the strategy will be published as part of the Social Care White Paper by the end of 2011. This will include a more detailed timeline on implementation, dependent on decisions yet to be made on which aspects to take forward.

- As the proposals are clarified and the work ahead set out, a new group will be established to provide high-level governance and leadership to the agenda, from late 2011.

- The results of development work on social data will lead to the announcement of any agreed early changes to the Quality and Outcomes Data Set from the second year, April 2012. Any changes agreed by the sector would be likely to be staged over more than one year, depending on the development required and the scale of change. Any changes to update the supporting outcome measures will be announced at the same time.

- Subject to successful passage of legislation, NICE will assume responsibility for adult social care within its remit from April 2012, and aim to publish the first social care Quality Standards during that year.

7.4 Obviously, the final timeline will depend on the responses to this consultation, ongoing engagement, and the decisions we jointly make on how to progress this work. This is illustrative – but it is a good indication of how we will need to balance different elements over the short and medium-term.

# 8. Next steps: how to get involved

8.1 The previous section gives an indication of how development work on the areas within this strategy may be co-produced and delivered over the coming years.

8.2 The first opportunity to influence this strategy is to respond to this consultation, before the deadline of 9 February 2011. There will be further chances to engage, as we intend to continue the conversation over 2011, but this early stage is the best means of leading this process from the beginning.

8.3 This paper has explained some of the principles which underpin our approach to transparency, quality and outcomes, and how we propose to turn those principles into a workable framework. Along with the annexes which follow, there are many issues raised, and a number of consultation questions through which we are looking for your advice, opinion and expertise. Please follow the contact details in the box below to ensure your views are received by the deadline, and ensure your voice counts towards shaping this strategy.

**How to respond to this consultation**

This consultation closes on **9 February 2011**. You can contribute to the consultation by providing written comments to:

**By e-mail**: qualityandoutcomes@dh.gsi.gov.uk

**By post**: Quality and Outcomes Consultation, Department of Health, Room 114, Wellington House, 133-155 Waterloo Road, London SE1 8UG

We will also be arranging a number of consultation events around England. Details will be posted on the DH website as well as advertised through stakeholder networks.

# Annex A: Available outcome measures from 2011/12

1. The main consultation document has already set out the case for the Quality and Outcomes Data Set and the role for a set of supporting outcome-focused measures, as well as how this would fit into the wider strategy, and alongside other partners' equivalents.

2. This annex outlines a set of outcome-focused measures, based on data which will available nationally in 2011/12. It should be read in conjunction with the technical annex (Annex B to the consultation), which gives additional detail on the measures. These annexes form part of the main consultation, and views are requested on the particular measures put forward.

3. As the consultation makes clear, the purpose of the set of outcome measures is to be of genuine use to both councils for benchmarking their progress, and to citizens for holding local services to account. To do this, the set of outcome measures will need to be co-produced with the local government and social care sectors, to ensure that only what is useful is presented in this way. We have committed that the final set of outcome measures be jointly published in response to this consultation.

4. What follows is our initial assessment of some of the best available outcome measures, based on discussions with councils, community and voluntary organisations, and social care users and carers. It combines a number of sources, including data from other organisations which do not entail a reporting burden on councils. Whilst decisions on outcome measures will be subject to consultation and co-production, we would expect the final number of measures agreed to be fewer than under previous arrangements.

## How measures will be selected

5. The eventual set of outcome measures will be agreed on the basis of a detailed evaluation of their key characteristics. Clearly, the criteria used in such an evaluation will have a significant bearing on the overall robustness of the framework.

6. To support the selection process, we propose a list of the most important criteria for assessing measures. This does not aim to include every angle, but rather to highlight the most critical dimensions, as a means of assuring a common data quality. Whilst there are other aspects which may be part of defining a robust measure, and indeed other sets of criteria used in different frameworks, we believe the following to be the most appropriate to our aims and principles:

    - Essential: Relevant and meaningful to the public – measures should be intelligible and reflect what matters to people;

- Essential: Substantially influenced by social care – measures must be relevant to the work of adult social care to support accountability;
- Essential: Can be compared between local areas and over time – measures must be consistent to promote transparency;
- Essential: A measure of a social care-related outcome (for overarching and outcome measures), or consistent with the outcome focus (for quality data and measures) – we should be clear about the level of the measure its fit within the outcome domain;
- Desirable: Disaggregation by equalities – measures should be able to be broken down to support a focus on inequalities; and,
- Desirable: Currently collected – measures should, at least from 2011/12, be currently available from an existing data source.

7. In selecting the measures to be used locally, we need to consider the appropriateness of individual measures and the balance of the set as a whole. The relevance of the measures themselves will rely on the availability of evidence on interventions which can drive improvement in outcomes, and their cost-effectiveness. During the period of the consultation, we will do further work to research and bring together the available evidence on cost effectiveness. We are also asking for responses via this consultation in relation to such interventions.

8. We also need to consider the appropriateness of the set of outcome measures as a whole – how they fit together to reflect the outcomes that matter to people, and whether they balance the most useful presentation of issues for local benchmarking. Whilst some imbalance is unavoidable due to the lack of availability of data in certain areas, this must not overly distort the focus or value of the set as a whole.

9. We will be working with partners in local government during the consultation period to analyse the outcome measures in more detail. As already stated, we commit to co-producing the final outcome measures, and will agree them with the Association of Directors of Adult Social Services and the Local Government Group, taking on board all the feedback we receive through the consultation process, before publication in a joint response to the consultation.

**Consultation question**

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

## Introducing the measures

10. The main consultation document described four domains for social care outcomes, with the measures split into one of three levels representing how they operate. Taking each of these domains in turn, the next section outlines some of the outcome measures, based on the data expected to be available in 2011/12.

11. It is worth reiterating the point in the main consultation document that the first version is based on existing data sets and measures which can be drawn from them. There is a general recognition of a number of gaps in the current information – for instance in relation to the effect of all reablement services, the ability to disaggregate data to analyse dementia or autism, or the outcomes for young adults transitioning from children's to adults' services. We will need to identify these gaps and consider whether or how they could be filled, in line with the principles of proportionality.

12. There are 22 individual measures across the four domains below. Of these measures set out, eight are drawn from NHS or other non-council data, rather than local government sources. We have been keen to make the best use of all available information, not just social care data, where it is relevant and could be shared with councils and local people. These measures do not amount to a reporting burden on councils, but could be useful to support joint working on a local level by linking to both the NHS Outcomes Framework, and the proposed Public Health equivalent. They are included here to supplement measures based on council information on adult social care. They are marked with asterisks throughout.

13. The proposals below, therefore, represent the most robust measures which we believe to be currently available, based on conversations and development work in councils. In all cases, we are asking for your comments on both the strength of individual candidates, as well as suggestions for other measures which may have been missed. As already stated, the purpose of jointly defining a set of outcome-focused measures to support the data set is to help councils and people who use services to have an objective, consistent basis for benchmarking and comparisons. Your feedback is critical to agreeing the right basis for these measures in the first year.

**Consultation questions**

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.

## Promoting personalisation and enhancing quality of life for people with care and support needs

14. The purpose of this domain is to reflect the personal outcomes which can be achieved for individuals through the services they receive. Whilst other domains look at more universal services and whole-population responsibilities, this is focused on the services provided by adult social care and the effect they have on service users and carers. 'Quality of life' is obviously a very broad concept, which might encompass a range of different outcomes. To begin to break this down, the domain is supported by a number of contextual outcome statements:

- People live their own lives to the full and can maintain their independence by accessing and receiving high quality support when they need it.
- Carers can balance their caring roles and maintain their desired quality of life.
- People have control and manage their own support so that they can design what, how and when support is delivered to match their needs.
- People engage socially as much as they wish, to avoid loneliness or isolation.

15. As the outcome statements attempt to describe, there are a number of relevant issues within this domain: personalisation, choice and control, independence and social participation.

## Overarching measure

16. The overarching measure in this domain should give us a high-level summary of quality of life for those receiving social care services. Since 'quality of life' is such a broad area with many contributory outcomes, the measure needs to provide an overview of a number of issues.

17. We propose **social care-related quality of life** as the best fit for this domain. This measure provides a composite picture of a number of user-reported outcomes. It is drawn from the Adult Social Care Survey, and based on the Adult Social Care Outcome Toolkit (ASCOT) model developed by the Personal Social Services Research Unit (PSSRU)[13]. It has already been subject to substantial development, and is planned be used for the first time nationally in 2010/11, so giving a year's data to set a baseline before 2011/12.

18. In the short and medium term, there are further possibilities for developing how councils can use the quality of life measure, should they find these useful. By 2012/13, it will be possible to create a 'contextual value-added' equivalent measure which demonstrates the actual effect of social services on an individual's quality of life – the value which has been added by services. This will give a quality-adjusted measure which will be of real value for determining how social care has improved outcomes, and allow for the quality of life measure to be compared alongside a version which maps the effectiveness of services provided. It may be possible to introduce an interim version of the value-added measure in 2011/12 to support the first year of the new approach, if considered a helpful addition to the overall set. Further information on the development work which has taken place on this measure, and a discussion on future options, will shortly be published on the PSSRU website (www.pssru.ac.uk).

## Outcome and quality measures

19. The diagram below sets out the proposals for further outcome-focused measures in this domain. Whilst this domain is focused on outcomes achieved by social care, it should respect the interaction between social care and other partners who also support the themes of control, independence and social participation. Of the measures, two are drawn from NHS data rather than local government sources so could be useful to support joint working on a local level by linking to the NHS Outcomes Framework. We would be interested to receive views on how further links could be made to other local partners to support integrated commissioning and delivery.

[13] The Adult Social Care Outcome Toolkit is designed to capture information about an individual's quality of life. See the Personal Social Services Research Unit for more information at www.pssru.ac.uk/ascot

| 1 | Promoting personalisation and enhancing quality of life for people with care and support needs |
|---|---|

**Overarching measure –** *Frames the outcome domain at the highest level*

- Social care-related quality of life

**Outcome measures –** *Describe the outcomes relevant to the domain*

**Enhancing independence and control over own support**
- The proportion of those using social care who have control over their daily life

**Enhancing quality of life for carers**
- Carer-reported quality of life

**Enhancing quality of life for people with learning disabilities**
- Proportion of adults with learning disabilities in employment

**Enhancing quality of life for people with mental illness**
- Proportion of adults in contact with secondary mental health services in employment*

**Ensuring people feel supported to manage their condition**
- Proportion of people with long-term conditions feeling supported to be independent and manage their condition*

**Supporting quality measures –** *Support commissioning and analysis of productivity of services*

**Promoting personalised services**
- Proportion of people using social care who receive self-directed support

** Measures drawn from NHS or other non-council data sources*

## Preventing deterioration, delaying dependency and supporting recovery

20. This domain is about achieving better health and wellbeing by preventing needs from increasing where people have developed, or are at risk of developing, social care needs. It is aimed at early intervention to prevent or delay needs from arising, and supporting recovery, rehabilitation and reablement where a need is already established or after a particular event. This domain is supported by a number of contextual outcome statements:

- Everybody has the opportunity to have optimum health throughout their life and proactively manage their health and care needs with support and information.
- Earlier diagnosis and intervention means that people are less dependent on intensive services.
- When people become ill, recovery takes place in the most appropriate place, and enables people to regain their health and wellbeing and independence.

### Overarching measure

21. To support this domain, we need an overarching measure which gives a view of the two key aspects: preventing and delaying dependency; and supporting recovery. There is no

clear single measure which covers the breadth of this domain. Public health measures such as 'healthy life expectancy' are not suitable as there is no evidence to show that they are relevant to adult social care. We therefore propose that, at least initially, we use two proxy measures to capture the two aspects at the highest-level:

- For supporting recovering, we propose **the percentage of emergency admissions to any hospital in England occurring within 28 days of the last, previous discharge from hospital after admission**. This is an NHS-derived measure, also proposed in the NHS Outcomes Framework. By giving an indication of the success of health and social care in preventing readmissions to acute hospitals, it can demonstrate how well intermediate care, reablement and rehabilitation are enabling people to regain their independence.

- For preventing and delaying dependency, we propose **admissions to residential care homes, per 1,000 population**. Placements in care homes are a good indication of increasing dependency, and local health and social care services should be working to reduce admissions.

22. This domain has parallels with the NHS focus on recovery, as well as the public health agenda on population health improvement, and social care prevention is linked to similar objectives. The overarching measures represent an opportunity to design a clear overlap between the adult social care, NHS and public health outcomes, to support the new local partners in identifying common goals.

## Outcome and quality measures

23. Many of the themes in this domain around prevention are things which adult social care does not achieve on its own, but in partnership with other local services. The measures need to reinforce this and support taking a broader, cross-sector view on how services work together. There is also a strong focus on efficiency, since one of the outcomes of prevention will be delaying or avoiding clinical interventions or inappropriate care placements.

24. The measures outlined attempt to reflect this. All outcome measures were proposed in the initial scoping for the NHS Outcomes Framework, offering the opportunity to align the incentives for whole-system efficiency, by looking at the effect of preventative measures on reducing hospital admissions or enabling people to remain at home. Four are drawn from NHS data sources. By operating at the margins of health and social care, but equally relevant to both, we believe this domain will act as a driver to integrated working.

25. There is also a focus on what social care can do to avoid inappropriate care placements which impact negatively on outcomes, and can be more costly, leading to a less efficient service. This is reflected in the proposals around hospital discharge and residential care placements, supporting the focus on reablement. The diagram below sets out the proposals for outcome and quality measures in this domain.

**2 Preventing deterioration, delaying dependency and supporting recovery**

**Overarching measures –** *Frame the outcome domain at the highest level*

- Emergency readmissions within 28 days of discharge from hospital*
- Admissions to residential care homes, per 1,000 population

**Outcome measures –** *Describe the outcomes relevant to the domain*

**Helping older people to recover their independence**
- Proportion of older people (65 and over) who were still at home after 91 days following discharge from hospital into reablement/rehabilitation services

**Preventing deterioration and emergency admissions**
- Emergency bed days associated with multiple (two or more in a year) acute hospital admissions for over 75s*

**Improving recovery from falls and falls injuries**
- The proportion of people suffering fragility fractures who recover to their previous levels of mobility / walking ability at 120 days*

**Supporting quality measures –** *Support commissioning and analysis of productivity of services*

**Supporting recovery in the most appropriate place**
- Delayed transfers of care*

**Delivering efficient services which prevent dependency**
- Proportion of council spend on residential care

** Measures drawn from NHS or other non-council data sources*

## Ensuring a positive experience of care and support

26. The quality of care and individuals' outcomes will be directly influenced by their experience of the care and support they receive. How easy it is to find and contact services, and how people are treated when they get them will have a major impact on perceptions and expectations of social care. This domain is supported by a number of contextual outcome statements:

- Social care users and carers are satisfied with their experience of care and support services.
- Carers feel that they are respected as equal partners throughout the care process.
- People know what services are available to them locally, what they are entitled to, and who to contact when they need help.
- People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual.

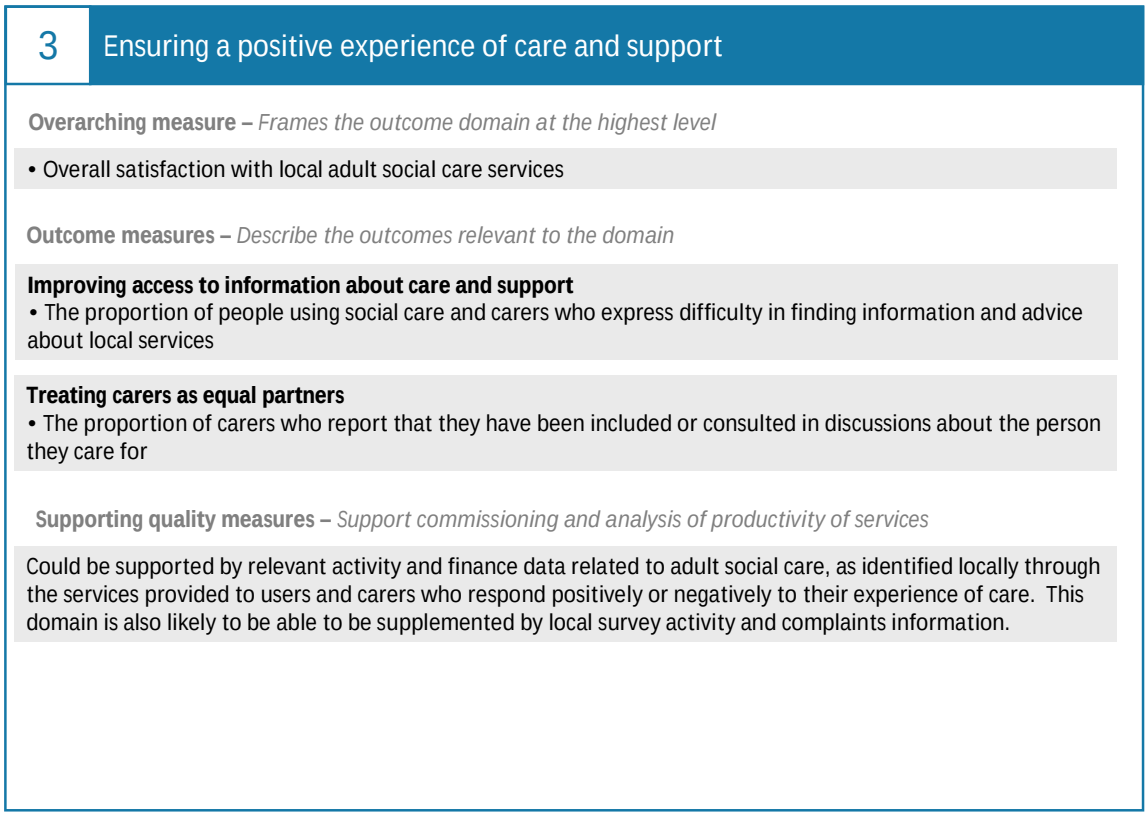
## Overarching measure

27. The best overarching measure is one which combines the different factors affecting experience into a single, generic measure. We propose that **overall satisfaction with local adult social care services** be used as this overarching measure in this domain.

28. 'Satisfaction' is not the same as the other outcomes captured through the domains – it is a more subjective, personal reflection on experience, related to expectations. Whilst other measures derived from the Adult Social Care Survey reflect more objective outcomes, the satisfaction measure is an overview which demonstrates in part how councils are communicating with service users.

## Outcome and quality measures

29. The outcome measures proposed in this domain are a further breakdown of relevant individual questions in either the Adult Social Care Survey or the Carers' Survey. These support the key themes in the outcome statements – dignity and respect, access to information, and carers being treated as equal partners. Since all questions are part of the core surveys, these measures are available at no additional burden, but provide a useful context for examining user and carer experience. The diagram below sets out the proposals for outcome and quality measures in this domain.




30. In terms of supporting quality data, there are no specific measures available in this domain. This is because the area of experience covers all services, so none is more or

less relevant for inclusion. Much of the service activity data collected could potentially be used in this domain, alongside outcome measures which have been broken down for that purpose. For instance, the overall satisfaction measure could be disaggregated to focus only on the experience of those receiving personal budgets; this information could then be considered with the relevant quality data on self-directed support. There could be a number of such options which councils may want to consider in best analysing the outcomes for different groups in this domain.

31. We also know that many councils will have significant resources of local data which could support here. This may arise from local survey programmes, complaints data or other local intelligence, and will mean that the pool of information available is greater on a local level.

## Protecting from avoidable harm and caring in a safe environment

32. This domain reflects one of the intrinsic objectives of social care: keeping vulnerable people safe. It will be closely linked to the registration requirements for essential standards of quality and safety. However, it is not just about the 'safety net', but rather focused on a wider aspiration of protecting from avoidable harm and caring for people in a safe, sensitive environment which respects their needs and choices. This domain is supported by a number of contextual outcome statements:

- Everyone enjoys physical safety and feels secure. People are free from physical and emotional abuse, harassment, neglect and self-harm.
- People are protected from avoidable deaths, disease and injuries.

### Overarching measure

33. There are few available measures which act to give an overarching view of protection or safety. One of the issues is that by aiming to prevent harm or abuse, measures would be trying to capture an event not happening.

34. We propose a user-reported outcome measure as the best proxy for success in ensuring the safety of individuals: **the proportion of people using social care services who feel safe and secure**. This arises from the Adult Social Care Survey, and could provide an indication of whether needs are met in this area. It does not cover carers, but it does include the views of those in residential care, as well as people with learning disabilities. More work will be needed over time to consider whether improved measures become available for this domain.

## Outcome and quality measures

35. There is a significant focus on avoidable harm in the outcome measures, in particular in relation to falls prevention. This is a key issue in improving outcomes for older people – falls are the single largest cause of emergency hospital admissions for older people, and significantly impact on long-term outcomes. The diagram below sets out the proposals for outcome and quality measures in this domain.

**4 Protecting from avoidable harm and caring in a safe environment**

**Overarching measure –** *Frames the outcome domain at the highest level*

- The proportion of people using social care services who feel safe and secure

**Outcome measures –** *Describe the outcomes relevant to the domain*

**Protecting from avoidable falls and related injuries**
- Acute hospital admissions as a result of falls or falls injuries for over 65s*

**Ensuring a safe environment for people with mental illness**
- Proportion of adults in contact with secondary mental health services in settled accommodation*

**Ensuring a safe environment for people with learning disabilities**
- Proportion of adults with learning disabilities in settled accommodation

**Supporting quality measures –** *Support commissioning and analysis of productivity of services*

**Providing effective safeguarding services**
- The proportion of referrals to adult safeguarding services which are repeat referrals

Could also be supported by relevant activity and finance data related to adult social care, including the Abuse of Vulnerable Adults (AVA) data collection.

** Measures drawn from NHS or other non-council data sources*

36. The importance of safeguarding and protecting people means that this domain should share some of its content with other partners, to engage in a more holistic view of how public services ensure safety. All the outcome measures proposed here were included in the proposals for the NHS Outcomes Framework, and two of the three are drawn from NHS data sources.

37. At the level of quality information, there are two sources of council data which are particularly relevant, on adult safeguarding and on the use of Mental Capacity Act 2005 to deprive individuals of liberty. Both could be used to demonstrate the actions which councils are taking to protect vulnerable adults.

38. There is currently an under-representation of data related to protection, safety and safeguarding in social care. Subject to the proposals arising from the zero-based review, it is possible that this will be improved in the medium-term and lead to improved inclusions in the quality data level of this domain.

## Other considerations

39. As we have already made clear, the proposals above for 2011/12 are based on available data collections. Whilst longer-term initiatives may help to improve the data and measures available, this is a limitation for the first version of the framework. This consultation, however, does offer the chance to ask for views on strategic questions around the future development of outcome measures, and the balance which should be sought between eliciting powerful outcome information, and imposing burdens on the councils who will be most likely to collect it. In relation to this, there are two issues on which we would like your opinion.

40. **The Carers' Survey**. Carers are a vital part of the health and social care economy, and supporting them is a key priority shared by national and local government alike. Understanding their needs, experience and outcomes is critical to inform commissioning and hold organisations to account. The Carers' Survey has been developed by the Personal Social Services Research Unit to capture the first comparable picture on the outcomes experienced by carers. It was subject to national testing, on a voluntary basis, in 2009. Having been successfully tested, a decision needs to be made on whether, and how frequently, the survey is repeated in the future.

41. We believe that the Carers' Survey is a vital source of information on outcomes for carers. It is currently the only means of eliciting this type of comparable information. However, it is organised and administered by the council, in addition to the Adult Social Care Survey, the equivalent survey for service users.

42. To balance the desire for information on carers' outcomes with the commitment to not raise the burden on councils, we propose that in the future the Carers' Survey be conducted on a biennial basis. This would mean that every two years, there would be two surveys conducted by councils (since the Adult Social Care Survey would remain annual). We would structure the guidance on sampling timescales so that the two would not be simultaneous in that year, to manage workloads. We would be grateful for views on this proposal.

43. **The use of standard models for capturing outcomes**. As the proposals for outcome measures demonstrate, there is a reliance in social care on using survey vehicles for capturing information on outcomes. Whilst the surveys are themselves robust and the data extremely valuable, we recognise that experiential outcome measures will always be more subjective, and the aim would be supplement these with objective outcomes which are measured in a different way.

44. Objective social care outcomes are more difficult to define and capture. Whilst the proposals above do include some more objective measures, these are principally related to hospital admissions or discharge and are sourced from NHS data. In the same way that the NHS uses clinical outcomes as a more objective counterpart to patient-reported measures, we want to examine how we might build on this approach in social care.

45. The social care assessment and review processes – a common process for all those who receive services – offer a good location in the care process for capturing objective outcome information, recorded by the social worker and based on professional judgment. By developing standard models for capturing this information as part of the assessment and review process, there could be an opportunity for a new understanding of outcomes.

46. One example from Scotland shows how this could work:

**Indicator of Relative Need (IoRN)**

The IoRN is a tool for monitoring needs based on an assessment of activities of daily living (and certain other characteristics) carried out by the social worker within the assessment process. It classifies individuals into nine groups according to their level of relative need. The IoRN group ('score') is identified after an assessment and draws on information social workers will already have gathered as part of the assessment.

Scores are updated at a planned review, or when a reassessment is carried out as a result of a significant change in a client's situation. This allows a client's score (and the components) to be tracked as they proceed along their care pathway.

The IoRN can be used to support professionals and managers in decisions about the use of resources and the planning of services and, after time, it allows comparisons and trends to be observed. It can also be the basis of an objective assessment of outcomes achieved: in relation to reducing needs (in the case of a reablement service, for instance) or in maintaining needs or reducing deterioration over time.

47. This is one example of an approach which could present many benefits, and build a new source of benchmarkable outcome information of significant and growing value. Of course, there is no reason why individual councils, acting alone or in groups, could not adopt such mechanisms in keeping with the aims of sector-led improvement. However, to develop a truly consistent and comparable pool of information with cross-area resonance, this would need to be universally adopted.

48. We would interested to hear views on whether there would be an appetite to investigate further how such standard approaches could be implemented in all councils, building on similar approaches to sector-led benchmarking already underway.

**Consultation questions**

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?
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?

## Next steps

49. Annex B to the consultation document provides some further technical detail on the measures proposed above. This includes our initial assessment of whether each measure meets the criteria laid out, and some information on the measure itself. This is not intended to be exhaustive at this stage, and does not include full data definitions, but indicates the source for each.

50. We will continue our analysis of the proposed measures, incorporating all comments and feedback received through this consultation process, as well as working to ensure that data publication channels are ready to support implementation from April 2011. In doing so, we will co-produce our response with the sector to agree a set of measures which reflects what is most useful locally.

51. Subject to completion of the consultation, we will announce the agreed set of supporting outcome-focused measures in March 2011, alongside the response to the consultation.

# Annex B: Technical detail

## 1: Promoting personalisation and enhancing quality of life for people with care and support needs

| | | | | |
|---|---|---|---|---|
| **Measure** | Social care-related quality of life | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **P** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **Y** |
| **Desirable criteria** | Can be disaggregated by equalities | **Y** | Currently collected | **Y** |
| **Domain** | Promoting personalisation and enhancing quality of life for people with care and support needs (overarching measure) | | | |
| **Rationale / Description** | A composite measure reflecting social care users' reported experience of seven outcome domains: control, dignity, personal care, food and nutrition, safety, social participation and accommodation. Provides an overarching view of quality of life based on outcomes relevant to social care. Can be weighted and able to be developed to show 'value added' by social care within 1-2 years. | | | |
| **Data source** | Adult Social Care Survey (Social care data collections, to be published by NHS IC from 2011) | | | |
| **Frequency of collection** | Annual | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | The proportion of people using adult social care services who have control over their daily life | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **P** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **Y** |
| **Desirable criteria** | Can be disaggregated by equalities | **Y** | Currently collected | **Y** |
| **Domain** | Promoting personalisation an enhancing quality of life for people with care and support needs (outcome measure) | | | |
| **Rationale / Description** | A self-reported measure, reflecting the individual's perception of their control over their daily life. Control is a key aspect of independence, and contribute to quality of life for people who use social care. | | | |
| **Data source** | Adult Social Care Survey (Social care data collections, to be published by NHS IC from 2011) | | | |
| **Frequency of collection** | Annual | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | Carer-reported quality of life | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **P** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **Y** |
| **Desirable criteria** | Can be disaggregated by equalities | **Y** | Currently collected | **?** |
| **Domain** | Promoting personalisation and enhancing quality of life for people with care and support needs (outcome measure) | | | |
| **Rationale / Description** | A composite measure reflecting the combination of a number of carer-reported outcomes: control, personal care, safety, occupation, time and space, social participation, support and encouragement. This is the only current measure related to quality of life for carers available, and supports a number of the most important outcomes identified by carers themselves, to which social care contributes. | | | |
| **Data source** | Carers' Survey (ongoing status to be determined, subject to consultation views) | | | |
| **Frequency of collection** | Biennial (to be confirmed) | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | People with long-term conditions supported to be independent and in control of their condition | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **P** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **Y** |
| **Desirable criteria** | Can be disaggregated by equalities | **Y** | Currently collected | **Y** |
| **Domain** | Promoting personalisation and enhancing quality of life for people with care and support needs (outcome measure) | | | |
| **Rationale / Description** | A patient-reported measure, through which people with a long-term condition report on whether have had enough support from local services to manage their condition. This is a broader measure using NHS-sourced data, which captures a wider group of individuals than the social care user equivalent, but within the same outcome theme. Social care will be one of the major services influencing responses. | | | |
| **Data source** | NHS GP Patient Survey (www.gp-patient.co.uk/results) | | | |
| **Frequency of collection** | Annual | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | Proportion of adults with learning disabilities in employment | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **P** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **Y** |
| **Desirable criteria** | Can be disaggregated by equalities | **P** | Currently collected | **Y** |
| **Domain** | Promoting personalisation and enhancing quality of life for people with care and support needs (outcome measure) | | | |
| **Rationale / Description** | This measures the proportion of adults with learning disabilities known to the council who are in paid employment. It is a key outcome for people with learning disabilities, supporting improved quality of life and reducing the risk of social exclusion. | | | |
| **Data source** | Adult Social Care Combined Activity Return (Social care data collections, published by NHS IC: http://nascis.ic.nhs.uk/) | | | |
| **Frequency of collection** | Annual | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | Proportion of adults in contact with secondary mental health services in employment | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **P** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **Y** |
| **Desirable criteria** | Can be disaggregated by equalities | **Y** | Currently collected | **Y** |
| **Domain** | Promoting personalisation and enhancing quality of life for people with care and support needs (outcome measure) | | | |
| **Rationale / Description** | This measures the proportion of adults in contact with secondary mental health services and on the Care Programme Approach who are in paid employment. It measures an important outcome for people with mental health problems, improving quality of life and reducing the risk of social exclusion. | | | |
| **Data source** | Mental Health National Minimum Data Set (NHS Information Centre: www.ic.nhs.uk/services/mental-health/mental-health-minimum-dataset-mhmds) | | | |
| **Frequency of collection** | Annual | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | Proportion of people using social care who receive self-directed support | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **Y** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **Y** |
| **Desirable criteria** | Can be disaggregated by equalities | **P** | Currently collected | **Y** |
| **Domain** | Promoting personalisation and enhancing quality of life for people with care and support needs (supporting quality measure) | | | |
| **Rationale / Description** | Personalisation is one of the most important policy objectives for adult social care, and this measure is intended to demonstrate the success of councils in providing self-directed support (including personal budgets) to those who use services. Although this is an activity measure, it is closely related to improved outcomes and supports the aims of the Social Care Vision and partnership agreement. The definition of the existing indicator will be reviewed with the sector, and appropriate amendments made to ensure this reflects policy intent. | | | |
| **Data source** | Referrals, Assessments and Packages of care (RAP) (Social care data collections, published by NHS IC: http://nascis.ic.nhs.uk/) | | | |
| **Frequency of collection** | Annual | | | |

## 2: Preventing deterioration, delaying dependency and supporting recovery

| | | | | |
|---|---|---|---|---|
| **Measure** | Percentage of emergency admissions to any hospital in England occurring within 28 days of the last, previous discharge from hospital | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **P** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **P** |
| **Desirable criteria** | Can be disaggregated by equalities | **P** | Currently collected | **Y** |
| **Domain** | Preventing deterioration, delaying dependency and supporting recovery (overarching measure) | | | |
| **Rationale / Description** | This measure follows individuals discharged from hospitals to monitor success in avoiding emergency readmissions. Health and social care will play significant roles in putting in place the right reablement, rehabilitation and intermediate care services to support individuals to return home or regain their independence, so avoiding crisis in the short-term. This is a good overarching measure, since it captures a broad range of adults and links to the NHS. | | | |
| **Data source** | NHS Hospital Episode Statistics (National Centre for Health Outcomes Development, NHS IC: www.nchod.nhs.uk) | | | |
| **Frequency of collection** | Annual | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | Admissions to residential care homes, per 1,000 population | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **Y** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **P** |
| **Desirable criteria** | Can be disaggregated by equalities | **P** | Currently collected | **Y** |
| **Domain** | Preventing deterioration, delaying dependency and supporting recovery (overarching measure) | | | |
| **Rationale / Description** | Permanent placements in residential care homes are a good indication of increasing dependency, and local health and social care services will be working together to reduce avoidable admissions. This measure gives an indication of number of admissions to care homes, expressed in terms of the size of the local population. | | | |
| **Data source** | Referrals, Assessments and Packages of care (RAP) (Social care data collections, published by NHS IC: http://nascis.ic.nhs.uk/) | | | |
| **Frequency of collection** | Annual | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | Older people discharged from hospital to rehabilitation or intermediate care, who are living at home 91 days after discharge | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **Y** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **Y** |
| **Desirable criteria** | Can be disaggregated by equalities | **P** | Currently collected | **Y** |
| **Domain** | Preventing deterioration, delaying dependency and supporting recovery (outcome measure) | | | |
| **Rationale / Description** | This measures the benefit to individuals from reablement, intermediate care and rehabilitation following a hospital episode, by determining whether and individual remains living at home 91 days following discharge. It captures the joint work of social services and health staff and services commissioned by joint teams | | | |
| **Data source** | Adult Social Care Combined Activity Return (Social care data collections, published by NHS IC: http://nascis.ic.nhs.uk/) | | | |
| **Frequency of collection** | Annual | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | Emergency bed days associated with multiple (two or more in a year) acute hospital admissions for over 75s | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **P** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **P** |
| **Desirable criteria** | Can be disaggregated by equalities | **P** | Currently collected | **Y** |
| **Domain** | Preventing deterioration, delaying dependency and supporting recovery (outcome measure) | | | |
| **Rationale / Description** | This measure focuses on the incidence of repeat emergency admissions to hospitals, and their subsequent impact on the NHS in terms of bed days required. Health and social care services should work together to prevent crisis and emergency admissions through intermediate care and reablement, to support older people to live independently. This measure focuses on over 75s since evidence suggests that repeat admissions are most common in this group. | | | |
| **Data source** | NHS Hospital Episode Statistics (NHS IC: www.hesonline.nhs.uk) | | | |
| **Frequency of collection** | Monthly | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | The proportion of people suffering fragility fractures who recover to their previous levels of mobility / walking ability at 120 days | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **P** |
| | Comparable between local areas and over time | **P** | A measure of social care outcome or consistent | **P** |
| **Desirable criteria** | Can be disaggregated by equalities | **P** | Currently collected | **Y** |
| **Domain** | Preventing deterioration, delaying dependency and supporting recovery (outcome measure) | | | |
| **Rationale / Description** | This measures the success of NHS and social care in supporting recovery for individuals who have suffered fragility fractures, usually after a fall, by measuring their mobility and walking ability 120 days after their admission to hospital. Data is collected by acute hospital so would have to be amended for council area. | | | |
| **Data source** | National Hip Fracture Database (http://www.nhfd.co.uk) | | | |
| **Frequency of collection** | Annual | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | Delayed transfers of care | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **P** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **P** |
| **Desirable criteria** | Can be disaggregated by equalities | **P** | Currently collected | **Y** |
| **Domain** | Preventing deterioration, delaying dependency and supporting recovery (supporting quality measure) | | | |
| **Rationale / Description** | This measure reflects the impact of NHS and adult social care services in facilitating timely and appropriate discharge from hospitals for all adults. Although it is more focused on activity, it is a whole-system measure which remains a useful proxy for system health and efficiency, as well as being linked to better outcomes for individuals. | | | |
| **Data source** | NHS hospital data (UNIFY2, access limited to NHS and local authority partners: http://nww.unify2.dh.nhs.uk/unify/interface/homepage.aspx) | | | |
| **Frequency of collection** | Monthly | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | Proportion of council spend on residential care | | | |
| **Essential criteria** | Relevant and meaningful to the public | **P** | Influenced by adult social care | **Y** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **P** |
| **Desirable criteria** | Can be disaggregated by equalities | **P** | Currently collected | **Y** |
| **Domain** | Preventing deterioration, delaying dependency and supporting recovery (supporting quality measure) | | | |
| **Rationale / Description** | Councils can increase efficiencies and improve outcomes for people by focusing on lower-cost, more appropriate services, particularly for older people. The balance of overall spend on residential care is a measure of how councils are designing services, including reablement and preventative services, to avoid more costly care. | | | |
| **Data source** | Personal Social Services Expenditure (PSSEX1) (Social care data collections, published by NHS IC: http://nascis.ic.nhs.uk/) | | | |
| **Frequency of collection** | Annual | | | |

## 3: Ensuring a positive experience of care and support

| | | | | |
|---|---|---|---|---|
| **Measure** | Overall satisfaction with local adult social care services | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **Y** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **Y** |
| **Desirable criteria** | Can be disaggregated by equalities | **Y** | Currently collected | **Y** |
| **Domain** | Ensuring a positive experience of care and support (overarching measure) | | | |
| **Rationale / Description** | This measures the overall satisfaction of people using social care with the services they receive from the council, as reported through a survey. Satisfaction is a more subjective outcome, incorporating expectations as well as experience. This is a high-level representation of the success of councils in achieving outcomes for people. | | | |
| **Data source** | Adult Social Care Survey (Social care data collections, to be published by NHS IC from 2011) | | | |
| **Frequency of collection** | Annual | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | The proportion of carers who report that they have been included or consulted in discussions about the person they care for | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **P** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **Y** |
| **Desirable criteria** | Can be disaggregated by equalities | **Y** | Currently collected | **?** |
| **Domain** | Ensuring a positive experience of care and support (outcome measure) | | | |
| **Rationale / Description** | Carers should be respected as equal partners in service design for those individuals for whom they care – this improves outcomes both for the cared-for person and the carer, reducing the chance of a breakdown in care. This measure reflects the experience of carers in how they have been consulted by both NHS and social care, so provides a link to successful partnership work on supporting this group. | | | |
| **Data source** | Carers' Survey (ongoing status to be determined, subject to consultation views) | | | |
| **Frequency of collection** | Biennial | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | The proportion of social care users and carers who express difficulty in finding information and advice about services | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **P** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **P** |
| **Desirable criteria** | Can be disaggregated by equalities | **Y** | Currently collected | **?** |
| **Domain** | Ensuring a positive experience of care and support (outcome measure) | | | |
| **Rationale / Description** | This measure reflects social care users' and carers' experience of access to information and advice about social care. Information is a core universal provision, and a key factor in early intervention and reducing dependency. This is a combination of relevant questions in the surveys for social care users and carers – an alternative measure might look at one group alone. | | | |
| **Data source** | Adult Social Care Survey and Carers' Survey (Social care data collections, to be published by NHS IC from 2011) | | | |
| **Frequency of collection** | Annual | | | |

## 4: Protecting from avoidable harm and caring in a safe environment

| | | | | |
|---|---|---|---|---|
| **Measure** | Percentage of adult social care users who feel safe and secure | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **Y** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **P** |
| **Desirable criteria** | Can be disaggregated by equalities | **Y** | Currently collected | **Y** |
| **Domain** | Protecting from avoidable harm and caring in a safe environment (overarching measure) | | | |
| **Rationale / Description** | This measure gives an overview of social care user-reported experience of safety, and acts as a good overarching measure for this domain. It is a single question in the ASCS, so this is strongly linked to the SCRQOL measure. Responses on safety are likely to include factors outside of social care control, so the nature of the link to social care will have to be developed through further analysis. | | | |
| **Data source** | Adult Social Care Survey (Social care data collections, to be published by NHS IC from 2011) | | | |
| **Frequency of collection** | Annual | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | Acute admissions as a result of falls and falls injuries for over 65s | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **P** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **P** |
| **Desirable criteria** | Can be disaggregated by equalities | **P** | Currently collected | **Y** |
| **Domain** | Protecting from avoidable harm and caring in a safe environment (outcome measure) | | | |
| **Rationale / Description** | Falls are the single largest cause of emergency hospital admissions for older people, and significantly impact on long-term outcomes. A measure which reflects the success of services in preventing falls will give an indication of how the NHS, public health and social care are working together to tackle issues locally. | | | |
| **Data source** | NHS Hospital Episode Statistics (NHS IC: www.hesonline.nhs.uk) | | | |
| **Frequency of collection** | Monthly | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | Proportion of adults in contact with secondary mental health services in settled accommodation | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **P** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **Y** |
| **Desirable criteria** | Can be disaggregated by equalities | **Y** | Currently collected | **Y** |
| **Domain** | Protecting from avoidable harm and caring in a safe environment (outcome measure) | | | |
| **Rationale / Description** | This measures the proportion of adults in contact with secondary mental health services and on the Care Programme Approach who are in settled accommodation. Like the learning disabilities equivalent, it measures an important outcome for people with mental health problems, improving safety and reducing the risk of social exclusion. | | | |
| **Data source** | Mental Health National Minimum Data Set (NHS Information Centre: www.ic.nhs.uk/services/mental-health/mental-health-minimum-dataset-mhmds) | | | |
| **Frequency of collection** | Annual | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | Proportion of adults with learning disabilities in settled accommodation | | | |
| **Essential criteria** | Relevant and meaningful to the public | **Y** | Influenced by adult social care | **P** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **Y** |
| **Desirable criteria** | Can be disaggregated by equalities | **P** | Currently collected | **Y** |
| **Domain** | Protecting from avoidable harm and caring in a safe environment (outcome measure) | | | |
| **Rationale / Description** | This measures the proportion of adults with learning disabilities known to the council who are in settled accommodation. The nature of accommodation for people with learning disabilities is linked to better outcomes, and has a strong impact on their safety and overall quality of life and reducing social exclusion. | | | |
| **Data source** | Adult Social Care Combined Activity Return (Social care data collections, published by NHS IC: http://nascis.ic.nhs.uk/) | | | |
| **Frequency of collection** | Annual | | | |

| | | | | |
|---|---|---|---|---|
| **Measure** | Percentage of all referrals to adult safeguarding services which are repeat referrals | | | |
| **Essential criteria** | Relevant and meaningful to the public | **P** | Influenced by adult social care | **P** |
| | Comparable between local areas and over time | **Y** | A measure of social care outcome or consistent | **P** |
| **Desirable criteria** | Can be disaggregated by equalities | **Y** | Currently collected | **Y** |
| **Domain** | Protecting from avoidable harm and caring in a safe environment (supporting quality measure) | | | |
| **Rationale / Description** | This a measure of the quality of local safeguarding procedures and services, drawn from activity data supplied by councils. The measure captures repeat referrals of vulnerable adults to safeguarding services, as a proxy for success in securing safety and reducing multiple referrals for the same individual. | | | |
| **Data source** | Abuse of Vulnerable Adults (AVA) Return (Social care data collections, published by NHS IC: http://nascis.ic.nhs.uk/) | | | |
| **Frequency of collection** | Annual | | | |

# Annex C: Consultation questions

**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?
2. How can we categorise Quality Standards in adult social care, and what should be the topics for the first Quality Standards?
3. How can Quality Standards be developed to support service users as commissioners, and local people in their role to hold councils to account?

**Demonstrate progress**

4. Do you agree with proposals for a single data set for adult social care, supported by a single collection and publication portal?
5. Do you support the case for a set of consistent outcome-focused measures, which combine the best available data on social care outcomes?
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?
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?

**Support transparency**

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?
9. Do you have any local examples and evidence of the benefits of a local account-type approach?
10. What is your view on the balance between requiring standard elements in reports, and allowing freedom to fit to local circumstances?
11. The proposed accounts would only apply to council commissioners. What further actions, if any, might be considered to promote transparency amongst service providers?
12. Would you support an assurance role for the local HealthWatch in the production of accounts?
13. We would also be keen to receive views on whether user and carer-led assessments could support transparency and empower local people?

**Reward and incentivise**

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

**Secure the foundations**

15. How should the Care Quality Commission ensure that future service inspections are risk-based and proportionate?
16. Does the regulatory model of registration, compliance and inspection provide sufficient safeguards for ensuring minimum quality standards across adult social care?
17. How best might independent monitoring of local council arrangements for managing services be secured?

**Available outcome-focused measures from 2011/12**

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

**How to respond to this consultation**

This consultation closes on **9 February 2011**. You can contribute to the consultation by providing written comments to:

**By e-mail**: qualityandoutcomes@dh.gsi.gov.uk

**By post**: Quality and Outcomes Consultation, Department of Health, Room 114, Wellington House, 133-155 Waterloo Road, London SE1 8UG

We will also be arranging a number of consultation events around England. Details will be posted on the DH website as well as advertised through stakeholder networks.

# Annex D: Consultation process

This consultation follows the 'Government Code of Practice'. In particular, we aim to:

- formally consult at a stage where there is scope to influence the policy outcome;
- consult for at least 12 weeks - the policies in this document were included in the NHS White Paper, *Liberating the NHS*, which was launched on 12 July for a 12 week consultation period closing on 11 October;
- be clear about the consultations process in the consultation documents, what is being proposed, the scope to influence and the expected costs and benefits of the proposals;
- ensure the consultation exercise is designed to be accessible to, and clearly targeted at, those people it is intended to reach;
- keep the burden of consultation to a minimum to ensure consultations are effective and to obtain consultees' 'buy-in' to the process;
- analyse responses carefully and give clear feedback to participants following the consultation; and,
- ensure officials running consultations are guided in how to run an effective consultation exercise and share what they learn from the experience.

The full text of the Code of Practice and related guidance is on the Better Regulation website at: www.bis.gov.uk/policies/better-regulation/consultation-guidance.

## Comments on the consultation process itself

If you have concerns or comments which you would like to make relating specifically to the consultation process itself please contact:

Consultations Coordinator
Department of Health
3E48, Quarry House
Leeds
LS2 7UE
e-mail: consultations.co-ordinator@dh.gsi.gov.uk

Please do not send consultation responses to this address.

## Confidentiality of information

We manage the information you provide in response to this consultation in accordance with the Department of Health's Information Charter (available at www.dh.gov.uk). Information we receive, including personal information, may be published or disclosed in accordance with the access to information regimes (primarily the Freedom of Information Act 2000 (FOIA),

the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004). If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this, it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department. The Department will process your personal data in accordance with the DPA and in most circumstances this will mean that your personal data will not be disclosed to third parties.

## Summary of the consultation

A response to this consultation will be made available at www.dh.gov.uk by April 2011.

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