

Key lessons and observations from Phase 1 of National Core Service Specification Development. September 2012 to March 2013

This work has now moved into its second phase led by Chris Bean, to include core principles and standards for services commissioned for children and young people as well as adults. This is very welcome and necessary.

The concordat commitment was for a draft core service specification to be ready by the end of March 2013 so this work is now behind schedule.

Early feedback on the toolkit produced at the end of phase 1 suggests that this tool will be a valuable starting point for developing more detailed local specifications for services in both health and social care for children, young people and adults.

However this should be set against some expressed concerns that by having a core service specification we are promoting a service centred solution rather than a person centred solution. We also need to be realistic about what a commissioning tool like this proposal can do to significantly change the system and bear in mind Baroness Hollins recent comments about the efficacy of telling people what they should do.

Specific points

1. Service specifications for existing services from all over England were generously submitted from local authorities and PCTs for analysis by the steering group. These were generally of very poor quality for the following reasons:
 - Often written by providers rather than commissioners
 - Contained a lot of rhetoric, jargon (person - centred, idealism and re-quoting of significant previous publications
 - Did not contain specific intended health or care outcomes for individuals
 - Had largely vague and process centred quality measure recommendations

In addition on visits it was observed that there was sometimes a poor correlation between the specification and the service delivered.

There appeared to be an inverse correlation between the length of the specification and the quality of service observed.

1. Family carers and self advocates requested that when 'personalisation' is spoken about or written into specs that there needs to be an assurance process to make sure that it is both meaningful and measurable. Personalisation goes beyond personal budgets. Examples of poor personalisation included not being able to make drinks in services, kitchens being locked, patients not being allowed to do their own clothes washing and being given the clothing of other patients repeatedly as it all got 'muddled up'.
2. Family carers and self advocates wanted to be listened to more. They have the answers we are seeking in many instances. We need to be careful not to just listen to the Learning Disability Partnership Boards or the people that routinely attend meetings. The risk is tokenism. Some carers are too busy caring to get to meetings and some self advocates do not have verbal communication but still need for their needs and experiences to be understood. Suggestion: telephone conversations with

harder to reach carers especially of those more profoundly disabled. One carer expressed her frustration at being told she was being given a 'short break' when it didn't equate to anything that she would have considered as a break.

3. Physical Healthcare is every providers responsibility. Whether they are a health provider, social care provider or residential provider they have responsibility to enable access to routine screening services, healthcare appointments, immunisations, health promotion activities and diet. They also have a responsibility to make sure that health action plans are dynamic documents that are used and not just kept in the records.
4. Quality Monitoring needs to be addressed within the core specification. Commissioners do not want 'tea & cake tours' of providers services brute similarly need to be enabled to actually see the services they are commissioning. They need more sophisticated ways of assessing quality which may involve proxy measures e.g. enabled access to dental care. These may not always be paper based and fully objective. The importance of gut feeling and family and friends test was pointed out. Carers pointed out that it was pointless trying to assess quality at a distance e.g. For out of area placements and that it was impossible to measure or be assured of quality in a service that you had never seen. Some carers and self advocates suggested a voluntary trip advisor type scheme to which service users and carers could contribute their experiences.
5. Housing stock and housing policy were seen as crucial enablers without which very little could be achieved in terms of person centred solutions. It was felt that departments of housing in local authorities had to be enabled to take responsibility for this.
6. Pooled Budgets were seen as another key tool in achieving more integrated health and social care but there was wide variation in what people understood to be pooled budgets. This varied from just a few complex patients having a pooled budget arrangement in some localities to another locality which had a pooled budget for all learning disability and autism related commissioning across all of health and social care. It was observed though, that a pooled budget alone did not often achieve the intended outcomes. The important catalyst for making a pooled budget effective was an effective and trusted leader (one person) equally trusted and followed by health and social care commissioners and providers.
7. Leadership. Following on from the last point it was felt by the steering group that where good leadership existed that this was due to the leader serendipitously being in post. There was no witnessed evidence of any commissioning organisation strategically developing leaders to commission jointly across health and social care and be responsiveness for leading and integrated health and social care commissioning team.
8. Community Learning Disability Teams. Multiple models and huge variation in size and remit. Perhaps this team could be the key leader in future commissioning of integrated care, but we would need to be clear in the specification what the vision, remit and scope of this team could be and what the optimum size and skill mix might look like.

9. Training and development of providers. The steering group felt clearly that this was a key responsibility of the commissioner. It worked best when the commissioner worked with small numbers of providers and were very clear about their own vision and values. Long term relationships enabled good development and the best model we saw was where family carers were trained and developed alongside professional providers with the commissioner leading the training and development. In some areas there was fear that this close relationship would lead to conflicts around competition law and giving some providers favourable advantage. To counter this it seemed to lead to better outcomes for individuals and their families.

10. Responsible commissioners. In many instances it appeared that some commissioners were anything but 'responsible' when it came to placing people out of area. We were told many examples of where receiving authorities knew nothing of somebody being in their area until the placement was breaking down and they had to formulate a healthcare related response or deal with a safeguarding issue. Despite the established rules for communication between placing and receiving authorities this rarely seems to be occurring in practice. There was a desire for sanctions and whistle blowing for when this occurred. Similarly a number of authorities expressed concern that this lack of communication often led to people being placed with providers in receiving areas that the receiving authority would not place their own residents in.....they had better insight into the safety and quality of the provider and often very accurate predictions related to the likelihood of placement breakdown (in many incidences this appeared to correlate more closely with the provider than it did with the individual who had been placed with them)This is also relevant to this issues of ordinary residence

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