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Ideas that change health and care

Building capacity and capability for improvement in adult social care

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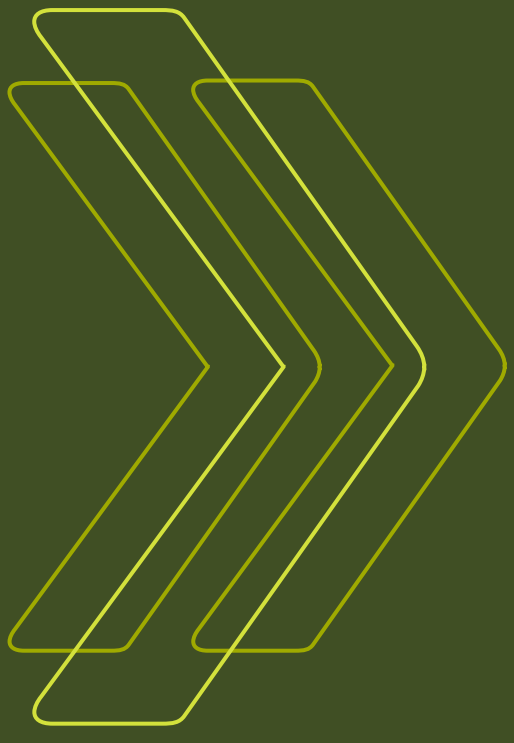

About this report

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1 Introduction

If the aim of adult social care is to make sure that we all receive the help (such as personal care or practical assistance) we need – whether due to age, illness or disability (Think Local Act Personal 2022a) – to live our lives as comfortably and independently as possible, then few would question that we need to do more to improve it. Local authorities spend £23 billion a year commissioning adult social care services and huge effort is put into trying to improve the quality of adult social care both locally and nationally. This improvement activity primarily aims to enhance the quality of life of those who draw on social care, but it can also focus on improving the experience of the workforce or putting the finances on a more sustainable footing.

In this discussion paper, we look at how local authorities in England make improvements in the quality of adult social care. This discussion is timely because the government has set out its intention to increase funding for improvement activities to support the reforms of adult social care. There are also plans to introduce a new Care Quality Commission (CQC) assurance framework to assess local authority performance in delivering all of their adult social care functions (Department of Health and Social Care 2021). We think this provides an opportunity to think afresh about how best to improve adult social care, alongside new independent regulatory assurance.

Importantly, we recognise that most care is not delivered by local authorities but by independent providers, families, friends and the community. More work is undoubtedly needed on how everyone can collectively improve the quality of care. However, our focus here is on how local authorities go about improving adult social care (although this can include working with people who rely on social care, their families, providers, community groups, as well as politicians and NHS partners).

This discussion paper draws on research we carried out between September 2021 and June 2022, commissioned by the Department of Health and Social Care. This work provides insights into how local authorities go about making

improvements, how they measure success, and what type of support they use to make improvements. We approached five local authorities in England. In each area we interviewed stakeholders involved in improving adult social care, including those working in local authorities and the NHS, as well as those involved in care provider associations and user groups. We also interviewed consultancies that provide improvement support to local authorities (*see* appendix for details on our methods).

Throughout these interviews and the analysis that has informed this discussion paper, we have adopted a quality improvement lens. The term 'quality improvement', as used in this report (*see* full discussion in section 2), relates to a systematic approach to make things better, rooted in the discipline of improvement science, and which is used widely in the public and private sectors.

First, we used this quality improvement lens in our interviews as a way of navigating the varied approaches taken by local authorities to improvement work. Indeed, we found, throughout this research, that improvement in adult social care is an activity that is steeped in obscurity. We found that those carrying out improvement work in local authorities do not agree on some fundamental issues such as what good adult social care should look like or how you might attain it. Therefore, we use a quality improvement lens, and its associated stages of improvement, as a way of better teasing out and understanding these journeys.

Second, we have used a quality improvement lens in our analysis and interpretation as a way of prompting and provoking discussion about the future of improvement in adult social care. Importantly, it is not our intention to prescribe or seek to transplant an approach for improvement that is found in health care. Nor did we enter this research expecting to hear the language of quality improvement; we knew it was not a familiar or widely used concept in adult social care. However, the promise of improvement science is that consistent, systematic and evaluated approaches to improvement can more reliably lead to improved outcomes. Using a quality improvement lens, therefore, is a way to identify which aspects of this quality improvement approach are already being used by adult social care teams in local authorities, and to pose a series of questions about how such an approach could be further developed.

In the following sections, we look at how adult social care teams in a small number of local authorities approach improvement, and review the challenges they could face in trying to adopt a quality improvement approach. We explore the type of support they draw on, and conclude by posing a series of questions to prompt discussion about how adult social care, as a sector, can be supported to achieve more in terms of quality improvement.

We have structured our findings around four key questions:

- Why use a quality improvement lens to explore improvement in adult social care?
- How do adult social care teams make improvements, and who helps them do this?
- What hampers adult social care from adopting a continuous quality improvement approach?
- What does the future look like for improvement in adult social care?

This work is not an evaluation. Nor is it a comprehensive look at how adult social care teams attempt to make improvements across the range of their responsibilities (including the provision of information, assessment, meeting the needs of those eligible for services, and the promotion of wellbeing and safeguarding), or across the diversity of needs people have. Instead, it offers insights into the challenges of improving adult social care at a time of great flux and financial challenge. Our work focuses on how improvements are made, rather than what improvements are made.

We hope people will read this discussion paper in the spirit of quality improvement and approach the issues with curiosity and an openness about how to continue working to improve the quality of adult social care.

Before looking in detail at what we learnt from the research, we first consider some definitions and our interpretations of the phrase 'improvement support for adult social care'. It is a term that is used widely, but often with little clarity or transparency about what is involved.

2 Defining terms of improvement

Adult social care is delivered through complex arrangements, which means that the routes to improvement are multiple and varied. This complexity is further confounded by the lack of clarity used to describe both quality improvement and the support on offer to help adult social care teams to improve. We share our interpretations – how we have chosen to define the terms associated with quality improvement in adult social care. We start with a description of the different types of support that adult social care teams draw on to make improvements.

Support available to improve the quality of adult social care

For the purposes of this report, we use a broad definition of 'improvement support'. We were interested in what local authorities are already doing and using, and what they would value being able to use in future, to help them do a highly skilled, complex task – to improve the quality of life of those who draw on adult social care.

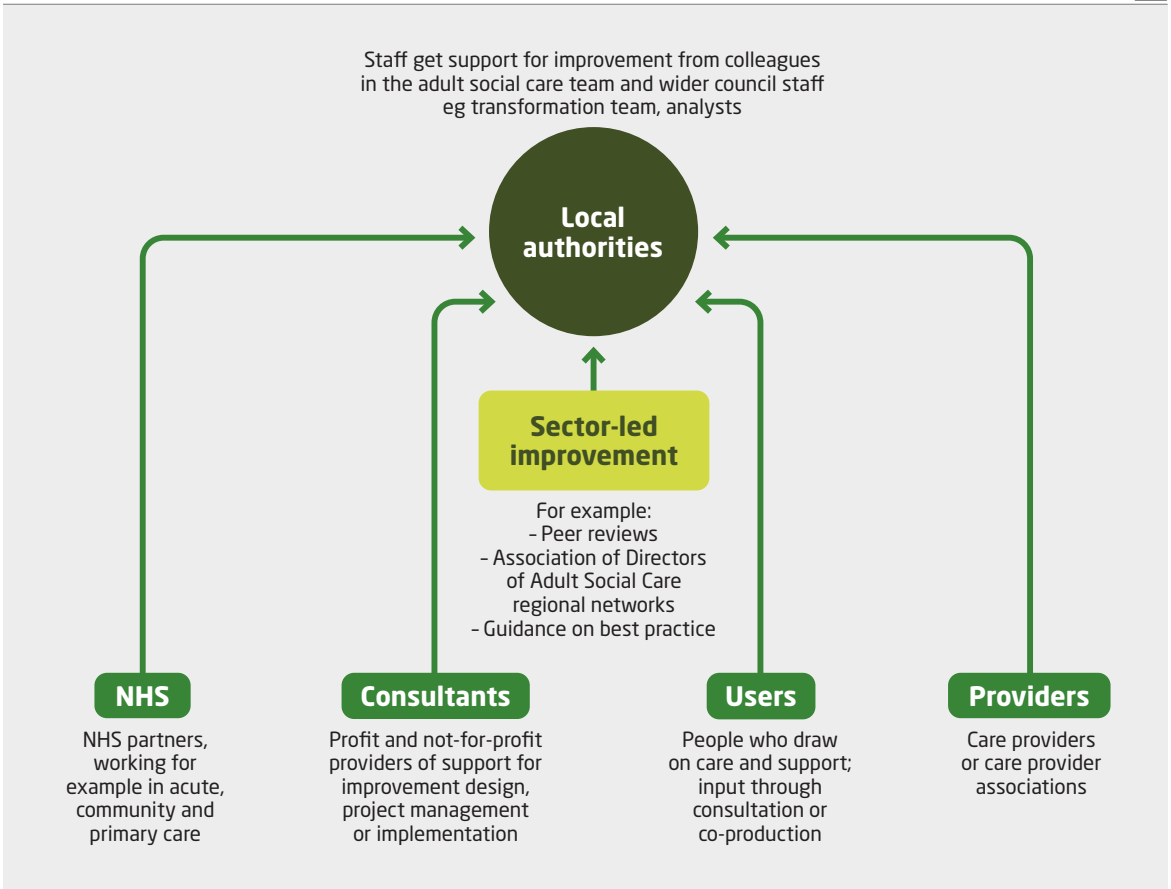
There are different ways to categorise the range of support on offer – for example, free versus paid for or local versus regional. Alternatively, improvement support can be defined by method (for example, peer review, benchmarking, self-evaluation, or coaching) or thematically (for example, the use of resources, carers' support, safeguarding or commissioning).

Most of the people we interviewed who work in local authority adult social care teams said that they receive most of their support from their immediate colleagues and others working in the council (eg, business support or transformation teams). And given the range of functions that fall under adult social care activities, alongside the diversity of people's needs, and our decision to let interviewees choose which improvement activity to tell us about, we found it most helpful to think about improvement support in terms of internal versus external support rather than by client or service need.

Types of improvement support

We have outlined the types of support local authorities draw on for their improvement work in Figure 1.

Figure 1 Types of improvement support



Sector-led improvement

What is sector-led improvement?

Sector-led improvement is an approach to support councils to continuously improve. It is premised on a culture of collaboration, sharing learning, peer challenge and review, and underpinned by a set of principles:

- Local authorities are responsible for their own performance.
- Local authorities are accountable locally, not nationally.
- There is a sense of collective responsibility for the performance of the sector as a whole (Local Government Association 2020).

Local government has a long history of using peer support and peer review, but sector-led improvement was formally established over a decade ago, alongside the abolition of national support for improvement, which had included independent regulation of local authorities and national improvement and efficiency resources and programmes. As part of the localism agenda, sector-led improvement was positioned as a way to reduce the burden of bureaucracy and ensure that councils were accountable to their local residents for their own performance and improvement, and not to central government or inspectorates.

Sector-led improvement is currently used in a number of ways, including supporting councils across corporate-wide and service-specific functions, such as adult social care, children's services and housing.

Adult social care has its own dedicated sector-led improvement programme: the care and health improvement programme (CHIP). It is largely funded by the Department of Health and Social Care, and jointly led and delivered by the Local Government Association (LGA) and the Association of Directors of Adult Social Services (ADASS). It provides materials and hands-on support to local authorities and their partners. Peer collaboration is facilitated regionally through nine regional ADASS networks. Additional elements are delivered by other partners, including Think Local Act Personal (TLAP), the Social Care Institute for Excellence and the Care Provider Alliance. Local authorities can access this support at no financial cost. That said, large parts of the programme are dependent on local authorities being willing to participate to support their neighbours and share their expertise and experience. Some local authorities supplement the national/regional offer by contributing to a collective fund for improvement in their region.

Sector-led improvement has been found to be highly valued by leaders across local government and adopted widely (*see* Shared Intelligence 2020), and recent studies have highlighted the value of peer reviews specifically for improving adult social care (Miller *et al* 2021).

We assumed, somewhat naively, that everyone working to improve adult social care would have a good understanding of what sector-led improvement was. Instead, we found people struggling to articulate its different components – or even being sure if the support they were benefiting from was part of the sector-led improvement programme (*see* box). One director of adult social services reflected that sector-led improvement is 'a bit like blancmange' – an image that chimed with our findings that people can struggle to pin it down or be able to name it.

To be clear though, the fact that sector-led improvement seems to have low visibility, low coherence or low brand recognition does not mean that people are not using this support or valuing it. We found senior leaders in each of the sites accessing significant support from the sector-led improvement programme. They used its networks, collaborated with their neighbours, and were involved in peer reviews. They just did not always identify this formal and informal support as sector-led improvement.

Consultancy support

Local authorities may also choose to purchase support from profit or not-for-profit consultancies. This support can range from large multi-million pound transformation programmes to smaller pieces of bespoke work around commissioning or co-production, for example.

Other sources of improvement support

Improvement is a corporate-wide activity across a council, and local authorities choose to approach this differently. Adult social care, as one directorate within the council, can therefore benefit from wider improvement strategies as well as the support of internal transformation teams or business intelligence/analytical support. Beyond the boundaries of local authorities, adult social care teams also work closely with NHS partners, and this working relationship often creates opportunities to collaborate and share improvement expertise.

We note that care provider associations and user groups are also a potential source of improvement support, but they were not always positioned as such.

A quality improvement lens

We began from a position that if you want to understand what local authorities do to improve social care, then the disciplines of improvement science and quality improvement are a good place to start. Continuous quality improvement is an approach that has been adopted widely by both the public and private sectors – in fields as diverse as car manufacturing (Sturdevant 2014), retail (Onetto 2014), health care (Institute of Healthcare Improvement 2022) and education (Dixon and Palmer 2020). The reason for its popularity and broad applicability is that it provides a systematic way of solving a problem and embedding improvements in complex systems. The approach uses common principles and a broad range of tools and methods. We thought that given its principles and shared approaches, it made sense to use a quality improvement lens to explore how improvements were being made in adult social care.

The Health Foundation provides a helpful definition:

> *Quality improvement is about giving the people closest to issues affecting care quality the time, permission, skills and resources they need to solve them. It involves a systematic and coordinated approach to solving a problem using specific methods and tools with the aim of bringing about a measurable improvement.*
>
> The Health Foundation 2021

What is a quality improvement approach?

Although we talk about a quality improvement approach, it is not a single or unified thing. Quality improvement is applied differently in different sectors, and it encompasses a range of tools and methods. However, the approach is defined by a set of shared underlying principles based around designing, testing and implementing changes and using real-time data to measure improvements. It is an approach where you can find evidence of:

- being able to define and agree what quality means
- clear theories of change
- using data to measure improvement, rather than for accountability
- the participation of people who use or benefit from the service or product
- the participation of staff who deliver the service or product
- continual efforts to improve and efforts to sustain and embed successful improvements.

Fundamentally, there are three key questions to address if you want to put in place continuous quality improvement: What are we trying to achieve? How will we know if a change is an improvement? What changes can we make that will result in an improvement?

We note that much of the literature on quality improvement, and its tools and methods, focuses on health care. This provides a useful resource, and indeed there are many parallels to be made between quality improvement in health care and in adult social care. Importantly, however, we started with an assumption that adult social care should not be expected to adopt the way quality improvement is implemented in the NHS. Instead, we were interested in the extent to which local authorities are already using – consciously or unconsciously – the principles and methods of quality improvement to focus on the needs of people who use adult social care, and in ways that reflect its culture, workforce and systems.

In the following two sections, we explore how – if at all – local authorities adopt a quality improvement approach to improve adult social care. In section 3, we look at the degree to which adult social care teams describe a typical improvement journey – an idealised series of steps to help implement a quality improvement approach, which starts with understanding the problem, and then moves to developing solutions, testing them, measuring the impact, and embedding improvements. Then, in section 4, we review how local authorities might be creating the conditions that support a quality improvement approach and building the culture, capability and infrastructure in which everyone can tackle problems effectively. Running through both these sections, we also review how different types of improvement support can promote a model of continuous quality improvement.

3 Do local authorities use quality improvement methods?

Describing improvement as a journey is a well-used analogy for doing quality improvement – a process that is full of ups and downs and wrong turns. It is also a journey that never ends. Continuous quality improvement is, by definition, ongoing, and it can be more helpful to think of the steps involved as cyclical rather than linear. However, to tease out how local authorities go about making improvements in adult social care, we asked them to break down their actions into four, broad, repeatable stages.

1. Prioritising areas for improvement.
2. Exploring and understanding these areas for improvement.
3. Implementing change – testing and embedding solutions.
4. Demonstrating (measuring) impact.

What emerged from our conversations was not straightforward. Across our interviews, the language of these four stages began to feel like an artificial structure that we were imposing on our participants' descriptions of their improvement activity. Instead of this structure, what we saw was a much more fluid approach that often blurred the lines between these stages.

This disconnect between our quality improvement framing and the way that participants described their improvement activity continued further when we dived down into specific activities within each stage. Again, we found a high level of inconsistency between the five sites in the approaches that they adopted, and a large gap between the type of approaches we might expect. For example, small tests of change or pilots were largely missing from our discussions with local authorities. This does not mean that this type of activity is not taking place; indeed, interviewees described numerous examples of improvement. Yet the absence of the common language of improvement approaches, which is prevalent in other sectors, is in itself striking.

Finally, as well as this blurring between the different stages of improvement, we also observed a blurring between discrete improvement projects and more 'business-as-usual' performance monitoring. Indeed, many of the techniques and approaches that were highlighted and discussed as part of our interviews were primarily used for performance monitoring and accountability, not improvement. For example, existing methods for gathering data for performance monitoring were being used both to help identify areas for improvement and to demonstrate whether there had been an improvement.

This tension between our quality improvement framing and what we saw is in itself revealing, particularly when one contrasts it to what we heard from our interviews with those who worked in the NHS and those who work for consultancy firms supporting local authorities with quality improvement. Consultants were more fluent in talking about the various stages and described some of the approaches that we might have expected to see. Of course, one would expect them to be able to articulate well the services they are selling to local authorities. This suggests that while a quality improvement approach may not be used consistently by local authorities, it is one that many value and choose to purchase.

With this in mind, we have continued to use the framing of these four stages to help describe the different methods, approaches and support that local authorities are using in their improvement activity. While this is not the language that local authorities use, it helps to isolate areas of greater strength or weakness in the current approaches being deployed by adult social care teams.

Prioritising areas for improvement

Of all four stages of the improvement journey we explored, this first stage was the clearest and easiest to identify, with directors of adult social services describing their process in detail. This included both descriptions of the various data sources as well as the methods used to prioritise.

We found that there are huge efforts going into collecting data from numerous sources to help inform decisions about where to focus improvement activities. Adult social care data is often imperfect, and one director explained that they collect 'anything they can get their hands on'. Activity data, performance data, outcome data from surveys, human resources (HR) data and finance data was all used alongside national policies, reports from practice reviews and consultations with care

providers, health partners or people who use care services. Data and dashboards on performance measures were among the most commonly used inputs, with directors of adult social services describing systematic and regular reviews of this data.

This phase also exhibited some of the clearest uses of the sector-led improvement support offer. Peer reviews and benchmarking were commonly identified as routes for adult social care teams to identify areas for improvement. Similarly, the self-assessment process formed a key part of some of the approaches by directors to scrutinising their data and developing strategies and delivery plans. Finally, participation in regional networks and offering informal support to other directors helped in identifying key areas to address.

All the sites valued the support provided by working at a regional level. The process of regional review, which involved a self-assessment followed by both peer and external challenge, gave directors of adult social services important insights into which areas needed improving. This comparison and self-audit was well-embedded in each region and attracted high levels of commitment from the directors we interviewed. However, some spoke of bringing across different approaches from regions they had worked in previously, which they thought were better. This again highlights the strong regional differences that seem to exist in terms of sector-led improvement.

Despite the fluency with which local authorities described this stage of the improvement journey, we were struck by the lack of consistency in the approaches and language used to describe how they prioritised areas for improvement. Each site described a different set of data sources that fed into this decision-making process and a different approach. Some had developed their own bespoke dashboards, which they reviewed regularly with their development teams; others emphasised the importance of external consultation and co-production. What was clear is that there is no set way of approaching this prioritisation activity; this stage of the journey is heavily driven by the individual approach of the director of adult social services, as one director explained:

> *So we look at [a] cut of headline information every week, particularly, we call it the winter pressure information but in fact, we have it all year round, which is stuff like number of referrals, caseload sizes, that kind of stuff, hospital delays. But every month in the leadership team… so I chair a meeting every week with the Director*

> *of Public Health and the three ADs [assistant directors] for adult and social care and the other members of our leadership team, and once a month our performance leads come and take us through the numbers, but actually what the journey is telling us. So how's it changing over time? And we also, from that, commission any deep dives we need to do if we've got areas of concern. So for instance, we had two teams where we had caseload sizes, which were at various significant variation from the standard we set. And we've done some deep dive work in there and looking at what are some of the possible solutions to helping them improve their situation.*
> Director of Adult Social Services

Directors of adult social services and their teams were able to flex their improvement activity to better match – or align – the overarching strategic direction of the local authority or adapt to take up opportunities to work with local health partners. However, we also heard a desire from several interviewees for greater national direction on what they should be aiming for, what the priorities are, what data, and what kind of approaches would help them get there.

As well as this lack of consistency in language and methods, we also observed that much of the activity in this stage was described as part of more 'business-as-usual' performance monitoring processes. While in practice we would expect many of the data sources to be the same for these two different activities, the strong link between performance monitoring and prioritising areas for improvement appeared, in many cases, to result in improvement activity that was largely reactive. Indeed, many of the areas described as the subject of improvement activity were either a reaction to a poor performance indicator, a gap in a certain policy or protocol, or a response to a new national policy initiative. While all these areas are part of quality improvement, we saw little room in this fairly reactive approach for more proactive continuous improvement cycles.

Exploring and understanding areas for improvement

Once potential areas for improvement have been identified, this second stage aims to help adult social care teams identify, with confidence, the root of the problem and potential solutions. This stage can also involve an aspect of validation, where local authorities interrogate the data and assess the degree to which the problem is one of data – due to the frequency, reliability or validity of the data – or an actual challenge in the system that needs to be tackled.

This stage was often referred to as a 'deep dive'. We found it hard to discern distinct methods or approaches. Again, we have used our own interpretations to label activity under this stage. For example, below is a description of how one local authority approached this stage with a design to improve reablement services (which help people regain or maintain their skills and confidence after being ill or being in hospital), which just hints at the detailed work that must have been involved:

> *So, we've done some improvement work to understand what was behind that and understand how we're supporting people, understand how our services might be reabling or create independence, and use that to work in some improvement programme around how we develop providers, how we assess people in a way that maximises independence, and then how we review that, and to get people back home and back living independently wherever possible.*
>
> Director of Adult Social Services

Seemingly, a significant amount of this exploration and understanding occurs at the regional level. While rarely mentioned in our conversations, we can see online from the regional ADASS websites that local authority staff are actively involved in the regional networks supported through the sector-led improvement programme. These networks provide a forum where staff can explore topics in depth and share good practice. This includes work undertaken by the principal social worker networks, which we discuss in the next section.

What emerges through these descriptions is a great deal of activity around exploring and understanding what the problems are, but few consistent methods or underlying principles of what 'good' looks like, and where sector-led improvement support, if present, is not visible, applied consistently or recognised.

Unsurprisingly, most of the consultancies have a very clear narrative about the methods they use for this – and other – stages.

> *Our four-stage journey is the change journey we take people on, which is around reframing our problem space, so you're clear on what is it, what is the challenge you're trying to solve, getting confidence in delivery, which is often by small-scale delivery and doing some behavioural change on the ground. And then scaling up to show that that's… that can work across a whole piece. And then sustainability. So, it's ongoing, sustainable, we're not just delivering piecemeal change.*
>
> Consultant

Implementing change

Using our quality improvement lens, there were several steps of the implementing change stage that we wanted to explore in our interviews.

First, using information from the prior exploratory stage, we would have expected to see adult social care teams identify and develop some form of solution – whether that be a new strategy, policy, practice or tool. Ideally, this solution would come with an accompanying theory of change and a plan for how to measure the impact of the change.

Next, we would have looked for examples of clear small tests of change or pilots – again, ideally with a clear feedback loop between these pilots and iterations to the planned change.

Finally, we would have expected to see work to fully embed the change in such a way as to ensure that it had its intended impact and was sustainable.

While we did not hear this exact (and fairly idealised) process, we did hear something approximating this method from the health partners we interviewed who were working alongside the local authority. These participants focused on the principles of 'plan, do, study, act' (PDSA) cycles, and starting small and scaling up as you gathered more data. Similarly, the consultants we interviewed also talked fluently about their approach and methods to testing cycles and embedding change.

The same, however, was largely not true in our interviews with those in local authorities, and when we did see it, it was found most frequently in projects such as those delivered in conjunction with NHS partners – for example, improving outcomes for people in nursing homes. As with other stages, what we heard was a great deal more blurring between various steps and very few methods being mentioned consistently.

Furthermore, what we observed was a greater emphasis on the first of these three steps – developing new solutions. For many of those interviewed, this step blended seamlessly with the previous, exploratory stage, and the methods used for each were similar. Indeed, here again was an area in which the sector-led improvement support offer was more prominent, with adult social care teams using the peer reviews and regional networks to support their own internal efforts to identify best practice and to design solutions.

However, we heard comparatively little about the work to either test or embed these changes. We do not believe that this is because a lot of this work is not being done. We can see, for example, from case studies of improvement in local authorities across England published online, that methods are being used (such as development sprints, content workshops, usability testing, and prototyping) (Local Government Association 2021). However, the lack of consistent language and of shared, formalised approaches mentioned across the sites suggests that the quality improvement principles are not being as thoroughly embedded in local authorities as they are in other sectors or by consultancies.

> *So in a sense it's part of our jobs. Haven't we all got a duty to listen to soft and hard data and intelligence, try and make sense of it? Try and triangulate it with other people, both in our own organisations and beyond, and then think what on earth are we going to do about it? And then do something about it and then see its impact. I suppose it's a PDSA cycle in a way, isn't it? That should be at the core of what we do.*
>
> Director of Adult Social Services

Demonstrating impact

Measurement is at the heart of continuous quality improvement. Regular monitoring of data tells you if you are on track and delivering high-quality care consistently, or whether additional changes are needed. However, several local authority leaders commented that they faced significant challenges in measuring the outcomes of improvement activities, for several reasons, including pressure to move on to the next improvement project and a lack of data in terms of both quality and content. There is a paucity of data on care quality and care outcomes, or data that is available in a way that provides insights into people's experiences of adult social care. Interviewees recognised that this was an area that needs more investment.

When we explored what activities local authorities were undertaking to demonstrate impact, we found the descriptions fell into two broad camps.

First, we heard that in many instances, the local authority did not have the time or capacity to dedicate to a formal evaluation of a particular change – or the financial resources to commission it. Often, as soon as a new policy, programme or tool

had been implemented, the limited resource available for improvement needed to be redirected to the next project. In these cases, there may be some attempts to collect some informal feedback on the change that was achieved, but anything more formal did not seem possible.

Second, we heard examples of how local authorities sought to demonstrate impact by measuring changes in the data as part of their more 'business-as-usual' performance monitoring rounds. These accounts indicated that local authorities would identify a problem during performance monitoring, do some work to address the challenge, and would then be satisfied that they had had a positive impact if the numbers had moved in a positive direction at the next round of performance monitoring.

In both cases, local authorities recognised that there is more that they would like to be doing in this area.

> *If we're doing an improvement project, then we should be thinking about how we're going to evaluate it before we've started the project. And we should be building extra questions in to whichever is the most appropriate mechanism before we start the project, and then we would be able to measure it. But we're not in that discipline because we haven't got those staff in our little corporate teams that are minded in that way, we deleted them all. So we need to build back that expertise in measuring improvement.*
>
> Director of Adult Social Services

They also recognised that they could be doing more to collect data that would help demonstrate impact, and saw potential in the use of new technology to give a fuller view of people's lives, and in real time:

> *… we've just implemented a solution which will try and [collect real-time data from users], so through texts and emails. But we are bringing back feedback. So, what we're trying to do is to… very similar to a call centre, you know, you might have a call and then you rate it four to five stars and so on. And it's similar to that. It'll be very interesting to see take-up. I know I don't provide feedback on most of my Amazon or… and I just wonder whether some of these residents might not actually do that.*
>
> Analyst

Reflections from across all four stages

Across the five sites, we found examples of activity at all four stages of the improvement cycle. However, overall, we did not find a shared or consistent approach to improvement. Most of the support was directed at helping local authorities identify and understand what needs to improve, with comparatively little on offer from the sector-led improvement programme for implementing change or measuring impact.

It is also unclear whether (and to what extent) the lack of a shared approach relates to improvement support being largely targeted at those that commission care rather than those that deliver it. In health care, for example, most quality improvement activity is driven by the providers, and not the commissioners. We note that the ability to better articulate quality improvement methods does not necessarily translate into real service change or improvement. Indeed, we heard disagreement among consultancies over the effectiveness of their different methodologies, and many agreed that sustaining improvement and embedding improvement approaches remained a significant challenge.

Finally, a number of elements were striking by their omission from a large proportion of our interviews. First, financial considerations were rarely mentioned as a driver of these prioritisation decisions. Given the pressures on financial resources, perhaps it was assumed that financial concerns are always considered, or that financial considerations were intentionally separated out so as not to 'contaminate' conversations about quality of care. Nevertheless, the way financial outcomes become embedded in improvement and included as a dimension of quality care are important issues.

Second, with the exception of one site we spoke to who emphasised co-production, there was a striking absence of the voice of those who use adult social care services as well as that of providers, in much of the local authorities' activities and across all four improvement stages.

4 How do local authorities create an environment that supports quality improvement in adult social care?

Even if local authorities were to apply all the improvement steps or stages conscientiously – from prioritisation to measuring impact – improvements would still be limited. Successful improvement requires a supportive environment and attention to the elements that encourage and support people to improve outcomes for people using adult social care.

Four broad elements are known to be associated with effective, organisation-wide improvement: leadership, skills, culture and infrastructure (The Health Foundation 2021). However, we found it hard to group activities under these discrete headings. For example, we heard that leaders played a key role in making sure that people who use care services were included in improvement programmes; they helped create a culture in which this was seen as the norm, and that staff had the right skills to support this work. As a result, we have chosen to highlight some of the most significant ways that interviewees described these four elements playing out in their improvement activity.

Building the capacity for quality improvement

Several directors of adult social services described how depleted their workforce had become in terms of improvement capacity, particularly within middle management.

> *When austerity hit, the first thing they did was strip out middle management layers. And they're the layers who generally [had] got time to do that quality assurance work and that reflective supervision and spot things that are going wrong and improve them. And [the city] took them all out and we lost about 40 middle managers.*
>
> Director of Adult Social Services

Efforts to rebuild this capacity focused on this group of staff, who often act as the interface with many staff delivering care:

> *[We've] introduced a new role between team manager and service manager and we've called them assistant service manager. And it's their job to do that quality assurance and improvement stuff, so that it's not all about having a team over here of project managers and analysts doing it. It's about the teams doing it.*
>
> Director of Adult Social Services

Interestingly, when areas had staff or teams with the term 'quality improvement' in their titles they were often struggling to focus their energies on improvement. Improvement sometimes felt like a tag-on – something to focus on once minimum standards had been met. In contrast, NHS partners had access to dedicated improvement teams and staff with qualifications in improvement methodologies. One NHS director explained: 'I think it is almost easier for me and my team because they are employed to do exactly that, that is their job.'

Given the pressures on the existing workforce, adult social care teams drew on support external to the local authority. The sector-led approach enabled teams to borrow staff with specific expertise or to access mentoring from colleagues in neighbouring areas. Others paid consultants to provide this extra capacity, covering all four stages of the improvement journey. Consultants were also described as acting as knowledge brokers between different organisations and parts of the adult social care system (eg, commissioners, providers):

> *We paid [a consultancy] to come in and analyse an older person's journey through the care, health, and back into the care system… And they were able to bring 20 staff with them to do desktop exercises on case records, interview staff. We haven't got time to do that and we haven't got the data at hand to do it straight away… because all the resources around performance and data have been nibbled away at over austerity, we don't have that wealth of information at our fingertips to inform what's the right thing to do.*
>
> Director of Adult Social Services

We noted that there were points during the interviews when project management skills became conflated with quality improvement skills – particularly when we asked about implementation. For example, implementation was understood to be

making sure that a project was delivered on time and that milestones were met, rather than being about ongoing, incremental measurement to assess change. While both forms of implementation may be under pressure in adult social care teams, the distinction is an important one.

Building capability for quality improvement

There are a number of routes for staff wanting to develop their skills and expertise in quality improvement. Sector-led improvement is a critical route, with some also receiving targeted training and coaching from the LGA and ADASS, as well as from external consultancies. In one local authority, staff had sought specific support for co-production from Think Local Act Personal. Staff also developed their skills more informally by observing and working alongside their local authority and NHS colleagues.

Best known within the sector-led improvement offer are the peer reviews. Staff valued the opportunity to participate in these as both a reviewer or a receiver of feedback. The regional networks, where people come together to learn and work on themes, were also mentioned, although not always identified as being offered through the sector-led improvement programme. These networks provide staff with collaborative learning communities. It was in these communities that we found some of the clearest evidence of specific quality improvement skill development, such as using small tests of change.

Several directors of adult social services highlighted their own role in developing staff expertise. They invited staff to participate regularly in weekly or monthly senior management discussions about performance and improvement. This was a deliberate strategy designed to expose a wider staff team to quality issues, and was seen as a key route to build staff understanding and their ability to lead improvement work. Staff were often encouraged to challenge the director and his/her interpretations of the data.

Several directors of adult social services singled out the principal social worker and occupational therapist networks as particularly good examples of improvement. Not only were they seen to be applying improvement methods successfully – testing and learning and measuring change – but they were also valued for bringing organisational visibility to individual experiences.

> *So, in essence, my view of the principal social worker network is the… is one of the strongest bits of the sector-led improvement approach. So, you've got a set of lead professionals there who are sharing, challenging, developing with each other what good social work practice looks like, implementing that in their own authorities with DASSs [Directors of Adult Social Services] and colleagues, and then reviewing social work practice through the peer challenges, you know, which then leads back into how that network needs to work together to further improve practice in the region.*
> Director of Adult Social Services

Although not a widespread practice, providing staff with real-time data was a powerful way to engage staff and embed an improvement approach. Using data for improvement rather than performance is another core tenet of improvement science. Again, this was not a concept that staff appeared to be familiar with. Data in adult social care tends to be used to measure performance – to benchmark against others or judge compliance with a target or standard. It also tends to be related to commissioning and contracts rather than the delivery of care, as one director explained:

> *We have some real-time, real-life feedback… It's the learning from it every time. Because every time we're doing it, we're realising we're getting some parts of it wrong, because it's not working. Quite frustrating at times actually, but really helpful.*
> Director of Adult Social Services

Leadership for quality improvement

Leading improvement in complex systems is challenging, particularly at times of acute financial pressure. It requires an ability to set a direction, take others with you, and know whether any change is an improvement. As well as introducing and enabling a quality improvement approach, we also heard that significant leadership skills are required at three levels for improvement to be successfully fostered.

First, directors of adult social services described their role in setting a clear strategic vision for quality improvement for adult social care (highlighting that this was not always in place). Second, directors and elected members worked hard to ensure that adult social care was a priority on the corporate agenda and aligned with both the corporate plan and the financial plan. (Again, this was not always the case, despite adult social care comprising a substantial proportion of the corporate budget.

Directors who had worked for a number of other local authorities noted the clear advantages of having an aligned approach to improvement across adult social care and the council as a corporate entity.) And third, directors described their role in making sure that improving adult social care was a shared aim across the system. In each of the five sites, interviewees described opportunities for improvement that reflect the complexity of residents' lives rather than the way services are organised. Examples included close working with housing, leisure and, of course, health.

Creating a culture for improvement to thrive

The concept of 'psychological safety' – where people feel comfortable raising concerns and disagreeing – was not mentioned explicitly by any of those we interviewed, and yet we found numerous ways in which this was being fostered. Staff were encouraged to question their own practice and to seek ideas – for example, from ADASS regional networks. In some local authorities, the leadership team built on this and encouraged senior staff outside the adult social care directorate to provide this challenge internally:

> *It's quite an interesting dynamic because we're under finance. So, I can actually be quite scrutinising, I can be more challenging than perhaps someone who is in the hierarchy of the department can be. And actually, the adult social care leadership actually, I think, want that.*
>
> Analyst

Overall, interviewees placed great value on fostering a safe, learning environment, with peer reviews playing a highly visible role. Peer reviews were seen as less intrusive or 'damaging' than formal regulatory visits and were thought to offer a more nuanced and considered assessment. Benchmarking against similar councils was also felt to foster higher levels of honesty than public performance league tables. More broadly, the sector-led improvement support was seen as providing spaces for honest conversations both within networks and between local authorities. We note that while most interviewees recognised the value of peer reviews, some also felt the format was somewhat tired, and that there should be follow-up to review whether any action had been taken.

As outsiders, we found it difficult to get underneath how people were supported by the sector-led improvement programme and understand what exactly was being

funded. However, what became clear through the interviews was that this private space – often existing behind paywalls or membership logins – brings its own benefits. It creates a feeling of safety and trust where local authority staff can be vulnerable and learn from each other's successes and failures.

Creating a culture where the focus is on learning – including learning from failure

When adult social care fails, it can have traumatic effects and come under intense public and political scrutiny. The way a local authority – or the wider system – deals with failure reveals a great deal about its culture of improvement. In one of the sites, where there had been serious failings in the care home sector, we found a clear focus on learning rather than blame, which extended across the region. In other areas, leaders were seen to model discomfort – to be able to sit with 'hard truths' about the shortfall in the quality of care. Their focus was on understanding where the local authority were currently at, and what 'good' would look like, rather than attributing blame.

The degree to which this culture of openness and curiosity also exists across a local system, with health, with providers or with people who use care services, was less clear – and, in some cases, appears to be still very much a work in progress. However, in some areas, we found that this safe, learning environment was being extended to include care providers. Again, Covid-19 had, for many, initiated new relationships based more on partnership and collaboration than contractual agreements and fee negotiations. And while many care providers remained afraid of failure and understandably focused on CQC inspection ratings, others clearly saw themselves – and indeed were seen by directors of adult social services – as key players in improving outcomes for people using social care.

Several interviewees described how the local authority and care providers had worked together to build trust and create a space where concerns and best practice could be shared more openly. Several directors of adult social services were keen to highlight the impact that provider associations could have on quality of care:

> *Now [care associations] can be a great force for good if they're harnessed and some resources are provided to them. So, we've started a [CITY] Care Association since I've got here and we're giving them £100,000 a year. I mean, it's not a lot of money,*

> *it only employs two or three part-time staff. But what they're able to do as care providers – to share knowledge, peer review, benchmark with each other, help each other when they're in crisis – is enormous.*
>
> Director of Adult Social Services

Providers also valued these new relationships and the acknowledgement of their role in the system.

In the next section, we look at the reasons why local authorities might find it harder than other sectors to embed quality improvement for adult social care in their day-to-day work.

5 Why is it so hard for adult social care to adopt a quality improvement approach?

We went looking for quality improvement, or something akin to quality improvement or its principles, as we knew it applied to other sectors, including health, manufacturing and education. We were looking for a shared language, a common approach, or methods that were accepted as more reliably leading to improved outcomes. We did not find any of these things.

In this section we set out some of the reasons why adult social care might find it harder to adopt a traditional quality improvement approach than other sectors. We ask whether the problem is simply one of capacity, or if the context in which adult social care operates is so different that it needs its own approach, tools and narrative. Or maybe, quality improvement is simply not appropriate or applicable to adult social care.

Adult social care, as others have explained, is 'mind-blowingly complex' (**Humphries and Timmins 2021**), which no doubt accounts for some of the reasons why approaches to improvement are so diverse. However, we found that it was not just this complexity that seems to be driving our sense that an improvement journey in adult social care can often look and feel very different from that in other sectors.

In earlier sections, we have touched on some of the common issues across the public sector that can hamper improvement, such as the lack of robust data, a shortage of staff, financial pressures and the need to work across a system. Here, we review whether adult social care faces distinctive challenges that create a unique barrier for successful quality improvement.

Finding the headspace – 'it's blinking difficult'

Those working in adult social care are not unique in finding it hard to find the time and energy to devote to improvement. Yet it is a sector that is facing widespread and longstanding pressures, including workforce shortages, particularly since Covid. Several interviewees commented how tired and stretched staff were, with very little bandwidth to look ahead or focus on improvement. One director felt that perhaps they needed to recover completely from Covid before focusing on improvement. He described staff being tired, many being ill, and how 45 per cent of their care homes had closed.

Staff described a culture where it felt hard to work through all the steps of improvement. They felt under pressure to move on to the next thing before they had time to evaluate or embed an improvement:

> *But there's a bit of a culture in local government of, 'you've done this, now you've got to move on to your next thing, now your next thing'. And the evaluation, it's been an area, you know, I've been in local government for 14, 15 years and it's definitely an area I've never seen systematically implemented.*
>
> Analyst

Many of the directors we spoke to had broad portfolios that encompassed adult social care as well as public health, housing and leisure. This gave them huge opportunities to shape outcomes across an area. Although these leaders did not see the wide-ranging and diverse nature of their responsibilities as a challenge, we were struck by how different their roles feel from leaders within other sectors such as education or health, and how this potentially limits their ability to focus on improvement.

The lack of a national framework for quality assurance beyond regulated care services

Quality assurance, which deals with compliance and ensuring minimum standards, is not the same as quality improvement. However, quality assurance, and the frameworks that underpin these systems, can provide an important starting point for what improvement activity should be seeking to achieve.

Unlike individual care providers (including local authority in-house provision), however, there is no national framework for quality assurance for adult social care functions and, as a result, no way currently to identify either the best or the worst local authority performers, or those that have improved most. National survey measures such as the Adult Social Care Outcomes Framework (ASCOF) are valuable and scrutinised by local authorities, but they cannot be used to compare areas. Some local authorities also try to give themselves comparative tools by aggregating the CQC inspection scores for the individual care providers in their local area to track improvement.

To fill this gap, and as we outlined in section 3, local authorities collaborate at both national and regional levels to create their own data to benchmark against and to conduct self-assessment. Resources such as LG Inform, benchmarking clubs and regional dashboards are highly valued, but are themselves not without challenges. Leaders reported that it was still hard to gauge where they were doing well and where they were not, and that comparisons were difficult because local authorities were not comparing like with like:

> *But we almost pick, don't we, we pick what we look at and how we do that? And when you speak with colleagues regionally, that becomes really apparent. But the first conversations we were having was 'if we're going to do something as a region we've got to make sure we're comparing apples and apples because at the minute we're comparing apples and pears'. And that's a challenge within adult social care because we're disparate and we can go off and say, this is… But you don't have some of those indicators that are actually imposed for all NHS trusts.*
>
> Assistant Director for Adult Social Care

The levers available to drive improvement

Continuous quality improvement is not something that can be imposed top-down. To be successful, you need to be able to engage the people who use care services and the staff who provide those services, and create a culture in which everyone feels able to make improvements. The challenge facing local authority leaders in adult social care is that unlike leaders of NHS trusts, they do not directly employ most of the workforce that delivers that care and support. As one NHS leader explained, this can pose particular barriers:

> *[The local authority] may not have the levers to do the service improvement it wants to do, 'cause the provider might say, 'I'm not paid to do that, go away'.*
> Director of Performance and Governance NHS

Given this contractual relationship between local authorities and the hundreds of care providers that deliver care, the traditional levers of commissioning and contracting are often used to drive improvements. However, we also saw evidence of a shift from transactional to partnership-based relationships. Directors described the value in developing a relationship with care providers that went beyond fee negotiations and contracts. Leaders in one area spoke very positively about the impact of a new quality improvement team – or 'flying squad' – that provided practical help to struggling care providers. Providers, too, were clear that partnership working with the local authority was a real achievement:

> *… even prior to Covid we were on the exec board, which had the other chief execs, and felt included and a vital part of that system. And that has continued and it's strengthened with the gold and silver meetings, and it has absolutely made a tangible difference to the quality and the outcomes of providers and the outcomes that we've had for people in receipt of services… So it has had a massive difference.*
> Chief Executive, Care Association

Leaders from the care sector and local authority staff welcomed these moves towards a position where there was mutual appreciation and recognition that improvements in adult social care required joint action and shared decision-making. We also saw examples of where this collaborative approach was reaping benefits within areas, such as in training, sharing information and workforce strategy.

Political influences

Adult social care is unusual in the degree to which the strategy and vision – and therefore the improvement agenda – is influenced by local politics. In one of the sites, for example, the priority placed on co-production was very clearly driven by the political leadership across the council. This was seen as a strength and was used to support improvement, but the political attention also brought with it greater scrutiny and a pressure to deliver results fast. Directors also noted that the improvement agenda is obviously affected by a change in political leadership, and several commented on the degree to which stability and longevity of relationships with elected members impacts the improvement agenda.

We found strong local political leadership for adult social care. Councillors were very much engaged in improvement work and in ensuring that people's lived experience of using adult social care was heard. They described their efforts to connect with people who use adult social care, and met regularly with directors of adult social services, often weekly, to raise their views and share concerns. However, for many, their efforts were in contrast to what some perceived as a distinct lack of local public interest in adult social care, despite the substantial budget that it commands locally:

> *I could count on one hand the number of pieces of casework, queries, complaints that come directly to me… My fellow executive member for highways, as an example, probably gets more correspondence in a week than I'll get in a term in four years, because the wider public just doesn't get what we do… Quite frankly, I don't think the public cares, I really don't. The public cares when it hits them personally.*
> Elected member

Despite this perception that the public are not interested in adult social care, in some areas fear over local public reaction seemed to inhibit an openness and transparency about data and improvement.

Ability to work across a system

People using adult social care, like all of us, cross organisational boundaries. Successful improvement relies on finding solutions at a system level and breaching the divide between health and social care in particular. It helps when people from different parts of the system share a common aim, language and data.

The integration agenda between health and adult social care is not new, but we found that working together can still feel like 'different worlds colliding'. It was not simply the fact that one service talks about 'patients' and the other refers to 'residents' or 'users'. There was a more deep-seated feeling that the two do not really understand each other and can have very different approaches to quality:

> *… our cultures are totally and fundamentally polar. I mean, I can actually describe it that way, we are polar extremes. So, the NHS… we are a very hierarchical command and control system… And I think what we've took a long time to recognise is, we need to understand that cultural difference, and what it means, therefore, how we work with our local authority partners to do service improvement. 'Cause the thing that we might think is important, might not be the thing that they think is important, for that very reason just explained.*
>
> NHS partner

While it is certainly true that both the NHS and local authorities face similar challenges in working across a system, adult social care faces additional challenges. First, and in contrast with improvement activity in NHS trusts, the adult social care market tends to be made up of multiple and often small-scale, independent providers, funded through diverse financial arrangements. Indeed, it was the care provider associations in particular that highlighted the difficulties of engaging a hugely diverse network of providers in system-working. One care provider association chief executive explained they had more than 200 providers in the city, many of which were small and very dispersed. Second, compared to large parts of the NHS, including hospitals and primary care, adult social care has to contend with a lack of quality data from providers. This makes it harder for adult social care to engage across a system, and harder to measure improvement.

Measuring change

Not having enough data or the right kind of data to measure improvement is often a barrier to quality improvement – whatever the sector. And adult social care would have just cause to complain about the adequacy of its data. Indeed, the government has committed to address this, acknowledging that 'we do not currently have good enough data to know whether people are consistently getting the care they need' (Department of Health and Social Care 2021), and new ambitions for the collection and use of adult social care data have recently been set out (Department of Health and Social Care 2022).

It therefore remains hard for adult social care teams to measure change following an intervention – whether it be new digital technology, financial incentives, practice, pathways or processes. But it is not just the lack of data that remains challenging for adult social care; it is also the type of change that needs to be measured. Finding ways to measure whether a conversation was 'strength-based' is a very different task from measuring how many people have received an assessment. As one director of adult social services explained:

> *You can't like put metrics around how good a social worker does an assessment other than that was good enough and that was not – so that becomes much more story-based and almost like a combination of case file audits and reviews and feedback that gives us a view about whether you're moving in the right direction or not.*
>
> Director of Adult Social Services

Measuring the complexity of people's lives is not a unique challenge for adult social care, but it is an important one. We heard how people's stories were being used effectively to demonstrate change, but this qualitative data tends to be overshadowed by quantitative data. Regulators, government and auditors create an environment in which numbers are more highly valued than insights. One consultant argued that if you really want to understand the difference adult social care makes to people's lives, then those in senior positions needed to become more comfortable with using and interpreting qualitative data. She argued that:

> *The opportunity for improvement is missing because it's those stories and insights and circumstances and situations that provide the richest learning, which then*

> *provide the improvement. The data and numbers go some way down that line, but they don't tell you the whole story.*
> Consultant

People's lives are multi-layered, and so is the data that reveals whether adult social care has improved someone's life.

And finally, a lack of clarity on fundamental quality improvement concepts

One of the biggest and least tangible challenges that shapes how quality improvement is adopted in adult social care is disagreement over what improvement is for. If you want to adopt a quality improvement approach, you need to agree what the problem is that needs solving. For example, in health, there is a broad consensus that quality must include the dimensions of safety, effectiveness, patient-centredness, timeliness, efficiency and equity; but there is no agreed definition of quality for adult social care. Without a similar consensus, improvement in adult social care can be defined in a polarised way, with interdependent outcomes such as financial savings and the promotion of independence being seen to be on opposing sides.

The lack of clarity over definitions extends beyond the purpose of adult social care. We found that it was also hard to identify what people meant when they talked about improvement. In adult social care, quality improvement is used interchangeably to describe improvement, innovation, transformation and performance – often with limited detail about what each term might cover. When we asked people to describe a successful improvement project or programme, we heard of a huge range of activities being undertaken. They ranged from large-scale change programmes to making sure there were enough staff to deliver the minimum care in a care home. It was an impressive list, but we were left wondering – for two reasons – whether we would have labelled them all as examples of 'continuous quality improvement'. First, quality improvement happens when you make a change, and you can measure that the change has made a positive difference. The second thing that puzzled us was whether some activities described as quality improvement might more accurately be defined as quality assurance, compliance or performance measurement.

Although adult social care faces multiple and sometimes distinctive challenges, we think a quality improvement approach still has merit. It is appropriate and relevant to the sector, and it offers a credible way for people to improve the quality of care and more reliably achieve their intended outcomes. Moreover, it is clear that local authorities are already benefiting from quality improvement approaches, often without recognising it or identifying them through the sector-led improvement programme. Some authorities also choose to purchase very explicit quality improvement methods, approaches and skills – often for very considerable sums.

To date, adult social care has not had the capacity, capability or infrastructure to support continuous quality improvement effectively. Indeed, it could be argued that a series of national policy choices have resulted in a lack of money, a lack of strategic direction, a failure to invest in data capabilities, and a lack of regulation. In 2022, the government announced significantly more investment to strengthen the support offered to local authorities. In the final section of this discussion paper, we draw on our research and suggest how improvement support might itself be improved.

6 The future of improvement

Planned reforms to adult social care, further integration with health, and the introduction of a new CQC quality assurance framework create significant demands on the existing sector-led improvement programme. Layer these reforms on top of existing pressures, and it will come as no surprise that local authorities are looking to sector-led improvement for significant support.

What is the new care quality assurance framework?

The Care Quality Commission (CQC) has new responsibilities under the Health and Care Act 2022 relating to oversight of health and care systems. For integrated care systems (ICSs), this will include reviewing and assessing how they are delivering against their core purpose. For local authorities, the CQC will be reviewing and assessing whether they are meeting their social care duties under part 1 of the Care Act 2014.

The approach will be drawn from CQC's single assessment framework, underpinned by detailed quality statements and clear evidence requirements. This is a new regulatory approach being developed to assess providers, local authorities and ICSs. It will ensure a consistent and transparent approach that will provide an up-to-date view of quality. The CQC is currently developing its approach, with reviews expected to start in April 2023.

The introduction of the CQC quality assurance framework (*see* box) was the dominant theme in our conversations about the future of improvement. At the time of our interviews, there was widespread uncertainty about what exactly this new framework would look like. Local authorities were already anticipating that this new regime would have profound implications for how they approach and prioritise improvement activity. There was a strong expectation that much of a local authority's capacity for improvement work in social care will be diverted initially to help understand, prepare for and respond to the new regime.

The new assurance framework therefore creates both risks and opportunities for improvement in adult social care and the sector-led improvement support

offer. There is an expectation from local authorities that the new oversight mechanism will motivate greater and enhanced internal scrutiny of improvement activity. Yet, as we highlighted earlier, quality assurance is not the same as quality improvement.

Caution is needed. In a context where both local authorities and providers can already struggle to find resource to carry out improvement work, there is a strong risk that the small resource that is available is wholly diverted to deal with requirements of the assurance framework. This risks that the vast majority of improvement activity will focus on compliance and meeting a set of minimum standards. Similarly, the principle of improvement activity being informed by local needs or priorities is also seen to be at risk from the incoming framework:

> *… with CQC in particular I think there will be a new type of intervention support that will have to happen… I think the danger could be [that] sector-led improvement gets seen as only that, only for basket cases. So, a clear space that says the best… actually it's the best who want to keep improving.*
>
> Consultant

As well as dealing with this new regime, local authorities are also increasingly going to need to contend with how they continue integrating with health as part of integrated care systems (ICSs). While our research has identified examples of successful collaboration across sites, there is a strong recognition that this will need to accelerate now that ICSs have become statutory bodies.

These challenges, and the introduction of wide-reaching reforms, have implications for the sector-led improvement support offer. It is clear that local authorities are asking for a greater level of support to help them understand and adapt to these imminent changes. However, our research suggests that a refreshed sector-led improvement offer – one that simply pivots and expands to meet these challenges – will be a missed opportunity.

We conclude with some suggestions, drawn on insights gained during our research. They are designed to catalyse fresh thinking about how best to improve the lives of adults who need support to live full and independent lives.

What if sector-led improvement crafted a new narrative around continuous quality improvement?

An opportunity exists for sector-led improvement to define a strong identity for itself outside of the CQC assurance framework – one focused on continuous quality improvement. For this to happen, we ask whether sector-led improvement needs to craft a new narrative that provides people with a shared language of improvement that feels relevant and appropriate for adult social care.

Throughout this research, we found it hard to decipher the nomenclature of quality improvement in adult social care. Interviewees did not talk about key concepts such as small tests of change or data for improvement, for example. With the exception of peer review, many struggled to name specific improvement skills, methods or techniques. Codifying further the types of improvement methods, techniques and skills that are being used in adult social care could provide clarity and an opportunity to contribute learning across the sector more widely. It could also help raise expectations that staff could and should be developing their skills and expertise in quality improvement methods. Without a shared language, the skills and expertise needed to improve can get lost and become conflated with broader project and performance management skills.

The ability to classify or name a range of improvement techniques and approaches raises their profile and status. It also provides a way for people to debate which particular improvement approach is most appropriate to use in any given situation. Sector-led improvement offers a range of improvement approaches, but it was unclear to us which method was designed to solve which problem; for example, what were the potential improvement methods most suited to a local authority with severe financial difficulties as opposed to one that was already performing well but wanted to do even better. Again, we were struck at how some of the consultants had the luxury of being able to determine when they would or would not take on improvement work. They were very clear about their terms of engagement or conditions of success for their specific improvement offer. Consultants, it seemed, were clear about when they would be able to add value and when they would not.

It is worth reiterating that we are not arguing for adult social care to do quality improvement in the same way that the NHS does quality improvement. Rather, we are saying that adult social care should look at how other sectors (including

health, education and public health) have adapted a quality improvement approach, and create an approach that is focused on the needs of people who draw on adult social care.

What if sector-led improvement has done enough to instil confidence in the value of a sector-led approach to allow it to focus more on 'improvement'?

While the rallying cry of 'for the sector, by the sector' comes across powerfully, the 'improvement' aspect of the sector-led improvement programme has got lost. We think that the political context in which sector-led improvement emerged over a decade ago has contributed to this, but there is now an opportunity to shift attention to continuous improvement.

Sector-led improvement was formally introduced as part of the localism reforms, and it has, to date, made sense for local government to spend time and effort defending this decision and making a case for continued investment. However, the government's recent decision to invest more in improvement and support, and its restated commitment to enable the sector to drive its own improvement, is an endorsement of the value of improvement being led by the sector. A decade on from these reforms, we ask whether the sector might consider how it evolves and what kinds of relationships it can now build for further improvement.

Renewed confidence in a bottom-up, locally informed approach could allow local authorities to engage in a broader discussion about who comprises 'the sector'. Although the current sector-led improvement partnership programme delivers limited support to care providers, most people assume that 'the sector' receiving support consists solely of local authority adult social care staff and elected members with responsibilities for health and care. Our research suggests that an updated definition of 'the sector' – one that includes care providers, carers and people who use care services – would better reflect the reality of who provides adult social care and who is involved in efforts to improve it. It would also reflect the reality that some local areas are already working with partners to deliver improvement, and in doing so have moved beyond the more traditional contractual commissioning arrangements.

What if co-production sat at the centre of this new narrative on continuous quality improvement?

User engagement throughout all stages of the improvement cycle is seen as a prerequisite to successful improvement. However, we found mixed evidence on the extent to which people who use adult social care are routinely and systematically involved in improvement activities. There is an opportunity for sector-led improvement to provide greater clarity and leadership about how and when the people who use adult social care can be involved in improvement.

The term 'co-production' refers to a way of working whereby everybody works together on an equal basis to create a service or come to a decision that works for all involved. It recognises that people who use services have knowledge and experience that can be used 'to design, deliver and monitor services and projects' (Think Local Act Personal 2022b) – something that sounds very much like continuous quality improvement.

In our interviews, we heard co-production described as an improvement approach, a method to apply at various stages, or an improvement skill that staff needed to develop. Indeed, Think Local Act Personal helpfully explains that the definition of co-production changes depending on the approach taken in different settings. We think there is value in working out how co-production 'fits' with continuous quality improvement.

What if sector-led improvement rooted itself more in the wider quality improvement community?

Improvement in adult social care offers a rich source of learning for anyone interested in continuous quality improvement, but the lack of a shared improvement language within the sector seems to prevent the dissemination of ideas and learning. Those interested in improving education or health may find it hard to relate to the language used to describe improvement in adult social care (and vice versa). For example, co-production and safeguarding partnerships offer considerable insights for those interested in user engagement and system-wide working respectively.

Situating sector-led improvement more firmly within the broader quality improvement community might also offer exposure to new ways of approaching entrenched problems, such as using the Joy in Work approach to tackle workforce

burnout (Perlo *et al* 2017). It might also flag emerging quality improvement issues in other sectors that adult social care would have much to contribute to, such as addressing inequalities and promoting equity through quality improvement (**ihub 2020**). The application of sector-led improvement in public health offers an interesting comparison. It is developing its own narrative of quality improvement that neatly bridges the improvement worlds of health and local authorities.

The integration agenda also creates new opportunities for those leading improvement in adult social care to showcase their approaches to improvement. A shared language, and being more rooted within the quality improvement community, can only help facilitate a joint approach between the NHS and local authorities that drives improvements for people using both health and social care services. Indeed, we heard that in some areas, local systems are already developing shared approaches to quality improvement. However, there is a danger that ICSs will fail to learn from adult social care improvement approaches – and that improvement will, instead, be dominated by the way quality improvement approaches are applied in the NHS and driven by the health data that is more readily available than data on social care.

What if the Department of Health and Social Care recognised its contribution to a sector-wide culture of quality improvement?

Leadership for quality improvement is required at every stage of the improvement journey and at every level of the system. Our research indicates that the lack of an overarching strategic vision for adult social care is problematic for many in the sector who are working to improve outcomes. The Department of Health and Social Care has a critical leadership role to play in setting strategic direction and, working with others, can help to address the confusion that exists over the purpose of social care, and the role improvement support plays. In shaping that strategic direction, the Department may also need to mitigate the risk that national leaders will increasingly look to inspection/regulation as the lever of change at a time when the CQC's oversight role is growing.

Perhaps looking to the Department for strategic leadership is no surprise, and it would be easy to leave it there. But we suggest that it can do more to foster a culture in which quality improvement thrives. Quality improvement depends on a culture of openness and collaboration, and a focus on learning, including

learning from failure. With the introduction of a separate mechanism to monitor the performance of adult social care – and new powers of intervention where necessary – there is an opportunity to foster a new dynamic between central and local government based on improvement, rather than blame and judgement. Such a relationship, which depends on high levels of trust and honesty, will be hard to build and navigate. However, there is merit in starting conversations early about what it might take to build this relationship, and what can be learnt from other sectors. In particular, there are likely to be lessons on how other sectors such as children's services might have successfully fostered an improvement culture that goes beyond the expectations set out by an assurance framework.

This discussion paper is intended to prompt fresh thinking about how to support people to improve adult social care – a highly skilled and challenging task. Quality improvement is not a magic bullet that can be adopted to solve all the problems associated with adult social care. As we have shown, it needs resources, expertise, and a willingness to work differently. In carrying out this research, we have found people – working in central and local government, the NHS, in consultancies, as well as providers and people who use adult social care – who are willing to work differently. They are, without exception, interested in learning by doing, committed to driving improvements, and championing the distinctive contribution that adult social care can make to people's lives. What if the time is now right for adult social care to embrace continuous quality improvement?

Appendix: Methodology

The research for this report took place between September 2021 and June 2022. It consisted of three phases.

Phase 1: scoping activities

We carried out a review of the literature available on sector-led improvement produced by government bodies and sector-led improvement partners to better understand the concept and offer to local authorities. We also discussed the sector-led improvement offer provided by partners funded by the Department of Health and Social Care, specifically the Local Government Association (LGA), the Association of Directors of Adult Social Services (ADASS), the Social Care Institute for Excellence, the Care Provider Alliance and Think Local Act Personal. These activities informed our approach to the subsequent interviews.

For the purposes of the research, we were asked to approach local authorities who had demonstrably made progress with their improvement journey in one or multiple areas of adult social care. The aim was to seek out sites that were three to five years into their improvement journey and who would have a story they would be happy to share. These sites are not, and were never intended to be, representative.

We were unable to find any single dataset that could indicate which sites we should select. Subsequently, we had discussions with the Department of Health and Social Care and others with expertise in adult social care and reviewed local authority websites to help identify potential sites. We reviewed websites for evidence of improvement journeys. Between the Department and the research team, a longlist of potential sites was created based on publicly available information on websites such as Joint Strategic Needs Assessment reports or Local Account reports. This list was reduced further to produce a sample demonstrating a range of political control, geographical locations, population characteristics, types of council, Index of Multiple Deprivation scores, adult social care budgets and Adult Social Care Outcomes Framework (ASCOF) ratings, as well as novel improvement initiatives or overarching programmes (for example, co-production). Given the pressures the

social care system is currently under, we also retained a smaller number of 'first reserve' councils; however, we did not need to contact these.

Our shortlisted sites included: the London Borough of Hammersmith and Fulham; North Yorkshire County Council; Coventry City Council; Bradford City Council; and Central Bedfordshire Council.

Phase 2: interviews

We conducted a total of 27 interviews across the five local authorities and with consultants who provided improvement support separate from the aforementioned Department of Health and Social Care-funded sector-led improvement partner organisations. Interviews took place between December 2021 and the end of March 2022. Our approach to these interviews is outlined below.

Local authorities

Up to five people from each local authority were recruited to take part in an online interview lasting up to 60 minutes. Directors of adult social services were identified via the local authority websites and were approached initially by a project co-ordinator. Following their interview, they were asked to provide the names and contact details of at least three other people in any of the following roles, or anyone else they thought could talk about methods of improvement in adult social care in their area:

- Portfolio-holder/lead member with responsibility for adult social care.
- Chair of a local provider forum/organisation (if one exists).
- Representative of the local user group (if one exists).
- NHS lead for quality/integration/Better Care Fund.

Twenty people from local authorities were recruited for the research, including: directors of adult social services (n=4) and one director for Covid standing in for a current director of adult social services; elected councillors (n=4); chairs/leads of local provider forums (n=2); experts by experience (n=1); assistant directors (n=1); heads of business intelligence (n=1); chairs/directors of areas such as commissioning,

planning, performance, quality, governance, partnerships, or nursing (n=5); and a regional Association of Directors of Adult Social Services lead. Between three and five participants were interviewed for each local authority.

We provided participants with information sheets, privacy statements and consent forms ahead of their interview, and obtained verbal consent from interviewees. We created semi-structured interview schedules, with one version for elected councillors and another for local authority staff, reflecting their level of involvement in improvement. For the latter schedule, content included questions eliciting: examples of improvement projects; the approach they took to improvement (including specifically how they approached prioritising areas to focus on, understanding and exploring areas to focus on, implementing change, and measuring and demonstrating impact); types of support used for improvement work (including a specific question about use of sector-led improvement support and what was beneficial and what might be missing from it); approaches taken to building capacity for improvement work; and the future of improvement in adult social care. Although we planned to ask respondents about their approach to reducing inequalities within their improvement work, we discovered during piloting that we rarely had time to cover this item. For the elected councillors, content was changed to include a reduced focus on the approach to improvement, although they were still asked about how they demonstrated impact. They were also asked about the biggest challenge for conducting improvement activity in adult social care.

Consultants

Seven consultants were recruited and interviewed. We provided participants with information sheets, privacy statements and consent forms ahead of their interview, and obtained verbal consent. We created semi-structured interview schedules. Content included questions about: their support offer; at what stage in the journey they might get invited to contribute; what types of projects local authorities sought their support for; challenges for improvement in adult social care; their perception of the sector-led improvement offer and how it intersects with consultancy offers; and the future of improvement in adult social care.

Phase 3: analysis and member-checking

We digitally recorded all interviews except one, and took field notes. Participants did not receive any remuneration for their involvement. We sent recordings to a third party (1st Class Secretarial) for transcription and anonymised returned transcripts before we undertook our analysis.

Three members of the research team descriptively analysed the interviews using MAXQDA 2020 Plus software. Initial and subsequent codes were devised and adapted following discussions of discrepancies based on dual or triple coding of four complete or partial transcripts (two directors of adult social services, one consultant, and one chair of a provider forum). Changes to the coding framework resulted in the revision of some code definitions and removal and introduction of new codes. Subsequently, the rest of the transcripts were coded without any further changes to the framework. Data under each code was then reviewed for cohesiveness and summarised to aid write-up. Thirteen high-level descriptive codes, with additional subcodes, were ultimately used (*see* Table 1, page 49). Subsequently, parallels were drawn between the coded data and factors that foster supportive environments for continuous quality improvement, including culture, leadership, capacity and skills.

Following analysis, we conducted a form of member-checking by inviting all participants and representatives from each of the sector-led improvement partners to attend a presentation of the findings. This enabled us to sense-check our interpretations. Informed by this process, we made minor adaptations to our planned output, including better clarification of terms and views expressed. At this time we also queried what (if any) further research in this area would be of value.

Table 1 Codes and subcodes

Code	Subcodes
Stages of improvement	Prioritising Exploration/understanding Implementation Governance/project management Demonstrating impact
Data and measurement	
Accountability	
Who's involved in improvement	
Benefits of improvement	
Drivers for improvement	
Facilitators for improvement	
Challenges for improvement	
Beneficial support for improvement	Sector-led improvement support Other support
Challenges of support for improvement	Sector-led improvement support Other support
Clarity of sector-led improvement	
Changes or improvements to sector-led improvement	
Future	

Patient and public involvement and approvals

The Chair of the Health Sciences Research Governance Committee at the Department of Health Sciences, University of York, waived the need for a full panel review for this research project due to it being considered low risk.

We consulted with the University of York's Involvement@York programme lead on multiple occasions to determine how to meaningfully involve people who use adult social care and the public in this project. We found that the lack of clarity surrounding the topic would not facilitate effective engagement, at the start of the project, of those who draw on social care. Therefore, we initially agreed to engage those who draw on social care at the end of the project to review and prioritise recommendations.

However, given the nature of our findings and our prompt to embed co-production into quality improvement, we are planning to involve those who draw on adult social care in additional activities following publication of this discussion paper. The aim will be to give them direct access to policy-makers and facilitate policy-makers' understanding of the challenges and value of the approach. We believe this offers the most value to the Department of Health and Social Care, as well as offering a meaningful contribution to the people who use adult social care.

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We know that our decision to write a discussion paper rather than a traditional research report, and to try to prompt debate, has inevitably meant that we have not done justice to the range and breadth of improvements we found across all five local authorities. In a separate report, we have shared with the Department of Health and Social Care examples of successful improvement stories, including specific examples of the role that sector-led improvement has played (available on request).

We would also like to thank everyone who helped us navigate the world of sector-led improvement, especially those involved in delivering this approach. We have appreciated your openness and the way you have engaged with us on what the future of improvement support could look like.

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Ideas that change health and care

It is a time of great change in the adult social care sector, with plans to introduce a new Care Quality Commission assurance framework and integration with health services under way. This moment of change is an opportunity to rethink the approach to improvement in adult social care and the support that is offered.

Building capacity and capability for improvement in adult social care looks at how local authorities go about making improvements, measure success and what type of support they use to do this. This discussion paper is based on interviews with those involved in improving adult social care in five local authorities as well as consultancies that provide improvement support and comparisons with approaches to and principles of quality improvement in other sectors. It finds that there are examples of excellent work on improvement in adult social care and that local authorities value improvement support, but also huge variety and a lack of shared language around the methods of improvement.

The report concludes by asking what the future could look like for improvement in adult social care, and considers what it might take for the sector to get there.

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