

South West Dementia Partnership



Dementia Quality Mark operating framework

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Overview

There has been a great deal of interest in the development of a dementia quality mark (DQM) and the need has become more pressing with the cessation of CQC quality ratings and the changes to registration conditions. A DQM will be particularly helpful for families wanting to select a care home.

Across the country a number of providers, councils and private companies have been developing various types of quality assurance “marks”. In the southwest it was felt a collaborative approach could assist in developing a single standard. This would be both an efficient approach and reduce duplication across local authorities.

The project forms part of the work of the South West Dementia Partnership and builds upon the work which has already been undertaken to promote improvement in care homes.

This proposal is based on in depth discussions with a wide range of stakeholders including people with dementia and their carers, Alzheimer’s Society, CQC, ECCA, National Care Forum, providers and provider associations, local authority and PCT commissioners. Research was also undertaken into other similar schemes (e.g. Worcester, Leicestershire) and consideration given to other models of quality assurance (PEARL, Dementia Care Matters “Kitemark”, My Home Life). A scoping paper was produced and a focus group held including providers, commissioners, trading standards and the Alzheimer’s Society. This proposal is the result. Producing something that is reliable, fair and low cost is not easy. However there is strong agreement that there is a need to have something in place

Purpose and benefits

The primary purpose of a DQM is to provide people choosing a service reassurance that the care being given meets the needs of people with dementia. It also sets standards, which those providing services can aspire to.

The problem with quality standards in care services is that they are subjective and often fail to measure outcomes. In addition care practice is forever evolving and expectations changing. In the field of dementia care this is particularly so.

In the context of this proposal the awarding of the DQM will indicate that:

- The care service has a sound approach to the provision of dementia care
- The essential building blocks are in place to deliver good care.
- The care service has an effective quality assurance system to check that the outcomes for people with dementia are good.
- The service is committed to ongoing improvement and development.

The DQM is **not** in itself an independent assessment of the quality of care being given. The danger of such systems is that standards can easily lapse between assessments. Instead the DQM rightly places the onus on the provider to have effective systems in place to assure care. The DMQ also provides a number of tools, which can be used by providers.

Principles

At the focus group meeting in July 2010 there was an excellent debate about the challenges of implementing a DQM. This led to agreement on a set of principles.

A DQM should:

- Be based on principles of person centred care
- Be **improvement** focussed and place emphasis on evidencing a provider's commitment for improvement
- Be as simple and transparent as possible
- Include direct visits to the care service
- Have a low cost burden for providers and commissioners, although some were prepared to make modest investments if the benefits were clear (e.g. access to improvement networks, replacement of existing quality reward schemes)
- Promote provider accountability
- Be aligned to CQC quality standards
- Not duplicate other quality assurance systems and where appropriate recognise and passport in other quality marks
- Include but not be the sole preserve of commissioners
- Not discriminate against people with dementia. Should cover older people and dementia specific services with additional demarcation for specialised services.
- Be developed and operated with input from people with dementia and carers
- Include **fair** reference to other sources of intelligence e.g. CQC and commissioners. (There is some contention here).
- Have "grip" and consequences and the potential to be removed

Development and governance

The DQM is being developed at a difficult time with major changes in the structure of public services. It is also a time of significant budget reductions, which are likely to impact on public services and voluntary organisations alike. At present the DQM is a regional initiative, which is being driven and co-ordinated by the South West Dementia Partnership. During 2011 Plymouth City Council will take over coordination and ongoing development, with five SW councils taking part in a trial, BANES, Bristol, Dorset, Plymouth and Wiltshire.

During the development of the model there was discussion about the potential role of local authority commissioners and the advantages and disadvantages in respect of their involvement.

The advantages cited are:

- Local authorities will be here to stay and have responsibility for developing and shaping the local care services market.
- Local authorities already have investment and experience in contract monitoring
- Local authorities as commissioners have the leverage to apply “grip” to DQM
- Local authorities have market intelligence, for example prevalence of safeguarding concerns
- Local authorities have responsibility and experience in the development of the social care workforce
- Local authorities have a duty and role in providing information to the public on services in their area, e.g. for dementia
- Most local authorities recognise the value of DQM and are motivated to support its development.

The disadvantages are:

- Strong provider concern that over involvement of local authorities would give them too much power, i.e. price, contract specification and quality.
- Strong provider concern about the use of safeguarding information, which providers cannot fairly challenge.
- The need to ensure that a local authority perspective does not dominate the shape of DQM.

On balance it was concluded that the local authorities needed to play a significant role in the development of a DQM as at present there is no other long term regional player with capacity or commitment to deliver a scheme. This approach however will need to be carefully balanced with the interests of providers and people using services.

It is recommended that the governance arrangements are allowed to evolve as the DQM is tested and developed and that one of four scenarios may evolve:

- 1) DQM becomes a universal tool applied by different local authorities as is happening elsewhere in the country but with co-operation between local authorities.
- 2) Once DQM is established a consortium of local authorities commission an independent organisation (e.g. voluntary organisation, provider association) to undertake the running of the tool.
- 3) An independent organisation with universal recognition takes over the running of DQM or offers a similar but universally acceptable alternative.
- 4) DQM proves unworkable or is overtaken by other developments e.g. in regulation.

Operation and structure

At the centre of the scheme is a small panel organised by, but not necessarily run by, the local authority. It is suggested that the panel has three representatives and if possible is not chaired by anyone from the local authority:

- Local commissioner/ contract officer
- Person representing a provider perspective e.g. from local provider association or a leading learning disability provider (would not have competitive interest).
- Person representing people with dementia who live in care homes. This could be a person with dementia, a care home resident or an ex carer. This is in line with the current policy of promoting local involvement and accountability.

(Note: the panel may include others, e.g. health perspective, Skills for Care etc but there is a danger of it becoming too large).

The process begins with an application by the provider using a standard template (see Appendix 4). This is essentially a self-assessment and has been carefully aligned to selected CQC standards which are particularly relevant to good, person centred dementia care (see Appendix 1).

When the application is received it is allocated to a member of the panel or a person nominated on the panel's behalf. This person reviews the application and in addition considers:

- Latest Quality Risk Profile and report from CQC (when these become available)

- A simple reference from local commissioners indicating whether they have any objection to a DQM being awarded. If commissioners have an objection they must be prepared to explain to providers the reasons why.

If the application has insufficient information or appears to be unsound it will be returned to the provider with a short written explanation and recommendations.

If the application appears to be sound the allocated person will then arrange to make an announced visit to the home. The purpose of the visit is to check that the key elements of the self-assessment are in place and are in evident in practice. Particular emphasis will be placed on the quality assurance system and the daily experience of people living in the home.

A statement of expectations has been set out to provide a benchmark for achieving the DQM, (See Appendix 2) and a simple recording sheet captures the assessments made in respect of each standard (Appendix 3).

The outcome of the visit could be:

- 1) Recommendation to the panel that DQM is awarded
- 2) Recommendation to the panel that DQM is awarded but with recommendations for further action by the provider
- 3) Recommendation to the panel that DQM is deferred with recommendations for further action by the provider
- 4) Recommendation to the panel that DQM is not awarded

The panel then considers the recording sheet and the recommendations and makes a decision.

Once a DQM is awarded the process is repeated annually but with less scrutiny, and a primary focus on seeing ongoing improvement checking the operation of the home's quality assurance system.

A certificate has been designed and will be issued to services achieving DQM and arrangements made for the DQM to feature on care home listing provided by local councils.

The self-assessment and expectations in more detail

The self-assessment and expectations are directly aligned to CQC standards for achieving compliance. This will assist in demonstrating compliance to CQC standards and can be used as evidence for CQC annual self-assessments.

Those services with existing, robust quality assurance schemes should have no problem in completing the self-assessment. For example confirmation of the PEARL award (as used by Four Seasons) should be sufficient to meet the standards in respect of quality assurance.

It is recognised that some services will require time to meet all the expectations. Therefore the expectations have been written to include:

- 10 areas which are "must dos" and are essential to achieve the DQM
- 8 areas which are "should dos"

(These are laid out in the checklist in Appendix 3).

In the first year it is proposed that in addition to the “must dos” services must also achieve two of the “should dos”, in year two they should achieve six of the “should dos” and in year 3 all eight.

Development and piloting

Five council areas are trialling the scheme BANES, Bristol, Dorset, Plymouth and Wiltshire. Limited funding has been made available by the South West Dementia Partnership to assist with administration and support and there will be no charge to the providers taking part in the trial.

Development plan

During 2001 regional project co-ordination will be undertaken by Plymouth Council.

The expectation is that by December 2011:

- Each council in the pilot will complete a minimum of 3 “tranches” for DQM applications ideally with minimum of 24 successful applicants.
- The model will have been tested, refined and developed through experience.
- The model will have been evaluated in respect of mutually agreed success criteria.
- Long-term costs will have been quantified and an options appraisal completed.

Each pilot council area will need to ensure there is:

- A named person within LAA to act as co-ordinator and reference point.
- A panel in place with administrative and development support. This will need to meet a minimum 3 times.
- Recruitment and identification of care homes, aligned to “tranches”.
- Support to homes applying; for example introduction/preparation days.
- Linkage to other activity within dementia action plan especially workforce development
- Quarterly feedback to the regional co-ordinator

The role of regional project co-ordination is to:

- Facilitate an action learning approach between communities by capturing and sharing learning and promoting mutual support. This is particularly in relation to preparing providers, training “panels” and visitors and establishing “thresholds” for DQM.
- Design and monitor a simple project programme across the region with milestones.
- Collate and disseminate simple agreed “outcome success criteria” representing the perspectives of people with dementia and carers, providers and commissioners and collating end of year feedback to make an evaluation against these.
- Act as regional reference point for key stakeholders especially CQC, Alzheimers Society, Skills for Care, provider associations and incoming enquiries.
- Complete an options appraisal including costs and risk analysis with a report to SWDP and Regional Directors of Social Services.

Suggested timeline for project roll out in local communities:

Timescale	Activity with providers	Panel activity
Oct / Nov 2010	Identify first adopters Convene preparation meeting	Identify local co-ordinator and identify panel members
Mid Jan 2011	Deadline for receiving first tranche applications Advertise for further interested providers	Panel and visitor training
Jan / Feb 2011	Visits to services	
Late Feb 2011		First Panel
March 2011	Convene preparation meeting for second tranche	
Mid May 2011	Deadline for receiving second tranche applications	
June 2011	Visits to services	
July 2011	Convene preparation meeting for third tranche	Second Panel
Mid Sept 2011	Convene preparation meeting for third tranche	
Oct 2011	Visits to services	
Early / mid Nov 2011		Third Panel
Nov / Dec 2011	Feedback collated and regional evaluation completed	

Note: It is likely that services that are interested in these early phases will need help in understanding and interpreting the standards. Some will need extra time to up their game and put in place requirements and gather information. So early publication of the scheme and identifying a larger pool for potential providers with early and later adopters is important.

Mainstream and specialist dementia services

This is a difficult area as two thirds of people in care homes are likely to have dementia and many live in traditional older people homes. However there is a need for a **range** of specialist dementia services, some residential, some nursing, some catering for people with complex conditions and other mental disorders. It is also complicated by the fact that some services offer flexibility and a range of services in one establishment e.g. with specialist wings or in reach support.

In developing the DQM it was felt that it should be a universal standard and that services offering specialist dementia care should make this clear in their statement of purpose, outlining the nature of the specialism and the particular facilities available.

Whether a provider is or is not offering a specialist service will be recorded on the DQM certificate.

The basic principles of being committed to improvement and good quality assurance are the same for specialist providers, and the features and outcomes of offering a specialist service should be evident and reflected in the self-assessment completed by the provider.

Resources / cost

Considering a local area where 50 care homes are on the scheme. It is likely one day a week administration time will be required to send out and receive applications and references, allocate applications, co-ordinate the panel and to deal with routine enquiries. The panel is likely to meet bi monthly, ~ 8 applications per meeting.

If an area had 100 care homes on the scheme, one could anticipate two days a week administration and a monthly panel.

Each application will require on average:

- 1 hour preparation time (professional rate with overheads estimated at £30 hour)
- 3 hour visit/ report time plus 1 hours travel time and costs
- 15 mins panel time (3 x professional rate plus room to be ~£100 hour)
- 30 mins admin time (estimated at £20 /hr)
- 10% contingency costs and contribution to general running of scheme (training etc).

On this basis the average application using professional rates could be calculated as follows:

Activity	Cost £
1 hour pre visit preparation time	30
3 hour visit / report time plus 1 hours travel time and costs 100@ 40p	120 40
15 mins panel time	25
30 mins admin	10
Sub total	225
Plus 10%	23
Total	248

Now this cost assumes a high level of input paid at a “professional” rate. Ideally people other than paid professionals would be involved in the scheme particularly with the visits to care homes, which could reduce costs, however reasonable expenses, and allowances should be available.

In some areas existing staff may be redirected from current activity e.g. contract monitoring at no marginal cost, especially during the development phase of the scheme.

These costs are based on average estimates. It is expected that well organised, high quality services will take much less time to assess and others who have less developed quality assurance systems will take longer.

Benefits

To people using services:

- Greater confidence when making choices
- Better lives as a result of on going improvement and the application of best practice
- Greater confidence through improved quality assurance

To providers:

- Positive selling point
- Provision of best practice tools and materials
- Access to improvement networks, peer support and learning

To local commissioners

- Improved quality of dementia care in local market
- Confidence in developing dementia specifications
- Ability to place in people with dementia assured places

Extension

This scheme is designed around CQC standards and in time could be adapted for use in domiciliary care agencies, hospital wards etc. It could also be used for day services.

Further development

It is recognised that further attention to detail is required including:

- Finding a catchy name for the scheme!
- Information protocols and confidentiality

- Equality impact assessment
- Development of learning networks
- Long term ownership and governance

Appendix 1: Alignment between CQC core standards with key aspects of a good dementia care service.

Involving and information

- Outcome 1j Involving people in how the service is run
- Outcome 2c Consent: MCA; advance decisions

Personalised care and support

- Outcome 4a Plans of care
- Outcome 4a Occupation and activity
- Outcome 4k End of life care
- Outcome 5a,c,h Nutrition
- Outcome 6a,b Co-operation with other providers

Safeguarding and safety

- Outcome 7a,e Safeguarding
- Outcome 9a Medicines; only appropriate antipsychotic use
- Outcome 10a,f Premises; environment

Suitability of staffing

- Outcome 13a, 14a Staffing numbers and qualifications.
Dementia training + LINK workers

Quality and management

- Outcome 16a Assessing and monitoring quality of provision
- Outcome 16c Dementia improvement plan identification of senior member of staff

Suitability of management

- Outcome 24a Leadership by managers: keeping up to date, inspiring and coaching

Appendix 2: The DQM Standards: statement of expectations

Quality and management

- *Outcome 15 Statement of purpose*
- *Outcome 16a Assessing and monitoring quality of provision*
- *Outcome 16c Improvement plan and senior member of staff*

The home's statement of purpose **must** explain how the home meets the needs of people of dementia. It should be clear as to whether it is a specialist service offering care and support to people with more complex needs.

It **should** also reflect the support it gives to relatives and carers.

Having a robust, dementia sensitive quality assurance system focussed on outcomes is the key to achieving the dementia quality mark.

Examples of quality assurance tools, which have been developed by the South West Dementia Partnership, are included in Appendix 5.

To achieve the DQM the quality assurance system **must** include:

- Evidence of continual improvement in dementia care practice.
- Having a dementia improvement plan in place. This should be updated quarterly. An example of an improvement plan template is available on the website.
- Having an accountable member of staff for this plan who has sufficient influence to ensure changes happen.

- Evidence of the use of external best practice guidance e.g. through consultancy, conferences, peer networks, internet research etc.
- Evidence of the use of regular feedback from people with dementia and relatives/ carers to lead improvements.
- Evidence of organisational learning from critical incidents and complaints in relation to dementia care.
- Regular (minimum quarterly) observational audits of the care being given with emphasis on the relationships between staff and people with dementia and the level of occupation in the home. These should be recorded but may be undertaken in house or independently by peers, consultants or local voluntary groups.
- Evidence of improved outcomes

Some providers have purchased external quality assurance services (e.g. Dementia Care Matters Kitemark) or have developed corporate systems (e.g. PEARL). Where these are robust they will naturally be assumed to meet the standard for quality assurance.

Involving and information

Outcome 1j Involving people in how the service is run

Outcome 2c Consent: MCA; advance decisions

To achieve the DQM care homes **should** be able to demonstrate that people with dementia and carers have influenced how the service is run, particularly in terms of flexibility of routines and occupation and activity.

The care home **must** be competent in applying the mental capacity act, understanding and applying the law in relation to best interest decisions, DOLS and advance decisions. Evidence of staff training and application of these processes must be in evidence, along with information being made available to people living or moving into the home and their relatives.

Personalised care and support

- Outcome 4a Planning care
- Outcome 4a Occupation and activity
- Outcome 4k End of life care
- Outcome 5a,c,h Nutrition
- Outcome 6a,b Co-operation with other providers

There **must** be evidence of planning tools which:

- Are person centred and promote people remaining active and in control of their lives. They must include an understanding of people's biographies and their cognitive abilities.
- Are easily accessible to staff
- Highlight what staff need to do to keep people safe and free from harm.

There **must** be evidence of ensuring people are positively occupied, with opportunities to use existing skills and pursue interests.

The care home **should** consider advance decision making and best interest planning in relation to end of life care at the point of admission and during subsequent reviews.

The use of end of life care plans **should** be in evidence reflecting the ascertainable wishes of the person.

The care home **should** be alert to and apply best practice in respect of nutrition and hydration with attention to preparation, presentation and flexibility in eating routines and habits.

The care home **should** ensure that it co-operates positively with other providers, accesses expertise when required and appropriately sharing information which will help others provide person centred care and support (e.g. supplying information like “This is Me” to hospitals, ambulance crews).

Safeguarding and safety

- Outcome 7a,e Safeguarding
- Outcome 9a Medicines
- Outcome 10a,f Premises

People with dementia are particularly vulnerable. The home **must** ensure that the particular risks facing people with dementia are anticipated and that its procedures and staff training emphasises that changes in behaviour may indicate possible abuse.

The care home **must** ensure regular (at least six monthly) reviews of medication take place and pay particular attention to ensuring only those who need anti psychotics require them.

The home **must** undertake an environmental audit in respect of meeting the needs of people with dementia, identifying strengths and weaknesses and have in place an ongoing plan to create a safe,

enabling environment sympathetic to meeting the needs of people with dementia.

Advice and an example of an environmental audit is available on the website.

Suitability of staffing

- Outcome 13a, 14a Numbers + Dementia training + LINK

The home **should** have in place a system to ensure that there are sufficient staff available to meet the psychological and social needs as well as physical care needs. This could be based on monitoring outcomes (e.g. support for individualised activities) or levels of dependency.

All staff, including non-care staff **must** receive dementia awareness training within 12 weeks of starting as part of their induction. In particular they must be able to understand the importance of appreciating the perspective of the person with dementia.

The home **must** have a written dementia training plan to enable care staff to have training and development opportunities in line with the qualifications and credits framework.

An example of a dementia training plan template is available on the website.

As a rule the home should ensure all care staff in specialist homes achieve the level 2 certificate in dementia or an effective equivalent which maps across to the same competencies within 12 months, and 50% of staff in non specialist homes. Non-care staff in specialist

homes who have significant contact with people in dementia should also achieve level 2 or an equivalent.

The care home **should** identify and establish a trained dementia LINK worker who can provide a resource to other staff.

Suitability of management

- Outcome 24a Leadership by managers

The manager **must** be able to demonstrate effective leadership in inspiring staff to delivering person centred care. The home should have a clear ethos, which is reflected in the expectations on staff. e.g. not using uniforms, people before tasks.

The manager **should** complete leadership and development workshops and programmes.

Assessing and evidencing “leadership” is difficult. Good leadership ensures results in workforce “wellbeing” which is evident when:

- Everyone is clear about their role and has a sense of purpose
- Everyone is positive about the difference they can make to the experience of those they are supporting
- Everyone has self-confidence in the skills they are using
- Everyone feels recognised for their contributions and feels a sense of achievement.

During the visit to the home these outcomes can be used to provide an indication of the quality of leadership being provided.

Leadership extends beyond the staff group and includes the people living in the home, relatives and visiting professional and wider community. Leadership should be visible and “felt” across this range of people.

Positive use of “360 degree feedback” reporting is a good indication of leadership development.

Appendix 3: Score sheet - Analysis of must dos and should dos

	Standard	Met Y/N	Comment
MUST DO	Statement of purpose is clear		
	QA system is comprehensive		
	Mental capacity act understood		
	Person centred care		
	Positive occupation		
	Risk management		
	Medication reviews		
	Environmental audit		
	Awareness training		
	Training plan		
	Leadership		

	Standard	Met Y/N	Comment
SHOULD DO	Support to relatives		
	Advance decision making		
	End of life planning		
	Nutrition / hydration		
	Co-operation with others		
	Monitoring staffing levels		
	LINK worker scheme		
	Leadership development		

Appendix 4: Application for DQM

Name of home:	
Completed by:	
Date:	

Why do you believe you provide good quality dementia care?

What evidence do you have to support this belief?

Quality and management

Please supply the home's statement of purpose.

Please supply your dementia improvement plan.

Who is the person accountable for the improvement plan?

What improvements in dementia care practice have you made in last 12 months?

What evidence can you provide to demonstrate improved outcomes for people with dementia?

What are the key challenges are you facing in making improvements?

What external best practice guidance have you adopted in the past twelve months?

How has this changed the service you provide?

Please explain your approach to quality assurance.

How do you gather feedback from people with dementia and their relatives and carers?

Give three examples of improvements you have made in relation to dementia care in response to people's feedback or critical incidents / complaints.

How do you undertake observational audits of the care being given?

What changes have you made as a result?

Involving and information

How do you ensure that the views of people with dementia and carers influence how your home is run, particularly in terms of flexibility of routines and occupation and activity?

Please give examples of any changes made.

What has been the impact for people living in the home?

How can you demonstrate that your home is competent in applying the mental capacity act, understanding and applying the law in relation to best interest decisions, DOLS and advance decisions?

Personalised care and support

Please explain your approach to planning care and support and supply a copy of your support / care planning tool.

How do you ensure people in your home positively occupied and have opportunities to use existing skills and pursue interests?

Please give examples where you have been successful.

Does your care home routinely consider advance decision making and best interest planning in relation to end of life care at the point of admission and during subsequent reviews?

Please give an example of good quality end of life planning which has occurred in your home.

How has your home applied best practice dementia guidance in the preparation, presentation of food and drink and flexibility in eating routines and habits?

Give an example of how your care home co-operates positively with other providers, e.g. accessing expertise when required or appropriately sharing information which will help others provide person centred care and support.

Safeguarding and safety

How does your home ensure that the particular risks facing people with dementia are anticipated?

Please give an example:

How many safeguarding alerts have there been in the last 12 months for people with dementia?

What percentage of your residents have had a medication review in the past 6 months?

How many of the people living in your home take anti psychotics of how many in total? (e.g. 3/24)

Please supply an environmental audit in respect of meeting the needs of people with dementia.

What actions have you taken to improve the environment?

What has been the outcome for people living in the home?

What action have you planned for the future?

Suitability of staffing

How do you ensure that there are sufficient staff available to meet the psychological and social needs as well physical care needs.

On a typical mid morning shift what is the ratio between care and nursing staff and the people living in your home?

What percentage of your staff have received dementia awareness training.

How has this training been given?

Please provide a written dementia training plan in respect of your home, explaining what training you are using, and an analysis of the numbers of the staff who you believe are competent and those requiring training.

Does your home have a trained dementia LINK worker who can provide a resource to other staff?

Yes / No / In training

If so what is their name?

If not are you planning to have a LINK worker? Yes / No.

Suitability of management

How does the home's manager inspire staff to delivering person centred care? How is the ethos of the home underpinned?

Has the manager completed dementia leadership and development workshops and programmes. Yes / No

If so what courses?