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Quality measurement and assurance of long-term care for older people

Corinna Sorenson

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Between 2004 and 2050, Europe's population aged 65 and over is projected to rise sharply, by 58 million (approximately 77%), and the fastest-growing segment of the population will be the very old (aged 80+).[1] This rapid growth in the older population will have a major effect on the demand for, and supply of, long-term care services. While improvements in overall health have been realized, many older people are dependent and frail, with one or more chronic conditions or disabilities that typically increase with age. Some of these conditions may be life threatening; others affect quality of life. Given increases in life expectancy, the number of people requiring long-term care at some point is likely to grow.[2]

To meet the needs of the growing older population, a vast continuum of long-term care services has emerged, ranging from nursing homes to alternative non-institutional settings, such as home health care, residential care, and care management services. As long-term care has become more pervasive, ensuring its quality has become an ever-pressing issue for local, regional, and national policy-makers. Moreover, recent reports of poor conditions, neglect and abuse, and medical errors in long-term care facilities, particularly nursing homes, have captured national and EU-level attention, raising concerns not only for providers, but also for quality assurance organizations.[3] These concerns are reflected in public and private initiatives and national reforms to assess and regulate the standards and quality of long-term care for older people.

Such efforts have been primarily focused on improving the quality of care, either by introducing quality improvement practices or by reporting the performance of providers to consumers and decision-makers (for example, regulators, purchasers) for quality assurance and enhanced consumer choice and competition.[4] Quality improvement strategies (such as setting targets) and reporting quality indicators to the public aim to improve clinical care through comparative reporting of performance. The underlying principal is that providers will be motivated to invest in activities to improve quality of care, provided that consumers and decision-makers use public information on performance and quality to select providers.[4] Furthermore, quality improvements will ensue if providers are faced with regulatory sanctions based on poor performance. While a few countries in the EU, such as Finland, Germany, and Ireland, currently have such systems or processes in place, the US has been at the forefront of quality measurement and assurance of long-term care.

Defining and measuring quality

Accepted indicators of quality of care are often employed to assess the care given to older people across a variety of care settings, but most commonly in nursing homes and home health services. Given the differentiated care needs and environments of long-term

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care, quality of care emphasizes both the health and social realms of care. The former relies on clinical expertise and treatment, while the latter is aimed at services to assist patients with functional limitations to live in ways that maximize their independence and quality of life. Many aspects of long-term care can affect a patient's perceptions of quality of life; therefore, sense of well-being is intimately intertwined with quality of care. For instance, a nursing home resident's quality of life can be enhanced by an environment supporting independence and some degree of personal control over treatment decisions and daily activities. Quality of life also includes such issues as financial security, privacy, and personal safety. Consequently, to accurately reflect the multidimensional nature and diverse needs and interests of this population group, a variety of issues need to be considered to effectively assess older people's quality of long-term care.

Quality of care is typically measured by using structure, process, or outcome indicators, although a combination of process and outcome criteria are most frequently employed. Structure refers to a health provider's or facility's capacity to provide high quality care. Structural variables encompass the level, mix, education, and training of staff; characteristics of the facility, such as ownership, size, and accreditation; and, the demographic profile (for example, age, gender), case and payer mix of patients. Process aspects of care include the services actually provided or administered, encompassing such deficiencies as overuse of care, underuse of care, or poor technical performance. Outcome of care represents changes in health status and conditions, both functional and psychosocial, that are attributable to care provided or not provided. In quality assessment, two types of outcomes are generally measured: subjective and objective. The subjective component may include satisfaction with one's treatment environment or morale. Alternatively, objective aspects of outcome focus on changes in functional and mental status, such as the ability to perform daily living activities (for example, bathing, dressing) and cognitive capacity.

Typically, a combination of process and outcome criteria is most often employed in quality measurement. While evidence on the impact of structural elements on quality of care is somewhat inconclusive, in long-term care, certain structural factors are highly associated with quality, such as nurse-patient ratios and the availability of basic equipment. Although process and outcome indicators are most commonly used, it is likely that process indicators are more important in the context of long-term care than outcomes, as the latter are not as directly attributable to services provided compared to acute heath care.[5] Moreover, process indicators are often deemed preferable in assessing the care of older persons in that processes are considered a more efficient measure of quality and are amenable to direct action by providers and other relevant stakeholders.[6] While these various dimensions provide the foundation of quality measurement, quality of care should also be evaluated in terms of accessibility and variation of care, as well as the ability to be influenced and improved.

Quality assessment involves collecting indicators at both patient and provider levels. In the US, and increasingly elsewhere, standardized and mandatory patient assessment systems are computerized in all nursing homes and home health agencies (See US Case Study). Typically, individual data derive from clinical assessment of patients at specific intervals during their care (short- or long-term). These assessments are conducted by medical staff (for example, nurses) upon patient admission and periodically thereafter, often at discharge.* Data is normally collected with standardized instruments for only those patients that undergo more than one assessment and exhibit the potential for improvement in the areas being measured.[5] Such information is then used to calculate an aggregate measure of quality, typically at the provider-level. In the US, provider- or facility-level data is subsequently used by state-level survey agencies to target survey and quality monitoring activities. The data are also shared with the facilities; each facility receives a report of its own data, as well as state-wide information. The reports are typically used by providers and facilities as a tool to rate performance compared to the overall state and to target areas of care for improvement. In addition, this information can be used by third-party payers in service determination and rate-setting for reimbursement purposes. As these data reports can be generated for sequential time frames, they are also useful for tracking trends.

Key challenges

The development and use of valid and reliable quality measures are critical to effective quality assurance efforts in long-term care. Moreover, good measurement of quality has positive implications for the planning and provision of care, as well as informed consumer choice. However, several technical and methodological challenges currently exist.

First, existing measures of quality of health status are often inappropriate for older people. In the past, quality of care measures in older people focused solely on specific diseases or aspects of care. Such approaches may not present a complete picture of overall quality; on the other hand, broader systems of quality of care evaluation may exclude quality indicators for aspects of care that are most important to the well-being of older adults. This is slowly changing, as quality of life is increasingly viewed as a key quality indicator of long-term care. However, quality of care may be more difficult to measure for older people than for younger people, due to the fact that older adults show substantial variation in preferences for care and may be less able to advocate for themselves.

** Data is collected on the patient's physical and clinical condition and abilities, as well as preferences and care objectives. The data collection instruments include both micro- (limited to specific conditions) and macro- (multidimensional across health conditions) measures.*

Another concern is the accuracy and completeness with which data are collected and the uniformity of data reporting over time and across providers. For example, as quality assessments are, in part, based upon clinical evaluations made by different staff in varying facilities, the resulting quality measures may reflect differences in assessment practices or training and education, rather than true variations in quality.[4] In addition, complicated care processes may be difficult to document and assess based solely on medical records, which may not accurately represent actual provision of care. These concerns have implications for both comparative benchmarking and quality improvement. Small sample sizes, rare events, and instability of some conditions experienced by older people also affect quality measurement.[4]

Other methodological issues concern appropriately accounting for regional variation and patient case mix. Residents of nursing homes are generally more disabled than people using home health care services and may, therefore, be at greater risk for certain adverse health outcomes regardless of the quality of care they receive. Even within a single care setting, it is common for the populations served by some providers to possess more serious health problems than those cared for by other providers. To address these issues, risk adjustment techniques are used to 'equalize' patients, compensating for case mix differences between providers.*[4]

Finally, quality information can be collected and reported by providers themselves, purchasers, or an independent body. In cases where providers are also owners of the long-term care institution or affiliated with its management, conflicts of interest may arise. In a similar vein, there may be a propensity to underreport quality-related problems due to potential regulatory sanctions.

EU and national quality measures

As already mentioned, there are two primary goals of either EU-level or national quality measurement: (1) to inform regulation, in terms of standards, capacity, and sanctions, and (2) to enhance consumer choice and competition, primarily through benchmarks. In terms of the former, collecting quality information is essential to set standards and monitor performance. For the latter, this information is vital for both consumers and purchasers to make informed choices.

Most of the progress on quality measurement and reporting has originated in the US, especially in terms of mandatory and standardized patient assessment systems. In contrast, few EU Member States have some sort of systematic compilation of quality indicators for long-term care. However, this situation is changing, with several countries developing national, standardized quality measurement efforts or, at minimum, debating potential policy issues and solutions related to long-term care for older people. For instance, in November 2006, a mandate to promote personal autonomy and care for dependent persons was approved in Spain. The law guarantees the universal access to publicly-provided long-term care for every Spanish citizen. It also entrenches the need for quality assurance through the development of broad criteria for assessment. England also provides an example of policy activity in quality assurance for long-term care services (See Case Study on England).

There is some evidence, most notably from the US, that adopting standardized, clinically-relevant patient information and service performance reporting systems for long-term care institutions has led to quality improvement. Moreover, the measurement and reporting on quality has informed organizational change to reduce the occurrence of adverse clinical events and to increase the rate of functional improvements among patients.[7] There also is evidence that public reporting of provider performance across quality indicators has had positive implications: it has spurred greater participation of providers in national and regional quality improvement initiatives, and led to more informed decision-making among consumers.[8]

However, there remains limited understanding of the extent to which the objectives of quality measurement are truly achieved. For example, it has been suggested that public reporting may be of more interest to providers than consumers and policy-makers.[4] Other studies have found that reporting only has a slight impact on practice patterns, patient choice, and quality improvements to care.[9] Moreover, establishing minimum benchmarks for quality indicators may prove problematic if there is a lack of evidence-based standards from which to determine the benchmark. In setting benchmarks, there is also minimal consensus on whether and how to account for geographic differences in practice patterns, case mix, and payment structures that may impact on quality of care.

Future directions

Ensuring the quality of long-term care is of significant importance to patients, providers, and policy-makers. The provision of high quality care is especially central for older populations, given often complex, diverse, and protracted health needs. Moreover, as many long-term care settings serve as both a treatment facility and a home for many residents, quality of care has implications for effectively managing relevant health conditions and quality of life.

Various initiatives and reforms have been developed to improve quality long-term care. While the majority of developments in this area have occurred in the US, several EU Member States are introducing efforts for more formalized quality measurement and assurance activities. Such efforts range for standardized collection of quality indicators to public

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* *However, there are limitations to the usefulness of risk adjustment. For example, the methods used to account for risk may vary by facility type, and the increasing specialization of providers may result in less healthy patients being referred to certain providers. Both of these factors hinder the ability of risk adjustment to account for substantial differences in outcomes.*

reporting. However, too little is being done in Europe, and where efforts are being made, it is unclear to what extent the information being collected is used to achieve better quality services. A number of actions are recommended to improve current practices.

Research needs

- Despite a plethora of evidence on the scope of quality improvement activities in long-term care facilities, there have been few systematic evaluations of their impact and, in existing studies, the evidence is mixed. Additional investigation is needed in this area.
- Further exploration of improved processes for handling measurement errors is needed; such errors may confound true quality differences.
- Further research is required on improving the overall value of quality measures/indicators and how they can be expanded to capture a more global notion of quality of care for older people.
- Most of the research to date on quality measurement has focused on nursing homes; evaluation should be conducted on other long-term care settings.
- To enhance the usefulness of quality information, more research is needed on what elements of quality consumers, purchasers, and advocates value.

Quality measurement

- Although patient and family or caregiver satisfaction is often considered in nursing home environments, there is limited use of such data in national reporting systems.
- More resources should be dedicated to training and educating staff on good patient assessment practices (from data collection to reporting).
- Additional focus on methods development is required to better handle methodological issues, such as small samples and rare events.
- Better understanding is required of existing measures, how they are reported, and how audiences use quality information to make decisions.
- As many EU Member States are beginning to develop quality assurance frameworks/systems, the conceptual and technical basis of quality indicators should be grounded, where possible, on the frameworks already developed, to allow countries to build upon previous experience and best practice.
- Strategies should be devised to help circumvent existing tensions between regulatory compliance and quality improvement. For example, quality improvement requires identifying and documenting problems in preparation for action. However, in doing so, this highlights care problems for regulators, thereby creating an incentive problem for providers to fully and accurately measure quality. One potential tactic entails better training of providers on quality assurance and improvement principles to help create a culture of quality improvement, rather than one focused on regulatory compliance.
- For comparative purposes, further discussion is required on whether quality benchmarks should be based on national norms or some other standard(s) (for example, specific geographic region; type of provider).

Long-term care provision

- Quality in long-term care depends also on the extent to which services are coordinated with (acute) health services. Morris et al. suggest that care for older people remains insufficiently integrated and unreliable, particularly for older people with mental health problems such as dementia and depression.[10] Greater integration between acute and long-term services will help provide older people with a consistent continuum of care.
- Currently, in many countries, there is a general lack of adequate social care qualifications and training among the majority of long-term care staff. A greater emphasis is needed on improving qualification levels of care staff and monitoring relevant educational and training standards. The UK, for example, has introduced the National Vocational Qualification (NVQ) system* to ensure certain staff qualification standards are met.
- While quality information plays a role in spurring quality improvement efforts among providers, it is important to ensure that the necessary human, technical, and financial resources are available to facilities to adequately institute continuous quality improvement processes.
- Initiatives to improve quality should be aligned and streamlined to guard against undue administrative burdens on care facilities. Regulatory bodies across the health and social care divide need to work in partnership to ensure the efficiency of quality assurance activities.

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* *NVQs are competence-based vocational qualifications based on national occupational standards.*

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Corinna Sorenson is a Research Officer at LSE Health, London School of Economics and Political Science.

The US experience in long-term care quality measurement

Corinna Sorenson

From the mid-1980s, there has been notable attention in the US on the quality of health services, especially long-term care. As a result, an assessment system was developed to provide a standardized basis for establishing nursing home care plans, termed 'the minimum data set' (MDS). While the initial goal was to capture information needed to principally plan care, quality indicators were later developed based on the MDS as part of the Centers for Medicare and Medicaid Services' (CMS)* Nursing Home Case Mix and Quality Demonstration Project (NHCMQ)**.[1] The indicators included measures for short-stay, post-acute, and long-term residents. Their development was predicated on the need to monitor changes in residents' conditions and outcomes of care, in order for state surveyors to identify problem areas in individual resident characteristics and overall services within facilities.

Concurrently, similar quality assessment systems were established for home health agencies (Outcome and Assessment Information Set or OASIS) and for a variety of Medicare and Medicaid certified health facilities, such as nursing homes, hospice, and rehabilitation centres (On-line Survey and Certification and Reporting System or OSCAR)***. OASIS is comprised of core areas of a comprehensive resident assessment system and forms the basis for measuring patient outcomes for the purpose of outcome-based quality improvement. In comparison, OSCAR primarily functions to maintain and retrieve survey and certification data for providers and suppliers approved to participate in Medicare and Medicaid programmes. However, it is conjointly used as a quality assessment tool, as it provides information on how well nursing homes meet regulations and other areas of performance. In fact, OSCAR data is often used to link facility-level variables with the MDS. With regards to both systems, quality data are collected and updated on a regular basis.

Table 1 displays the types of indicators collected by these systems. These measurement efforts have stimulated broad interest and financial support from state and federal quality initiatives, as well as provider-based quality improvement programmes.

In addition to quality measurement, the US has made significant strides towards public reporting of quality information. In 2002, the CMS mandated public reporting of quality indicators for nursing home facilities and, later, extended requirements to other long-term care providers. To report such information, many states in the US. have assembled their own Internet-based 'report cards' summarizing the quality of facilities using different schemes for presenting information. While interest and demand for the use of report cards is high, there is uncertainty regarding who actually uses this information, how it is accessed

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** Medicare is a health insurance programme for individuals age 65 and older, under age 65 with certain disabilities, and with End-Stage Renal Disease. Medicaid provides health benefits to eligible low-income individuals and families. As it is a state-administered programme, guidelines vary regarding eligibility and services. However, eligibility criteria typically includes age, pregnancy, disability, blindness, income and resources, and US citizenship.*

*** Established in 1989, the NHCMQ was initially developed to refine nursing home case-mix classification systems used for both service planning and reimbursement purposes. These systems provided clinically relevant, universal, uniform, and computerized information from which to create quality indicators.*

**** CMS maintains and oversees both systems.*

and interpreted, and whether it actually informs decision-making.[1] For instance, existing evidence suggests that public reporting may be of more interest to providers than consumers and policy-makers, although payers are increasingly using this information for provider contracting purposes.[1,2] In addition, the impact of current mediums of reporting may be limited, as some studies have found only a slight impact on practice patterns, patient choice, and quality improvements to care.[3,4]

While progress continues toward improving current systems, the US provides a good example of how quality information can be obtained and employed to improve the long-term care of older people.

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Table 1: Key US long-term care quality assessment systems (selected quality indicators)

Minimum Data Set (MDS)			
Accidents	Incidence of new fractures Prevalence of falls		
Behaviour/ Emotional Patterns	Residents who have become (more) depressed or anxious Prevalence of behavioural symptoms affecting others (overall) Prevalence of behavioural symptoms affecting others (low risk) Prevalence of behavioural symptoms affecting others (high risk) Prevalence of symptoms of depression without antidepressant therapy		
Clinical Management	Use of nine or more different medications		
Cognitive Patterns	Incidence of cognitive impairment		
Elimination/ Incontinence	Low-risk residents who lost control of their bowels or bladders Residents who have/had a catheter inserted and left in bladder Prevalence of occasional/frequent bladder/bowel incontinence without toileting plan Prevalence of fecal impaction		
Infection Control	Prevalence of urinary tract infections Residents given influenza vaccine during the flu season Residents who were assessed and given pneumococcal vaccination		
Nutrition/ Eating	Residents who lose too much weight Prevalence of tube feeding Prevalence of dehydration		
Pain Management	Residents who have moderate to severe pain		
Physical Functioning	Residents whose need for help with daily activities has increased Residents who spend most of their time in bed or in a chair Residents whose ability to move in and around their room gets worse Incidence of decline in range of motion		
Psychotropic Drug Use	Prevalence of antipsychotic use, in absence of psychotic or related conditions (overall) Prevalence of antipsychotic use, in absence of psychotic or related conditions (high risk) Prevalence of antipsychotic use, in absence of psychotic or related conditions (low risk) Prevalence of anti-anxiety/hypnotic use Prevalence of hypnotic use more than two times in last week		
Quality of Life	Residents who were physically restrained Prevalence of little or no activity		
Skin Care	High risk residents with pressure ulcers Low risk residents with pressure ulcers		
Post-Acute Care	Short-stay residents with delirium Short-stay residents who had moderate to severe pain Short-stay residents with pressure ulcers		
On-Line Survey and Certification Assessment Reporting (OSCAR)			
Facility Characteristics	Facility data (bed size, ownership type, occupancy)		
Staffing	Number of full-time position equivalents over previous 14 days		
Resident Characteristics	Number of residents with particular problems (bed sores, incontinence, psychological problems) Number of residents receiving special services (tube feeding, rehabilitation)		
Deficiencies (in meeting regulatory standards of care, by both scope and severity) *	Quality of life	Use of restraints	Resident rights
	Discharge rights	Resident assessment	Admission transfer
	Dietary services	Physician services	Physical environment
	Nursing services	Pharmacy services	Rehabilitation services
	Infection control	Dental services	Activities of Daily Living (ADLs)
	Nurse staffing hours per residents over previous two-week period		
Complaints	Number of complaints		
Outcome and Assessment Information Set for Home Health Care (OASIS)			
	Demographics	Equipment management	Living arrangements
	Supportive assistance	Sensory status	Respiratory status
	Elimination status	Neurological/emotion/behavioural status	
	Medications	Activities of daily living (ADLs)	
	Patient history	Administration/discharge information	

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* *The scope of each deficiency is included, ranging from 'affecting few residents' to 'affecting many residents'. The severity of each deficiency is included ranging from 'potential for minimal harm' to 'immediate jeopardy'.*

Improving the quality of long-term care services in England

Juliette Malley

Approaches to measuring the quality of long-term care (LTC) in England have developed within the context of public service reform, for which improving the quality of LTC has been a specific goal. The Government's approach to public sector reform post-1997 is best described as based upon four tenets: (1) greater competition and contestability in the provision of public services, (2) growth in top-down performance management, (3) enhanced consumer choice and participation, and (4) strengthened capability and capacity of civil and public servants and government officials to deliver improved public services.[1] In the early days of the Labour government, LTC initiatives focused primarily on top-down pressure from government, with the development of structures to strengthen the capacity of public servants, for example, through the establishment of the Training Organisation for Personal Social Services (now Skills for Care) and the Social Care Institute for Excellence (SCIE)*. The market reforms of the 1990 National Health Service and Community Care Act were partly redirected with a focus on collaboration rather than competition, but the central elements remained. More recently, there has been a shift away from the top-down approach towards enhancing consumer choice and participation through initiatives such as Individual Budgets (a pilot scheme in 13 LAs where individuals receive a clear cash or nominal sum to use in designing their care or support package).

Table 1: Quality improvement structures in England

Best Value Regime (BV) Introduced under the Local Government Act 1999	A system of performance management, placing a legal duty on all local government (LAs) to deliver services to clear standards set by central government, thus increasing accountability. Until 2004, also provided the framework under which audits, performance reviews and inspections were carried out by the Audit Commission and the former Social Services Inspectorate. LAs are required to measure their performance on centrally set performance indicators (PIs) and to set targets for improvements against them. They are also required to review their services, producing annual BV performance plans which are audited. Although the legal duty to undertake BV assessments still remains, the regime has been overtaken somewhat by events, including the introduction of the Comprehensive Performance Assessment (CPA) by the Audit Commission in 2002 and the establishment of the Commission for Social Care Inspection (CSCI) in 2004.
The Personal Social Services Performance Assessment Framework (PAF) Introduced 1999	Introduced by central government to support the local planning function in BV. The PAF is a statistical collection system composed of several sections – national priorities and strategic objectives, cost and efficiency, effectiveness of service delivery and outcomes, quality of services for users and carers (through experience surveys), and fair access – each having a number of performance indicators (50 in all). The data are collected by LAs and reported annually to the Department of Health. They are made available to the public and are included in the performance review assessments conducted by CSCI.
Care Standards Act 2002	The Act established several agencies with a specific role in improving quality of care, including the Training Organisation for Personal Social Services, SCIE and the National Care Standards Commission (NCSC). Until 2004 the NCSC regulated all providers of care, including care homes, nursing agencies and domiciliary care agencies in accordance with new and compulsory National Minimum Standards (NMS) – benchmarks established to ensure the safety and dignity of service users. In 2004, the NCSC was abolished and its functions were subsumed by the CSCI.
Commission for Social Care Inspection (CSCI) Established 2004	Brought together, and is now responsible for, the inspection, regulation and review of all social care services provided by LAs.

The principal LTC initiatives span inspections of service providers and commissioners to ensure structural and legal regulation compliance, development of a programme of quality management, and measures for consumer and client protection. In addition, local government commissioning organizations (Local Authorities (LAs)) have their own accreditation procedures and contractual arrangements for providers, which vary by authority, but can include criteria to assure the quality of services. Since the late 1990s there have been many changes, with various reorganizations and rationalizations of some of the structural elements; Table 1 outlines key milestones.

While these structural instruments advanced the quality improvement agenda, their top-down and, some argue, overly bureaucratic approach, has been subject to several critiques and is seen as unpopular with frontline staff, providers and commissioners of services (LAs). Specific criticisms include the burden of regulatory requirements; fragmentation of inspection; and unintended consequences of targets and indicators, such as limiting innovation and creating perverse outcomes, such as 'meeting the target but missing the point'.[2, 3]

Moreover, staffing issues have posed significant limitations to success. Evidence suggests that widespread problems with recruitment, retention and skill levels have hindered improvements in quality of care.[4] Influential factors include an ageing workforce and poor pay and working conditions. Similarly, it is widely perceived that LTC services are underfunded, serving as a major constraint on improvement, through its deleterious effect on the workforce and quality and range of available services.[5]

** The role of SCIE is to improve social care services by identifying and disseminating good practice.*

THE EUROPEAN OBSERVATORY ON HEALTH SYSTEMS AND POLICIES IS A PARTNERSHIP BETWEEN

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Action has been taken to address some of these concerns, including streamlining reviews and inspections; merging organizations; reducing the number of targets; and removing some of the requirements of BV. Two key changes were the introduction of Commission for Social Care Inspection (CSCI) which merged organizations with roles in quality improvement, and the Comprehensive Performance Assessment (CPA), a separate assessment of local authorities undertaken by the UK Audit Commission.

CPA was designed to be a ‘lighter touch’ form of review, with significant freedoms for high performing LAs (determined by star ratings), such as fewer inspections and reductions in monitoring requirements. The CSCI has followed this design for reviewing social care and the outcomes of CSCI assessments feed into the CPA reviews. There is, however, some debate as to whether such an approach to inspection is appropriate, with some commentators arguing that performance changes too rapidly and its assessment requires accurate information that is perhaps not available.[6]

The introduction of CSCI’s star ratings in 2002 was as an attempt to make performance information more user-friendly. The star ratings (Box 1) are determined by bringing together information from inspections, the PAF and LA self assessments. It is viewed as popular with the public, but some commentators have raised concerns over its accuracy, highlighting its potential to mask poor performance as a result of its composite nature.[7]

The recent history of improving the quality of LTC services in England is marked by continuous and incremental change. There is not one but several approaches, carried forward simultaneously by a number of different institutions within a changing landscape. The newest addition to this story is the outcomes framework, where improving quality is viewed in terms of improving ‘outcomes for all people’.[8] There have been considerable efforts across government to define a set of welfare outcomes against which services can be judged. New proposals to streamline and merge organizations are driven in part by this focus. In line with the outcomes agenda, the CSCI has drafted the *Key Lines of Regulatory Assessment* to report on the achievement of the National Minimum Standards (NMS) for each type of provider in terms of outcomes groups, and the Department of Health has proposed developing a new outcomes-based set of standards to replace the NMS. The star ratings system will also change to report improvement in terms of outcomes, while changes to the PAF are also proposed to align it with this agenda.

Box 1: Performance star ratings for adults’ social services in England

★★★	**Excellent**
★★	**Good**
★	**Adequate**
0	**Inadequate**

Notes:
Children’s services evaluated separately since 2006.
The star ratings combine weighted judgements on two assessed criteria: current performance and capacity to improve. See www.csci.org.uk/care_professional/councils/council_star_ratings_for_adult.aspx

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Juliette Malley is a Research Officer at the Personal Social Services Research Unit, London School of Economics and Political Science.

To join the mailing list, please contact
Anna Maresso
Observatory – London Hub
Tel: +44 20 7955 6288
Fax: +44 20 7955 6803
Email: a.maresso@lse.ac.uk

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B - 1070 Brussels, Belgium
Tel: +32 2 525 09 33
Fax: +32 2 525 0936
Email: info@obs.euro.who.int
Website: www.observatory.dk

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