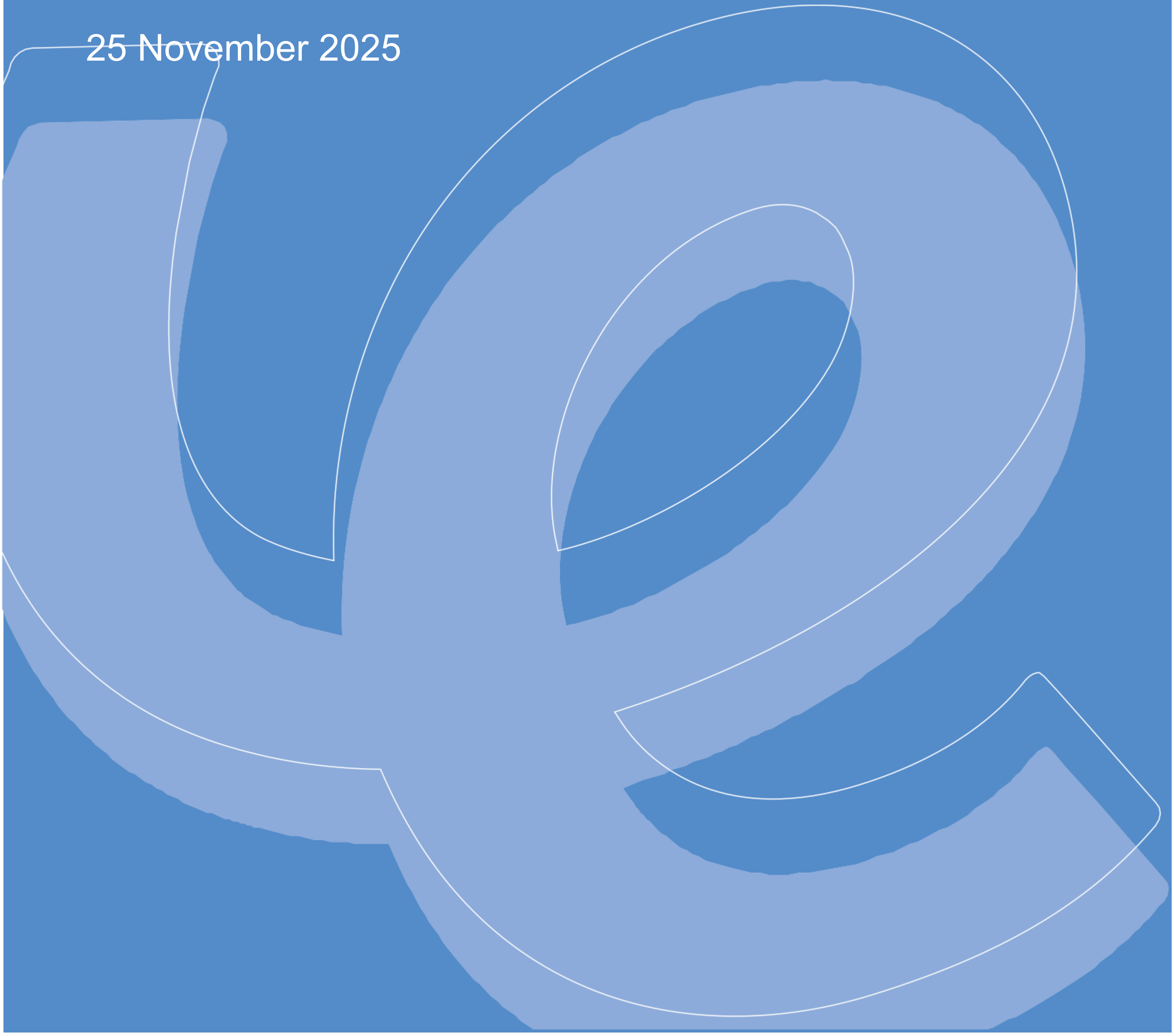
social care
institute for excellence

Roundtable series on national standards of care: measurement, accountability and future policies

Insights from the fourth SCIE and The Access Group roundtable

25 November 2025



About SCIE

The Social Care Institute for Excellence (SCIE) is an independent social care charity with deep experience of bringing partners and people with lived experience together to collaborate and innovate to improve people's lives (e.g. national government, DHSC, local authorities, care providers, academics, foundations). Working across social care, health and related services such as housing, for adults, children and families, we contribute to the development and implementation of better care, support and safeguarding at local and national level.

As we are not-for-profit, our income goes towards improving social care. We deliver four main offers, across all of which we support the DHSC annually:

- **SCIE Consultancy** – working with local and national organisations to identify and implement improvements
- **SCIE Insights** – research, evidence and policy insights to drive improvements and innovation, and influence national policy and practice
- **SCIE Training** – bespoke online or face-to-face learning and development, including safeguarding, co-production and strengths-based approaches
- **SCIE Resources** – guidance and tools to support best practice, co-production and innovation.

Co-production with people with lived experience of social care underpins and informs what we do, and with over 20 years' experience we bring a wealth of trusted, evidence-based expertise to work together to help transform care. Our staff – former practitioners in social care, researchers, experts in training – bring immense depth of experience and passion for the cause, based on frontline work, using the best available knowledge about what works in practice.

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Executive summary

This fourth and final roundtable explored how national care standards can be implemented, evaluated and continuously improved over time. Building on earlier discussions about purpose, data, technology and integration, the session focused on three interconnected themes:

- Accountability for national standards – who is responsible for delivering, monitoring and acting on standards, and how accountability can support learning rather than fear and blame.
- Measuring progress and outcomes – how to define and assess ‘progress’ in ways that reflect what matters to people, combining data, stories and continuous feedback rather than narrow compliance metrics.
- Future-ready standards – how to design standards and supporting infrastructure that can adapt to changing needs, strengthen the Care Act’s ambitions, and make constructive use of data, technology and international learning.

Across the discussion, a central tension emerged around where accountability should sit. Participants agreed that accountability must be shared across the system but recognised that shared responsibility can easily become blurred responsibility, especially where implementation requires cross-system collaboration and joined-up funding, but benefits accrue to only one of the partners. There were live debates about whether a single accountable body is needed to give clarity, how regulation should balance support and enforcement, and how to ensure national standards survive short political cycles and day-to-day operational pressures.

As with the previous roundtables, there was a clear recognition that the existence of care standards doesn’t guarantee they will be achieved. Participants were concerned about proportionality and offered a strong steer to avoid adding the burden of additional compliance to an existing pressurised care system. Similarly, there was an acknowledgement that accountability for the use of public money can direct the attention of system leaders away from the more ambitious goal of using care standards for improving care outcomes.

A recurring theme was the need to shift from compliance to curiosity. Participants argued that standards must enable honest feedback, flexibility for local responses and learning from innovation, and not reinforce or encourage the risk-aversion often associated with compliance regimes and inspection. With co-production a core principle, this requires moving away from task-based metrics towards outcomes defined by people themselves, using both qualitative and quantitative evidence, and recognising that for many people, maintaining stability or a chosen way of life is a positive outcome. Using care standards for improvement should also create opportunities for continuous feedback from people about their experiences and how they are changing.

Finally, the roundtable highlighted the importance of trust, including transparency and inclusion. For many, trust, especially around data use and decision-making, was viewed as currently fragile. People drawing on care, families and providers fear that sharing of personal information could be used against them. Future-ready standards will therefore need to place data ownership, transparency and co-production at their core. This approach would be consistent with the Care Act and existing frameworks such as TLAP’s Making It Real framework.

Accountability for national standards

The issue

Throughout the series, participants have returned repeatedly to the question of who is accountable for national standards – not only for writing them, but for ensuring they are implemented, reviewed and improved.

Earlier roundtables identified that standards must include clear accountability from central government to local authorities, providers and regulators, but also warned that accountability mechanisms risk becoming purely compliance-driven if they are not designed to support learning and culture change.

In this fourth roundtable, the discussion deepened around:

- Whether accountability should be shared across the system or sit with a single identifiable body.
- How to create structures that allow for “you said, we did” transparency, rather than opaque decision-making.
- The role of regulators such as CQC, and whether their current approaches to inspection and regulation support or inhibit innovation.

Participants recognised that accountability is often experienced as something done to people and providers, rather than a shared framework for improvement. There were concerns that “shared accountability” can become a “sticky concept”, allowing organisations to avoid responsibility and enabling finger-pointing when things go wrong. At the same time, locating accountability solely in one national body risks reinforcing siloed, top-down control that does not reflect the complexity of people’s lives or local systems.

The political context also matters: participants described how short political cycles and changing ministerial priorities undermine long-term commitments, investment and confidence. Any new national standards will need a form of accountability that is durable across electoral cycles and can support a long-term view.

Where agreement exists

Standards should focus on probabilities, not certainties

Participants agreed that national standards should be viewed as creating conditions that increase the probability of good outcomes rather than guaranteeing specific results. Standards should “tilt the odds” of achieving positive outcomes for people drawing on care and support, recognising the complexity and variability of individual situations.

Accountability must be shared across the system

There was some agreement that accountability cannot sit with a single entity, but needs to be distributed across regulators, government, providers, commissioners, and other system partners. Participants emphasised the need for a "Venn diagram" approach where responsibilities overlap and interconnect, with clear visibility of these relationships to all stakeholders and evidence of the action taken (you said we did), so people “own the outcomes” they were accountable for. Bearing in mind system complexity, both clarity and transparency of accountability are crucial.

Co-production and lived experience must be central to accountability frameworks
Strong agreement emerged that people who draw on care and support must be meaningfully involved at all levels – from individual care planning to national standard-setting. This includes creating formal mechanisms for feedback and ensuring diverse representation across the spectrum of care needs.

Standards should enable accountability for earlier intervention and support
Participants agreed that current standards focus too much on immediate crisis response rather than foreseeable prevention and early support. National standards should enable earlier action to prevent people from reaching crisis points, recognising this requires measuring things that haven't happened rather than just responding to problems.

Flexibility within an accountability framework is essential
There was consensus that standards must balance consistency with personalisation – allowing flexibility for individual choice, risk-taking (with appropriate safeguards), and local variation. Standards should enable, rather than restrict, supporting people to live the lives they choose.

Areas of tension

Shared vs single accountability

While shared accountability across government, regulators, local authorities, providers, community organisations and people drawing on care was widely supported in principle, some participants argued that this can become too diffuse. Proposals ranged from a single national body (for example, DHSC or a new independent commission) with overall responsibility, to a model where an organisation such as SCIE hosts standards within a cross-sector governance structure that includes regulators, local government, providers and people with lived experience. Ultimately, resolution of these differences rests on having a clear purpose and scope for the use of care standards.

Support vs enforcement – the “carrot and stick” balance

Participants recognised that standards require real consequences when they are not met, but stressed that punitive approaches can encourage defensiveness, data-gaming and fear of transparency. Many argued for accountability mechanisms that are explicitly about learning, peer support and improvement, alongside proportionate enforcement for persistent or serious failures. Care standards can inform priorities for system regulation whilst also shining a light on priorities for local improvement.

Local vs national levels of accountability

Views differed on where different elements of accountability should sit. Some emphasised the statutory role of local authorities and the need for local forums bringing together people, providers, commissioners and regulators. Others highlighted the benefits of national consistency – particularly for rights and entitlements – and suggested that core standards and oversight processes must sit nationally, with local adaptation and delivery. As with the debate about shared accountability, clarity and transparency are crucial to resolving this debate.

Accountability vs bureaucracy

Participants worried that without careful design, new accountability arrangements could add further layers of meetings, reporting and performance management, diverting energy away from relationships and direct support.

Unresolved questions

- Who holds ultimate responsibility for the delivery of national standards – the Secretary of State, an independent commission, local authorities, or a new arm's-length body – and how is this responsibility shared with local partners?
- How can shared accountability be made real and visible, rather than becoming a way to avoid responsibility?
- What is the right mix of national and local accountability, and how should responsibilities be distributed across different levels of the system?
- How can accountability structures be designed to support candour, risk-taking and innovation, rather than driving fear of inspection or blame?
- What mechanisms (such as citizens' assemblies, local forums, national panels) are needed to give people who draw on care and support a formal role in scrutiny and decision-making, not just in consultation?

What SCIE and The Access Group think

Shared and layered, not centralised or fragmented

Accountability should be distributed across the system – people, providers, commissioners, regulators, local and national government – but with clear lines of sight about who is responsible for what at each level. This aligns with earlier findings that national standards should provide a single framework of roles and responsibilities across the system.

Anchored in co-production and lived experience

People who draw on care and support should be active partners not only in service design, but in monitoring, review and challenge, for example, through well-supported local forums, national panels and co-chaired governance structures. This builds on Roundtable 3's emphasis that co-production must be genuine rather than tokenistic and that lived experience is the most reliable measure of whether standards are working.

Focused on learning, not just compliance

Accountability mechanisms should be designed to surface problems early, support honest reflection and spread good practice, echoing the shift from "inspection and punishment" to "learning and improvement" identified in earlier discussions.

Cross-party and long-term

To avoid standards being re-written with every change of minister, SCIE and The Access Group support establishing cross-party agreement on core principles, potentially via parliamentary or independent commissions, and embedding accountability for standards beyond a single government department or agency.

Connected to integration and prevention

Accountability for national standards should explicitly include expectations about early intervention and system integration, building on Roundtable 3’s focus on key “touchpoints” and shared outcomes across health, housing and social care.

Measuring progress and outcomes

The issue

Across the series, participants have repeatedly highlighted that current measures of performance in social care often bear little relationship to what people say matters most in their lives. Systems tend to count what is easy to measure – visits, tasks, bed numbers, waiting times – rather than capturing experiences of belonging, safety, dignity, relationships, and the ability to live in “the place we call home, with the people and things we love”.

This roundtable asked: How do we define and measure progress in ways that reflect what truly matters to people – and what data, metrics, stories and feedback loops are most meaningful?

Participants stressed that:

- “Progress” is not always about improvement or independence; for many people, stability or even a chosen reduction in activity can represent success.
- The word “progress” itself can be problematic, as it implies constant forward movement rather than living well on one’s own terms.
- Meaningful understanding of impact requires both stories and data, and a shift from compliance to curiosity, with continuous feedback rather than one-off surveys.
- Earlier roundtables had already underlined that national standards need measurable, outcome-focused indicators, linked to frameworks such as Making It Real and aligned with integrated, interoperable data systems.

Where agreement exists

People not process – progress understood through human connection

Trust is critical to progress; however, participants agreed that "progress" should not assume constant forward movement or independence. For some people, maintaining stability or even choosing less activity (like the example of the former teacher who chose to stay in her room) represents success. Progress should be measured against individual goals and what matters to each person, not against standardised expectations of improvement.

Shift from task-based to outcome-based measurement

Strong consensus emerged that current measurement focuses too much on compliance with specific tasks (plug socket heights, bed measurements) rather than outcomes that matter to people. Standards should focus on what people want to achieve in their lives – whether that's maintaining a hobby, connecting with friends, or simply being comfortable – rather than prescriptive processes.

Need for both stories and data

Shift from compliance to curiosity – need for space for risk-taking. Participants agreed that both qualitative stories and quantitative metrics are essential. Stories provide a rich understanding of individual experiences and help evidence what's working locally, but data and metrics are needed to demonstrate accountability, secure funding, and "stand up to the

NHS" in budget negotiations. The challenge is balancing both without creating an industry focused solely on compliance.

Standards must allow for local variation

There was clear agreement that one-size-fits-all approaches won't work given geographical differences (rural Cumbria vs metropolitan areas), varying population needs, and local contexts. Standards need to provide a framework while allowing flexibility for local implementation and innovation.

Cross-party, long-term ownership is essential

Participants stressed that standards must survive political cycles through cross-party agreement and should be owned by a coalition of organisations rather than government departments alone. The standards should be co-produced with people who draw on care and support, continuously reviewed and evolved, but with core principles that endure beyond electoral cycles.

Areas of tension

Individual outcomes vs population-level standards

Participants strongly supported defining progress through individual goals and **'Making It Real'**–type “I statements”, but recognised that national standards must also operate at population and system level. This raises questions about how to aggregate personal experiences without losing nuance, and how to avoid benchmarks that re-impose standardised expectations of “improvement”.

Qualitative vs quantitative evidence

There was broad agreement that both are needed, but no consensus on which should take priority when they conflict. Systems often privilege quantitative indicators for funding and accountability, while people’s experiences are better captured through stories, open questions and relational feedback.

Measuring prevention and early intervention

Participants saw a need to recognise and fund things that do not happen – crises avoided, deterioration prevented, relationships sustained – but acknowledged that these are difficult to evidence through existing datasets (for example, ASCOF or activity-based NHS metrics).

Trust and data-sharing

Persistent trust deficits around how data is used - particularly fears that information will be “weaponised” to reduce support – create reluctance to share experiences honestly. This undermines the very feedback loops needed for learning and improvement.

Standardisation vs local innovation

While participants wanted national principles and minimum expectations, there were concerns that over-standardised measures could stifle innovation or fail to reflect local contexts, especially in areas with very different geographies, demographics and market conditions.

Ongoing testing

There were discussions around whether we need to test or pilot standards in certain key areas, for example, transitions or hospital discharge. However, there are already huge amounts of attention and resources put into these areas, so would pilots be an asset or a hindrance?

Unresolved questions

- How should “progress” be defined within national standards so that it reflects individual aspirations while still allowing for system-wide reporting and accountability?
- What combination of metrics, stories, sentiment and experience data best evidences whether standards are improving people’s lives, and how can this be made proportionate rather than burdensome?
- How can frameworks like ‘Making It Real’ be embedded across individual, service and system levels without becoming so generic that they lose meaning, or so detailed that they become a new checklist?
- What mechanisms are needed to ensure family and friend carers’ insights are systematically captured and used, given their unique perspective on long-term impact?
- How can national standards enable continuous, real-time feedback (including digital tools) while ensuring that people own their stories and are not required to re-live trauma or share more than they wish?

What SCIE and The Access Group think

Start with what matters to people

Progress should be defined as movement towards – or maintenance of – the things people say matter most to them, not as reduced demand on services or achievement of pre-set milestones. Frameworks such as Making It Real and the Social Care Future vision provide a strong foundation for this.

Combine stories with data, ethically and transparently

Narratives, case studies and experience data should sit alongside quantitative indicators. People should own their stories, choose how they are used, and see how their feedback leads to change. Data collection should be designed to avoid “trauma porn” and focus on learning.

Shift from compliance to curiosity

National standards should explicitly promote a learning culture, in which feedback (including negative feedback) is welcomed, and people and providers feel safe to say “this isn’t working” without fear of punitive consequences. Measures should underpin continuous improvement cycles, not only inspection.

Use continuous feedback loops, not one-off surveys

Building on earlier insights about data infrastructure, the focus should move from retrospective, point-in-time surveys to more continuous, relational feedback mechanisms, integrated into everyday practice and supported by digital tools where appropriate.

Be proportionate and locally meaningful

A core national framework of outcomes and indicators should be co-produced, but local areas should be able to adapt measures to reflect their context, including rurality, demographics and market structure.

Future ready standards

The issue

A central concern across the roundtable series has been whether national care standards can be designed in ways that are not only fit for today's system, but also capable of adapting to future demographic, technological, workforce and funding pressures. Participants recognised that adult social care is operating within a context of:

- Rapidly changing population needs, including increasing longevity, rising levels of complexity, and growing numbers of people living with multiple long-term conditions.
- Persistent workforce shortages, skills gaps and high turnover, alongside limited progression routes and inconsistent training quality.
- Unsustainable funding models, with local authorities already spending a very high proportion of their budgets on adult social care, and self-funders subsidising publicly funded care.
- Fragmented digital and data infrastructure, with local authorities, the NHS and providers using systems that do not communicate effectively.
- Low levels of trust, particularly around how data is used, how decisions about support are made, and whether standards genuinely improve people's lives or simply tighten eligibility.

Participants also raised the challenge of future-proofing standards in a system dominated by short political cycles but long-term human needs. Care providers invest over decades; people draw on support across lifetimes; yet national policy priorities frequently shift within a few years.

There was strong concern that without addressing infrastructure, trust, workforce capability and funding, national standards risk becoming aspirations that cannot be delivered. Future-ready standards must be capable of:

- supporting innovation and new models of care
- strengthening existing legal frameworks rather than creating parallel systems
- remaining meaningful as technology, demographics and expectations evolve.

International examples such as New Zealand's Enabling Good Lives, the Netherlands' Buurtzorg, Scotland's health and social care standards, and integrated systems in Northern Ireland were cited as evidence that different approaches to standards, accountability and integration are possible.

Where agreement exists

Data infrastructure and ownership must be fundamentally reformed – with restoring trust central to progress

Participants agreed that people should own their own data with the ability to choose what to share. Current data collection is fragmented, inconsistent across local authorities, and not trusted by people who draw on care and support. There was consensus that a national infrastructure is needed where individuals control their information rather than having it held by multiple providers and systems that don't communicate.

Strong agreement emerged that the lack of trust between people who draw on care and support and the system is preventing effective use of data and technology. People fear their data will be weaponised or misinterpreted to deny them services. Participants noted that people willingly share data with commercial companies but not with health and social care due to fears about how it will be used against them.

Standards should build on and strengthen the Care Act’s vision and provisions

Consensus that the Care Act already contains the right principles (rights-based, preventative, person-centred, promoting wellbeing) but lacks implementation and accountability mechanisms. Future standards should strengthen existing legislation rather than create new frameworks, focusing on making the Care Act's ambitions a reality.

Standards could be used to support innovation and shape provision (and markets)

Agreement that standards cannot guarantee specific outcomes but should "tilt the odds" towards better outcomes. Standards need to acknowledge that people's lives are complex and unpredictable, moving away from rigid checklists toward creating conditions that increase the likelihood of good outcomes.

International models offer valuable learning for future-proofing and practical use of standards

Participants highlighted successful international examples including New Zealand's ‘Enabling Good Lives’ approach, the Netherlands' Buurtzorg model focusing on neighbourhood-based care, and Scotland's health and social care standards. These models demonstrate how to shift from measuring tasks to measuring capabilities and wellbeing.

Areas of tension

Technology as enabler vs threat

Participants saw major potential for digital systems, interoperability and AI to support earlier intervention, smarter care planning, improved transitions between services and better population insight. However, this was counterbalanced by deep concern that technology could intensify surveillance, automate complex decisions, entrench bias or exclude people who are digitally marginalised.

Market-shaping vs over-regulation

There was tension between using standards to shape markets (for example, around quality, transparency, innovation and profit) and the risk that overly prescriptive standards could drive providers out of the market or stifle creative, community-based models of care.

Generalist vs specialist workforce models

Participants recognised the value of generalist roles that offer continuity and flexibility but also stressed the growing need for specialist expertise (for example, in neurodiversity, sight loss, adolescent to adult services and multiple long-term conditions). The system currently struggles to support both effectively.

Local variation vs national consistency

International models were seen as inspiring, but participants cautioned against importing approaches without regard to local context, funding structures and cultural expectations. There remains tension between allowing local adaptation and maintaining national entitlements.

Short-term system pressures vs long-term reform

Immediate operational pressures (hospital discharge, workforce vacancies, provider instability) often crowd out long-term investment in prevention, technology and transformation. Participants questioned how future-ready standards can thrive in this environment.

Unresolved questions

- How can data ownership and consent be made real in practice, rather than symbolic, while still enabling safe information sharing across systems?
- What national digital and data infrastructure is required for social care, and who should govern it?
- How can national standards actively support innovation, rather than defaulting to risk aversion and compliance?
- What balance should be struck between local authority responsibilities, provider markets and national oversight in shaping sustainable provision?
- How can the system plan for future workforce needs, including specialist skills, without undermining generalist community-based care?
- Should future standards address the role of profit and self-funding more explicitly, and if so, how?
- How can standards be future-proofed across political cycles, remaining stable while still adaptive?

What SCIE and The Access Group think

Trust through data ownership and transparency

People who draw on care must have meaningful control over their information – including the right to see it, correct it, and decide how it is shared. National standards should require transparency about how data is used and demonstrate clear benefits to people, not just to organisations.

Strengthening – not replacing – the Care Act

Future standards should operationalise the Care Act’s existing vision of rights-based, preventative, person-centred care. The problem is not the principles of the Act, but the lack of implementation infrastructure, accountability mechanisms and political will to deliver them consistently.

Using standards to enable innovation, not constrain it

Standards should define outcomes and conditions, not rigid processes. This creates space for neighbourhood-based care, personalised approaches, micro-providers and new models to flourish while still protecting people’s rights and safety.

Learning intentionally from international evidence

International models demonstrate that it is possible to move away from task-based measurement towards capability, wellbeing and community connection. National standards should draw explicitly on this evidence while adapting it to the UK context.

Investing in workforce and community capacity

Future-ready standards are only credible if the system has the workforce, skills, funding and community infrastructure to deliver them. Without sustained investment in training pathways, career progression, fair pay and community capacity, standards risk remaining aspirational rather than achievable.

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