

# Measuring the quality of long-term care in England

Juliette Malley

*Summary: Improving the quality of long-term care has been central to the agenda of successive UK Governments since the late 1980s and a number of mechanisms have been introduced to achieve this end. The quality assurance framework that exists in England is comprehensive and supported by legislation. It is also supported by a number of national quality measures, including performance indicators from administrative systems to user surveys and composite measures of quality. There is close interaction between the quality assurance system and the collection of data for quality measures; additionally, the measures are used to support quality assurance activities. This relationship has consequences for the accuracy and validity of the measures.*

*Key Words: Quality assurance; long-term care; quality indicators; England*

Improving the quality of public services, and long-term care (LTC) more specifically, has been central to the agenda of successive UK Governments since the late 1980s. This article focuses on the situation in England, where a variety of mechanisms have been implemented to achieve this end, including the introduction of quasi-markets, an independent inspectorate, national standards for care providers, a national performance management regime and a variety of other regulatory and guiding bodies for the workforce and practitioners. Given the investment in quality improvement, it is important to ask how high is the quality of LTC in England? To provide some background to this question, the first part of this article explores who the key players are, what measures are used and how these measures fit within the quality assurance (QA) framework. Then, the evidence about the quality of LTC for adults in England is critically reviewed. LTC for children is not considered – this is the responsibility of Children's trusts, which are subject to different policies and are accountable to the Department for Education. Furthermore, the article does not look at the situation in the other three

countries in the UK, where, since 1999, responsibility for long term care has been the responsibility of the devolved national administrations.

## The quality assurance framework in England

Local authorities (LAs) and care providers are the focus of QA inquiry in England, not the National Health Service (NHS). This is because the majority of LTC, including residential and nursing care homes, domiciliary care and day centres, is defined as 'social care'. The dual focus on LAs and care providers arises for two reasons. First social care, unlike health care, is means tested. Therefore in addition to public provision there is a private market for care. Adult social services departments (ASSDs), within the LAs, are responsible for ensuring that people with little means receive services. LAs are primarily commissioners of care; only a small proportion of publicly-funded care is commissioned from in-house services; the vast majority is purchased from the independent sector.<sup>1</sup> However, the emergence of consumer-directed support means increasing amounts of publicly-funded care are purchased by service users themselves from the market.

There are two government departments with a role in measuring and assessing the quality of LTC. The Department of Health (DH) has primary responsibility for social

care (and NHS) policy. However, since ASSDs are part of local government, the department with responsibility for local government policy, currently the Communities and Local Government department (CLG), also has a role in social care policy. The influence of the CLG over social care policy is particularly important in the area of quality, as the CLG sets the broad regulatory and performance framework for local government. The DH works within the framework set by CLG applying it to social care, for example, by specifying performance indicators and quality objectives for care providers and LAs.

The regulator for social care also has an important role in measuring the quality of LTC. Currently, the Care Quality Commission (CQC) regulates health and social care. Under the *Health and Social Care Act 2008 (Regulated Activities) Regulations 2009* certain services are subject to regulations and must register with CQC. These services include nursing and residential care homes and those domiciliary care agencies and day centres that provide personal care\*.

## Approaches to quality assurance

The QA system in England is national and is supported by legislation. It is also fairly comprehensive as CQC is required to inspect all registered providers and assess the quality of their provision. Only non-personal care services such as home help,

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sitting services and day centres, which provide companionship or domestic services, are not subject to regulations. However, where these are commissioned by the LA, their contribution to the well-being of their users will be assessed. This is because through its role in improving social care, CQC also inspects LAs and formally assesses their performance, focusing specifically on how they discharge their duties with respect to social care. There is also a sizeable amount of care purchased privately on the grey market, which is not regulated.

QA follows a ‘business approach’: quality is systematically defined, evaluated, maintained and improved through the process of performance assessment.<sup>2,3</sup> In addition to the regulations outlined, LAs are legally required to develop performance plans, known as ‘Local Area Agreements’ (LAAs), in consultation with local partners. These plans have objectives and targets, which are agreed in negotiation with central government, and include some targets relevant to LTC.<sup>4-6</sup> LAs are required to monitor their own progress against these plans. CQC applies external evaluation and pressure to improve. Following performance assessment, CQC maintains contact with LAs and providers throughout the year to ensure they make progress against recommendations. The business approach is supported by inspections, which are targeted, focusing on those providers and LAs that have not had a recent inspection or are performing poorly.

#### *Quality measures*

There are two types of measures of quality: performance indicators (PIs), which are based on administrative data and social care user experience surveys (UES) and apply only to LAs, and composite measures of quality, measured on a four-point scale from poor through adequate and good to excellent. The latter are awarded by CQC. When they are given to LAs they are known as performance judgements; for providers, they are known as quality ratings. These measures are described in Box 1.

### **Box 1 Quality measures in England**

#### **Performance Indicators (PIs)**

PIs are collected for LAs and derive mainly from LA administrative systems, although in recent years some have come from user experience surveys (see below). The Performance Assessment Framework (PAF) data collection consisted of fifty PIs for social care, of which roughly ten were specific quality indicators. These focused on aspects, such as the timeliness of care, the state of the infrastructure and adherence to procedures. Examples include: the percentage of older clients for whom time from completion of assessment to provision of all services in care package was less than or equal to four weeks; percentage of items of equipment and adaptations delivered within seven working days; percentage of people going into care homes allocated single rooms; and percentage of adult and older clients receiving a review of services. In the new National Indicator Set (NIS), which replaced the PAF in 2009, the number of PIs has been substantially reduced to roughly eight social care PIs.<sup>9</sup>

#### **Social Care User Experience Survey**

User experience surveys (UESs) are mandatory annual surveys of publicly-funded social care clients conducted by LAs to collect information on users’ views of their care. The survey has covered a number of different client groups and service types but only two surveys have been repeated. The UESs have questions about aspects of the care process, such as the timeliness and flexibility of care, the characteristics and behaviour of care workers, and satisfaction with care. Examples include the percentage of respondents to OPHCS claiming their care workers ‘always’ do things that they want done; the percentage of respondents to a survey of adults with physical disabilities and sensory impairments asked ‘I can always contact Social Services easily if I need to’ who answered ‘Strongly agree’ or ‘Agree’; and the percentage of respondents to the OPHCS reporting they are ‘extremely’ or ‘very’ satisfied with their care. A new survey is currently being developed to cover all client groups and measure outcomes.<sup>10,11</sup>

#### **Performance judgements (previously ‘star ratings’)**

LA performance assessments result in a performance judgement, which is awarded annually. The measure is calculated by combining information from various sources, including PIs, and qualitative sources of information, such as inspections (if these are available for that year), self declarations and information from ongoing monitoring and meetings. The data are organised into outcome domains, scored at this level then combined with rules to a single score.

#### **Quality ratings**

Ratings are only given following a key inspection, which is a major evaluation of care providers. During the inspection, quantitative and qualitative data are gathered as evidence from self-assessment forms and fieldwork. The latter can include data from interviews with service users and a small survey. These data are assessed against National Minimum Standards, organised into outcome domains and scored. Rules are used to combine scores across domains into one figure.

In the past, quality measures have focused on ‘process’ and ‘structural’ quality,<sup>7</sup> but in recent years the government has refocused quality around improving outcomes for people.<sup>6</sup> CQC uses the ‘Outcomes Framework’, to define quality for LAs, which captures the domains of improved health and emotional well-being, improved quality of life, making a positive contribution, increased choice and control, freedom from discrimination or

harassment, economic well-being, and maintaining personal dignity and respect,<sup>5</sup> plus two others for commissioning and use of resources. For providers, quality is defined in service-specific National Minimum Standards (NMS), which are also organised into outcome domains. CQC evaluates the performance of LAs and providers against these definitions, ensuring that these definitions influence the composite measures. Currently the PIs still measure structure and process quality, although new PIs are in development which will be more outcomes-focused\*\*.

\* Personal care activities are defined in law as “physical assistance given to a person in connection with (a): (i) eating or drinking (including the administration of parenteral nutrition), (ii) toileting (including in relation to the process of menstruation), (iii) washing or bathing, (iv) dressing, (v) oral care, or (vi) the care of skin, hair and nails (with the exception of nail care provided by a chiropodist or podiatrist); or (b) the prompting, together with supervision, of a person, in relation to the performance of any of the activities listed in paragraph (a), where that person is unable to make a decision for themselves in relation to performing such an activity without such prompting and supervision.”

\*\* Interestingly, the focus of these PIs is not around clinical outcomes, such as pressure ulcers, as is common in LTC instruments elsewhere,<sup>8</sup> but on the outcomes listed for the ‘Outcomes Framework’.

## How high is the quality of LTC in England?

The general picture from official measures is that the quality of LTC in England is good and improving.<sup>1</sup> CQC finds that more than 77% of adult social care providers were providing an excellent or good service in 2009, an increase of 11% from the previous year. There has been consistent improvement over time, with the number of providers meeting NMS increasing for six consecutive years to 2008. In 2003, about 60% of care homes met or exceeded the NMS, but by 2008 over 80% of care homes hit this target. The picture is similar for domiciliary care providers, where about 65% met the standard in 2005 (the first year data were available) compared to over 80% in 2008.<sup>11</sup>

For LAs the picture is also one of good performance and continued improvement. CQC found that in 2009 95% of LAs were performing well or excellently and that three-quarters of all places purchased by LAs were in good or excellent care homes. The number of LAs rated as performing well or excellently has increased year-on-year since 2005.<sup>12</sup> Prior to 2005, when a slightly different metric was used, performance also improved in successive years.<sup>13</sup>

In general, scores on PIs have also improved year-on-year;<sup>13</sup> only the PIs based on the UES have not shown improvement. Data from the 2001 and 2002 survey of newly assessed clients showed a 1% decline in the likelihood of getting help quickly between 2001 and 2002. The older people's home care survey reported an increase in the numbers 'extremely' or 'very' satisfied with their services between 2003 and 2006 of 1.5%, followed by a decrease of 1% between 2006 and 2009. The same survey also reported a 4.5% decline in the likelihood that care workers always came at suitable times over the period from 2003 to 2009. The decline in user-assessed quality is not large but it does raise questions, including: what explains the vast improvement in composite scores and how can this be squared with the lack of evidence of improvement in user-assessed quality? Unfortunately, no studies have addressed this question directly. Therefore, the remainder of this article discusses potential explanations.

## What explains changes in quality?

Perhaps the most important factor explaining the vast improvements in the

composite quality score is that they are not neutral measures: a lot is at stake for those perceived to be failing. The worst performing LAs are subject to increased monitoring and intervention;<sup>14</sup> poor ratings have led to negative media attention and changes to senior management teams. Similarly, providers with poor ratings are subject to increased intervention and monitoring and CQC has powers to enforce them to improve. CQC can (and has in the past) close providers that persistently fail to meet standards. For good organisations there are benefits, so LAs with good ratings have various 'freedoms and flexibilities', including a less burdensome inspection regime. Equally good providers have less frequent key inspections: while poor and adequate providers are inspected at least annually, good and excellent providers are inspected biennially or triennially respectively. Intensive intervention alongside 'carrots' and 'sticks' is likely to have a significant effect on the behaviour of organisations, although the effect has not been demonstrated in the LTC sector.

Freedom from regulatory burden for the best performers is laudable from the perspective of targeting resources but it does affect the interpretation of improvement. For example, providers are only awarded quality ratings following a key inspection. Since these are not updated annually for good and excellent providers, unless those at the bottom make no improvement, over time the proportion achieving good and excellent performance can only increase. In intervening years, when inspections are not available the regulator relies on other evidence including self assessments and reporting of untoward events to monitor performance. The success of this system rests on having open and stable organisations. High staff turnover in the sector and the experience from other areas regarding the stability of performance and the tendency to game the system suggests that neither of these factors should be taken for granted.<sup>15</sup> These problems suggest that composite measures are unlikely to be reliable measures of quality, particularly for the best performers, where there are fewer checks and more incentives to game the system.

Another issue that affects the accuracy of composite measures is how data from various sources are combined into a single score. Commentators have criticised these measures for not demonstrating consistency in inspector judgements, using different data sources to form judgements

for the same organisation in different years and different organisations in the same year,<sup>13,16</sup> and being very sensitive to the rules applied to arrive at an overall rating.<sup>17</sup> All of these problems affect the interpretation of the measure and comparisons both between organisations and over time. This suggests that it is probably better to regard composite measures as quality standards rather than sensitive quality measures, where 'poor' ratings indicate the standard is missed and ratings of adequate and above indicate the standard is met. Evidence of differences in users' outcomes between organisations would of course help to determine how much weight should be placed on differences in ratings.

The focus of measures is probably a key factor explaining the difference in the picture painted by the UES data and the composite measures. The UES data focus on specific services and client groups (a survey of newly assessed clients and a survey of older people receiving domiciliary care); LA composite measures are broader, covering all client groups and services; provider composite measures are specific to certain services like the UES, but they are not client group specific and anyway include privately-funded clients who are excluded from the UES. Although a straight comparison is difficult because of the differences in focus, a more detailed examination of differences between the UES data and the provider quality ratings is possible and would be of value: provider quality ratings are intended to improve market efficiency and correct information asymmetries, by providing LAs and prospective users of services with straightforward information about the quality of care providers so they can make informed commissioning decisions,<sup>18</sup> and if the ratings do not reflect what matters to users they will not be useful for this purpose.

In general, there is a need for more detailed research into the reliability of provider quality ratings and their usefulness. At present, there is limited evidence about how useful LAs and prospective users find this information. Research conducted for CQC found that LAs and prospective users were generally positive about the ratings. There was evidence of LAs using the information and of people using the ratings to inform their decisions about choice of provider, although this is more the case for care homes rather than domiciliary care providers. A very small proportion of users did report that they found the ratings to be unreliable and there

were also questions over the appropriateness of what is measured.<sup>19</sup> With the growing importance of personalisation and the expansion of consumer-directed support, it will clearly be important to see how use of this information changes over time in order to make sure it is relevant and useful.

### Conclusion

The QA system in England is well-developed and comprehensive. It is supported by an array of quality measures, which provide data on an annual basis. It is clear that there have been improvements in the quality of LTC during the period under the previous Labour government, but it is hard to say whether improvement has led to more organisations achieving excellence or just fewer failing organisations. Because the quality measures are used to change the behaviour of the organisations they study, their usefulness as independent, reliable measures of quality is questionable. Research that explores the validity and reliability of the official measures, and in particular examines their sensitivity to changes in users' outcomes, would be of great interest and value.

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