

Social care quality standards workshop

15th July 2011

Report on group discussions

Introduction

A workshop was held with a range of stakeholders from the social care community on the 15th July 2011. The purpose of the workshop was to set out the context and vision for developing social care quality standards by NICE in collaboration with SCIE and to hear the views of stakeholders on the proposed process for developing social care quality standards and what we can do to ensure that they are useful and can be implemented in social care.

Discussion groups were held after each session and focused on 4 key questions. The morning session focused more generally on how NICE quality standards could help improve care and what the focus of these should be. The afternoon session looked at communication with the social care community and how to get quality standards embedded into the system. The discussion groups also considered the scopes of the two pilot standards: Health and wellbeing of looked after children and Care of elderly mentally ill people in residential settings.

Summary points

In summary, three main messages emerged from the workshop:

- 1) Social care quality standards developed by NICE were welcomed as a potential driver for improving quality across the sector.
- 2) There needs to be clarity about what aspects of social care will be covered by the standards and how they fit with other national, quality or quality related activity, including the work of the Care Quality Commission.
- 3) The standards will need to recognise an approach to social care which places considerable weight on services tailored to individuals, designed to achieve the outcomes that are important to the individual, within the context of the personalisation agenda.

Questions and themes

The following section outlines the questions asked in each workshop group, and a summary of the themes that emerged from these sessions.

Question 1: How can we ensure that NICE quality standards help to improve the quality of social care?

Theme 1: Purpose of the Quality Standards

Scope of the quality standards

- A social care quality standard (QS) should ensure consistency in services and challenge poor practice, and adherence to the QS should drive up quality and lead to service level change. It was felt that the QS should act as a reference point, not as a protocol to follow, to allow services to be shaped around the individual client, within the context of the personalisation agenda.
- One group also noted that the standards should be more than a tick box exercise for providers, while another stated that they should be about how services are commissioned and how services are provided, as there is often a mismatch.

Impact of the quality standards

- One group felt it was important to evaluate the impact of quality standards on services, and others noted that there was a risk that the QS would only be followed by already high quality services, widening the gap between good and bad services.

Theme 2: Audience

- There was consensus that the audience for the standards was diverse and included:
 - o Managers
 - o Providers
 - o Regulators
 - o Users
 - o Carers
 - o Commissioners (inc. individual purchasers of care)
- It was noted that commissioners of services are not always those procuring the service, which may have an impact on choice, and that commissioning needs to be realistic.
- There was emphasis that the QS needed to be relevant to both small and large organisations and that different audiences have different needs.
- Currently, any form of national guidance tends to target the service manager, but quality standards need to reach those actually delivering services if they are to have an effect. The QS should therefore also be relevant and

accessible to these staff. All users should be able to have a stake in the guidance.

- One group noted that workforce issues may be a barrier, as training and career structure are often limited with a high turnover of staff.

Theme 3: Outcomes

Outcomes as a framework

- All groups felt that an outcomes-based approach was helpful, but noted that it was important to differentiate health outcomes from social care outcomes, although it was suggested that shared learning from care for chronic and long-term conditions in health could be useful. It was also noted that a good outcome could be framed as preventing a bad outcome. This complexity needs to be discussed further. Another group suggested considering the method of “results-based accountability” practised in Wales and Northern Ireland.

Outcomes in the context of personalisation

- Generally it was noted that social care outcomes are usually tied to the individual’s personal preferences of the care and support that they receive, and that it was essential to couch outcomes in this way, especially considering the importance of the personalisation agenda. One group stated that what people want in terms of outcomes is security, conformity, purpose and significance – ‘see me, include me, connect with me’. However, one group suggested that personal preferences do not always align to the best outcomes. For example, in the case of looked-after children, some children may express a preference to stay with their parents, when the best outcome for them would be to be placed in care, and child-centred care ensures their needs come first. Therefore, it is important to couch choice within an understanding of effectiveness. It was noted that expectations and desires do not always fit with what is available or what is best practice

Theme 4: Measures

- Measuring overall quality of services by outcomes is difficult as they vary by individual but there was an appreciation that it was important to be able to measure whether organisations were achieving the quality standards. It was noted that there is a lack of data in social care and it would be important to measure where we are now and then measure the gains. One group felt that the measures should be flexible and based on the user’s experience of a service.
- Using a quality of life measure and giving consideration to a social care equivalent of the Quality Adjusted Life Year, used by NICE in assessing the cost effectiveness of health interventions was suggested. The QoL indicator

project was also mentioned. Self-reported quality of life was one way to measure outcomes and methods for capturing this data and measuring it would be useful. Another group suggested the development of rating systems for services that could be rated through experience surveys.

Theme 5: Evidence & methodology

- A number of groups felt that inclusion of practice-based evidence, including a focus on soft outcomes, would be useful, and a focus on existing good practice rather than on untested innovation was desirable. There was a suggestion to include evidence from regulators and that people could be encouraged to submit evidence. Economic evaluation was also considered important by one group.
- Additional points noted by the different groups included shared learning between health and social care and that training and support across sectors could be useful. Maslow's hierarchy of needs or the Nolan Senses Framework were discussed as useful ways of placing the user at the centre of the product. Finally, that it was important to consider the presentation and implementation of the QS throughout the development process.

Theme 6: Engagement

- All groups felt that engaging with the user base was important as they should drive an understanding of what outcomes are important to users. It was suggested that novel ways of engaging via field testing and iterative approaches could be adopted. One group suggested that NICE needed to find ways to engage with young people for topics that concern them.

Theme 7: Links with other initiatives

- Most of the groups felt that it was important to outline the links with other government-led and CQC-led initiatives. There needs to be clarity about how they fit with and differ from the essential standards, the excellence awards and 'Think local, act personal'. Clarity is also needed around who will monitor that organisations are complying with the QS and develop the reporting tools for the purpose of monitoring.

Theme 8: Incentives

- Three groups felt that the drivers for change were not clear and wondered whether incentives would be used to encourage organisations to deliver the QS. It was felt that incentives could drive competitiveness in the market.

Theme 9: NICE's credibility

- One group felt that the perception of NICE as an organisation which focuses on health will not be important but another noted that if the QS are to be useful, then NICE should think about how it projects its image.
- It was noted that it was important to use the correct form of language in the QS, to ensure that it is not couched in health terms etc. and that NICE's engagement with the social care community was a good first step to building links with social care.

Question 2: What aspects of social care should be the focus of quality standards?

Theme 1: Focus of topics

Setting

- All the groups felt that it was important to take an individual, holistic approach when planning the focus of topics, rather than a condition-specific approach, as this is not how people interact with social care. This is further reinforced by some groups noting that this should be framed within individual, personal preferences. One group noted that a focus on the individual means that the standards will stay relevant, even after changes to the current health and social care structures have come into force.
- It was noted that although a service-level focus would be likely to provide more evidence and would be easier to implement, an individual focus would be more useful and have more impact. However, given the heterogeneity of settings, it may not always be possible to focus on one type of setting as, for some standards, the statements would need to vary for each specific setting.
- It was also noted that QS should focus on the fostering of relationships between users, carers and relatives. Consistency of services is also important for example, children moving through the care system. People need to build trust in their carers.
- Two groups noted that the scope of topics needed to be specific enough but also cover enough ground to be useful; otherwise outcomes are hard to identify.
- One group noted that home and domiciliary care was often considered in the shadow of the residential setting. What works in a care home doesn't necessarily translate or work in a home setting and these should be seen as distinct where relevant. Furthermore, it was noted that domiciliary care standards are highly variable and that staff turnover can be very high.

Potential topics

- The following topics were proposed as examples by a number of groups as being of importance, as they could form overarching principles to prevent duplication in future standards:
 - o Medicines management
 - o Care planning
 - o Assessment
 - o End of life care
 - o Transition between health and social care services
 - o Transition between children's and adults services
 - o Restraint

Other areas to consider

- Many groups suggested that social care guidance, and subsequently quality standards should focus on soft skills, such as addressing cultural and personal beliefs through training. Core competencies were also seen as important and could be developed on a topic basis. One group suggested that an understanding of confidentiality is needed within the sector and could be a useful area to consider in terms of practice points.
- One group suggested that a topic such as "Use of antipsychotics" could provide an opportunity to explore difficult issues and develop methods for future guidance and standards.
- It was also considered that gaps in the evidence base shouldn't prevent topics from being covered, as emerging evidence, front line evidence and user experience surveys could provide a bridge.
- There is a lot of working in silos and topics need to work across services and develop a shared language. It was suggested that overlaps with clinical guidelines and public health guidance should be explored.

Theme 2: Proposed pilot topics

- All groups agreed that work was required to refine the scopes of the two topics

Care of elderly mentally ill people in residential settings

- All groups noted that the term 'EMI' was not now in common use in social care. Five of the groups felt that a focus on dementia only would be preferable, whilst one group felt that it could be combined with serious mental illness only by focusing on challenging behaviour. It was noted that in social care, cognitive impairment is the term typically used to represent this group, and that other cognitive issues can have the same impact as dementia on quality of life. In addition, not all patients will have a specific diagnosis of dementia therefore would the quality standard be seen to apply to them, as their needs might be similar. However, even with just a focus on dementia, the

opportunity for improving the quality of life of all care home residents was still considerable.

- No group suggested that the pilot should consider broader mental health issues such as depression etc.
- Clarity was needed on what settings this covered. It is unclear as to whether it could apply to people in their own homes or hospices as well as residential care home settings. One group felt that care at home should be included in order to not reinforce the stigma which suggests that the default place of care for people with dementia is the residential care home. However, one group felt the two settings should be kept separate as what works in residential care may not necessarily work in the home setting but if it does cover both then tease out what is generic to both and tailor that which is specific to the setting and be very clear in the QS about the distinction.
- It was noted that the interface between health and social care was particularly important for this group of people.
- Additional points highlighted that for this group of people, quality of life measures are difficult to establish, as they often fall to proxies such as next of kin or children to identify; integrated personalised pathways for older people would be useful; and that “Life histories” and “Reminiscence therapy” are often successfully used in care of people with cognitive impairment which can form part of dementia care.

Health and wellbeing of looked-after children

- One group noted the importance of safeguarding and focusing on the issues which lead to the greatest number of safeguarding referrals. This group also noted that we must be careful to note that children are often referred where space is available, not where a local authority or child would necessarily choose.
- Another group felt that the pilot must include care leavers (0-25 years) and transition in and out of services. It also needs to take a broad view of wellbeing – physical, mental and emotional.
- It was considered that engaging with children directly for this work would be important, providing a tool with which looked-after children can challenge the care they receive. This was supported by all groups who felt that user involvement was vital.
- It was also noted that NICE should engage with the Department for Education, Care Quality Commission and Ofsted more generally and that the QS should link with the new Ofsted inspection framework and National Minimum Standards.

Question 3: What should the QS look like? And how can we make sure that we properly involve the sector – and its users – in developing them?

Theme 1: Format & Content

- The majority of the groups felt that the standards should be supplemented by good practice examples of how to implement them. The Practice points highlighted in existing SCIE guides were seen as a good example of this. It was considered that embedding the QS in practice would enable providers to use the QS more effectively. It was also noted that highlighting inputs (e.g. training) was as important as highlighting outcomes. One group felt that the standards shouldn't differ substantially in appearance from the CQC minimum standards that already exist.
- Most groups felt that different products should be developed for different audiences. One example of this was that support tools could be developed to enable a service to evaluate itself, and at the same time, allow a user of a service to evaluate the service received or offered. One suggestion was to link with existing information produced by user organisations.
- A number of groups mentioned the importance of the measurability of the statements, linking with data collected by the NHS Information Centre, although it was noted that there is a lack of measurable data in social care.
- One group felt that 10 to 12 statements was too narrow to have an impact, whilst another felt that this was appropriate, so that they are relevant to the service user in terms of what they can expect.
- Highlighting the link between health and social care was considered important by some groups as failures in each sector can have an impact on the other.
- Finally it was noted that printed versions of any guidance remain useful because people wouldn't always go to the web to find this type of information.

Theme 2: Involvement of the sector

- One group felt that expert input was needed at an early stage to scope the topics, including managers. This group also noted that the sector may be best engaged through professional bodies and trade unions, using fieldwork and iterative methods as appropriate.

Question 4: How should we go about communicating quality standards in social care?

Theme 1: Accessibility and dissemination

- All groups reiterated the importance of producing multiple versions of quality standards (QS) to recognise the diversity of their audiences. One group suggested adapting the audience descriptors to give different versions of the statements for different audiences.

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- Other important principles to note is that documents should be easily available/searchable on the web, that printed material is still important for dissemination as is joint badging the QS either with SCIE or other provider organisations, as social care staff and support workers may take more note of their organisational policy documents.
- One group felt that using visual media can have an impact, both on users and providers of a service. An example was given of a young person talking about their experience of care, and the impact it had on providers of care for children and young people.
- One group suggested that local authorities should be encouraged to use the QS as part of their contracts for the delivery of their commissioned services and that the QS should be flexible enough to be used within local initiatives, for example, engaging with local audit, such as Think Local, Act Personal.

Appendix 1: Next steps

After the workshop, the following next steps were agreed by the Programme Board:

Late July 2011	Receive referral for two pilot topics from Department of Health and Department for Education
19 th August 2011	Adverts for Topic Expert Group (TEG) chairs go live on NICE website
31 st October 2011	Briefing workshop on two topics with interested stakeholders to be held in Manchester
November 2011	Adverts for Topic Expert Group members go live on NICE website
January 2012	Topic Expert Groups convened and scopes of two topics drafted
March 2012	Engagement with stakeholders on pilot topic scopes
May 2012	TEGs draft quality statements. Publication of pilot topic scopes
16 th August to 16 th October 2012	Consultation on draft quality standards with stakeholders and fieldwork carried out
November 2012	TEGs consider consultation comments and redraft quality standards
December 2012	Final fieldwork report published
2 nd April 2013	Publication of final quality standards

NB. All dates are provisional and are subject to confirmation.

Appendix 2: Organisations represented

The following organisations were represented at the social care quality standards workshop on 15th July 2011:

Action for Children

Age UK

Alzheimer's Society

Anchor Trust

Association of Directors of Adult Social Services

Barchester

Barnardo's

Brighton and Hove City Council

British Association of Social Workers

British Geriatrics Society

Bupa

Care Leavers' Association

Care Providers Alliance

Care Quality Commission

City University

Clarendon Home Care

College of Occupational Therapists

Community Practitioners and Health Visitors Association

Crossroads Care

Dementia Care Matters

Department for Education

Department of Health

English Community Care Association

Fostering Network

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National Association for Providers of Activities for Older People

National Association of Adult Placement Services

National Care Advisory Service

National Care Association

National Children's Bureau

National Collaborating Centre for Mental Health

National Skills Academy for Social Care

NHS Information Centre for Health and Social Care

Ofsted

Registered Nursing Home Association

Research in Practice for Adults

SACCS

Skills for Care

Social Care Association

Social Care Institute for Excellence

Social Services Research Group

The Relatives and Residents Association

UK Homecare Association

University of Bath

University of York

Voluntary Organisations Disability Group

Welsh Government

Who Cares? Trust