

'The Four Pillars' of Quality Assurance

Guiding Principles Document for ADASS Yorkshire & Humber Region

The ADASS Yorkshire and Humber regional Commissioning Network undertook a Quality Assurance Stocktake in all 15 local authorities of their commissioning arrangements.

From this areas of good practice were identified, shared learning took place and it was agreed that a set of regional quality assurance (QA) principles should be established for regulated services (that is those inspected by CQC). It is important to note that these are **not inspection principles**, but more from an 'eyes and ears' perspective, to ensure people are safe.

'The Four Pillars of QA', and the guiding principles which commissioners should have in place to ensure quality of provision and safety of practice, are set out below.

Intelligence - sources/capture and crucially, used as an evidence base to inform quality improvement related actions.

- As a minimum, commissioners should operate a RAG rated system approach to identify risk areas in order to prioritise quality assurance and monitoring visits. This should include feedback from sources such as Fire Service, Service Users and Family/Carers, Complaints as well as Concerns. Also intelligence from Elected Members, Community Nursing and Care Management Staff.
- Commissioners should have a system of capturing customer feedback from the services they commission which informs their contract monitoring. This intelligence should provide a 'real time' indicator of how good services are.
- Commissioners should be an active member of, and comply with, the ADASS Yorkshire and Humber Commissioning Network's "Social Care Market Information Sharing and Support Protocol".
- Care home providers should be utilising the Care Home Capacity Tracker to aid occupancy and capacity analysis.

Whole system - the extent to which partners – CQC, CCG, IPC, Healthwatch Providers etc. are involved/link in e.g. provision and exchange of intelligence, any routine/periodic meetings/fora to discuss, action plan etc. join visits/working etc.

- Quality standards are clear and set out what good care looks like.
- Provider visits, support and interventions are responsive and proportionate to the needs of individual organisations' requirements and are based on a range of intelligence from different sources, taking into account CQC ratings, trends and themes and partnership intelligence.
- Commissioners maintain good and effective working relationships with partners for the sharing of intelligence and quality assurance activity supported by a provider forum or similar.
- Commissioners have robust provider involvement (co-production) structures in place e.g. Providers are involved in production of the Market Position Statement and designing future contracting arrangements.
- Commissioners should undertake an annual self-evaluation against the Integrated Commissioning for Better Outcomes Standards and participate in a regional benchmarking analysis, identify areas of good practice and areas for development and partake in shared learning.
- Commissioners should have in place regular and routine meetings with CQC to discuss quality assurance, a minimum of once a quarter.
- Commissioners should aim to have strong links to Healthwatch including involvement in quality assurance activity. However it is recognised that the effectiveness of relationships will vary from area to area across the region.

Process/systems – the framework which underpins delivery of the quality monitoring/improvement work and how systematised it is to support consistency/standardisation of approach e.g. triggers for actions, proforma/documentation, allocation of work etc.

- Commissioners should ensure they operate a system where they can gain a good skills and knowledge base across the services they operate. This could include undertaking 'Back to the floor' visits for commissioners to understand more about how the provider implements the requirements of the service specification.
- Commissioners should have in place a local market failure protocol which has been developed in conjunction with providers, Health partners and CQC and is reviewed accordingly.
- Frequency, complexity and length of monitoring visits to providers should be proportionate to the size, value and risk assessment of the commissioned service and a clear rationale in place. Consideration should be given to a portion of these visits being unannounced visits.
- The Quality Assurance process will be inclusive and supportive of care providers and reflect proportionate, responsive actions required to support each provider; with appropriate escalation processes should this not be achievable.
- Commissioners require all providers to undertake self-assessments/provide performance monitoring data – either to inform quality monitoring visits or in between quality monitoring visits.

Resources – essentially the quality improvement/monitoring staffing levels to undertake the work (this is important as this will probably influence and impact on the design and delivery of Process/systems e.g. things like the number/frequency of contact/visits), recognising that it is not intended to determine what an appropriate level of resource should be, but to contextualise and inform this work.

- Commissioners should have a sufficient number of skilled staff and a recognised structure in place to undertake appropriate quality assurance and monitoring of services, particularly services which are commissioned jointly with partners.
- Commissioners should complete the Regional Performance and Risk Dashboard on a quarterly basis to support benchmarking and sector led improvement in Commissioning and Quality Assurance.
- Commissioners have put in place systems to ensure that commissioning activity and provision is of the highest standard possible, providers are supported to improve and service users are safe.
- Commissioners have systems and resources in place to ensure that the communication of outcomes arising from quality assurance activity and safeguarding are linked and vice-versa. This should not be limited to Section 42 concerns but to safeguarding issues more generally or where numerous low level concerns are received.
- There should be robust links between commissioning staff and care management staff in order to form a rounded view of the quality of individual services from both a locality and a council wide perspective.