REPORT
October 2010

Finding excellence in adult social care services

Scoping and Engagement Report
October 2010

social care
institute for excellence

Introduction

The Care Quality Commission (CQC) commissioned the Social Care Institute for Excellence (SCIE) to define what an excellent regulated adult social care service looks like. It is intended that this definition will form part of CQC's new quality information scheme for regulated adult care services in England. This scheme will be designed to support people choosing and arranging care, as well as providing an incentive for quality improvement. It will cover services for adults providing activities that CQC regulates such as residential care, nursing homes, shared lives (adult placement schemes) and home care services. CQC intends that the overall scheme will be based on the essential standards of quality and safety; it is developing a separate assessment to show if services are doing more than meeting essential standards. If a service provider wants to be considered for this assessment, they will need to meet all other requirements before applying to be considered as 'excellent'.

This scoping and engagement document, together with a supporting paper setting out some of the frameworks and tools to promote quality in social care, supports the definition of excellence. These papers draw upon a range of perspectives across the sector to shape the definition. Since early July, SCIE has been drawing together relevant research about the outcomes people value most, and information about quality initiatives and frameworks. We have had discussions with a range of key stakeholders (face to face, by telephone and online) and followed up their ideas and suggestions – including visiting a selection of services to hear first-hand from people providing and using them which elements are key to an excellent service. We have also been working closely with our CQC colleagues to share early thinking and emerging ideas. We have not been able to follow up all offers of help within the tight timescale but are assured that there will be further opportunities for people to share their views as CQC takes this work forward over the coming months.

SCIE focused on the things that people using services consider to be the essential elements that make a service excellent. SCIE's findings suggest that an excellent care service is one that:

- makes it possible for people to have control over both day to day and significant life decisions, and to have a say and, if they wish, play a role in how services are run
- supports and encourages people to maintain good relationships with their partners, family, friends, staff and others
- enables people to spend time purposefully and enjoyably, doing things that bring them pleasure and meaning
- can demonstrate that organisational and service factors ensure that people achieve and sustain the three outcomes above.

Overview of selected approaches to excellence in social care

The supporting paper to this document sets out the results of a time-limited search of relevant literature plus examples that practitioners in the field highlighted to us as part of our engagement activity.

SCIE has not developed a systematic framework for analysing the concepts behind all these tools and frameworks for assessing, assuring and improving quality in social care. As we drew upon emerging information about the frameworks as well our early engagement activity, however, a number of themes consistently emerged to shape the definition of excellence. We were able to explore these further through events and visits.

As the overview paper describes, we noted the association early in the project between a high standard of care and quality of life. We also highlighted the difficulty in capturing the complexity of an individual's circumstances to assess their quality of life. One tool – the Adult Social Care Outcomes Toolkit (ASCOT) – emerged from our initial scoping exercise as a strong mechanism for measuring social care-related quality of life. The domains have been developed by the Personal Social Services Research Unit (PSSRU) through extensive consultation and focus group work with people using services and other experts and the conceptual basis is informed by the social model of disability.

Whilst further testing is taking place to establish whether ASCOT can reliably capture quality of life information for people with mental health issues, there is evidence that the tool has the benefit of being applicable across care settings and for both adults of working age and older adults. We explored how the ASCOT domains might both apply to and enable assessment of excellence in social care. As a result, from the eight domains described on page 5 of the attached paper, we concluded that three might be seen as 'higher level domains' that, together, illustrated aspects of quality of life that would be evident in the best quality regulated services, beyond essential standards – **control over daily life, occupation** and **social participation and involvement.**

Using these outcomes-focused domains as a starting point, we continued to explore what excellence looks like in our one to one discussions with key stakeholders and through other literature. The concepts of 'meaningful relationships' and 'meaningful activities' – both a feature of descriptions within ASCOT domains - emerged as key concepts. Some people found the term 'occupation' misleading as a way of describing a concept in quality of life for older people; others thought that the term 'meaningful' was too subjective or that 'activities' implied a more task-based institutional concept.

There was wide-ranging agreement that people having 'control' over their daily life was a strong feature of an excellent service. However, there were mixed views about whether it was sufficient in itself or whether 'voice' and/ or 'choice' should be explicit or were an implicit aspect of being in control. With input from the *My Home Life* Team and commissioners and providers that are testing out the approach, and drawing upon the evidence about relationship-based care particularly for older people living in residential setting and for those living with dementia, we re-framed the way we described the key outcome areas – **voice, choice and control; good relationships; spending time purposefully and enjoyably.**

The work of both Moullin and the Social Policy Research Unit (SPRU) helped us to make the link between quality – and quality of life in particular – and excellence; the first focused on the three outcome areas described above; to define excellence these elements needed to be linked to business processes and sustainable results. We highlight this on page 2 of the overview report. A range of approaches consider leadership, partnership, continuous learning and improvement, people development, innovation and having a customer focussed culture as being key elements of an excellent service. This reflected both our informal discussions and was evident in our visits.

The overview of selected approaches is not a systematic review; neither is it comprehensive but we hope it provides useful background for the regulator as well as the beginning of a resource list for providers and others with an interest in assuring and improving quality in care. Through our research, however, we have identified a number of gaps in the literature that need be addressed. For example, in the time allotted we found few tools and quality frameworks specifically to support quality assurance and improvement in domiciliary care services. We also noted few examples where equalities and diversity issues were specifically addressed as part of the frameworks for assessment of quality. Similarly, despite advances in the field of quality of life and dementia, there remains to be considerable gaps in knowledge and certain areas need to be addressed; for example variation in quality of life in different settings such as in the community and in care homes.

As the policy and economic drivers for increasing integration of health and social care gather pace, we have tried to identify frameworks that social care services will need to be aware of or are already contributing to, but cannot at this stage predict what the proposed new aligned outcomes framework for social care, signalled in the recent Government White Paper, *Equity and excellence: liberating the NHS,* (DH, 2010) will look like.

Engagement

Based on an initial overview of selected research and examples of quality frameworks, as well as informal discussions, and drawing particularly on the PSSRU's ASCOT measures, we produced a draft definition of excellence in adult social care services and tested this informally in consultation with stakeholders, including people using services, carers, commissioners and providers.

Stakeholder workshops

We held four workshops with stakeholders in September 2010. These took place in London, Bristol, Birmingham and Leeds and were attended by a total of 113 people. Each workshop consisted of two main discussions. For the first discussion, participants were allocated according to 'type' of stakeholder (service user, carer, provider, commissioner) and invited to comment on the draft document as a whole. For the second, participants joined mixed groups, which discussed specific elements of an excellent service, as defined in the draft. Feedback about these events was generally good.

Overview

Stakeholders were largely positive about this initiative to define, measure and assess excellence in adult social care. But people told us that it is hard to pin down exactly what constitutes excellence; many said that it goes beyond policies and procedures and encompasses the culture of organisations and the quality of leadership. Stakeholders took the view that the definition should be rights-based, and should explicitly highlight 'dignity'.

The challenge is to create a definition of excellence that leaves enough room for creativity and innovation. An overly prescriptive definition of excellence runs the risk of stifling innovation, which is often how excellent services evolve and develop.
Some stakeholders questioned whether excellence is truly achievable in a climate of budget restraint. Commissioners are concerned that services rated 'excellent' may become unaffordable. Providers are not all convinced that it is possible to create a definition of excellence that applies equally across all adult social care settings. They also want to have some way of understanding when they might be ready to submit an application for 'excellent' status, and they have concerns about the cost of applying. Providers also believe that excellence requires investment. There was some concern that all elements of the definition are essentially subjective, and therefore difficult to measure. One person expressed the approach needed as somewhere between a 'gut feeling' and a 'tick-box exercise'.

The clear view expressed by people using services, carers, commissioners and providers was that it is impossible to decide whether a service is excellent without seeing it in person. They believe that the regulator should not rely on self-assessment, but should use a variety of approaches to test a service's claim to be excellent. They

strongly support visits or some other means to gather information directly from listening to or observing interactions between service users and staff. They also noted that a service rated as excellent can change in a very short time. They want the views of service users, carers and staff always to be taken into account when making judgements on the quality of a service, and want the regulator to make more use of experts by experience.

Below is a brief summary of the key points made by stakeholders on each element of the draft definition. Please note that these elements have slightly different descriptions to those in the final definition we submitted to CQC which were re-framed as a result of people's comments.

Choice and control over decisions

People told us that:

- Personalisation is a prerequisite for an excellent social care service, but should not **in itself** be an indicator of excellence. This is because they thought that people using services should expect to experience choice and control – which are central to a personalised, rights-based approach – as a feature of *all* services, not just excellent ones.
- Putting choice and control into practice means understanding people as whole individuals (considering their history, their interests, their aspirations), not just looking at their particular care needs. People warned that there is a danger of sounding too 'top-down' in the definition, focusing on people's disability rather than helping them to have the life they want.
- Information is central to choice and control – helping people understand their options and how to exercise them. Independent advocates have an important role to play in helping people make choices and exercise control, and they should be mentioned in the definition.
- Communication is key, and should not be dependent on the service user being able to assert and express their needs. This requires staff that are sufficiently informed and empowered to support people to make choices. All staff should have high aspirations for themselves and the people they support, which should mean robust recruitment processes.
- The definition should address the question of risk-taking. Could supporting people who use services to choose to take risks be a sign of an excellent service, if it helps promote choice and independence? People thought that risk is too often used as an excuse for doing nothing.
- Excellent services are enabling: they should enable people who use them to think ahead about their lives, not simply maintain the status quo.
- Some stakeholders were concerned about whether minority or disenfranchised communities would be able to have access to choice and control and considered this an important equalities issue to consider.

Good relationships

People said that:

- The definition should not make the assumption that everyone has positive family relationships. It should recognise that people do not always have friends or family, and that families are not always supportive.
- The issue of relationships is part of choice and control – an excellent service will enable people who use services to choose who they wish to spend time with, and support them in maintaining contact with the people they choose. This should be reflected in an individual's care-plan.
- The definition should be practical and achievable. It is important to look beyond immediately present family and friends and think about other types of relationships people may form, such as through online forums or social networking. An excellent service should enable users to develop friendships in this way if they wish, and should have 24-hour internet access.
- Good relationships between people who use services and staff are also important. There was agreement that the quality of these relationships could be a mark of excellence.
- It is difficult for the regulator to measure the quality of relationships, and the extent to which service providers enable users to develop and maintain relationships. Observation should play an important role in this type of assessment.

Meaningful activity

In general, feedback on this issue was that:

- People who use services were unenthusiastic about the term 'meaningful activity'. Some would prefer the word 'activity' not to be used at all, as it sounds too institutional. The definition should consider people's lives as a whole, not the 'activities' they undertake (or not) each day.
- It is difficult to capture what 'meaningful' might mean for people as individuals. Excellent services consider the needs, wishes and preferences of individuals and reflect these in individualised care-plans.
- What people do each day is part of exercising choice and control – it may involve 'activity', or it may not. It is about wellbeing, which considers the entire person. One size clearly does not fit all. Care services should see themselves as facilitators – their goal should not simply be to get someone dressed and fed, but to help them do what they wish with their day.
- An excellent service is responsive to people's changing needs and circumstances. Providers of an excellent service challenge and support service users to reach their own goals – for example, to study or to find employment. It should be a shared responsibility, and about 'doing *with*' rather than 'doing *to*'.

- It is important to avoid making assumptions about what people will need or want to do based on their culture or ethnicity.
- Excellence in this area (as in others) can only be judged by hearing directly from people who use services.

Organisational factors

People's views on this included that:

- Organisational factors are crucial – this element can influence the other three.
- Organisations should focus on individuals. Individual care and support plans are essential to a person-centred culture.
- Excellent services have excellent staff, who have been properly trained in their role – particularly in communicating with service users. All staff need to be part of a quality system.
- Excellence means excellent leadership throughout the service, not just at senior management level.
- Comments and complaints should be dealt with effectively and should lead to tangible improvements.
- Excellent services should actively look for ways to share good practice with other organisations and service providers.
- People who use services should be fully involved with every aspect of the service, from choosing the menu to helping recruit staff.
- Excellence cannot be determined simply by looking at an organisation's policies and procedures. Observation and discussion with service users, carers and staff are also vital. There should be evidence of how well a service listens to its users.

Equalities and diversity issues

The overview of the stakeholder workshops attempts to reflect the general mood of what was a reasonably good spread of people from a range of perspectives. We have highlighted this range in our acknowledgements section at the end of this document. The weaker areas of representation were carers, people from LGBT communities and older people using services, particularly people living with dementia and from BME communities. We tried to address some of these shortfalls in other ways, in particular through visits and online discussions. We did not, however, receive a response from any of the LGBT forums within the time available. CQC may wish to pick up these issues as part of the consultation.

Other engagement with stakeholders

As a result of some of our initial discussions with providers and commissioners, we were invited to visit care services that were keen to show us what they thought excellence looks like in practice. In the time available we were not able to follow up all offers. By visiting this small sample, however, we were able to test out emerging thinking about the definition with people using the services, their relatives/ friends and carers and with staff. We have summarised visits to five areas and have some of the practice we observed or heard about just to give a flavour of the service.

Visits

Four care homes in the Eastern Region, two with nursing - one 3 star and three with 2 star CQC quality rating – with registration for people with dementia. The proprietor provided a tour of the homes and we had considerable insights from the business director, clinical director and managers about the person-centred ethos and on developing partnerships to improve services as well as talking to and observing staff and residents;

Stories and practice examples:

- Mr T was part of a lively activity session. He had been living in a shared room with his wife for some years. His wife died two weeks ago and this was his first trip downstairs as staff had supported his wish to remain in his room. After watching the wide-ranging activity and quietly listening to music for a while he said to a care assistant – 'I think I'd like to try a waltz'. So they did.
- In a small unit for people with dementia, the mood among residents was light-hearted as they had afternoon tea. Prompted by staff, Mrs S sang a verse of 'the Lambeth Walk' to illustrate to visitors that she was 'from London' and the general mood was light-hearted. However, appearing unhappy and frustrated, Mrs R said 'They don't do it right; I can't have this; it's awful; it's not right'. The manager responded, immediately realising that Mrs R was referring to her egg sandwich which was just not what she fancied and suggested she ask someone to fetch the biscuit tin. Mrs R's face lit up as she smiled and said, 'Ahh. That's it'.
- A group of three or four residents were engaged in a reminiscence session, led by a care staff member using an interactive computer display. Each person had created support plans using photos, letters etc to describe their life history with support of relatives. Some residents had shared their stories and featured in a training video created by the home to help staff understand about dementia by relating theory to the lived experience of the people they were working with rather than more formal training.

A CQC 3 star rated purpose **built care home with nursing in the West Midlands** designed with input from people using the service and relatives – Four units of 20 en suite bedrooms) including 5 'virtual beds' commissioned by a GP consortium; specialist care for people with dementia, nursing and end of life care; day centre for people living with dementia about to open. The managing director talked about her passion for excellence and her pride in having been awarded beacon status for the gold standard for end of life care was evident. Staff, residents and relatives and other visitors, such as the regular GP, were pleased to talk about the home.

A CQC expert by experience, with life experience as a carer who has visited many care homes as part of key inspection activity joined us for this visit. In her report she said that she found this *a "pleasant and inspiring visit".* The following were some of her comments:

- *'I heard that residents are asked their opinions on aspects of the home and that their choices are respected*
- *'The interactions I observed between staff and individual residents were friendly and relaxed- they appeared to know residents' preferences well and to be caring rather than controlling.*
- *'B (a relative who visited his wife daily) said "the attitude of staff is excellent; the meals are excellent; the care and the way patients are treated are excellent. I couldn't have wished for a better place for my wife"*
- *'The home has a positive and energetic feel, and consistency of purpose, fostered by strong leadership and ethos. From what I could observe the relationship between staff and the manager appeared good. There is also an apparent willingness to listen and continually implement improvements to the service provided and to strive for transparency was refreshing.'*

Stories and practice examples:

- Mr A – Originally from Italy; suffered a stroke and verbal communication is limited. The home arranges for him to communicate with family by internet using Skype so that he can see his relatives and they can talk to him.
- Mr B – living with dementia, moved from another care home which was having difficulty managing his challenging behaviour. Person-centred planning and engagement with his son revealed that he had once been a keen gardener. He was introduced to the courtyard garden which, with support, he designs and manages. With the oversight of the visiting GP, his need for anti-psychotic drugs has reduced. Mr B proudly showed off the pots he had sowed, the sticks he put in for new seedlings to grow and the pond where ducks come to feed.
- Following a series of severe strokes, Mrs C was virtually bed bound and required constant nursing care. Family and staff had covered the walls of her room with drawings and photos which were frequently updated. As the manager knocked, entered her room and greeted her she smiled and lifted her arm to squeeze the manager's hand and stroke her face.

A CQC 3 Star rated **care home in North East London area provided by a South London/ Kent based voluntary sector provider**. The home is located in two connected purpose built bungalows in a housing development for 10 men with complex physical disabilities and learning disabilities. Person-centred active support *('**just enough** support to people to take part in all everyday tasks')* is intrinsic to the ethos and all ways of work in the service. The Chief Executive talked about the organisations overall approach and commitment to quality across over 40 regulated services. His Deputy then spent time talking about the challenges of embedding and continuously assuring quality in practice, introducing us to the manager, staff and residents in their bungalow.

Stories and practice examples:

- Support plans are living documents developed and owned by users – 'my plan' posters with photos and other images on bedroom wall. Strong engagement with the local community and other organisations with a range of activities – within the home as well as externally.
- Observational tools are used to assess progress and evidence of engagement as well as reduction in challenging behaviour. Person centred active support means there is always an opportunity to involve residents even in relatively small practical daily tasks – e.g. cleaning razors, peeling potatoes, posting a letter. This is reinforced through induction, training, supervision, team meetings and, generally, through reflective practice.
- One resident shared his 'my plan'. He had been helping to prepare dinner when we arrived but stopped to talk about his enjoyment about playing football recently and his aspirations to get up from his wheelchair and walk. He was excited about going on holiday and kept stopping the conversation – via signing – to check that arrangements were on track.

A CQC 3 star rated registered **domiciliary care service located as part of extra care housing complex in SE London** which also has a purpose-built day centre. The Manager showed us around, describing the customer service focus of the service, challenges and opportunities – including continuous learning and development of her and her staff. The emphasis is placed on promoting independence and staff are not expected to enter flats without permission of tenants. To reinforce this for staff and service users the Manager describes the corridors as 'a street with a roof'.

Stories and practice examples

- Tenants chair and run their own monthly meetings and activities – with support and a separate suggestion box to ensure that loudest voices do not always dominate. They are also able to access other services provided through the day service such as independent living home skills which the service has initiated for day centre users;
- The Manager was keen to continually promote good relations with commissioners and regulator. She is also exploring ways of offering support to local community to maximise the benefit of the resource;
- Mr J – invited us into his flat and talked with enthusiasm about the support he receives to help him be in control of his life. He pointed out, for example, that he likes to hang his shirts around the bedroom to help him choose which one to wear, rather than putting them away. The manager remained outside but later commented that support for people's independence needed to be constantly reinforced and it was sometimes difficult for staff to resist 'tidying-up' for tenants rather than supporting them to arrange their space the way they want to.

Council in the Eastern Region – judged in a recent CQC service inspection to be performing excellently in safeguarding adults and in supporting the improved quality of life of older people with excellent capacity to improve - is working with care providers and through commissioning and procurement to create an environment to encourage quality improvement in care.

Stories and practice examples

- Council-wide commitment to respecting dignity for all people at the heart of all areas of service, integral to customer service approach; initiated by the Chief Executive with sign-up by Members. Integral to contracts and awards and recognition for success.
- Event for 100 care home managers, drawing upon My Home Life approach and expertise to improve quality of life. Key partners are City University, Joseph Rowntree Foundation and Age UK. Leadership support, contributing to research, inclusion and outreach.
- The council had enabled and were supporting establishment and running of a county-wide relatives and residents association, providing independent advice and support on all aspects of life in residential care for older people.
- A tender exercise for domiciliary care, described as a 'journey' towards outcomes-based support , took account of a service user survey, CQC quality ratings and key standards such as recruitment and training – assuring a balance of quality and cost.

Discussions and online dialogue

We received responses in writing or by email from a number of individuals. To address our concerns that we may not have sufficient input from people using services, carers and friends, we set up a discussion forum on the Carers UK website and a short survey on the websites of Shaping our Lives and National Centre for Independent Living. We also promoted the events and invited service users and carers to contact us via the SCIE website and through our contact database

In addition, CQC posted an invitation to comment on its provider reference group forum. They also invited CQC staff to comment. These generated over 50 submissions.

Feedback from carers, setting out their stories and those of the people they support, provided us with some rich information. Some shared poor experience of care and of services working in isolation and not joining up to support them. One family carer said that she thought that regulation should focus on 'encouraging excellent outcomes as defined by the client and carer, not on controlling inputs or prescribing processes'. A more positive example is described below; we have removed any personal details.

Stories and practice example

".... to my mind, excellence is about pure PERSONALISATION in ANY service and it doesn't have to always cost more..... Quality needs creative, laterally thought out, enthusiastic support from people who believe life is for living not just existing. Many of [my son's] PA's have no institutional background and therefore see him as just a 25 yr old guy wanting to do much the same things his peers do. They have learnt the other things about him along the way with our support. The many individuals we meet from care homes could have far more enlightened life experiences if this attitude was adopted.....

"Society needs to be constantly reminded that we all have the right to live with defined quality -- and if this is only being able to go to bed when you want and sit outside watching the planes fly over with a cappuccino you have made with candles and incense sticks you have lit with a gas gun at 1am in the morning--- then like [my son] this quality provides excellence and it all comes from true PERSONALISATION."

Emerging issues – what people told us

The environment for excellence

Stakeholders raised a wide range of issues in the course of discussions on how to define excellence. Some of these issues go beyond the actual definition, but are nonetheless relevant to the wider debate on how to assess and recognise excellence in adult social care. A brief summary is given below.

Providers

- Providers want to see more outcomes-based commissioning, which allows sufficient scope for trust and flexibility and move away from 'time and task'.
- They want to be able to engage proactively with commissioners – especially health partners – to develop intermediate care.
- They are frustrated with compliance monitoring by different organisations – specifically the regulator, local authorities and PCTs – who each require different pieces of information. They would like all these organisations to share information with each other, to reduce the burden on providers.
- Some noted that quality assurance is the responsibility of, and needs to be owned by, the provider.
- They also noted the changing environment for care with expectations to account for and report on quality improvement to health as well as social care commissioners; with this in mind, a few asked whether the quality system would apply to the NHS and to integrated services.
- They are concerned about the cost implications of applying to CQC for 'excellent' status.
- Above all, providers are keen to emphasise the relationship between cost and quality, particularly in a challenging economic climate. They thought that is difficult for providers to offer an excellent service without more money. They also recognise that councils and self-funders will want to be certain that they are getting value for money.

Commissioners

- Commissioners want excellence to cover productivity. They expect providers to be creative and innovative in delivering the best possible care within available resources.
- They expect to see robust and transparent quality assurance.
- They want to see a move away from dependency and towards reablement and rehabilitation. Independence should be a measurable outcome.
- Some said that more outcome focused commissioning would help this but thought it would still take time to transform the culture of how the purchaser/ provider relationships worked to achieve better outcomes. They agreed that commissioners could provide the conditions both to promote and to inhibit excellence.

People who use services

- Many service users expressed the view that the draft definition of excellence they were shown, particularly the section on 'choice and control', was what they should be able to expect of *all* services.
- They made the point that it is impossible to determine whether a service genuinely is excellent without going to see it. Many service users were emphatic that CQC should inspect all regulated care service on a regular, frequent basis.

Engagement and consultation feedback on possible sources of evidence of excellence

While the core remit for CQC's commission with SCIE was to draw up a definition of excellence in regulated adult care services, the issue of how excellence could be demonstrated when applying for the 'excellent' rating came up repeatedly in our consultation and engagement activities. The key messages are set out here.

Asking people who use services, their carers, and staff

There was, in all the engagement activities, unanimous support for the need to garner the views of people who use services, and their carers, families and friends, when judging whether a service is excellent. As a notion, it seems entirely uncontroversial; indeed, given the definition's focus on outcomes for people using services, not asking those people about their experiences would be peculiar.

Many people, however, made the point that seeking the views of people using services can be extremely difficult, especially where people have severe cognitive impairments. In some cases, the views of proxies – which should include, but not be limited to, family members - may need to be sought. It was also pointed out that some people will never be happy to be in residential care, and this will be reflected in their views of the service. There are also services, such as drug rehabilitation hostels, where people may be quite appropriately denied certain freedoms, and this would need considering when seeking people's views of the support they receive.

A lot of support was also found for surveying the views of staff. Many people stressed the need to ensure that everyone expressing a view on a service, be they a user, carer, or staff member, was comfortable that doing so would not lead to any unwanted impact if their comments were negative.

Visiting the service

The method of measuring excellence that was brought up most often was the need for someone independent of that service to visit it, and judge whether it is excellent. Many aspects of the definition, people felt, such as the warmth expressed to service users by staff, could only be captured by observation. People were fairly evenly split on whether using mystery shoppers was a good idea. There was greater consensus on experts by experience being part of the group visiting a service, with the idea supported by members of all of the stakeholder groups.

Submissions of evidence

There was general agreement that a service should submit evidence to whichever body would judge excellence. While people differed on the specifics of what could be included in such a submission, there was a lot of backing for the idea that a range of evidence ought to be admissible, and there should be flexibility for what was submitted, depending on the nature of the service. Suggestions for what could be offered included:

- existing quality awards, tools and benchmarks;
- testimony of users and carers – written, or multi-media;
- service policies, procedures, job descriptions and so forth;
- activity records, care plans;
- CQC and local authority compliance documentation;
- feedback from health professionals, Patient Advice and Liaison Services, and Local Involvement Networks/ Healthwatch
- feedback from local authority staff and councillors

Several people spoke in favour of the submission having a narrative or contextual element to it, rather than being only a suite of documents. Others mentioned the need for the different sources of evidence to be triangulated against each other.

Other points

A small number of providers were opposed to the idea of a separate assessment for excellence, and felt it should be included in the main CQC information system. Some suggestions that were made by one or two people included:

- different weighting for the different elements
- an award of excellence being given for certain aspects of the definition, much like councils are awarded Beacon status for specific elements of their work
- a panel judging the submissions, to include users and carers
- the award being given or the provider/ commissioner relationship

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Age UK
African Family Services
Alzheimer's Society and Lewy Bodies Society
Anchorage Care Group
ARC
Audley
Barnsley MBC/ NHS Barnsley
Bluebird Care (Wellingborough)
Bracknell Forest Borough Council
Brandon Trust
Bristol City Council
Bristol Learning Disability Partnership Board
Brunel care
Camden and Islington NHS Foundation Trust
Care South
Choices and Rights Disability Coalition
Clarendon Home Care
Concept Care Practice
Cornwall Care Ltd
Crossroads Care North Notts
DH Homecare Ltd
Dimensions (UK) Ltd.
Direct Health
Dorset County Council
Durham County Council
Ealing London Borough Council
Eclipse Home Care
Essex County Council
Gloucestershire County Council
Guinness Care and Support
Hampshire Association of Older People's Forums
Hapuk Ltd

Harrogate District Group, North Yorks LINK
Health is Wealth
Heath Lodge Care Services Ltd.
HICA Group
Home Instead Senior Care
Housing 21
Jewish Care
Joseph Rowntree Housing Trust
Lambeth Mind
Leeds City Council
Leonard Cheshire Disability
London Borough of Richmond on Thames
Medway Council
Mencap
Merseycare
National Care Association
National Care Forum
National Centre for Independent Living
Neurodiversity International
Northamptonshire County Council
National Voices
Nestor Healthcare Plc
NHS Warwickshire
Oxfordshire LINK/ Oxfordshire County Council
Paradise Independent Living Ltd
Ranstad Care
Registered Care Providers Association
Registered Nursing Home Association
Rica Solutions Ltd
Safe Care
St. Monica Trust
Sante Refugee Mental Health Access Project
Scope
SeeAbility
Selva Sound
Senior Council for Devon
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Signature Senior Lifestyle Ltd
Solihull Care Trust
Somerset Care Group
Somerset Older Citizens Alliance
SPDNS Nurse Care
Staffordshire County Council
Tenants and Residents Association (Bristol)
The Seniors
TLC Private Home Care Services
United Kingdom Home Care Association

Voluntary Organisations Disability Group
Walsingham
Wandsworth Older People's Forum
Westminster City Council
Westminster Society
West Somerset Seniors Forum
Wolverhampton City Council
Woodford Home Care and Support Services
Worcester Garden Ltd

Representatives from organisations and other individuals with whom we had discussions or who sent us contributions to help shape and test our thinking including:

Carers and people using services who posted on online forums or sent in e-mails as they couldn't attend events.
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Ann Macfarlane
Association for Real Change – James Churchill and Mark Gray
Avenues Trust – Steve James
David Finney
eATA
English Community Care Association – Martin Green and Ann McKay
Carers UK – Emily Hozhausen
CMG – Peter Kinsey,
Counsel and Care – Caroline Bernard
Dimensions UK – John Clarke
Essex County Council – Jenny Owen
Grove (Barchester Healthcare and Castlebar) – Stephanie Palmerone
Housing 21 – Les Clarke
LB Greenwich - Luke Addams
My Home Life/ City University – Tom Owen
National Advisory Group on Learning Disability and Ethnicity and its network
National Centre for Independent Living – Sue Bott
NHS Confederation – Frances Blunden and Jane Austin
National Care Association – Sheila Scott and members plus members at a regional NCA seminar in Brighton
National Care Forum – Sharon Blackburn and Des Kelly
RCC Limited - Rosemary Hurtley
Residential Nursing Homes association – Frank Ursell and Ian Turner
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Jenny Owen	Essex County Council

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