QUALITY STANDARDS IN SOCIAL PRESCRIBING AND RELATED AREAS OF HEALTH AND SOCIAL CARE

A SCOPING REVIEW

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Contents

1. Introduction

Quality standards '*set out the priority areas for quality improvement in health and social care*' by using a comprehensive list of statements to improve quality along with information on how to measure progress (NICE, 2021). Quality standards are often developed in collaboration with healthcare professionals, practitioners, and service-users and while they are crucial for supporting the ongoing development and improvement of care (Whittaker et al, 2011), they are not mandatory in the UK (NICE, 2021). Due to a variety of factors such as producers, location, training, experience, and individual differences (McLaughlin & Kaluzny, 2006), it is noted as difficult to reproduce consistent healthcare services (Mosadeghrad, 2013), this highlights the importance of having national and local quality indicators to develop a common set of standards by which care is designed, delivered, and monitored.

In recent years there has been a move towards a non-medical approach of care to address health and wellbeing issues through social prescribing. Social prescribing is defined as *"individuals being referred/self-referring to non-medical interventions run by a third-party organisation in order to contribute to their general health and well-being"* (Roberts et al, under review) and while social prescribing is becoming more utilised, there are no social prescribing quality standards in place at this time. Elliott and Wallace (in preparation) are currently conducting a study to identify a set of quality indicators for social prescribing, from which, quality standards can be designed. To further inform this, this scoping review will look to other areas of health and social care to better understand what other quality standards are available and how they are developed and used.

AIM

To identify existing literature which discusses the development and implementation of quality standards in social prescribing and other related areas of healthcare.

OBJECTIVES

- To identify what quality standards are available and currently used in other areas of health and social care
- To identify how they were developed
- To identify who uses them

2. Method and approach

Literature was reviewed using the search terms: *quality standards, social prescribing, social prescription, healthcare,* and *social care* Databases searched include: CINAHL, Scopus Online, Social Care Online (SCIE), PubMed and ProQuest Central.

The search was restricted to reflect the following eligibility criteria; articles published since 2010, articles with reference to quality standards in health and social care, articles published in English language. Additional Google searches were run using the same search terms and the first 5 pages of results were screened.

Titles and abstracts were screened for relevance before full text screening by one independent reviewer. Articles were excluded if they: contained no relevant outcomes, did not discuss development/design, or use of a set of quality standards in a related area of healthcare, were editorial/magazine articles or opinion pieces, or if the reviewer could not access the full text. See Figure 1 for full screening and exclusion process.

Table 1. Database Search Strategy.

Search String	**Database**				
	CINAHL	Scopus	Social Care Online	PubMed	ProQuest Central
Concept 1, 2 – Quality Standards [TI] and Healthcare [TI]	12	4	21	14	56
Concept 1, 2, 3 - Quality Standards [TI] and Healthcare [AB] and Development [TI]	5	12	2	10	3
				Total Hits	139

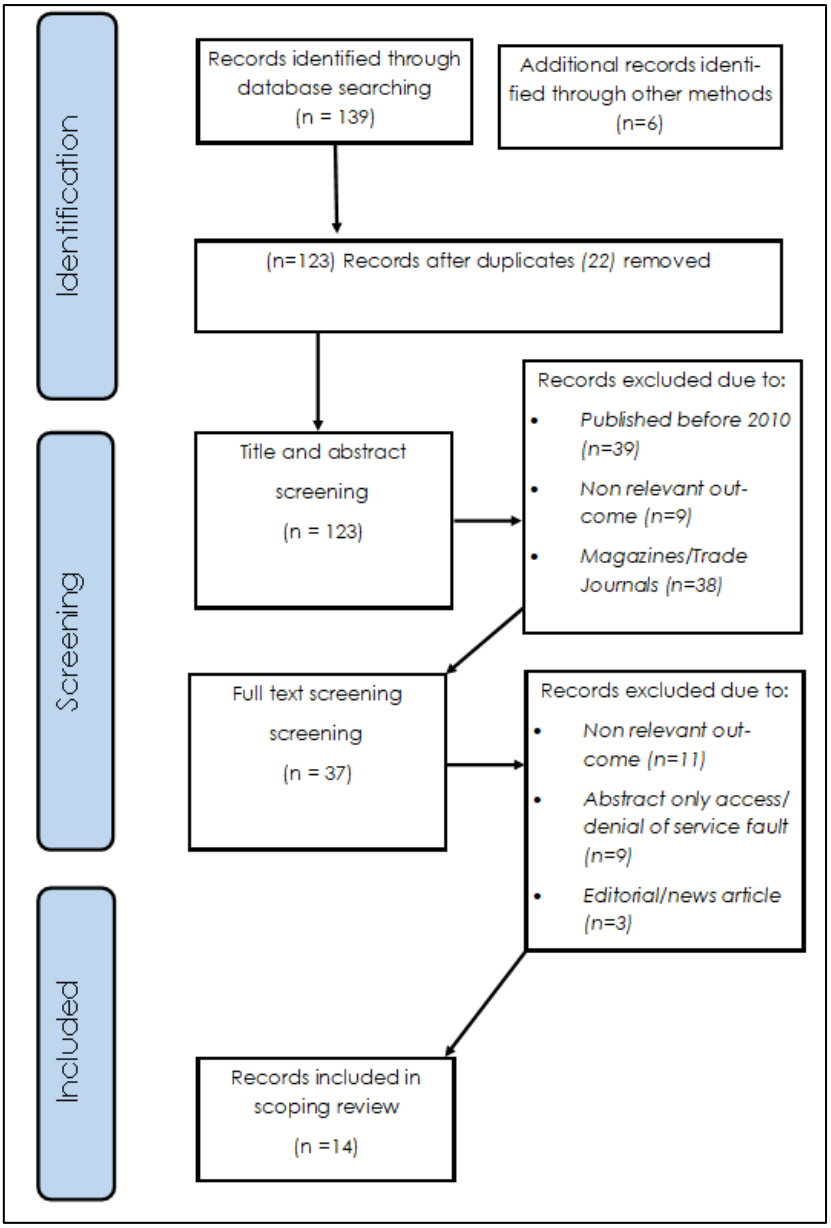


Figure 1. PRISMA Flow Diagram of Search and Screening Process.

3. Findings

A total of 14 articles were included in this review spanning 8 countries including the UK, USA, Ireland, Spain, Germany, The Netherlands, Australia, and Finland. All the articles noted some form of health or social care quality standards, from overarching national health and social care standards to disease specific quality standards. Most of the included articles discussed the quality standard development method, however 2 articles did not (Beacon Authority, 2012; Recovery Partnership, 2016). See Table 2 for full detailed article characteristics extracted from articles.

Many of the articles discussed how national quality standards can be embedded in complementary quality standards designed and implemented at local and service level, with one article (Beacon Authority, 2012), providing an overview of the documents pertaining to quality standards applicable to Directorate adult social care support services (see Figure.2). The diagram details national standards at the bottom tier, local standards in the middle tier and the overriding core standards based on the service values. Other articles also discuss how broad national quality standards are designed to be implemented in all manners of health care settings, services, and locations with consideration given to the design of the quality standard criteria to ensure this. For example, the NHS Wales Health and Care standards (2015) note that the criteria to meet each quality standard is flexible and that organisations can demonstrate adherence to the quality standards through other valid methods while implementing improvement plans to address any gaps.

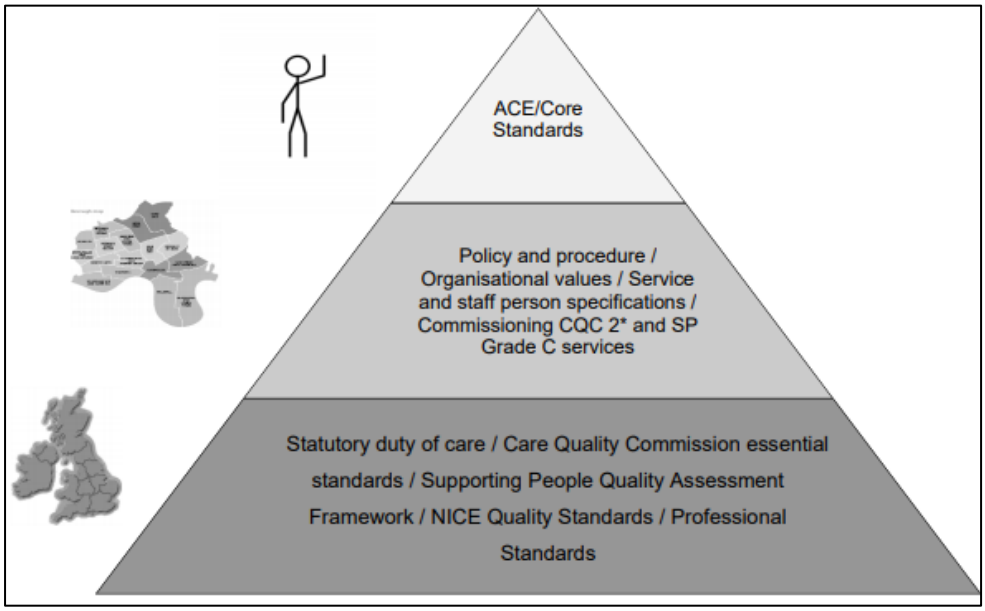


Figure 2. Quality Standards in Adult Social Care. (Beacon Authority, 2012)

A variety of standards were identified in this review with a variety of development methods. The most common type of quality standard encountered in this review was national quality standards designed for specific diseases, interventions, or services. The National Institute of Clinical Excellence (NICE) contributed 6 articles to the final data set in this review, and a further 2 referred to the NICE quality standards development process stating that their processes were informed by the NICE process guide and evidence base (Kiltz et al, 2020; Doncaster et al, 2011). NICE have developed a very clear and coherent process for developing quality standards which can be seen in Figures 3 and 4 below. Furthermore, all the included quality standards were developed from an appropriate evidence base, NICE clinical guidance or built on the work of existing quality indicators.

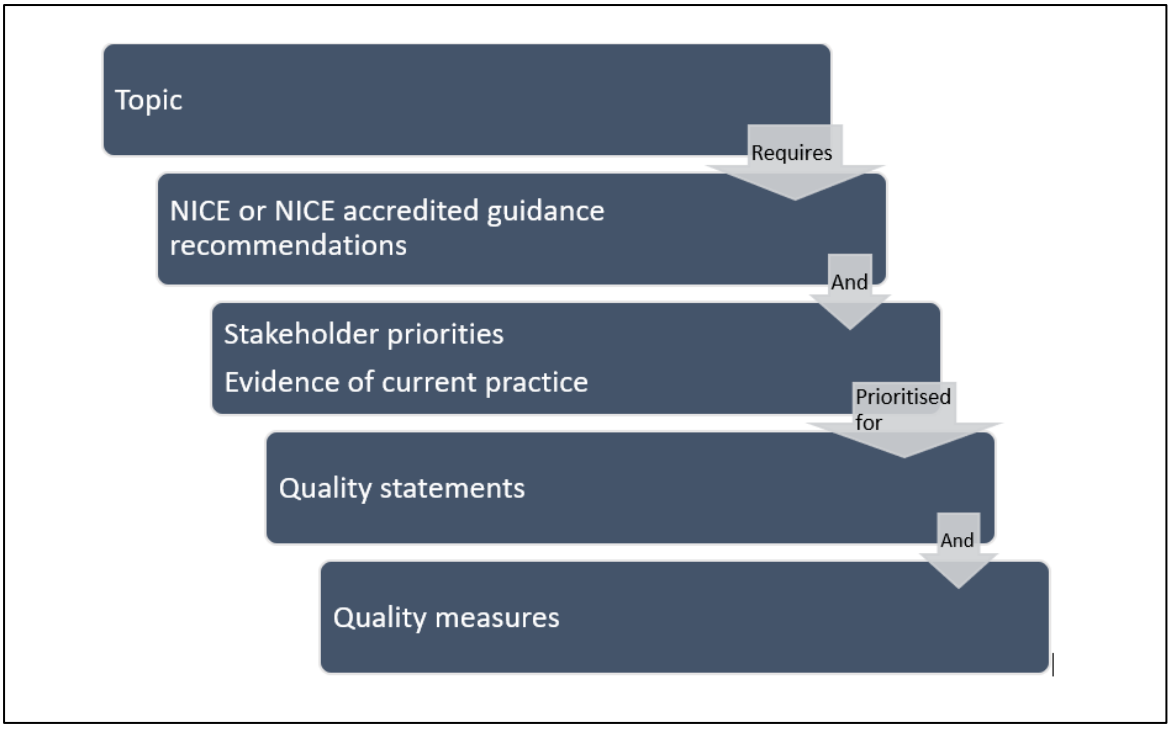


Figure 3. Overview of the NICE quality standard development process. (NICE, 2020)

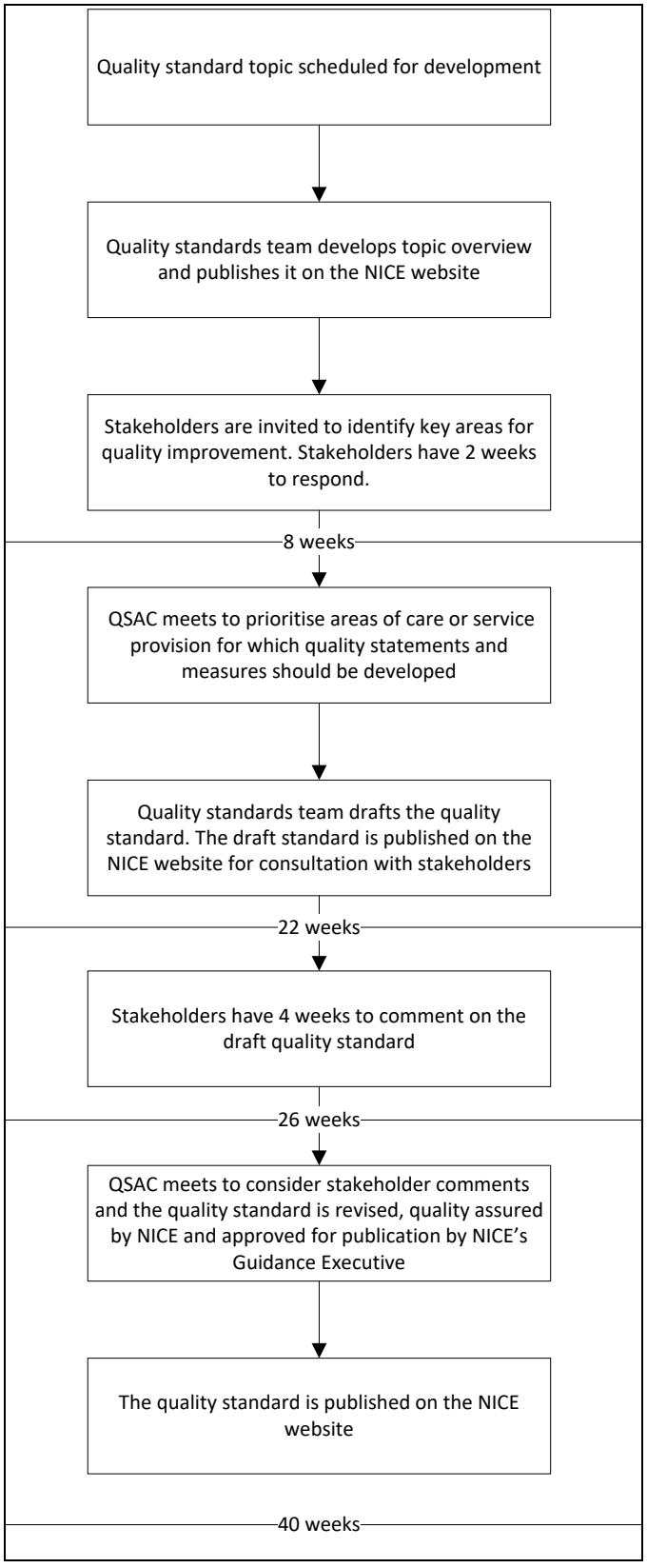


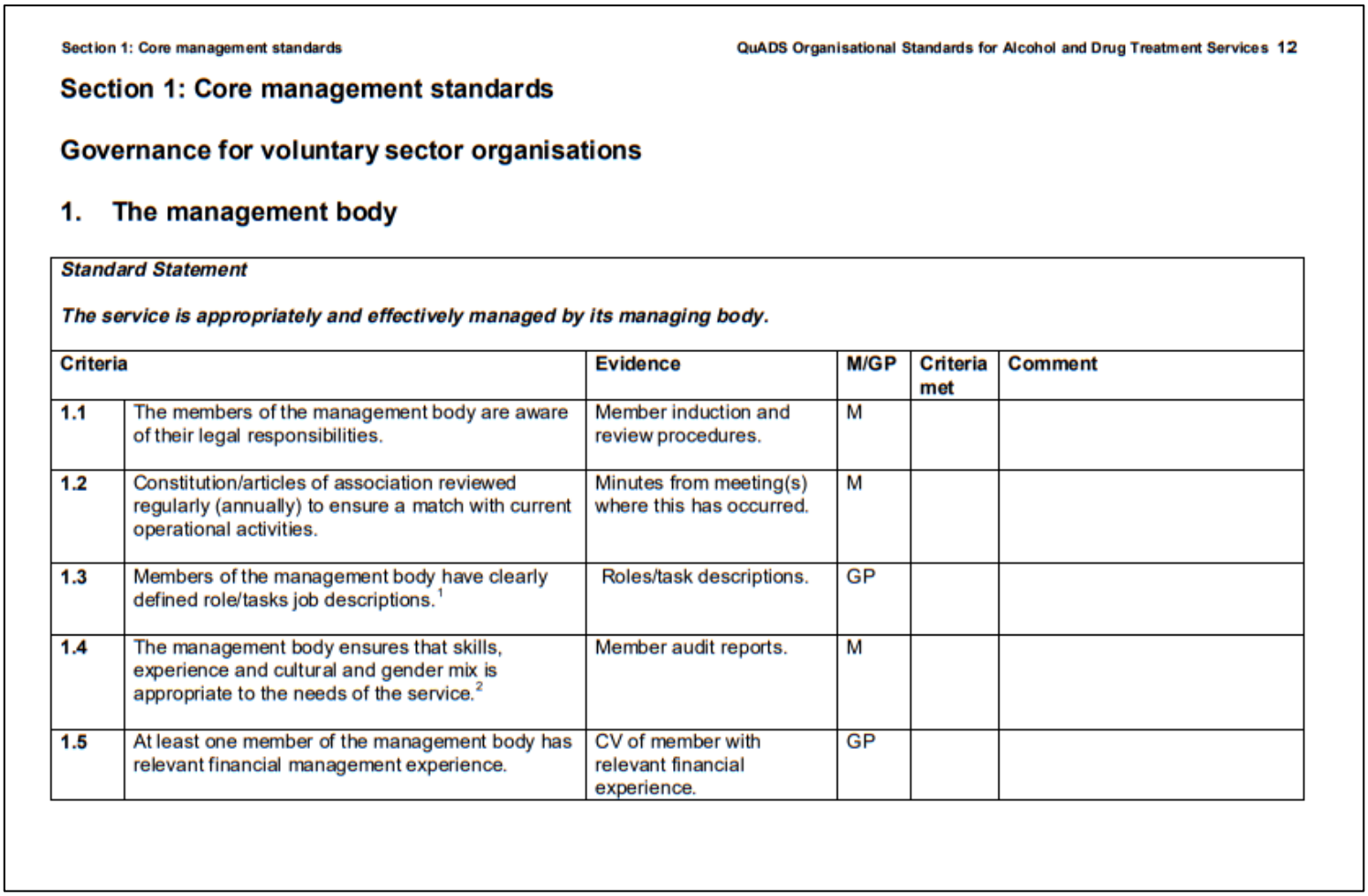
Figure 4. Overview of the NICE Quality Standard Development Process.

(NICE, 2020)

Other quality standards development methods identified in this review included: a stepwise approach, Delphi studies, and stakeholder workshops and consensus meetings, typically used following a review of current literature and quality standards. Most of the articles employed a very collaborative, co-productive approach, including stakeholder (*patients, carers, organisations, charities, involvement, healthcare providers, medical experts, commissioners*) involvement throughout the development process. Moreover, 2 articles noted that by including a variety of stakeholder's, community members can be involved as utilised as information sources (Schweppenstedde et al, 2014) and the representativeness of the quality standards can be improved (Kiltz et al, 2020).

Of the quality standards included in this review 11 were described as a set of national quality standards to be implemented throughout a variety of health and social care settings, 3 were developed specifically for specific health and social care settings across the UK such as community substance misuse services, or older people in care homes. The number of quality statements in each set of standards ranged from 4 to 148 but it should be noted that those with fewer items were to be considered alongside additional, broader sets of quality standards in related areas. The quality standards were often grouped into themes based on the supporting literature which each contains a number of standards, an example of this can be seen in figure 5 illustrating the seven themes which comprise the NHS Wales Health and Care Standards (2015). All of the standards included at least one way they could be used, ranging from setting expectations of service delivery for service users, to demonstrating quality of care in mandatory audits. Other uses of the quality standards throughout the literature included identifying areas for improvement and aspirational quality targets, supporting quality improvement initiatives, improve structure, processes, and outcomes of services, supporting quality assurance systems, supporting accreditation processes, along with using quality standards as a self-audit tool to demonstrate the standard of service provision against a set of agreed benchmarks. Many of the standards included tools or methods for measuring each quality statement alongside a set of criteria which must be evidenced to meet the requirements of the quality standard, an example of this can be seen in Figure 6. below. Torrejon and colleagues (2013) created a tool from the inflammatory bowel disease (IBD) nursing care quality standards they developed to assess and rate the quality of care provided by nurses working in IBD services. Whereas NICE (2011) made use of existing quality markers and measures (*Department of Health's End of life care strategy: quality markers and measures for end-of-life care (2009))* which pertain to structure process and audit. As stated in the introduction, NICE quality standards are not a mandatory set of indicators for performance management, however some of the quality standards identified in this review are used for mandatory review of services by appointed nation regulatory bodies. For example, organisations pertaining to the metal wellbeing of older people in care homes are required to meet Care Quality Commission (CQC) fundamental standards who are using the NICE (2014) quality standards among others to identify good and outstanding care. Furthermore, in Australia, the National Safety and Quality Health Service standards (NSQHS) are used as a mandatory measure for an external accreditation scheme. Both public and private clinical health services in Australia are also expected to comply with these standards as they represent the 'essential standards of care' used for internal quality assurance. While there are some mandatory quality standards in practice internationally, most regulatory mechanisms identified in this review rely on self-regulation by industry and associations, co-regulation, financial incentives, or voluntary adoption of quality standards (Schweppenstedde et al, 2014).

Figure 5. NHS Wales Health and Care Standards Main Themes



Section 1: Core management standards QuADS Organisational Standards for Alcohol and Drug Treatment Services 12

Section 1: Core management standards

Governance for voluntary sector organisations

1. The management body

Standard Statement

The service is appropriately and effectively managed by its managing body.

Criteria		Evidence	M/GP	Criteria met	Comment
1.1	The members of the management body are aware of their legal responsibilities.	Member induction and review procedures.	M		
1.2	Constitution/articles of association reviewed regularly (annually) to ensure a match with current operational activities.	Minutes from meeting(s) where this has occurred.	M		
1.3	Members of the management body have clearly defined role/tasks job descriptions.[1]	Roles/task descriptions.	GP		
1.4	The management body ensures that skills, experience and cultural and gender mix is appropriate to the needs of the service.[2]	Member audit reports.	M		
1.5	At least one member of the management body has relevant financial management experience.	CV of member with relevant financial experience.	GP		

Figure 6. Example of Quality Standard for Alcohol and Drug Treatment Services. (2013)

4. Conclusion

This scoping review has identified a number of quality standards currently used internationally in health and social care. Quality standards can be used by 'anyone wanting to improve the quality of health and care services' (NICE, 2020) to: ensure high quality services are commissioned, monitor service structure, delivery and outputs, highlight and monitor improvement areas, demonstrate quality of care via audit, accreditation or validation and to identify and define good quality care (NICE, 2016). The quality standards in this review were developed using a range of methodologies, but all were informed by an evidence base and had active contribution from a wide range of stakeholders. Many were overarching national standards which to be adopted in different settings is advised that they are interpreted within the public and regulatory policy concepts which support them (Schweppenstedde et al, 2014). This review highlighted that a majority of these quality standards were developed due to there being no nationally agreed model in place. There is currently no set of quality

standards available for social prescribing which is becoming a quickly adopted model of treatment in UK health and social care. Evidence based quality standards could improve the structure, delivery, and outputs of social prescribing services along with demonstrating the quality and value of their services to commissioners, governing bodies, service users, their families, friends and community.

6. Appendices

Author, Year and Country	Description of Quality Standards	Who Uses Them/how used	Development Method	Notes
Doncaster et al, 2011. UK Peer reviewed	QS for Memory Services National Accreditation Programme (MSNAP). The final set of 148 agreed standards were evidence based and mirrored recommendations contained in both policy and research literature. NICE clinical guidance formed the evidence base for many of the assessment and diagnosis standards. Standards regarding the composition and functioning of the memory service team were directly informed by both policy and research recommendations as were the identified quality assurance and service development standards.	Used as a quality improvement initiative by memory services in the UK. Accreditation Advisory Committee (AAC) - nominated representatives from professional organisations who considers evidence supplied for each service and recommends accreditation status depending on how standards are met. AAC uses this to highlight areas of improvement.	Developed as there was no nationally agreed model resulting in variance in quality, characteristics and functions of memory services delivered in the UK. Draft standards developed through 5 stages and then pilot tested when applied to 13 memory services through process of self and peer review. Stage 1: Literature review and content analysis. *Identified current recommendations for good practice. Content analysis identified a list of recommendations and whether they were mandatory, desirable, or aspirational. First draft of standards revised using Delphi exercise as detailed below.* Stage 2: Project Launch Event and Stakeholder Workshop *53 participants rated if each draft standard applied; only to memory clinics, only to memory services, both, or should be removed. Stakeholders also considered list of review sources. Feedback used to create V2 draft standards.* Stage 3: Email and Postal Consultation *Stakeholders including organisations, charities, patients, and carers consolidated on V2 and considered content, measurability, importance, clarity, succinctness, and face validity of each standard. Along with indicating importance of each using CCQI format.* Stage 4: Consensus Meeting *Results of above discussed with steering group and V3 of standards agreed.* Stage 5: Final Consolidation and Obtaining Endorsements *V3 shared with all partners from previous stages for final consolidation. Consensus agreed via steering group and V4 was endorsed by relevant professional organisations.* Pilot Study Audit tools developed to measure how each service currently adhered to standards. Adherence measured using audit tools and triangulation process, each standard measured by more than one tool. Audit tools included questionnaires, complement matrix, case note audit tool and organisational checklist.	At time of publish no research assessing the impact of QS on patient outcomes had been conducted. The pilot highlighted standards representing common areas where improvements had been made, such as ascertaining whether the patient wished to know their diagnosis, and areas where more attention was still required, for example surveying referrers, patients, and carers about their experiences of the service.

Kiltz et al, 2020 Peer Reviewed Set of international standards	The Assessment of SpondyloArthritis International Society (ASAS) developed a set of disease specific QS to help improve the quality of healthcare provided to adult patients affected by axial spondyloarthritis (axSpA) worldwide. QS were formulated for the key areas of referral, rheumatology assessment, treatment, education, self-management, and comorbidities. They include a clear description of priority areas for improvement and monitoring of quality. Final development of nine QS were agreed upon via nominated task force and endorsed by ASAS. Each QS consists of a quality statement and a quality measure and is supported by a rationale of scientific evidence for guidance and definitions of terms used. All QS described as achievable in daily care and intended to minimise variance across services.	Service users, care providers, governing bodies and members of the public can use the QS to identify the quality of services available.	Gaps in current care resulted in ASAS to start developing a set of quality standards (ASAS-QS) to help optimise access, treatment, and patient outcomes in axSpA. ASAS chose QS as a quality assessment tool, based on the methodology used by NICE. ASAS nominated a steering committee and a QS task group (ASAS-QS) comprised of SpA experts, patients, and healthcare providers. ASAS-QS group used stepwise approach to develop initial set of QS based on the NICE QS process guide. ASAS members consulted to identify key areas for quality improvement to identify gaps at a national level. The following steps were used to develop the QS. Step 1: Provisional list of key areas for quality improvement *ASAS-QS members decided on stepwise approach starting with identification of key areas where variation exists which are measurable and achievable and grouped into categories; structure, process, and outcomes* Step 2: Evaluation of list of key areas for quality improvement *ASAS members and patient representatives completed web-based survey to comment on provisional list and identify gaps. Key areas considered important is >25% of participants agreed.* Step 3: Prioritisation of key areas for quality improvement *Participants from previous step then contributed to development process by commenting on complete list of key areas via web survey along with prioritising key areas by level of importance.* Step 4: Identification of final key areas for quality improvement *ASAS-QS group regrouped most important key areas into domains so standards and measures could be developed. Group then proposed phrasing of important QS* Step 5: Phrasing of QS *ASAS-QS drafted statements, rationales, and measures for key areas. Phasing influenced by proposals of ASAS community.* Step 6: Voting on ASAS-QS *QS set presented to ASAS community and fed back their level of agreement via web-survey.* Step 7: Endorsement by ASAS membership	Stepwise approach to develop initial set of QS based on the NICE QS process guide. Disease-specific set of international standards Article noted the inclusion of a variety of stakeholders adds to the representativeness of the ASAS-QS set. Also noted that implementation strategies must be accompanied at national levels by education about the meaning of QS in order to specify the intention: optimise quality of care at a community level instead of describing current practice of daily care.
Recovery Partnership, 2016 UK	Community Substance Misuse Service Quality Standards Framework. A set of standards specific to community-based substance misuse services identifies what outcomes	Set of 18 standards used by services to demonstrate their quality against a set of agreed benchmarks.	Co-developed by Skills Consortium and representatives of community substance misuse services, and commissioners. No information in this paper about the development process of QS.	Consideration of different treatment journeys when designing QS Each standard has a section for service users comprising of an introduction to

	service users, commissioners and the family and friends of service users can expect of a service. QS designed to reflect the recovery orientation of drug treatment services described in 'Medications in Recovery' (NTA, 2012). They are based upon the 2010 national drugs strategy definition of recovery capital "the resources necessary to start and sustain recovery from drug and alcohol dependence." (HMG, 2010) with a consideration of the treatment journeys. The QS describe good practice in the delivery and management of a service. A drug and alcohol matrices are also provided for services which deliver specific interventions. Structured around 5 key lines of enquiry: • Clinical interviews • Quality of practice • Supporting recovery • Service user, family, carers, and significant others involvement • Staff management and development Each section has one or more standards with a measurable outcome.	QS framework also used as a self-audit tool to improve practice. Audit findings can be used to demonstrate to commissioners, service users and their family and friends the quality of the service how it will meet needs. Service providers use QS to identify if they undertake all the activities listed in the 'content of standard section', then build a portfolio of evidence to demonstrate that the activities are delivered in line with best practice.		the area (e.g., clinical interviews), the QS statement and what service users *should* experience, what standards providers will comply with to ensure this. Along with a section of prompts for providers detailing who is this standard for, what does this standard address, a link to CQC KLOE, the content of the standard and examples of appropriate evidence. Also provides implementation guide.
Torrejon et al, 2013 Spain Peer reviewed	QS developed for inflammatory bowel disease (IBD) nursing care (90 items) along with an evaluation tool based on the quality standards (NCQ-IBD).	The QS developed in this paper are used for quality evaluation via the NCQ-IBD evaluation tool. This tool allows an assessment rating the	178-item healthcare quality questionnaire was developed based on a systematic review of IBD nursing management literature. The questionnaire was used to perform two 2-round Delphi studies: Delphi A included 27 IBD healthcare professionals and Delphi B involved 12 patients. The NCQ-IBD was developed from the list of QS items resulting from both Delphi studies combined with the Scientific Committee's expert opinion.	To maximize representation within the scope of the study data from both healthcare professionals and patients across the country and care levels were collected.

	QS included care standards pertaining to resources, processes, training, and research, among others.	quality of care provided by nurses working at IBD services. The NCQ-IBD categorizes nursing quality of care into four categories from A (highest) to D (lowest). Application of this tool will assist improvement strategies for IBD management. Based on its ratings, minimum acceptable QS in healthcare, research and training can be identified. The NCQ-IBD can reduce large amounts of information into specific QS. These standards can then be applied by healthcare providers, patient associations, and the Healthcare Administration to homogenize IBD management protocols, reduce clinical practice variations, and improve nursing care in IBD.		
Ziebland et al, 2014 UK	This paper used a plethora of qualitative methods to explore patient experiences, covering over 60 health issues, to identify 8 consistently important aspects of care which can be used to inform the development of NICE quality standards. Information from this paper was used to inform the development of one	In collaboration with NICE, the interview collections could be mapped to the guidelines and QS programme.	Qualitative secondary analysis, interviews, observations, and focus groups were used to identify eight consistently important aspects of care: • involving the patient in decisions • a friendly and caring attitude • an understanding of how life is affected • seeing the same health professional • guiding through difficult conversations • taking time to explain • pointing towards further support • efficiently sharing health information across services.	Article notes that with regard to the NICE CG and QS development process, the usual source of evidence is published qualitative or quantitative research. Unpublished secondary analysis of qualitative data did not fit the usual criteria for evidence. Also notes, in collaboration with NICE, the interview collections could be mapped to the guidelines and QS programme

	NICE Asthma QS (importance of inhaler training).			
NICE, 2018 UK	QS developed for adults using social care services. Applicable to all social care service settings (e.g., personal homes, residential care, and community settings). Details high quality care in priority areas for improvement At time of publish these are draft QS for consultation. Made up of 4 Quality Statements to be used in conjunction with a variety of listed specific QS taken from other NICE QS in a similar topic. Each QS has a statement, rationale, quality measures relating to structure, process, and outcome, each with examples of data sources. Each QS also has a section on what the quality statement means for different audiences e.g., service providers, commissioners, service users and practitioners.	QS for use of commissioners, service providers, health, public health and social care practitioners and the public to understand the expected care experience and identify areas for improvement. Practitioners and provider organisations can use QS to demonstrate quality of care in national audits, monitor service improvements.	Developed following NICE process: • Quality Standards team develops topic overview for each QS including relevant national and routine indicators. • Quality Standards Advisory Committee (QSAC) identifies key areas for quality improvement, addresses any gaps in performance indicators/measures, assesses current practice information, prioritises quality improvement areas for statement development and advises on the content of the quality standards. • QSAC then agrees prioritised areas of care or service provision for which quality statements and measures should be developed. • Statements and measures developed using NICE guidance or NICE accredited guidance • A set of quality statements drafted based on the agreed prioritised areas for quality improvement and derived from the source guidance. • Quality measures are drafted after the wording of the quality statements has been agreed. They address the structure of care or services, process of care or service provision and, if appropriate, outcome of care or service provision. • Information for different audiences about what the high-quality care described in each statement is, the guidance used, the sources of data for measurement, definitions of the terms used, and if appropriate, equality and diversity considerations developed by QSAC. • Stakeholders invited to comment on draft QS via formal consultation. • Field testing to examine the relevance, utility, acceptability, clarity and potential impact of the draft quality standards. • QS refined following review of consultation feedback. • Revised quality standards undergo a process of internal quality assurance, consistency checking and approval. • Once approved by the NICE Guidance Executive, the final QS is published on the NICE website in the relevant pathways.	Offers a list of other specific QS which are advised to be considered alongside these QS. This quality standard is expected to contribute to improvements in the following outcomes: • Quality of life of people using adult social care services • Experience of people using adult social care services • Unplanned hospital admissions and readmissions

			• Quality standards are reviewed on an annual basis. A full update of a quality standard follows the same process as the development of a new quality standard (NICE quality standards process guide): https://www.nice.org.uk/standards-and-indicators/timeline-developing-quality-standards	
NICE, 2011 UK	QS for end-of-life care for adults. Also includes support for family and carers and is applicable to care provided by health and social care staff in all settings. National indicators that describe high-quality care in priority areas for improvement, desired levels of achievement defined locally. Is not condition specific. Comprised of 16 items	QS and quality measures aim to improve structure, process and outcome of care and are not a mandatory set of indicators for performance management. They are used by This QS makes use of existing measures and indicators (Department of Health's End of life care strategy: quality markers and measures for end-of-life care (2009)) which provides a variety of quality markers and measures pertaining to structure, process and audit, applicable to a wide range of settings along with the appropriate sources of evidence to use in support of the measures. The standard also highlights where related national quality assured indicators currently exist and measure the quality statement.	Developed following NICE process, see above. Article also includes a list of development sources which contains the clinical guideline recommendations which were used to develop the QS and measures.	NICE standards reviewed every August Notes that each quality statement will not apply to all groups due to the variance of specific illnesses. Has a wide range of measures/ marker sets which apply to a range of specific settings.
NICE, 2016	QS for transition between inpatient hospital settings and community or	QS aim to improve the structure, process, and	Developed following NICE process, see above.	These QS are designed to contribute to improvements outlined in 3 listed

UK	care home settings for adults with social care needs. d covers admissions into, and discharge from, inpatient hospital settings for adults with social care needs, separate QS for inpatient mental health settings. 5 Quality Statements with rationale, measures (structure, process & outcome) and what the QS means for service providers, commissioners, health and social care practitioners, patients and carers.	outcomes of care in areas identified as needing quality improvement. If national indicators exist that could be used to measure the quality statements then they should be used. If there is no national indicator, the quality measure should form the basis for audit criteria developed and used locally.	Article also includes a list of development sources which were used by the NICE quality standards advisory committee to develop the QS statements and measures.	department of health outcome frameworks. Article notes that the QS is considered alongside a list of current policy documents in relevant areas.
NICE, 2014 UK	QS of mental wellbeing of older people in care homes. 6 items included in this QS. Organisations are required to meet CQC fundamental standards. NICE quality standards are not mandatory. However, the CQC is using this quality standard and others to identify good and outstanding care.	This QS will help providers to know what to aim for and help people living in care homes and others to identify the quality of the service they are receiving.	NICE worked with an independent advisory committee and consulted a wide range of stakeholders. The advisory committee included carers, practitioners, providers, and commissioners, together with the quality standards team from NICE. This group looked at the evidence from the relevant NICE guidelines and other NICE accredited guidance that include recommendations intended to guide decisions in health and social care. The other guidance accredited by NICE was assessed by the NICE accreditation programme which looked at the processes used to produce this guidance. Additional evidence about variation in practice to identify the key areas for quality improvement was considered and developed into 6 statements.	Roundtable discussion was used 1 year after QS implementation to discuss how the NICE quality standard can help to improve the lives of older people in care homes and to encourage collaborative working with care homes

NHS, 2015 UK (Wales)	Health and Care Standards – Health in Wales designed to provide a framework for the organisation, management, and delivery of services. QS designed so that they can be implemented in all health care services, settings and locations. They establish a basis for improving the quality and safety of healthcare services by providing a framework which can be used in identifying strengths and highlighting areas for improvement. 23 QS statements included grouped into 7 key areas with Criteria health care services need to evidence to meet the standard.	Used via -assessment, well tested ough use of mechanisms such nternal audit and clinical it r review processes ernal review from bodies n as Healthcare Inspectorate les ng on feedback from bodies n as Community Health ncils and the community. The Health and Care Standards form the cornerstone of the overall quality assurance system within the NHS in Wales. Alongside the Framework for Assuring Service User Experience (2013)	Built on Doing Well, Doing Better: Standards for Health Services in Wales (2010) and the Fundamentals of Care Standards (2003) In 2014-2015 a broad range of stakeholders and gathered their views on the changes needed in developing new Health and Care Standards. Welsh Government, stakeholders and the public consulted and revised the aforementioned quality standards and produced an updated integrated framework of standards. It identifies key population outcomes and indicators grouped under seven themes. The themes were developed through engagement with patients, clinicians and stakeholders and identify the priority areas for the NHS to be measured against.	Supporting guidance to help services meet each standard is available on the NHS Wales Governance e-Manual (www.wales.nhs.uk/governance-emanual). Notes that the criteria is flexible and that organisations may demonstrate they meet the standards through other valid ways, and then put in place progressive improvement plans to address any gaps.
Social Services Inspectorate Department of Health Social Services and Public Safety Ireland	QS for social work and rehabilitation in sensory support services. Comprised of 8 statements (items) developed in the context of 5 core values central to social work practice. Each standard statement explains the performance level to be achieved and a series of criteria. E.g. *"Awareness training on human rights and equality is provided for all staff in Sensory Support Services."*	All commissioners and sensory service providers are expected to comply with QS. QS used by: • strategic health and social care authority, HSS boards and trusts, local commissioning bodies and practitioner services regarding planning, commissioning, provision, and auditing of services.	QS developed as part of inspection of social work and rehabilitation services for adults with sensory support needs. Draft standards produced following a comprehensive consultation process with staff and service users. Draft was then finalised based on feedback, findings, and recommendations of aforementioned inspection. Team also consulted closely with the Human Rights Commission and the Equality Commission.	Mandatory and monitored quality standards with external reviewers. Developed in line with human rights commission and equality commission. Does not give examples of how to evidence the QS criteria has been met

		• Service users, carers, and staff to clarify the level of quality that should be expected • Regulation and Quality Improvement Authority (RQIA) in its clinical and social care governance reviews services • Northern Ireland Social Care Council (NISCC) and training providers to ensure that rehabilitation training fully prepares staff to operate effectively in sensory support services.		
Australian Commission on Safety and Quality in Health Care, 2011 Australia	National Safety and Quality Health Service Standards. Includes 10 National Safety and Quality Health Service (NSQHS) Standards. Each Standard contains: • the Standard, which outlines the intended actions and strategies to be achieved • a statement of intent, which describes the intended outcome for the Standard • a statement on the context in which the Standard must be applied • a list of key criteria; each criterion has a series of items and actions that are required in order to meet the Standard	Provides a quality assurance mechanism that tests whether relevant systems are in place to ensure minimum standards of safety and quality are met, and a quality improvement mechanism that allows health services to realise aspirational or developmental goals. Health service organisations can use the Standards as part of their internal quality assurance mechanisms or as part of an external accreditation process. Australian Commission on Safety and Quality in Health	Developed by the Australian Commission on Safety and Quality in Health Care (ACSQHC) in consultation and collaboration with jurisdictions, technical experts, and a wide range of stakeholders, including health professionals and patients. The Standards have been designed for use by all health services.	National set of standards designed to assist health service organisations to deliver safe and high-quality care. The document presents the ten National Safety and Quality Health Service Standards and details the tasks required to fulfil them.

	Core actions are considered fundamental to safe practice. Developmental actions identify areas where health services can focus activities or investments that improve patient safety and quality. Health service organisations will be assessed against a three-point rating scale (Not Met, Satisfactorily Met, Met with Merit).	Care (ACSQHC) charged with maintaining standards.		
Beacon Authority, 2012 UK	The Quality Assurance Framework for Adult Health and Wellbeing Directorate services - structure through which the quality of Directorate services will be defined, measured, and improved. Core QS based on the adult social care service values which are consistent with QS communicated at, service, council, and national level. 4 core QS with additional complimentary standards for specific services or teams.	QS monitored through: • Audits • Hearing the views and experiences of people who use services. • Reporting • Visits and meeting The Quality and Involvement team in the Directorate act as the central point of contact for this information, and produce regular reports demonstrating the quality of Directorate services.	Directorate core quality standards for adult social care and support services are based on Directorate service values. Article does not note QS development method	This QS only applies to services where Adults Health and Wellbeing directorate are the lead commissioner.
Schweppenstedde et al, 2014. Comparison of 6 countries: Australia, England, Finland, Germany, the Netherlands and the USA	'standards of quality and safety' within health and social care systems across 6 countries. Review of regulatory mechanisms used to ensure QS of care adherence and policy instruments used to encourage and ensure quality improvement.	All countries reviewed, employ elements of regulatory strategies such as self-regulation and voluntarism, meta-regulation, command and control, and market mechanisms. The frameworks are embedded within overall health and social care governance and wider national legislative	The sources of QS in the health and social care systems vary among countries, as do the actors (responsible for assuring standard adherence) involved in standard setting. Sources of standards may involve overarching, high-level principles that inform quality regulation such as a country's constitution, national legislations, or frameworks. With the exception of the USA, all systems reviewed here have some form of national framework or principle in place guiding the overall development and implementation of standards. **Australia** - National standards usually developed through consultative and administrative strategies rather than legislative strategies, with adherence generally sought through financial incentives rather than 'command and control' enforcement sanctions. Many of the standards are aspirational rather than mandatory. However, NSQHS standards are a mandatory component of national accreditation scheme, from	In Germany and Australia, mapping standards across care boundaries, such as primary and secondary care. Conversely, in England, government standards of quality and safety apply to both health and social care sectors.

		framework informing the development of QS and frameworks for guiding service quality.	June 2013, all clinical health services (public and private) are expected to comply with these national standards, which represent 'essential standards of care' that can be used for internal quality assurance or external accreditation. Along with development of National Mental Health Service Standards (2010) for public, private and non-governmental organisations, and for community-based and primary care mental health services though these are not mandatory. Regulatory mechanisms tend to focus on co-regulation, self-regulation by industry and professional associations, financial incentives, and voluntary adoption of 'codes of practice' and 'frameworks'. **England –** Care Quality Commission (CQC) independent regulator of adult health and social care providers. NICE produces evidence-based guidance, quality standards and performance metrics. CQC regulates all health and social care providers against 16 essential standards liked to outcomes that service users can expect as a result of care receive. CQC registers providers compliance to QS through inspections and assessments. **Finland –** standards of care embedded in Finnish constitution providing legal foundation for national regulation. While they don't have any national QS they have key policy targets, guidelines and recommendations, priority action areas and monitoring. Characterised by self-regulation with some aspects of mandated improvement (external audit, incident reporting). **Germany –** hospitals required to implement internal quality management systems and must produce quality reports every 2 years. Federal Joint Committee (G-BA) mandated hospital reporting of 182 quality indicators to be submitted to social health insurance and private insurers and their respective associations. **Netherlands -** Dutch law provides legislative framework for quality and safety standards but does not stipulate a specific model or set of standards, enabling the development of sector-specific standards, monitoring, control and evaluation mechanisms. Relies on self-regulation. Set of performance indicators used by health care inspectorate (IGZ) to monitor quality of municipal health services and facilitate national comparisons. **USA -** has a national framework for creating national standards but does not have a strong central oversight and enforcement mechanism to assure the quality of care. Focus on quality assurance (ensuring minimal structural and operational requirements are met).	

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