

## Prioritising Capacity Tracker question

Care England posed the following question to members in February 2021 and the responses are collated below. We hope that the DHSC, NECS and NHSEI give due regard to our comments and that changes are made as suggested. We would like to work with colleagues on the development of the Capacity Tracker and the future landscape of ASC data collection generally in the light of the proposed changes set out in the NHS White Paper '*Integration and innovation: working together to improve health and care for all*' today 11<sup>th</sup> February.

Care England is the leading representative body for independent care services in England.

**Care England's members were asked, 'If they were applying Care England's data principles (see below) to the Capacity Tracker, considering the time taken to complete the tracker and the benefits received, what suggested changes would they make and what core questions would they like to see in the tracker?'**

### Care England's key data principles

#### 1. Benefit

Providers will ultimately be motivated to input into data systems if they see these systems as allowing them to improve the quality of life of the people, they provide care and support to and if such a system means that they do not have to enter data multiple times on different platforms. During the Covid-19 pandemic, care providers have often not been able to see the benefit of those data collection systems which have been created, and the analysis of the data has not been fed back to them efficiently to help them improve their service. To remedy the lack of data reaching the frontline, priority needs to be given to the issue of how adult social care providers can benefit from inputting the data. The case could be made to providers that they are doing this for their own benefit as well as for the benefit of the local and national organisations involved eg in responding to the pandemic across the whole system.

#### 2. Neutrality

National bodies responsible for the collation of data can often be viewed through a prism of suspicion by the providers who have to pass on the data. This is the manifestation of many years of interactions and concern as to how data is to be used and by whom. Going forward, it is therefore important that those who are tasked with the collation of data in future should be those who will be seen in a much more neutral light.

#### 3. Trust

Closely intertwined with the principle of neutrality is that of trust. Not only must care providers trust who they are giving the data of their residents and staff to, but they must also trust how the data is being used. There needs to be a far greater level of transparency in the data governance process.

#### 4. Soundness

As emphasised by the Covid-19 pandemic, not enough attention has been paid to the diversity of the sector. The government must take account of how data is collated across all social care settings (learning disability and/ or autism, Supported Living, Domiciliary Care) and health inequalities affecting BAME groups, for an accurate picture allowing meaningful data to emerge.

#### 5. Standardisation

What has not been clear is how the social care sector and the Government have been defining and recording data. There needs to be clarity around what data social care providers think needs to be collected and how we work to that same agenda with the Government and organisations such as PRSB.

#### 6. Centralisation

Evidence from social care providers suggests that they want to see a single source and repository of data within a centrally led body to gain a whole sector representation. The data inputted must also be segmented with a single-entry point. This data needs to be inputted as part of a clear data strategy which ensures benefit to both the Government, providers and the people they support and care for. This single source should be centrally funded, to ensure that additional pressures are not placed onto care providers or care organisations.

#### **Care England's Response to Prioritising the Capacity Tracker**

The purpose of the Capacity Tracker originally was to reduce Delayed Transfer and enable Local Authorities and CCGs to search for vacant beds. The tracker was set up in 2019 and pivoted early in the pandemic to be the collection tool for covid related data. When it was proposed that providers could receive government grants (ICF 1 and 2) in exchange for real-time updates on bed capacity, it was welcomed by the sector. However, many providers believe the CT has since moved away from its initial purpose and instead, has become an excessive burden. While the CT has enabled providers to receive government funds, it has come at a large cost to many organisations. Without addressing the broader concerns around the purpose of CT, it is impossible to review the current (182) questions and identify which might be removed or changed. What Care England has put together is an overview of key issues within the CT that need to be addressed, along with a summary of what aspects of the CT should be viewed as essential/unessential.

The first main issue that the CT was supposed to do, but has yet to accomplish, is to create a single centralised data system for LAs and CCGs to access. While in theory this has happened, the unfortunate reality is that this has not been the case. Many LAs and CCGs still ask service managers to fill out regional spreadsheets that request the same information which is already available in the CT. It has also resulted in other regional trackers being set up, such as the recent [Manchester Capacity Tracker](#), which Care England became aware of on the 3<sup>rd</sup> February. Furthermore, Brokerage is still calling providers about the availability of beds. Going forward, providers need to be assured by NECS and DHSC that there will only be one source of data collection and that LAs and CCGs stop requesting that other local trackers are completed as well.

Clarity over the governance structure and data collection process is also needed. Care England understands that this is currently being addressed, but many providers do not know where the data goes, who has access to it or how it is used. This needs to be amended as soon as possible. Providers would benefit if they knew and understood the ultimate purpose of the CT in its current state. Is it a now a COVID-19 related system or will providers be expected to continue updating it once we are past the pandemic? Greater transparency and

clarity are necessary to assure providers, who are ultimately responsible for their data, about who can access and edit their data. Providers are concerned about GDPR and how the segregation/manipulation of data is being managed by CT.

While it is understandable that the frequency of data changes and the need for extra questions may arise, there often is no explanation around the relevance of new questions, or what benefit they serve for the provider. This has recently occurred with an update on the 8<sup>th</sup> February. Providers were unaware of this update and many did not have the required data to hand. Although these questions will generate important data for the Government, it is difficult to persuade providers to continuously input excessive amounts of data without any reasoning. Furthermore, the lack of access to data means that providers are inputting a huge amount of sensitive data without seeing any of its benefits. Deadlines for inputting data are also very tight and larger organisations struggle to meet them. Some of the larger providers complete the CT centrally, relieving their service managers and allowing them to focus on delivering care. This is not to say that employees in the sector are unable to complete such tasks or are IT illiterate, but rather they are not experienced in completing high-level administration as the CT can require. Care homes are not set up to carry out such tasks and updating the tracker on a daily occurrence can be draining on the workforce.

Currently, providers and stakeholders do not have a shared reporting view. Providers that are unable to access the same reports as LAs/ CCGs limit their abilities to respond to queries received from these agencies. Better reporting and access to historical data/ trends would add significant value for providers.

CT is also structurally biased towards residential care services for older people with low regard to the specific requirements of community and other specialist services such as those for people with learning disabilities. Whilst there is now the bulk upload function, for providers with multiple services, the data entry/ upload process remains inefficient. Although the system now includes Supported Living and Community services, providers feel that there needs to be more relevant questions with different timeframes for completion, which reflect the diverse range of service users and care settings.

Despite these areas for improvements, the Capacity Tracker has been useful in helping provide key data. Certain LAs have been supportive and helpful, providing quick advice and aiding providers in their completion of the CT. This good practice should be promoted and encouraged throughout the country. The benefits of the Capacity Tracker could be realised if data entry requirements were streamlined/reduced and providers had access to some benchmarking or reporting feature that gave them an overview of local, regional and national trends when applicable.

#### **Summary of key issues on what could be prioritised/removed/added:**

##### **Essential/ Prioritised**

Vacancies: Essential for LA, CCGs, NHS or Social workers etc to locate any voids suitable for people waiting to be discharged from hospital. However, agencies need to stop contacting providers and requesting the completion of other regional spreadsheets. Care settings for people with learning disabilities also may not feel the vacancy requirement is relevant to them and certainly not needing to be completed on a daily basis.

COVID Monitoring

Flu Immunisation

COVID Vaccinations

## **Removed/Unessential**

Workforce: Not needed. It is a provider's role to make sure their services are covered at all times. It is time-consuming to input daily.

COVID Team Visits: Not a necessity as this information can be drawn out through the vaccination tab. Also, LAs are contacting services directly asking for the same information.

## **Current Status**

PPE: Is this still necessary to the same degree now a central portal for free PPE is established?

ICF2 questions weekly: Most of the questions once answered as a company would not change, only staff tested this week would change.

ICF2 questions monthly: Once answered would not change, cross working would be the same every week.

## **Added/Streamline**

Ensuring the questions for Supported Living and Community services are relevant questions that reflect the diverse range of individuals and settings.

For large providers it would be useful to have a tab for each care setting which can send direct requests from the CT to a central point. This will help larger organisations monitor the productivity of the CT as a tool to help reduce Delayed Transfers of care.

Care England

11<sup>th</sup> February 2021

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