

# Consultation response

## The King's Fund's response to the Department of Health's public consultation on *Transparency in outcomes: a framework for adult social care*

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The King's Fund seeks to understand how the health system in England can be improved. Using that insight, we help to shape policy, transform services and bring about behaviour change. Our work includes research, analysis, leadership development and service improvement. We also offer a wide range of resources to help everyone working in health to share knowledge, learning and ideas.

This response should be read alongside the responses The King's Fund has published on *An Information Revolution* (The King's Fund 2011a) and *Transparency in outcomes: a framework for the NHS* (The King's Fund 2010c). We confine our comments on this consultation to those areas where we have undertaken work that has direct relevance to outcomes in adult social care.

- The reform of adult social care funding and delivery (Humphries *et al* 2010) building on our earlier review by Sir Derek Wanless (Wanless 2006); this work includes our submission to the Health Select Committee inquiry into public expenditure and to the Commission on the Funding of Care and Support. These are available on our website, together with our previous consultation responses, and the original response to the White Paper, *Equity and Excellence: Liberating the NHS*.
- Work on quality in the NHS and in the area of clinical and service integration – we have recently published three reports that have significant implications for the government's approach to developing outcomes frameworks across health and social care: *Clinical and service integration: the route to improved outcomes* (Curry and Ham 2010), *How do quality accounts add up? Findings from the first year* (Foot *et al* 2011), and *Getting the measure of quality: opportunities and challenges* (Raleigh and Foot 2010). We draw on these in our responses but suggest that those developing policy in these areas may wish to refer to the reports directly.

### Overview

We welcome the ambitions in the *Transparency in outcomes: a framework for adult social care* consultation, to provide information to people who use services and the wider public in accessible and intelligible forms. That this information will also be used to improve services, and increase responsiveness within the local social care system, supports the coalition government's commitment to improving social care services to better meet people's needs. However, in many cases these needs straddle the responsibilities of the NHS, the social care system and other services; this raises the question as to whether the proposed framework is sufficient to promote a joined-up approach to evidence, data and transparency and how far it will adequately reward and incentivise providers and commissioners to work across organisational and service boundaries to achieve the best outcomes.

The government's proposals to strengthen the role of local authorities in improving health and in ensuring integration of health and social care offers a real opportunity to build on the place-based approaches to public services and to extend the role of local authorities in shaping health care locally. The relationship between GP commissioners and health and wellbeing boards will be critical in determining how these issues are played out in practice. Please refer to *Clinical and service integration: the route to improved outcomes* (Curry and Ham 2010), and *Liberating the NHS: Local democratic legitimacy in health*, our response to the White Paper (The King's Fund 2010a) for our ideas for ensuring that this integration takes place successfully.

We would raise a number of key points in relation to this consultation.

- To achieve better outcomes in social care, sustainable funding and reform of delivery is needed. The evidence we have provided to the Dilnot Commission (The King's Fund 2011b) suggests ways in which this fundamental reform can be achieved.
- There is a need for standardised, centrally stored data to enable comparison and benchmarking. There is a risk that without national data collection it will be more challenging to improve quality at the local level.
- The Health and Social Care Information Centre (IC) role in relation to social care needs clarifying.
- In addition to outcomes for health care, the NHS Commissioning Board needs to hold commissioners to account for outcomes associated with integrated care, including between health and social care. This is increasingly important given the growing prevalence of long-term conditions and co-morbidities.
- Overall, the outcomes framework needs to go further to support integration with the NHS and public health. Immediately, further work is needed to ensure that the outcomes frameworks align. Over time, the creation of a single outcomes framework across the three sectors would more effectively support integrated working.

## Resources

Knowledge about how resources are used within social care is growing but remains inadequate, as the Department of Health's own work attests (Department of Health 2009). From this starting point, quantifying outcomes becomes problematic. Defining 'high quality' in a system that is currently unable to comprehensively track the use of its resources, and the impact these have on the care that people receive, will require fundamental changes to the social care system.

New research for our recent report, *Securing good care for more people: options for reform* (Humphries *et al* 2010), shows that if the current system was left as it is the cost of social care would double over the next 15 years, with no improvement in outcomes. In contrast, our proposals set out ways to achieve better outcomes through a more sustainable and affordable system.

In our work on the funding of social care we have argued consistently that reform of funding should go hand in hand with reform of delivery otherwise the result will simply be pouring more money into a broken system. Offering good information about services has been an important feature of work across the social care sector to achieve a more personalised and preventive approach.

## Integration

We believe that fundamental issues will arise, and huge opportunities will be missed, if social care reform is not aligned and integrated with the NHS reforms. The recommendations we have put forward in our responses to the *Information Revolution*, and *Transparency in outcomes: a framework for the NHS* (The King's Fund 2011, The King's Fund 2010c) consultations need to be revisited when exploring the issues within this social care outcomes framework consultation, to understand and establish the right links. We also provide many recommendations for delivering effective integrated care in our recent publication, *Clinical and service integration: the route to improved outcomes* (Curry and Ham 2010).

For the social care outcomes framework to work effectively, the three outcomes frameworks (NHS, social care and public health) need to be aligned as much as possible. The development of separate frameworks is likely to prove unhelpful for the planning of integrated, person-centred care. The overarching Department of Health Transparency Framework needs to take account of the crossover between the three sectors and to provide a framework for future integration rather than inhibit joint working. We would suggest that the three frameworks are the starting point for moving towards a single framework in future that reflects the overlapping needs and responsibilities identified in the consultation document.

In our response to the *Transparency in outcomes: a framework for the NHS* consultation we emphasised that the framework needs to measure integrated care – in addition to outcomes for health care, the NHS Commissioning Board needs to hold commissioners to account for the quality of integrated care, for example, through quality indicators focused on care transitions and care pathways, including social care. These need to be aligned with the roles of local authorities. The specific exclusion of outcomes relating to social care (p 48, *NHS Outcomes Framework 2011/12*), for example, potentially hinders efforts towards integration.

By definition indicators are specific to topics. This potentially jeopardises the principle of integration because it could reinforce an organisational perspective. To mitigate against this, we suggest:

- using indicators along whole care pathways, including social care components where relevant – eg, stroke – as per standards set by the National Institute for Health and Clinical Excellence (NICE)
- including measures of the quality of integrated, co-ordinated care, which can impact on quality of life and patients' experience of services but may not translate directly into hard outcomes
- drawing on the success of joint quality guidelines for dementia developed by SCIE and NICE and apply this approach to other conditions
- making local organisations accountable for the same, system-level measures to foster co-operation (as outlined above).

The delineation between roles/budgets for GP consortia (NHS commissioning) and local authorities (public health, inequalities, social care) could also lead to a divide between 'treatment' and 'prevention' services, which this assessment framework could exacerbate. It is therefore important that any framework for assessing the performance of the NHS and general practice covers all the functions regarded as their core business and that it is aligned with the roles of local authorities.

## Data

The fact that the outcomes data will largely be available on a need-to-know basis, rather than provided for the purposes of national benchmarking, may result in local variations along the following lines:

- public, provider and commissioner awareness of the availability of information

- the content and quality of the information that is made available
- the outcomes that are ultimately achieved
- understanding of the processes in place to achieve these outcomes.

In a system where resources cannot yet be easily accounted for, localising the collection and provision of information on service provision as proposed could actually reduce the levers available to improve quality.

The focus should not be restricted to outcomes. As the NICE Quality Standards and many evidence-based measures of quality used internationally show, many dimensions of high quality relate fundamentally to processes of care. Please refer to our consultation response to the *Transparency in outcomes: a framework for the NHS* for more detail on this.

Data collections take years to implement and embed into central and local information and management systems. Any data returns that do not meet the specified criteria should still be examined carefully to understand whether or not they are still relevant. Data returns identified for termination should be publicly consulted on and responses taken into account before final decisions are taken.

As mentioned, both the relative costs of (including costs of development, implementation and collection) and the potential for improvement offered by any new data collections required by the framework (including patient surveys) should be reviewed in the round to inform decisions about new data collections. Such an assessment should form part of the forthcoming Information Strategy. There are many demands for new information (such as patient surveys), and for strengthening areas in which information is weak (such as general practice, community care). It is important that priorities are determined on the basis of a rigorous cost-benefit analysis.

Personal budgets within social care have been found to improve outcomes for individuals. The shift towards personalisation and self-management in health and social care requires a new system of data monitoring and measurement which captures individual outcomes and experiences. There may be some useful lessons from the experience of using patient reported outcomes measures in the NHS. Our report, *Getting the most out of PROMS: Putting health outcomes at the heart of NHS decision-making* (Devlin and Appleby 2010), outlines our views on capturing patient experience.

## **Presentation of data**

As expressed in our response to the *Information Revolution* consultation, it is important that careful consideration is given to the collection and presentation of data (outcomes or otherwise) before it is published. The emphasis is being placed on local collection and interpretations of data in this consultation, and it will be important that this localism does not lead to lack of comparability needed if the data are to be used by patients, the public, and professionals.

Publishing performance data can lead to improvements in the provision of high-quality care (see Raleigh and Foot 2010) and has also supported patients to make informed choices (Dixon *et al* 2010). In a similar way the Department's publication of information about geographical variations in spending and services is acting as a spur for councils to use data as a means of better understanding their performance. Much will depend on the outcome of the proposed zero-based review of social care data and ensuring there is robust data on which national and local performance can be assessed.

The expertise needed to quality assure and regulate information should be developed centrally (by the IC, see below) and this appears to be reflected in provisions within the Health and Social Care Bill.

## Experience of Quality Accounts: What lessons can we learn?

Evidence on the publishing of performance data via quality accounts has demonstrated how difficult it is to achieve the right conditions for capturing and publishing information to drive quality improvements. Our recent publication, *How do quality accounts measure up? Findings from the first year* (Foot *et al* 2011), suggests that quality accounts are a good first step in the government's planned 'information revolution', but if these accounts are to fully deliver a meaningful and transparent picture of quality for patients and the public, providers will need to give a clearer account of the quality of care in future. The report describes the variation in quality accounts as an 'inevitable' outcome of the way they have been designed, in particular the conflicting aims of publishing them both as a tool for local quality improvement and as a form of public accountability. While we support the retention of locally defined measures, the report concludes that the public would be better served by including some nationally comparative, quality-assured key measures of quality. This information could then be replicated consistently in all quality accounts, with providers adding other measures relating to local priorities.

## Health and Social Care Information Centre

The Health and Social Care Bill would give the Health and Social Care Information Centre significant powers to collect, analyse and publish information from NHS and social care providers. This is not reflected in the consultation document.

It is not clear at this stage how closely the IC will work with local authorities to ensure that data collections at the local level are reasonable, and of sufficient quality, to support work undertaken centrally to analyse and compare local performance. Further clarity is needed as to the relative powers of the IC, local authorities and NHS organisations to collect and analyse outcomes data.

We have outlined in our response to the *Information Revolution* that the role of the Information Centre should be significant, providing a vital central role in the collection and reporting of data. Significant investment will need to be made to support the development of the organisation along the lines we have set out in our response.

- The IC should have a role in developing standardised data sets and data collection methods that can be then be used by information providers to publish information for patients, the public, providers and commissioners.
- We argued in our response to the *Information Revolution* consultation that there is a strong case (as practised in most developed countries) for having centralised, quality-assured information (that, for instance, meets the Code of Practice for Official Statistics) about the performance of NHS providers, commissioners and services. The remit of this organisation could also be extended to cover social care. The Information Centre (IC) is the logical body to manage and publish this information across the two sectors.
- There is also a role for the IC to support the commissioning process by developing and providing tools, resources, and software for commissioners. These should deploy evidence-based approaches to data analysis to support joint strategic needs assessment (JSNA), commissioning and decommissioning decisions, contract management, tracking of outcomes and performance management.
- The Information Centre (IC) should prioritise supporting NHS and social care commissioners to get the data flows and analysis right, especially since there is likely to be a lack of co-terminosity between GP and local authority boundaries.

Locally, commissioners may not be able to regulate the flows of information across fragmented boundaries.

In terms of economies of scale, it will be more cost-effective to hold data centrally than to localise the majority of collections. Further, indicators by their very nature are more meaningful when they can be compared. The loss of much of the comparative data in social care would prove detrimental to driving quality improvements through the analysis and publication of data.

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