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Improving the quality of residential
care for older people:
a study of government approaches
in England and Australia

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Declaration

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Abstract

Improving the quality of residential care for older people is a priority for many governments, but the relationship between government actions and high-quality provision is unclear. This qualitative research study uses the cases of England and Australia to examine and compare regulatory regimes for raising provider quality. It examines how understandings of quality in each country are linked to differences in the respective regulatory regimes; how and why these regimes have developed; how information on quality is used by each government to influence quality improvement; and how regulatory regimes influence providers to deliver quality. The study develops a new typology of three provider quality orientations (organisation-focused, consumer-directed, relationship-centred) to examine differences between the two regulatory regimes.

The research draws on interviews conducted between January 2015 and April 2017 with 79 individuals from different stakeholder groups in England and Australia, and interviews with 24 individuals from five provider organisations in each country. These interviews highlighted greater differences between the two regimes than previous research suggests. For example, while each system includes a government role for inspecting or reviewing provider quality, there are differences around how quality is formally defined, the role and transparency of quality information, and how some provider quality behaviour is influenced by different policy interventions.

Two important findings emerge from the study for policymakers and researchers. First, the importance of considering the broader historical and institutional context of the care sector overall, not simply the regulatory environment, as shown by the more welfare-oriented approach in England when compared to Australia's highly consumerist approach. Second, the importance of considering the overall 'regulatory space' when designing policy interventions for quality. Policymakers should consider the effects and interaction of multiple policy interventions, the impact of funding mechanisms and the activity of multiple stakeholders, and not restrict attention to those policy interventions explicitly developed for quality improvement goals.

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For Ralph Barrie Trigg

July 1932 – September 2016

List of abbreviations

ACFI	Aged Care Funding Instrument
ACSA	Aged and Community Services Australia
ADASS	Association of Directors of Adult Social Services (England)
CDC	Consumer-Directed Care
COTA	Council on the Ageing (Australia)
CQC	Care Quality Commission (England)
CSCI	Commission for Social Care Inspection (England)
DAC	Daily Accommodation Contribution
DAP	Daily Accommodation Payment
DBMAS	Dementia Behaviour Management Advisory Service (Australia)
DoLS	Deprivation of Liberty Safeguards
FP	For profit
LASA	Leading Aged Services Australia
LLLB	Living Longer, Living Better
MDS-RAI	Minimum Dataset-Resident Assessment Instrument
NACA	National Aged Care Alliance (Australia)
NHS	National Health Service (England)
NFP	Not-for-profit
NICE	National Institute of Health and Care Excellence (England)
OECD	Organisation for Economic Cooperation and Development
RAC	Refundable Accommodation Contribution
RAD	Refundable Accommodation Deposit
RUG	Resource Utilisation Group
SCIE	Social Care Institute for Excellence (England)

Glossary of terms

Accommodation Bonds	The predecessor of the current system of Refundable Accommodation Deposits and Daily Accommodation Payments in Australia. The accommodation bond was paid by older people on entry to 'low care' and was in effect an interest-free loan to the care home provider.
Aged Care Funding Instrument (ACFI)	The instrument used by the Australian government to assess the relative care needs of residents and to calculate the Government Basic Care Subsidy to aged care providers for the care component of the resident's fees.
Aged care	Previously used to refer to residential care for older people in Australia, the term is now being used to refer to both residential and community care services.
Ageing in place	Often used to refer to policies which enable the older person to stay in their own home, avoiding the need for residential care. However, the term has a different meaning in Australia, and refers to regulatory reforms under the 1997 Aged Care Act which allow provider organisations to support older people in the same care settings as their needs increase.
Approved Provider	A legal term used for providers approved by the Australian Government to receive subsidies for the provision of residential or community-based care.
Association of Directors of Adult Social Services (ADASS)	ADASS is formed of directors of adult social services in England. The association is a charity that 'aims to further the interests of people in need of social care by promoting high standards of social care services and influencing the development of social care legislation and policy' (ADASS, 2018).
Basic Care Subsidy	A government subsidy to residential care providers in Australia to pay for the care component of resident fees. This amount is calculated using the ACFI and is a non-means-tested payment.
Consumer-Directed Care (CDC)	The term used in Australia to refer to the formal policy of allocating funds to individuals to make choices about services and care providers.
Daily Accommodation Payment (DAP) or Daily Accommodation Contribution (DAC)	Where residents receive no or limited government assistance for accommodation costs, they can spread the cost of accommodation in regular rental-style payments. A DAP applies to residents who receive no government assistance for the accommodation part of their cost; a DAC applies where they receive some assistance. Introduced with RADs and RACs in 2014 to replace the system of accommodation bonds.
Deprivation of Liberty Safeguards (DoLS)	A requirement for care homes and hospitals in England to apply for authorisation from local authorities if they use restrictions or restraint which will deprive a person of their liberty.

For-profit providers	Organisations where profits will be directed to the owners or shareholders.
High care	Official term formerly used in Australia to refer to care for people who require almost complete assistance with most daily living activities, also known as ‘nursing home’ care.
Independent sector	Collective term for non-government run providers, including both for-profit and not-for-profit organisations
Long-term care	A range of services required by persons with a reduced degree of functional capacity, physical or cognitive, and who are consequently dependent for an extended period on help with basic activities of daily living. This ‘personal care’ component is frequently provided in combination with help with basic medical services such as ‘nursing care’, as well as prevention, rehabilitation or services of palliative care (Colombo et al., 2011, p11)
Low care	Official term formerly used in Australia to refer to residential care for people with lower level needs for personal and nursing care, also known as ‘hostel’ care.
Low means residents	Term introduced in Australia in 2014 for residents who are eligible for assistance with accommodation costs.
MyAgedCare	The government website and portal in Australia established in 2014 for all aged care enquiries and assessment. The website includes information on aged care providers and prices and fees.
NHS Choices	The official website of the NHS in England to support people engaging with both the health service and social care. Established in 2007.
Not-for-profit providers	Non-government providers where surplus revenue is reinvested in the organisation for the benefit of its clients.
Refundable Accommodation Deposit (RAD) or Refundable Accommodation Contribution (RAC)	Where residents receive no or limited government assistance for accommodation costs, they can pay the full cost of accommodation as an upfront lump sum, which works like an interest-free loan to an aged care home. A RAD applies to residents who receive no government assistance for the accommodation part of their cost; a RAC applies where they receive some assistance. Introduced with DAPs and DACs in 2014 to replace the system of accommodation bonds.
Self-funders	Individuals in residential care in England who pay for their own accommodation and care.
Social care	The umbrella term for long-term care delivered in both residential and community-based settings in England.
Supported residents	Term used in Australia to refer to residents who entered care between 2008 and 2014 and whose accommodation costs are funded by the government.

1 Introduction

This study uses qualitative research methods to explore what governments might do to improve the quality of residential care for older people over and above minimum standards. To do this, it compares the examples of the residential care systems in England and Australia.

Most OECD¹ countries see the improvement of quality in both health care and long-term care as a critical policy issue (OECD/European Commission, 2013). In residential care, the discussion about quality often focuses on the poorest quality care provision. The media continues to expose cases of abuse and neglect, and residential care has long and frequently been referred to as a 'last resort' (for example, Townsend, 1962, Robb, 1967, Meacher, 1972, Kewley, 1973, Vladeck, 1980, The, 2008). While the standard of residential care is generally considered to have improved in line with overall standards of living, the problems of boredom and isolation observed by Townsend (1962) persist, and in some ways have been exacerbated by the increased physical dependency of people in residential care (Johnson et al., 2010). A UK survey of people living with dementia in care homes and their families found that, while two-thirds of families felt the quality of care was good, only 41 per cent thought that the same applied to quality of life (Alzheimer's Society, 2013).

However, while there are still examples of very poor care, there are also provider organisations which have managed to exceed the expectations of residents and regulators and provide care that helps even the frailest and cognitively impaired residents to live better lives. In the middle, many providers are neither poor nor excellent, and provide a level of care which is summed up as 'adequate' or 'compliant with requirements', depending on how providers are assessed and how quality is reported in their jurisdiction. It is not clear why some providers go above and beyond the required quality standards while others fail to meet minimum standards, or how policy actions by governments might influence provider quality.

¹ Organisation for Economic Cooperation and Development

Over the past three decades, the governments in England² and Australia have, like many other countries, implemented policies and legislation aimed at improving both the quality and efficiency of long-term care. These developments have included mechanisms to directly influence quality in both countries such as the set-up of inspection and accreditation bodies in England and Australia respectively. Both governments have also turned to the use of market mechanisms and consumer ‘choice’ to influence quality more indirectly. Both countries have also recently introduced major pieces of legislation for the sector. While both pieces of legislation are described as focusing on quality and efficiency, the two countries have started to diverge in their approaches. The Care Act 2014 in England enshrines the needs of carers in legislation and allocates responsibilities to local authorities for ‘market shaping’ – the duty to ensure that there is a supply of appropriate, high quality services for those who might need them (HM Government, 2014a). Almost in parallel, the Australian government has implemented the Living Longer, Living Better (LLLb) reforms, which are heavily focused on introducing consumer choice into the residential care sector and removing market controls which have been in place since the 1980s³.

Despite these legislative reforms, problems persist in both countries. In England, the government has committed to publishing a Green Paper on further reforms to the sector in 2018 (Cabinet Office, 2017). The main focus of the Green Paper is the ongoing funding and sustainability of the sector. In Australia, the implementation of the LLLb reforms are ongoing, and the exposure of neglect and poor care in 2017 at Oakden, a mental health ‘facility’ in the State of South Australia, triggered the latest round of inquiries into the sector. The first inquiry focused on the regulatory processes and was published in late 2017 (Carnell and Paterson, 2017); the second is a broader review into the sector, due to report in 2018 (Egan, 2017, Standing Committee on Health, 2017). As in England, these inquiries are the latest of multiple reviews of the sector since the 1980s. Improving the understanding of how to influence quality in the sector is part of these initiatives and a priority for both governments.

² The study focuses on England, rather than the UK as a whole, due to the existence of four separate regulatory systems across the UK in England and the three devolved nations (Northern Ireland, Scotland and Wales).

³ Further detail on the reforms in both countries is included in Chapter 2.

1.1 Residential care as a service

To understand the importance of protecting and promoting quality in residential care, it is essential to understand the characteristics of the people who live in it. Policies in many OECD countries are focused on supporting people to stay in their homes for as long as possible, and a consequence of these policies is that by the time older people move into residential care, they are frailer than ever before (Boyd et al., 2012). Residents often have high levels of physical dependency and multiple co-morbidities and are frequently living with dementia (Boyd et al., 2012, Gordon et al., 2014). In the UK, between 44 per cent (Lievesley et al., 2011) and 80 per cent (Alzheimer's Society, 2013) of residents are living with dementia, while in Australia, 50 per cent of older people in residential care are formally diagnosed as living with the condition (Department of Health, 2016c). Changes in the make-up of the sector reflect this move towards residential care focusing on older people with the most complex health needs. While in 1970, the ratio of nursing home places to residential care places in England was two to seventeen, by 2015, the ratio was almost one to one (Johnson et al., 2010, CQC, 2016d). In Australia, in 1970, the ratio of nursing home places to residential was one to four; by 2014 it was, as in England, one to one (Kewley, 1973, Department of Social Services, 2014).

Residential care covers a broad spectrum of services and tasks. The 'care' component itself includes help with personal care tasks, as well as clinical care and maintaining the physical, mental and emotional wellbeing of residents. As the figures above suggest, residential care often includes specialist care for people living with dementia. End of life care is another important aspect of residential care due to the high proportion of people who die in residential care – in England between 2006 and 2008, more than a fifth of people aged over 75 died in residential care (Ruth and Verne, 2010). Alongside these traditional care tasks however, is the fact that the setting also becomes the home of the older person, usually on a permanent basis. As well as accommodation, providers look after 'hotel' services such as food, laundry and cleaning services. In addition, supporting the quality of life of residents involves providing opportunities for engagement in meaningful activities and support for their emotional needs.

The complex health and cognitive status of the residential care population can also make it a difficult environment in which to work. The poor pay and conditions of care workers are well-documented (Colombo et al., 2011), however, less attention

has been paid to the violence that staff can be subjected to in carrying out 'body work' on a day-to-day basis (Daly et al., 2011). These issues present additional challenges for how to improve quality in residential care.

1.2 Defining quality in long-term care

The conceptual issues of defining and measuring quality in long-term care have been discussed by a number of authors (for example, Qureshi et al., 1998, Kane, 2001, Mor, 2005, Sloane et al., 2005, Malley and Fernández, 2010). Quality is multidimensional and subjective, and it is also difficult to attribute outcomes to care processes. Quality, however it is defined, is also shaped by many different influences, including social, economic and organisational factors (Day and Klein, 1987). In addition, the nature and goals of social care vary widely, as do the needs and expectations of its users (Qureshi et al., 1998).

Balancing the quality of care and quality of life issues is challenging and in the past many of the academic studies on improving practices and outcomes in residential care focus on the relatively straightforward question of testing clinical and treatment interventions, rather than on the broader issues associated with quality of life (Gordon et al., 2012). There has however been a growing recognition that the focus of 'quality' should shift away from purely the standards and processes associated with the care provided by an organisation, towards an understanding of the quality of life outcomes of its residents (Sloane et al., 2005, Kane, 2001). This shift is not straightforward due to the inherent tensions between a focus on safety and attempts to maximise quality of life outcomes, particularly in the care of people living with dementia. Focusing on quality of life can introduce a different set of challenges for quality, as it often involves difficult trade-offs with safety and risk (Berry, 2011, Evans et al., 2017).

Understanding what is meant by 'quality of life' also has multiple challenges, not least of which is that it is multidimensional, involves both subjective and objective components, and varies both between individuals and for the same individual over their life course (Schalock, 2004, Vaarama, 2009). With much of the provision of (often intimate) care occurring over an extended period of time, long-term care can have both positive and negative effects on the user's feelings of safety and security, autonomy and control, social engagement, skills and self-confidence (Malley and

Fernández, 2010). The multidimensional nature of quality has particular relevance in residential care where discussions of quality cover topics as varied as the quality of relationships, the design of the environment, the quality of food and food choices, how much freedom is allowed and issues of safety and risk management. While well-delivered care processes are an important factor for good quality of life outcomes, good care processes will not be sufficient unless supplemented by actions and activities with a specific focus on the quality of life of residents (Kane, 2001, Bridges et al., 2006).

This thesis emphasises quality at the level of the care provider organisation. Literature in service marketing and quality management suggests that there are broadly two organisational approaches to quality (Grönroos, 1978, Ghobadian et al., 1994, Moullin, 2002). The first is where the organisation prioritises its own internal process needs; the second is where the organisation views quality as meeting the expectations of its customers. Chapter 3 explores these two approaches, but also derives a third way of looking at quality specifically for residential care, based on the concept of relationship-centred care practices. For residential care, neither of the two previous ways of defining quality reflect the relationship-centred approaches which are regarded by many to be best practice in the sector. For academics who specialise in social work and social care practice, and for many practitioners, the pursuit of good quality in residential care is synonymous with models of ‘person-centred’ care, in the way it was defined by Kitwood (1997) as focused on the concept of ‘personhood’⁴. Chapter 3 therefore outlines three broad definitions of provider quality – as organisation-focused, consumer-directed or relationship-centred – as a basis for examining the respective understandings and policy actions in England and Australia.

1.3 Mechanisms for improving quality in long-term care

Over the last three decades, governments have increasingly turned to the independent sector⁵, both for-profit (FP) and not-for-profit (NFP), to deliver publicly-funded care services (Rostgaard, 2002). For some countries, reliance on

⁴ The term ‘person-centred’ has been used to refer to a variety of different concepts – this is discussed in Chapter 3.

⁵ The term *independent sector* will be used to refer to non-government provider organisations and includes both FP and NFP providers.

the private sector has stemmed from a historical lack of state involvement in the provision of long-term care, for example, in Australia, the Netherlands and the US (Braithwaite et al., 2007, Mot et al., 2010). In other countries, the shift to a mixed economy of care provision has taken the form of explicit policy decisions to withdraw from the direct provision of services, for example, in England and the Nordic countries, often described under the umbrella of ‘new public management’ (Knapp et al., 2001, Vabø, 2006, Stolt et al., 2011). This ‘steering, not rowing’ (Osborne and Gaebler, 1992), featuring arms-length relationships between funder and provider, brings considerable challenges of how governments can influence quality and efficiency.

Within systems based on ‘mixed economies of care’, governments have a number of options for intervening to assure and improve quality (Malley et al., 2015, Wiener et al., 2007a, OECD/European Commission, 2013). These strategies have previously been described and categorised by their level of coerciveness (Malley et al., 2015, Wiener et al., 2007a), or how ‘hard’ or ‘soft’ interventions are (Healy and Braithwaite, 2006, Goodship et al., 2004, Lahat and Talit, 2015). Malley et al. (2015) adapt the ‘Carrots, Sticks and Sermons’ model developed by Bemelmans-Videc et al. (1998) to identify three distinct types of policy intervention: economic instruments such as pay-for-performance and financial incentives (‘carrots’); regulatory instruments like command-and-control inspection (‘sticks’); and finally, information instruments such as training and education (‘sermons’). The following sections provide an overview of each of these distinct policy types.

Markets and consumers

The ‘soft’ end of the spectrum of options in terms of ‘coerciveness’ is for governments to take a hands-off, laissez-faire approach, relying on consumer pressure and market mechanisms to deliver improved quality. The reasons why governments rely on private provision for the delivery of long-term care are complex and linked to broader questions around the role of government in public services and the level of resources available. Marketisation has taken a variety of forms, from encouraging a mixed economy of care providers to the promotion of personalisation and consumer-directed care. These policies are positioned as a means of incentivising providers to address quality and efficiency issues (Hirschman, 1970). While the benefit of people having control of decisions about their own care and where they would prefer to live is indisputable (Scourfield,

2007b), several authors have noted the considerable challenges for older people in need of residential care to express their wishes (for example, Gilleard and Higgs, 1998, Braithwaite et al., 2007, Eika, 2009, Tanner et al., 2018). The health and cognitive status of residents can affect their capacity or ability to act as empowered ‘consumers’ of care. Exacerbating these issues, choices about residential homes are often made under suboptimal conditions, in the aftermath of health or carer crises, and affected by the often-limited availability of places (Bebbington et al., 2001, Trigg et al., 2017).

An additional issue with presenting choice as a strategy for quality improvement is that the selection of residential care provider is frequently made on behalf of the resident by others, with family members often taking on the role of decision-maker and ‘consumer’ in the process. The power of the resident (and indeed, his or her family) to influence provider quality is further diluted by the fact that care is often funded by the tax-payer and purchased by governments on behalf of residents (Vabø, 2006). While residents and their families may form more informed opinions once they have moved in to a home, they are unlikely to complain about poor quality, often due to fear of retribution. They are also unlikely to ‘exit’ the provider to find better care elsewhere, effectively making the decision a permanent one (Braithwaite et al., 2007, Eika, 2009, Wiener, 2014).

Despite these issues, governments have increasingly turned to the publication of quality information to support market policies, for example, through inspection reports and official ratings, provider data returns and consumer reviews. The publication of information is seen as a policy tool for quality improvement, either through its role in facilitating choice (the ‘selection’ pathway) or through providers responding directly to feedback to maintain their reputation (the ‘activation’ pathway) (Berwick et al., 2003). However, the effects of publishing quality information on provider behaviour are uncertain, potentially resulting in unintended consequences. Gathering information is also difficult, partly due to the challenges associated with collecting the views of residents who are living with dementia or are cognitively impaired (Bowers et al., 2001), as well as the reasons outlined above.

Regulation and inspection

Where long-term care is supplied by private, either for-profit or not-for-profit organisations, an alternative approach is to take a ‘hard’, interventionist, approach to quality improvement through the use of tools such as command and control regulation or inspection.

The outsourcing of public services for delivery by the private sector has been matched by expansion of a regulatory industry for both financial regulation and social regulation⁶ (Majone, 1994, Braithwaite, 2008). In parallel, the prevailing, pro-market, narrative has focused on the need to minimise ‘red tape’ for businesses and reduce the number of regulatory standards (see, for example, Hampton, 2005, Australian Government, 2006, High Level Group on Administrative Burdens, 2014). For residential care, however, there appears to be some acceptance, at least in countries with developed formal care systems, that the quality of care, whether state- or privately-funded, should be monitored to protect users who may be particularly frail and vulnerable. Even ardent critics of regulation support government intervention to promote quality in nursing homes: ‘[m]aking sure nursing homes provide a responsible, safe, and caring residence is an important societal goal’ (Howard, 2014, pp29-30).

Following these authors, the term ‘regulatory regime’ is used in this thesis to refer to the broad range of instruments governments deploy in the pursuit of better quality. Regulatory regimes have three components, and these inform the analysis in this thesis, namely standard-setting, information-gathering and behaviour modification (Baldwin et al., 2012). ‘Standards-setting’ includes the setting of standards, goals and targets. ‘Information-gathering’ is a vital and central part of all regulation and usually refers to the activity of inspection in gathering information to assess compliance with standards. In this thesis, the focus on information is broadened to consider multiple forms of information gathered and the wider usage in publicising quality performance. ‘Behaviour modification’ refers to the actions of governments in encouraging provider organisations to improve their quality, through either punitive, ‘deterrence-based’ actions or supportive, ‘compliance-based’ approaches.

⁶ Social regulation is regulation which protects ‘public interests such as health, safety, the environment, and social cohesion. The economic effects of social regulations may be secondary concerns or even unexpected, but can be substantial’ (OECD, 2002).

Regulation, or more specifically, inspections and standard-setting, is therefore a dominant tool used in efforts to address the quality issues in long-term care (OECD/European Commission, 2013). Evidence from long-term care suggests that inspections and standard-setting activity has served to raise the basic level of quality in the sector, but it is generally agreed that, in isolation, it is not sufficient to raise the quality over and above this level (Lathlean et al., 2006, Commonwealth of Australia, 2007). While inspection on its own is widely regarded as a tactic for bringing ‘laggards’ up to a set of minimum standards through picking the ‘low-hanging fruit’, improving quality past this level needs a more sophisticated approach (Coglianese and Nash, 2006).

Information

Other government strategies include the provision of information and training and education (Wiener et al., 2007b, OECD/European Commission, 2013, Mor, 2014, Malley et al., 2015). A number of governments have also set up organisations to promote better practice in long-term care, including England, in the form of organisations such as the National Institute for Health and Care Excellence (NICE) and the Social Care Institute for Excellence (SCIE), as well as France, The Netherlands and Sweden (Trigg, 2012). What is unclear, however, is how these, and the other policy interventions outlined above, influence providers to go over and above minimum standards.

Many of the assumptions underpinning regulatory strategies assume that provider organisations have the resources and capabilities to implement change, and the only challenge is to identify regulatory interventions which will provide the right motivation for quality improvement. However, improving quality is not straightforward, and studies show that most efforts to change the way things are done in organisations fail (Ferlie et al., 2003, Burnes, 2009). In addition, it is unclear to what extent quality improvement efforts can be influenced by the external efforts of governments.

1.4 Research questions

The aim of this thesis is, based on the examples of England and Australia, to investigate how can governments design regulatory regimes for the residential care sector which encourage quality improvement over and above minimum standards?

The thesis aims to answer the following questions:

1. What explains how and why the types of regulatory systems have developed?
2. How is quality understood in each country and how are those understandings reflected in the regulatory regimes?
3. How is information on quality used by governments to influence quality improvement?
4. How, and to what extent, do regulatory regimes influence providers to deliver quality over and above minimum standards?

The first research question seeks explanations for why the systems have developed in different directions and to understand what contextual factors might have been at play. The choice of different policy instruments depends on many contextual factors, for example, cultural and societal norms and expectations; the political, legal and wider regulatory structures and regimes; controls, both informal and formal, over regulatory bodies; and how resources are distributed (Baldwin and Black, 2008). For residential care, previous research on why regulatory systems have developed in the way they have focuses only on the role of interest groups (Hawes, 1997, Braithwaite et al., 2007). The benefit of using comparative methods for this study is to bring what Marmor (2012) refers to as ‘the gift of perspective’ (p19) to understand why the differences exist between the systems of England and Australia.

The study uses qualitative interviews with two different sets of participants in each country. The first sample was made up of stakeholders from groups including policymakers and politicians, user and carer groups, industry associations, professional organisations and academics. The data from these interviews was used to examine Research Questions 1, 2 and 3. The second sample consisted of individuals from provider organisations in both countries. This data was used to examine Research Question 4.

1.5 Overview of chapters

Chapters 2 and 3 set out the context for the study. The purpose of **Chapter 2** is to establish the policy context for residential care and regulation in England and Australia, with attention to the features of the system which might play a role in explaining differences in the regulatory regimes. **Chapter 3** explores the relevant literature for how quality in the long-term care sector is defined, the different types of quality improvement, how quality of care is regulated and how quality information is used, and what is known about how providers respond to regulatory actions. This chapter sets out three different quality ‘orientations’ which are then used in the empirical chapters, namely, *organisation-focused*, *consumer-directed* and *relationship-centred*. **Chapter 4** discusses the research methods used for the study. The chapter begins by discussing the rationale and benefits of utilising qualitative, comparative research methods.

Chapters 5 to 8 set out the findings of the research. **Chapter 5** examines why the regulatory systems have developed differently in Australia and England, using existing theories on policy and regulatory development. The chapter opens with a brief review of existing theories on the development of regulatory regimes. The findings are then structured around three themes which were identified as being particularly influential factors in shaping regulatory design for residential care in England and Australia: *the impact of ‘never again’ events and political triggers*; *the relative power of providers and the organisation of the sector*; and *the role of policy entrepreneurs*.

Chapter 6 examines the different understandings of quality in the two countries and how these are shaped by regulatory regimes. It presents four main findings about how the understanding of quality is shaped by regulatory and other policy interventions. These findings related to the relationships between *regulatory standards and organisation-focused quality*; *funding and organisation-focused quality*; *consumer choice policies and consumer-directed quality*; and *regulatory standards and relationship-centred quality*.

Chapter 7 explores how information on provider quality is used as a tool for quality improvement. The chapter compares each country’s approach to collecting and publishing quality information and finds three themes which differentiate their respective approaches: *differentiating and communicating performance*,

acknowledging and highlighting poor care, and whether reporting is focused on *process compliance or the lived experience of the resident*. The chapter also explores how each country regards the links between information and quality differently, with reference to the activation and selection pathways described by Berwick et al. (2003).

Chapter 8 turns to how the regulatory regimes in England and Australia might influence the quality of providers and reports the results of interviews with provider managers and staff in both countries. The chapter discusses the links between different government interventions and the types of quality they influence, as well as the extent to which external interventions can influence providers to go over and above minimum standards to deliver relationship-centred quality. The chapter also highlights the types of support which might be provided by governments to assist providers in the pursuit of relationship-centred quality.

Chapter 9 discusses the overall findings of the study and the implications for policymakers. The chapter begins by comparing and discussing the differences between the regulatory regimes of England and Australia, as identified in Chapters 6-9. The chapter then looks at the overall findings uncovered by the study. First, the chapter discusses how the differences between the systems go much deeper than simple questions of regulatory design, with the regime in England influenced by its welfarist origins and the role of local authorities, compared with a longstanding consumerist heritage in Australia. Second, the study highlights the need for policymakers concerned with quality to consider the broader ‘regulatory space’ in policy design, with attention to the roles of multiple stakeholders, funding mechanisms and the interplay of different policy instruments. The chapter then discusses the lessons for other sectors, followed by the limitations of the study and priorities for future research.

2 Residential care and the regulation of quality in England and Australia

The aim of this chapter is to examine how the systems of care and quality regulation are organised in England and Australia, and specifically the different approaches that have developed in the regulation of long-term care in each country. The chapter is organised in three sections. The first section describes how policymaking and governance for the residential care sector is organised in each country and some of the political changes which have directly influenced the development of the sector. This section also explores the different characteristics of care provision and the approaches to funding residential care places. An understanding of funding is important because, as the empirical chapters show, the respective funding approaches of each country have an impact on how quality is understood and on how funding affects the quality behaviour of providers.

The second section is concerned with government activity around quality and regulation and includes a brief recent history of regulation in each country and the current organisations in place. This section includes an outline of the current regulatory regimes, particularly the nature of the standards used in each country. Finally, the chapter sets out some of the issues currently affecting the sectors, particularly regarding financial constraints and the impact of so-called austerity policies in both countries. In both countries, there is concern that one of the impacts of these policies is the growth of two ‘tiers’ of care quality available to older people, depending on their financial resources.

2.1 The governance and organisation of the residential care systems

Policymaking and legislation

A major difference between the residential care systems in England and Australia is how government responsibilities are organised. While almost all responsibilities for

aged care in Australia are centralised at the federal level¹, in England only legislation and overall policy design are owned by central government, specifically the Department of Health. This is an important difference between the two countries as it has implications for how policy design is influenced and for how oversight of the sector is managed, as shown in the empirical chapters.

In England, managing the funding and provision of social care is the responsibility of 152 local authorities, which differ in size, demographics, financial strength and strategic competence, and this is reflected in many different strategies for commissioning social care services (Laing & Buisson, 2015a). In contrast, in Australia, the system of governance for aged care is highly centralised, even though Australia is a federation, formed of six states and two territories. Since the 1980s and the implementation of the Aged Care Reform Strategy (discussed in more detail in Chapter 5), the Australian Government has controlled all aspects of aged care policy and delivery, including policy direction, funding, contracting with providers, assessment of individual need and quality monitoring and assurance. All these functions are currently the responsibility of the Department of Health at the federal level. The federal Department of Health has its own offices in each state (separate to the health departments belonging to the state governments) which are responsible for the approval of residential care providers and communication about day-to-day operations. The centralisation of aged care contrasts with the provision of health care and most other public services in Australia, which are the responsibility of the states and territories.

Finally, the role of local government in each country is fundamentally different. Unlike in England, where local authorities have played an important part in the delivery of welfare since the Poor Laws were implemented in the early nineteenth century, local governments in Australia have never played a substantial role in welfare. This means that, except for the State of Victoria, the delivery of care in Australia has always relied on a ‘mixed economy of supply’ for both publicly- and privately-funded care.

¹ Some related responsibilities which are not specific to the aged care sector are held at the state level, for example, legislation regarding guardianship and powers of attorney; building regulations and food standards.

Recent legislation passed in both countries also presents a divergence in the respective approaches to roles in the sector. In England, the Care Act 2014 assigns a duty to local authorities to provide information and advice for individuals on care and support services in their area, and how to access them. Importantly, for the first time, this duty to provide information extends to supporting individuals regardless of how they are funded (HM Government, 2014a). Recent research suggests that this provision to provide information has not been successfully or uniformly implemented, with many self-funders continuing to struggle to find appropriate information about care provider options (Independent Age, 2016, Baxter et al., 2017, CMA, 2017a). Other aspects of the Care Act in England with relevance for this study are the increased responsibilities for local authorities in terms of market shaping, advocacy and safeguarding.

The LLLB reforms in Australia were based on a major inquiry of the sector by the Australian Government's Productivity Commission (Productivity Commission, 2011) and focus on empowering the consumer and relaxing market controls. The reforms related to quality have already been implemented in the first of three phases (2012-2014) and included the set-up of a new Australian Aged Care Quality Agency (addressed later in this chapter) and the launch of a project to implement 'MyAgedCare', a centralised 'gateway' to aged care consisting of a call centre and website, initially for the provision of information and channelling referrals to providers. In the future, it is intended that the gateway will include self service functions for older people and service providers as well as information about aged care service availability (Department of Health and Ageing, 2012). Future plans under the LLLB reforms also include a number of quality-related reforms under the development of a single Quality Framework, discussed later in this chapter and also in the empirical chapters of the thesis.

Provision of care

England and Australia are facing similar challenges in the provision of residential care. Both countries face unprecedented growth in the proportion of the population aged 85 and over: in the UK, the proportion is projected to grow from 2.3 per cent in 2015 to nine per cent in 2086 (Laing & Buisson, 2015a); in Australia, it is projected to grow from two per cent to nearly five per cent in 2055 (Aged Care Financing Authority, 2016b). The countries share many social, political and cultural features, and many aspects of the long-term care system are similar. Despite a focus on

shifting care from residential care settings to community-based care, residential care still forms a significant part of public expenditure on care: 60 per cent in England (National Audit Office, 2014) and 69 per cent in Australia (Aged Care Financing Authority, 2016a). While both countries now rely on a mixed economy of care for provision, there are however some key differences in how the sector is made up, particularly in the respective roles of the FP and NFP sectors. These differences stem from important historical differences in the development of the sector in each country.

The provision of publicly-funded residential care in England is, even today, affected by the stigma associated with the Poor Law enacted in 1834 (Hayashi, 2013). The repeal of the Poor Law started with the National Assistance Act 1948, compelling councils to provide residential accommodation for those who needed it and, at the same time, to replace ‘public assistance institutions’ with ‘a new form of non-stigmatising home to be run by local authorities’ (Means et al., 2002, p49). Combined with the National Health Service Act 1946, the move towards government-delivered services saw the shifting of responsibility for social provision away from voluntary organisations (Lewis, 1999). Many of the NFP providers currently in the sector in England are relative newcomers to the sector, in the form of organisations set up to take over ex-local authority run homes following the implementation of the NHS and Community Care Act 1990 (‘Community Care Act’) (Means et al., 2008). The Community Care Act set an 85 per cent target for the proportion of care to be sourced from the independent sector, resulting in a shift from direct to outsourced provision. Today, the residential sector in England is dominated by FP provision. In 2014, FP providers were responsible for 86 per cent (387,900) of independent places with NFP providers responsible for 14 per cent (65,000 beds) (Laing & Buisson, 2015a).

The picture in Australia is very different in terms of both the roles of the state and of the split between FP and NFP provision. The British settlers in Australia in the nineteenth century actively avoided implementing the Poor Law (Murphy, 2006) and most state governments were reluctant to take on direct responsibility for individuals in need. Voluntary organisations therefore became prominent in delivering all forms of social support and care, including hospitals and residential care (Kewley, 1973). Today, religious charities continue to provide services and their role has been ‘normalised to the point where it was taken for granted’ (Melville

and McDonald, 2006, p74). For example, the Catholic Church is one of Australia's largest employers with over 180,000 employees and provides services including education, health and aged care (Australian Catholic Council for Employment Relations, 2015). NFP provision in residential care in Australia expanded further between the 1950s and 1970s through the use of capital grants and subsidies from the government (Parker, 1987). NFP providers continue to have a larger share of the sector, with 60 per cent of private places (Aged Care Financing Authority, 2016b).

Another difference between the two countries is that while in England, there had been an emphasis on housing and residential care without nursing, this was the opposite in Australia. The respective share of the nursing home sector in each country was outlined in Chapter 1. In England in 1970, the ratio was two to seventeen (nursing home places to residential care places), in Australia the equivalent ratio was one to four (Kewley, 1973, Johnson et al., 2010). The government in Australia made incentives available for the building of nursing homes under the 1954 Aged or Disabled Persons Homes Act and the number of nursing homes doubled between 1962 and 1972. The extent of the domination of nursing homes in Australia led to the passing of the Aged or Disabled Persons Hostels Act in 1972 and the availability of funding to expand the provision of residential care homes (Braithwaite et al., 2007).

Markets and consumers

A fundamental difference between the two countries is the degree of government intervention in the market. The government in England has devolved 'market shaping' responsibilities to local authorities, where local authorities have a responsibility to ensure that adequate good quality services are available in their local area. Aside from this, however, the government explicitly does not intervene in the residential care sector. This contrasts with a system of market planning and controls in Australia, as explained below.

While the Conservative government in the UK introduced quasi-markets and the purchaser-provider split in the 1990s, Australia continued with a 'central planning approach' which had been in place from the early 1980s. Providers require 'bed licences' to operate government-subsidised residential care places. The number of bed licences made available to providers through an annual bidding process is based on demographic and statistical information and expressed in the number of places

per people over the age of 70 (Hogan, 2004). Removing these controls is now considered by many to be a high priority in Australia, with a perception that the promotion of competition and choice will deliver better quality and efficiency (Productivity Commission, 2011).

Another important feature of the two markets is the emergence of personalisation in the form of direct payments and personal budgets in England, and the recent implementation of Consumer-Directed Care in Australia, commonly referred to as ‘CDC’. In England, the idea of ‘choice’ of care provider has featured highly in policy documents since the 1990s (for example, Department of Health, 2000, Department of Health, 2005, Department of Health, 2010) with an instruction to local authorities to allow choice of residential care provider first issued in 1992 (Department of Health, 1992). Personal budgets for older people were subsequently launched in 2000, albeit only for community care (Glasby and Littlechild, 2009). The initiatives to promote personalisation and choice in both countries began with schemes for people with disabilities: in England, with the launch of personal budgets in the 1990s (Glasby and Littlechild, 2009); in Australia, with the piloting and then launch of the National Disability Insurance Scheme in 2016 (Buckmaster, 2017). In 2015, CDC was introduced into home care in Australia under the LLLB reforms. The model which was introduced is similar to the system of personal budgets in England, rather than a system of direct payments, where service providers take responsibility for organising care packages, a service for which users pay a fee (Low et al., 2012). Direct payments in England and CDC in Australia are currently only available for funding community-based care, although both governments are working towards introducing these funding policies into residential care² (KPMG, 2014, Williams et al., 2017).

Who pays for residential care

This section sets out how care is funded for older people in residential care in each country. The importance of understanding funding sources is illustrated by studies showing the emergence of two tiers of provider quality, particularly in England and the US, aligned with how residents are funded (Mor et al., 2004, Clement et al., 2012, Forder and Allan, 2014, Grabowski et al., 2014, Konetzka et al., 2015).

² Plans to implement direct payments into residential care in England have been put on hold until 2020 (Samuel, 2016).

In England, there are broadly two types of residents – those who fund their own care, and residents who are partially or wholly publicly-funded. In 2014, out of a total of 409,000 residents, just under half (167,000) paid all their own fees and are referred to as ‘self-funders’. Around 153,000 residents are fully funded by local authorities, and an additional 47,000 partially funded. For these residents, ‘third party top-up’ payments are made by families or friends to enable them to move into their preferred home. Finally, approximately 43,000 people, just over ten per cent of the residential care population, have complex health needs and are funded through NHS Continuing Healthcare (Laing & Buisson, 2015a). These percentages vary across the country, with higher proportions of self-funders in the South of England than the North (National Audit Office, 2014).

In Australia, government funding for the care component of residential provision is available to all residents, with means-testing only recently introduced in 2014 to identify people who can pay a contribution towards their care. This payment is called the *basic care subsidy* and is calculated using a dependency-based funding instrument, the Aged Care Funding Instrument (ACFI). More information on how the ACFI works is included in Appendix 1. All residents then pay a basic daily fee to cover living expenses, set at a maximum of 85 per cent of the single basic age pension. Funding for all other costs depends on means-testing. *Low means residents* receive additional government subsidies for accommodation, while other residents fund their own accommodation costs through either *Refundable Accommodation Deposit* (RAD) or a *Daily Accommodation Payment* (DAP) or a combination of both³. These payments replace the previous system of accommodation ‘bonds’, a change introduced under the LLLB reforms. A more detailed overview of the funding system in Australia is included in Appendix 2.

In England, local authorities are responsible for assessing both the financial eligibility and the care needs of individuals, now using new guidelines introduced under the Care Act 2014 (Department of Health, 2017b). In Australia, access to residential care is determined through an assessment by one of 80 Aged Care Assessment Teams. These teams are funded by the Australian Government but

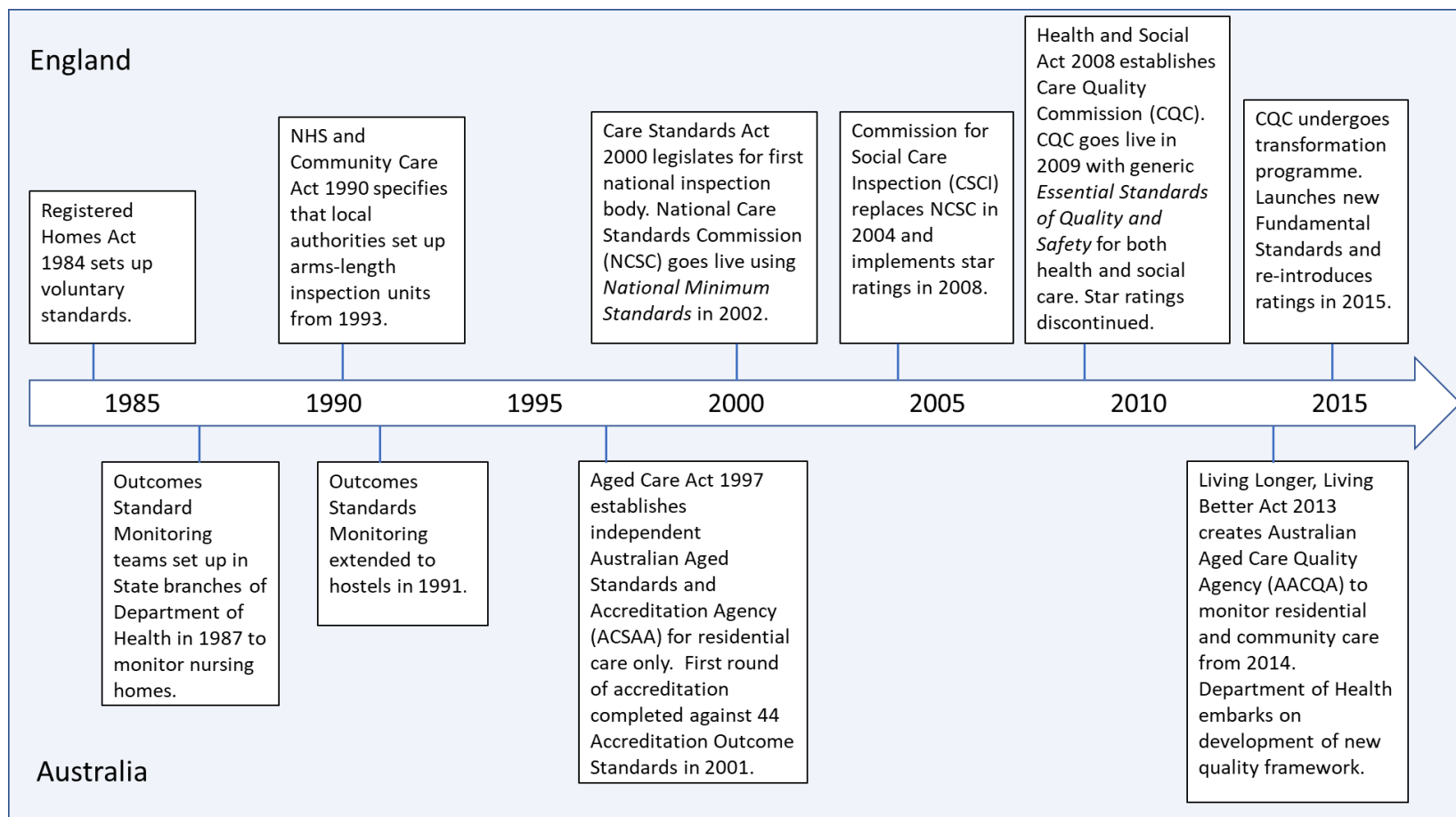
³ Where residents receive no government assistance for accommodation costs, they can pay the full cost of accommodation as an upfront lump sum (a Refundable Accommodation Deposit) or in regular rental-style payments (a Daily Accommodation Payment). Residents who receive some government assistance, these are reduced and referred to as *contributions* (Refundable Accommodation Contributions or Daily Accommodation Contributions).

administered through the state and territory governments. The eligibility requirements in Australia are set out in the Aged Care Act 1997 and the accompanying Approval of Care Recipients Principles 2014 (Department of Health, 2016c). Where in England, providers have the option of whether to accept publicly-funded residents, there are rules in Australia which mean that all providers must accept a certain percentage of low means residents, otherwise the rate of government subsidy for accommodation is reduced for all low means residents in their care.

2.2 Regulating for quality

Both England and Australia have established government bodies to monitor and review provider quality. Governments in both countries began to focus on quality in earnest from the 1980s onwards, even though local inspection processes existed in both countries much earlier⁴. The reliance on outsourced provision has been a major driver of the development of a regulatory framework for quality in both countries, but in different ways. In England, the expansion in inspection has emerged with the enlarged role of the independent sector since the implementation of the Community Care Act. In contrast, in Australia, where the state has never been a major direct provider of care, the expansion of regulatory activity has been explicitly linked to the significant quality problems identified through formal government inquiries into the long-term care sector, particularly the ‘Giles Report’ in 1984 (Senate Select Committee on Private Hospitals and Nursing Homes, 1984). The legislative and organisational milestones in the regulatory systems of both countries are shown in Figure 2.1.

⁴ The earliest inspections were of nursing homes in England under the Nursing Homes Registration Act, 1927 (Braithwaite et al., 2007).

Figure 2.1 Legislative and organisational milestones in quality regulation

Sources: Le Guen, 1993, Braithwaite, 2001, Means et al., 2002, Braithwaite et al., 2007, Johnson et al., 2010, Department of Health and Ageing, 2012, Nuffield Trust, 2013, Gray et al., 2014, CQC, 2015c

Following the election of the Labour government in England in 1997, a single inspection body, the National Care Standards Commission (NCSC), was set up under the Care Standards Act 2000 to monitor social care for older adults. However, within a month of the launch of the NCSC in 2002 it was announced that a new body, the Commission for Social Care Inspection (CSCI), would take over in 2004, inheriting additional responsibilities for reviewing the performance of local authority social services departments from the Social Services Inspectorate and the Audit Commission. The life of CSCI was subsequently cut short following a budget announcement in 2005 by Gordon Brown, the then-Chancellor, that CSCI would merge with the regulators for health care to form the Care Quality Commission (CQC)¹, in line with the recommendations from the ‘Hampton Review’ of regulation (Prosser, 2010).

The CQC was subsequently established under the Health and Social Care Act 2008 and began operating in April 2009. The CQC is a ‘non-departmental public body’ which is overseen by the Department of Health, its main purpose being ‘to protect and promote the health, safety and welfare of people who use health and social care services’ (HM Government, 2008, p2). The organisation has several responsibilities set out in the Act, including ‘encouraging’ quality improvement and ‘the efficient and effective use of resources’ in care services; to consider the views and experiences of people who use services and their families and friends; and to set up HealthWatch England, an organisation to act as the ‘independent national consumer champion’ for health and social care. The CQC is also responsible for providing an annual report to Parliament on the findings of its inspections across the health and social care sectors (National Audit Office, 2011). A responsibility to conduct periodic reviews of local authority commissioning was ceased in 2010 (National Audit Office, 2011), but since the implementation of the Care Act in 2015, the CQC can apply to the Secretary of State to conduct targeted reviews of local authorities (HM Government, 2014a). Likewise, the Secretary of State can ask the CQC to carry out specific studies and in early 2017 requested that the body carry out 20 ‘system reviews’ in local authority areas, to assess how well health and social care systems are working to support the needs of people aged 65 and over (CQC, 2017b). These reviews are however outside the legal remit of the CQC to focus on individual

¹ The CQC merged three regulatory bodies: the Commission for Social Care Inspection, the Healthcare Commission and the Mental Health Act Commission (National Audit Office, 2011).

organisations and as such were specially funded by the Department of Health (Committee of Public Accounts, 2018).

From a legal perspective, the CQC in England has more ‘regulatory clout’ than the Quality Agency in Australia. Unlike the Quality Agency, the CQC has responsibility for the registration of all providers of health and social care, as well as a range of enforcement powers, including issuing warnings, taking civil actions and stripping providers of their registration (CQC, 2015e, p1). Between 2014 and 2017, the CQC de-registered at least 140 different care homes (House of Commons, 2017). Since April 2015, the CQC has also had the power to prosecute providers for failing to provide care in a safe way (HM Government, 2014b) and exercised these powers successfully five times between March 2016 and April 2017 (CQC, 2017c).

The life of the CQC so far can be split into two distinct phases, for the purposes of this study called ‘Mark I’ and ‘Mark II’. ‘Mark I’ was the model implemented at the inception of the CQC in 2008 which experienced considerable leadership and operational challenges. Running parallel to highly critical reviews into its operations by the National Audit Office and the Health Select Committee (House of Commons Health Committee, 2011, National Audit Office, 2011) were investigations into a series of scandals at hospitals at Mid Staffordshire NHS Foundation Trust, Winterbourne View (a private hospital for people with learning disabilities and autism) and the University Hospitals of Morecambe Bay NHS Foundation Trust (CQC, 2012, Flynn, 2012, Francis, 2013)². These investigations eventually triggered a change of leadership at the top of the CQC, and the introduction of a raft of major changes in approach, changes welcomed by a parliamentary review (Commons Select Committee, 2014). The model of generic inspection teams was dropped and instead specialist teams were created in the new, ‘Mark II’, model under three Chief Inspectors for Hospitals, Primary and Integrated Care, and Adult Social Care (House of Commons Health Committee, 2014). The CQC was also given new responsibilities by the Department of Health in April 2015 to oversee the financial sustainability of the 43 largest adult social care providers; the purpose of this oversight being to alert local authorities about provider difficulties and allow local

² The first and most major of these scandals, commonly referred to as ‘Mid Staffs’, led to a major public inquiry and the publication of the ‘Francis Report’ (Francis, 2013).

authorities to make contingency plans for continuity of care (National Audit Office, 2015).

In April 2015, as part of the broader changes to the CQC, new *Fundamental Standards* (see Appendix 3) were developed and implemented. The Fundamental Standards replaced the Essential Standards of Quality and Safety in place between 2009 and 2015³. The Essential Standards had been a compliance/non-compliance model of generic standards, designed so that they could apply across all the health and social care services regulated by the CQC (National Audit Office, 2011). In contrast, the Fundamental Standards are accompanied by a system of ratings which scores each of five domains of quality as outstanding, good, requires improvement or inadequate (CQC, 2016a). These standards are discussed in more detail in Chapter 6.

The regulatory system in Australia

In comparison to the system in England, the system in Australia has been relatively stable since the 1980s, when inspection responsibilities were first formalised and centralised at the federal level. The move to a national system of quality monitoring was triggered by the 'Giles Report', which had exposed appalling neglect of older people in private hospitals and nursing homes (Senate Select Committee on Private Hospitals and Nursing Homes, 1984). Based on the recommendations of the Giles Report, Standards Monitoring Teams were launched in 1987 for nursing homes and 1991 for residential homes by the Australian Government. The monitoring teams were based in the State Offices of the Department of Health and had significant powers, including the potential to apply sanctions and withdraw government funding (Gibson, 1996). However, the nursing home industry lobbied heavily for reform of the inspection system and it was subsequently replaced by an accreditation regime when the Liberal government led by John Howard came to power in 1996 (Braithwaite, 1998). The Aged Care Act 1997 established the Australian Aged Care Accreditation Agency, a new national body to oversee quality standards within the residential aged care sector, removing the government from the direct regulation of the quality of care (Rosewarne, 2001), in line with a wide-

³ The Essential Standards replaced the National Minimum Standards, in place from 2001 to 2008 and specific to residential care (Department of Health, 2003).

ranging set of initiatives to limit the reach of the bureaucracy by John Howard's government (Tingle, 2015).

Under the recent LLLB reforms, the Accreditation Agency was replaced by the Australian Aged Care Quality Agency (from now on referred to as 'the Quality Agency'). There are two key differences between the two bodies; firstly, the new organisation is responsible for the quality accreditation of both residential and community-based care, and secondly, it is no longer an independent organisation and instead reports directly to the responsible Minister. The function of the Quality Agency is 'to assist the CEO in the performance of the CEO's functions, with the main focus on the accreditation of care providers (Commonwealth of Australia, 2013). The role of the Quality Agency in Australia is, however, broader than the CQC's in the dissemination of best practice. One of its responsibilities is to support providers in the continuous improvement of their care and to disseminate best practice. The Agency holds conferences and events for recognising and rewarding providers who have demonstrated examples of better practice care (Australian Aged Care Quality Agency, 2014a).

In comparison to the CQC, the powers of the Quality Agency in Australia are much more limited. Where the Quality Agency finds persistent or serious problems with provider quality, it refers them to the Department of Health to impose various different types of sanctions, for example, the suspension of funding for new residents or the revocation of the provider's licence (Ellis and Howe, 2010). The Agency can only make recommendations regarding enforcement and the ongoing approved provider status of organisations. Sanctions are relatively rare. Between 1999 and 2012 only 412 sanctions of all types were imposed across the sector, and only three per cent of these were to revoke provider approval status (Baldwin et al., 2014). More than half of the sanctions involved remedial action, for example, the compulsory appointment of an administrator or a nurse advisor or the provision of training.

Under the 1997 Act, only *approved providers* can offer residential care funded by the government. Responsibility for the registration of approved providers in Australia sits with the Department of Health, and not with the Quality Agency. As well as passing accreditation, providers have to pass building certification, demonstrate that they are financially sound, and that they have suitable staff and the ability and experience to provide aged care (Hogan, 2004). Unlike England,

where all providers have to be registered, the system of accreditation is, in theory, voluntary. However, given that providers cannot receive government funding without accreditation, it is in effect a mandatory process for residential aged care providers wishing to access government funding, which is an important revenue stream. However, organisations are setting up unaccredited services aimed at wealthier clients who forego government subsidies, for example, in the form of small group homes and retirement villages where community-based care is provided.

In Australia, following the set-up of the Accreditation Agency under the Aged Care Act 1997, the Accreditation Standards were introduced. The full list of 44 standards is included in Appendix 4 and is discussed in more detail in Chapter 6. The Accreditation Standards replaced a set of Outcomes Standards which had been in place between 1991 and 1997 and overseen by State Monitoring teams run by the Department of Health. The outcome of the accreditation review process then informs the length of the accreditation period granted to the provider, varying from one to three years (Rosewarne, 2001).

The Australian Government's approach to quality is currently under review, as set out by the LLLB reforms. In 2015 the Department of Health launched the development of a single Quality Framework, consisting of a single set of standards across both community and residential care, new quality assessment processes, and improved quality information for consumers (Department of Health, 2016c, p76). The project to develop the Quality Framework coincided with the fieldwork for this study. The main initiatives discussed in interviews were projects to develop Quality Indicators and Quality Standards, being run as separate projects but involving many of the same people from the aged care sector. The quality indicators will eventually be published on the MyAgedCare website 'when the data has been established as reliable and accurate and following stakeholder consultation' (Department of Health, 2016c, p81). Following the fieldwork for this study, the Quality Agency issued new draft standards for consultation, with a target of presenting the final standards to government and implementing them by July 2018 (Department of Health, 2017e).

Despite the challenges of evaluating inspection activity, qualitative research in both England and Australia suggests that regulatory efforts have been largely successful, at least in raising minimum standards and in forcing or encouraging the poorest providers to leave the sector (Lathlean et al., 2006, Commonwealth of Australia,

2007). In England, by the end of May 2017, 77 per cent of social care services had been rated as ‘good’, with 19 per cent rated ‘requires improvement’ and two per cent rated as ‘inadequate’. Two per cent of providers had achieved the ‘outstanding’ rating (CQC, 2017c). In Australia, providers rarely fail accreditation, and in 2015-16, 97.5 per cent of accredited providers were on accreditation periods of at least three years, the maximum duration granted (Australian Aged Care Quality Agency, 2016).

Finally, a difference between the two bodies is that the CQC in England is regarded as a deterrence-based inspection agency (Walshe and Phipps, 2013), that is, one which treats its regulatees as being ‘amoral calculators’ (Kagan and Scholz, 1984) or self-interested ‘knaves’ (Le Grand, 2003). In contrast, the Quality Agency tends towards a compliance-based model, which assumes that providers are altruistic ‘knights’ (Le Grand, 2003) or ‘political citizens’ (Kagan and Scholz, 1984). This view of the relative inspection styles is reinforced by the respective use of sanctions by each body, as highlighted above.

Other quality initiatives

Another difference between the approach of the two countries is the number of government-funded organisations formally involved in the quality process. In Australia, the government responsibility for quality sits mainly with the Quality Agency, along with a central body for handling escalated complaints run by the Aged Care Complaints Commissioner. As of 2016, this Commissioner reports directly to the responsible minister.

A feature of the quality landscape in England is the multiplicity of quality organisations and initiatives which exist alongside the CQC at the national level. The Social Care Institute for Excellence (SCIE) was set up in 2001 to promote and disseminate information on what works best in social care (Department of Health, 2000). Under the Health and Social Care Act 2012, the National Institute for Health and Care Excellence (NICE) assumed formal responsibility for producing ‘quality standards’ and guidelines for social care, with SCIE providing development support. These quality standards are intended to ‘show providers how they can continually improve the quality of care above and beyond CQC standards and aspire to deliver high quality care’ (NICE, 2014). The standards and guidelines are in theory voluntary; however, they form the basis of the CQC standards and so it is expected

that providers will refer to them for guidance in improving quality (NICE, 2015). Some of the quality standards are specific to residential care, for example, standards for the mental wellbeing of older people in care homes, for oral health and for managing medicines in care homes; others are generic standards but highly relevant to care homes, covering themes such as reducing falls, caring for people with dementia, and managing specific conditions such as depression and faecal incontinence (NICE, 2018). An additional arms-length organisation in the social care sector in England is Skills for Care, set up in 2002. The organisation provides 'practical tools and support' to help adult social care organisations in England 'recruit, develop and lead their workforce' (Skills for Care, 2017). Also involved with the oversight of quality in England are Healthwatch teams, which fall under the purview of CQC, but are run within each the local authority. The purpose of these teams is to represent the views of the public and users of health and social care (Department of Health, 2012b).

Another notable difference between the two countries is the extra layer of responsibility for quality at the local level in England. The responsibility for quality is enshrined under the Care Act 2014 with a legal duty for local authorities to ensure that people in their area who need care have 'a variety of high quality services to choose from' (HM Government, 2014a, p5). The way in which local authorities approach this responsibility can vary greatly, with councils using a variety of tools, including outcomes-based commissioning practices, the use of specialised improvement teams and their own in-house quality ratings⁴. There are also joint initiatives between many of these organisations focused on quality and 'sector-led improvement'. One, focused on personalisation, but targeting improvements in care standards more broadly, is the Think Local Act Personal (TLAP) partnership. Established in 2011 by the Department of Health, this is now a partnership led by SCIE (Think Local Act Personal, 2011).

Other, targeted, national government initiatives exist in England, such as the 50 *Vanguard sites* managed and funded by NHS England, consisting of projects to improve the quality of health care, including for care homes, with specific attention to reducing the burden on the acute hospital sector (NHS England, 2016). The

⁴ While interviews were conducted for this study with staff in two local authorities, the focus of this study was on the national systems and a detailed analysis of the different approaches of local authorities was outside its scope.

Australian project most comparable to the Vanguards programme is the Encouraging Better Practice in Aged Care (EBPAC) Project. Since 2007, the Australian government has funded the programme to evaluate the implementation of evidence-based practice, first in residential care, and then broadened to cover both residential and community care between 2012 and 2014. The initial evaluations were focused on specific clinical or psychosocial interventions, for example, palliative care, wound management and behaviour management; however, in the second phase of the project, they have been broadened to include practices such as developing leadership skills and implementing culture change practices (Masso et al., 2011, Fildes et al., 2015).

In general, the number of individuals and organisations ‘involved’ with oversight of different aspects of residential care is greater in England than in Australia and operate at multiple levels. Where in England, multiple stakeholders, for example, the CQC, the local authority, Clinical Commissioning Groups, Healthwatch and the Parliamentary and Health Service Ombudsman are all involved with oversight, this contrasts with the situation in Australia where the central Department of Health, Quality Agency and the team of the Aged Care Commissioner are the sole organisations involved.

2.3 Trends in regulation

In both countries, the general policy trend is a fixation on reducing regulatory ‘burdens’ and minimising ‘red tape’ across all sectors (Hampton, 2005, Tombs and Whyte, 2013, Department of the Prime Minister and Cabinet, 2014). The perceived burden created by the administrative requirements of the inspection of care homes has come under close scrutiny in both countries (EY, 2014, HM Government, 2016). As a result, in the future both the CQC and the Quality Agency are expected to increase the share of their costs recovered from provider fees (National Audit Office, 2011, Australian Government, 2015). Cutting regulation is presented as a particularly high policy priority in Australia. The Government has announced that it will introduce ‘contestability’ for accreditation services, that is, allowing private providers of accreditation services into the sector (Australian Government, 2015). An idea which has also taken hold in the sector in Australia is the concept of ‘earned autonomy’, something piloted with nine provider organisations in the *South Australian Innovation Hub Trial* (MP Consulting, 2016, p7). In England, the

emphasis for delivering cost reductions has been the use of risk-based regulation, where ‘intelligent monitoring’ is used to monitor data submitted by providers on a mandatory basis. This data has been specified by the CQC and assessed as important for predicting potential quality problems (CQC, 2016b). A list of the data required to be submitted for intelligent monitoring purposes is included in Appendix 5.

2.4 Current context

An important factor in determining provider quality is the financial status of provider organisations and therefore any discussion about quality has to be placed within the current fiscal and economic climates in each country. Over recent years and particularly since the imposition of the austerity programme imposed by the Coalition government in 2010, the social care sector in England has been under increasing strain. Government funding to local authorities decreased by 49 per cent between 2010-11 and 2017-18 (National Audit Office, 2018). It is estimated that the number of older people receiving social care fell from 1.2 million in 2005–6 to 850,000 in 2013–14, in spite of the increased needs of an ageing population (Communities and Local Government Committee, 2017b). A number of additional cost pressures are facing local authorities and providers, including the ongoing costs of implementing the Care Act; costs associated with administering safeguarding processes; and increased wage costs following the imposition (and subsequent increases) of a National Living Wage (Communities and Local Government Committee, 2017b). These factors have been linked to concerns about quality in the sector (Burns et al., 2016, CQC, 2017c, Healthwatch, 2017). The average rates paid by local authorities are now ‘significantly below the floor’ set in the Laing and Buisson benchmarking tool recommended by the Department of Health (Laing & Buisson, 2015a). The precarious nature of the market is illustrated by increasing numbers of care providers, both residential and community-based, handing their contracts back to local authorities (Communities and Local Government Committee, 2017a). The combined effect these financial pressures in public funding has been to exacerbate the cross-subsidisation of local authority-funded residents by self-funders, as well as providers completely withdrawing from the sector. Between 2012 and 2017 it is estimated that demand for residential care for older people grew by 16.2 per cent, while residential care places grew by only 4.3 per cent (Institute of Public Care, 2017). There is also growing polarisation in the sector as providers stop

taking local-authority funded residents altogether in favour of self-funders (Laing & Buisson, 2015b).

In contrast to the economic climate in England, the Australian economy has experienced 25 years of consecutive growth in its Gross Domestic Product (Smyth, 2017). Despite this, in 2014 the Australian Government embarked on its own 'austerity' programme with the aim of cutting its budget deficit (Smyth, 2014). In 2016, the government announced a series of measures to cut future spending on aged care, including changes to ACFI rules and the cutting of levies for building maintenance and replacement (Department of Health, 2016a, Tingle and Mather, 2016). The measures provoked a considerable backlash from providers, and the government subsequently responded with alternative proposals and an announcement that it had commissioned reports on replacing or redesigning the ACFI (Morrison MP and Cormann, 2016). The reports were published in 2017 and made alternative recommendations for improvements to the ACFI (Rosewarne et al., 2017) and a new funding system, albeit still based on an activity-based funding model (McNamee et al., 2017).

2.5 Conclusion

On the surface, Australia and England have relatively similar systems for managing quality in residential care as they both have a central body in place that conducts regular inspections and accreditation reviews. As this chapter has shown, however, there are differences across the systems. These differences include funding, the make-up of provision in the sector, and the powers and approach of the respective regulatory bodies. Another important difference is the nature of the policymaking space. In England, the fragmentation of policymaking and implementation, including the Department of Health and 152 local authorities presents barriers to the power of interest groups. However, in Australia, the consolidation of almost all aged care functions, including funding and commissioning, into the Department of Health, provides a wholly different context for policymaking and influence. This thesis will seek to understand the impact these differences have on the way quality is defined and communicated and on the relationships between policy interventions and provider behaviour.

3 Quality and regulation in residential care: theoretical and conceptual issues

This chapter reviews the relevant literature for three of the empirical chapters (Chapters 6 to 9). A separate, short literature review is included in the first empirical chapter (Chapter 5) which explores the factors explaining differences in regulatory design.

This thesis focuses on quality improvement at the level of provider organisations. Discussions about quality in long-term care often centre on abstract, conceptual issues around its definition, and the ensuing challenges for its measurement. The first task of this chapter is to establish definitions of quality which can be used for the analysis in the rest of the thesis. This chapter draws on a range of disciplines, including service marketing and quality management, to set out three new approaches to defining quality at the provider level, namely *organisation-focused*, *consumer-directed* and *relationship-centred quality*.

The publication of quality information is an increasingly common strategy for incentivising changes in provider behaviour, either through influencing consumer choice ('selection') or through more direct effects ('activation') (Berwick et al., 2003, Rodrigues et al., 2014). This trend exists despite the challenges in the definition, measurement and communication of quality. This increase in the availability of information comes even though there is limited evidence of it influencing either consumer or provider behaviour in social care (Rodrigues et al., 2014). This chapter therefore explores some of the theories around publishing information and discusses what is known about changes in the quality behaviour of providers.

This chapter then turns to what is known about how providers respond to regulatory interventions and the main issues to be considered in designing policies and regulatory interventions. The section outlines the key considerations for governments, for example, should owners and staff at regulated organisations be regarded as intrinsically altruistic or, alternatively, as self-serving, rational individuals (Le Grand, 2003). The section draws on broader regulatory theory to shed light on these design options, as well as outlining what is known specifically

about the effects of regulation in residential care. This chapter then explores the different organisational approaches of ‘quality improvement’ and what is known about quality improvement in the sector.

3.1 Organisational approaches to defining quality

The following section uses literature from a variety of fields to develop three potential approaches for looking at quality in the long-term care sector.

Organisation-focused quality

The first way of considering quality is focused on the internal needs of the organisation and primarily concerned with the way things work for the purposes of efficiency and cost containment (Moullin, 2002). This view of quality was primarily intended for the manufacturing sector and described in the 1950s by management and operations consultants such as Deming (1986) and Crosby (1979) following their experiences in the automotive sector in Japan. When applied to services, this definition of quality should - in theory - only be used in simple, standard services with low human contact such as rubbish collection or postal and courier services (Ghobadian et al., 1994). ‘Product’ and ‘value-based’ are also types of internally-focused quality from manufacturing. In long-term care, these quality approaches might apply to planning and costing the tangible aspects of residential care, for example, different standards of furniture or decoration, or the quality of food.

If this definition is transferred to residential care, the priority of a care provider with an internal focus would be to maintain patient safety and standardised processes (particularly clinical processes). Person-centred care may be a stated aim, but this is likely to be dominated by the documentation of care needs, for example, in care plans. Care is likely to form a series of interventions, either clinical or psychosocial, rather than a holistic approach to caring for the person and allowing for a range of different needs and preferences (O'Dwyer, 2013, Theurer et al., 2015). The role of the care worker will be to deliver a set of standardised tasks and processes which are dictated by the needs of the organisation. These standardised tasks and processes might overshadow the psycho-social and relationship needs of residents. In this

definition of quality, the resident is portrayed as a dependent, someone who is a helpless and passive recipient of care-giving work:

...care-giving work is characterized by a relationship between carer and cared for where the cared for, through illness, handicap or youth, is incapable of self-care, and hence is in a position of dependency and helplessness *vis-à-vis* their carer (Ungerson, 1990, p14).

The health status of most residents means they will have a degree of physical dependency; here the term ‘dependency’ is used to refer to the dependency defined by Baltes (1996) which develops due to environmental factors and unequal power relations between the individual and those caring for them. The later stages of dementia bring particular challenges in how residents are perceived; several authors have discussed the risk of a ‘social death’, where residents are no longer seen as being active agents by those caring for them (Sweeting and Gilhooly, 1997, Brannelly, 2011, Watson, 2017).

Consumer-directed quality

The second definition of quality draws on the work from the field of service marketing, a source of theory which has been neglected in the development of public services (Osborne et al., 2013). In service marketing, best practice in quality is about meeting and/or exceeding the expectations of customers and it is the customer’s concept of quality which counts (Grönroos, 1978, Ghobadian et al., 1994, Øvretveit, 2000). Delivering better quality is all about providing a service which most closely matches these needs and preferences. Here, the understanding of consumer expectations is at the heart of understanding what constitutes ‘over and above minimum standards’. In the consumerist paradigm, care becomes positioned as a ‘service’ which carries very different assumptions about need and dependency from traditional understandings of care (Higgs and Gilleard, 2016, Fine, 2007).

The positioning of residents (and users of other types of formal care) as ‘consumers’ in recent years has emerged under the banner of New Public Management (Clarke et al., 2007). The benefits brought by personalisation and choice are seen as preferable to dealing with services which have been described as over-professionalised, bureaucratic, standardised, inhumane and paternalistic (Vabø, 2006, Ferguson, 2007, Barnes, 2011). The benefits are presented as wholly positive,

regardless of the status of the person in need of care:

When it calls patients ‘customers’ the logic of choice opens up splendid panoramic views. From the top of the mountain you see no suffering. The language of the market contains only positive terms. Products for sale are attractive. Tellingly and non-neutrally, they are called ‘goods’ (Mol, 2008, p32).

As Scourfield (2007b) observes, even detractors of the consumerist narrative (including himself) would not argue against the benefits of people being able to choose where they live and have control over their lives. Indeed, one of the most negative experiences for people who have moved into residential care is the feeling of not having been involved in the decision-making process (Tyrrell et al., 2006, Nwe Winn et al., 2011). However, as discussed in Chapter 1, positioning the user of residential care as an empowered consumer is riven with difficulties. Choice and marketisation policies construct the person as ‘an autonomous, rational and self-serving individual’ (O’Rourke, 2015, p1010), ‘with the legal capacity to contract’ (Daly and Lewis, 2000, p283). Yet older people in need of residential care may have significant challenges in exercising choice (Eika, 2009, Trigg et al., 2017, Tanner et al., 2018). As Tanner and colleagues (2018) argue, the purchase of care and the purchase of commodities are inherently different because purchasers of care are typically in ‘a position of vulnerability and insecurity’ (p12).

Other features of the residential care sector present difficulties with this expectations-based model. Decisions are also complicated by the fact that the ‘consumer’ is also often not the resident, but instead a spouse or family member, who may have different needs, preferences, and expectations about quality (Davies and Nolan, 2003, Milte et al., 2016, Trigg et al., 2017). There can be tensions more broadly, not just between the expectations, needs and purchasing capacity of the resident, their families and unpaid carers, but also with the resources of government purchasers and the general public. The consumer may have preferences for high quality services, but it simply may not be possible to meet these within the constraints of available funding (Gaster, 1996, Moullin, 2002, Kelly, 2005).

A number of other conditions also need to be in place to facilitate ‘consumerism’, including access to a range of options, good information on which to base their decisions, the ability to make complaints and receive redress, and representation in terms of their needs and wellbeing (Potter, 1988), all of which have been found to be problematic in the residential care sector (Braithwaite et al., 2007, Eika, 2009). These tensions are demonstrated by the findings of the evaluation of direct

payments in residential care in England (Williams et al., 2017, Ettelt et al., 2018)¹. In this study, the ‘choices’ people spoke about were dominated by tangible choices or ‘search goods’, for example, choice of care home, choice of additional services, and hotel type features such as a larger room. However, giving people choice about the tangible aspects of care was not seen to necessarily lead to better of quality of life. Many of the choices older people valued, for example, having control over who they spend time with, were not determined by whether the person had access to a direct payment. Other studies have also found that improving control and quality of life are often related to day-to-day activities and decisions, rather than to issues related to financial power (Langer and Rodin, 1976, Burack et al., 2012, Wikström and Emilsson, 2014). This contrasts with a study in Australia on the implementation of CDC in residential care found that the intervention had a positive impact on resident quality of life (McCabe et al., 2015). A closer look at this study, however, shows that the focus of the intervention was on improving relational care rather than on aspects of consumer choice, and included training and support for improving communication between residents and staff; implementing a resident-driven care plan; fostering transformational leadership; and working towards organisational change.

Relationship-centred quality

This thesis uses the concept of relationship-centred care to develop a third way of looking at quality, that of ‘relationship-centred quality’, founded on the principles of person-centredness. In terms which would be used in service marketing, this approach is best aligned to the abstract idea of quality as excellence or something ‘transcendent’ (Ghobadian et al., 1994, p47). This is famously referred to in Zen and the Art of Motorcycle Maintenance: ‘...even though quality cannot be defined, you know what it is’ (Pirsig, 1974).

First, however, it is important to discuss the proliferation of often conflicting terms around the core idea of ‘person-centredness’ (Brownie and Nancarrow, 2013, O'Dwyer, 2013, Manthorpe and Samsi, 2016b, Stranz and Sorensdotter, 2016, Wilberforce et al., 2016, Waters and Buchanan, 2017). Authors, including O'Dwyer (2013) and Manthorpe and Samsi (2016a) have highlighted the tendency to conflate

¹ The ‘Trailblazers’ evaluation set out to review the experiences of 400 older people across 20 councils. Tellingly, however, the final figure was only 40 participants due to the low numbers of people in receipt of direct payments.

the different concepts of person-centred care, choice and control, individual care planning and personalisation. On one hand, there are elements of person-centred care which do not require choice and control, and on the other hand, approaches grouped under the banner of personalisation do not necessarily lead to delivery of the psycho-social and relationship-based care which works best for residents, especially those living with dementia.

For this thesis, the definition of person-centred follows the work of Kitwood (1997) in associating person-centredness with the idea of personhood. For Kitwood, the notion of 'personhood' applies to all individuals, regardless of their level of disability or cognitive impairment, and can be defined as:

...a standing or status that is bestowed upon one human being, by others, in the context of relationship and social being. It implies recognition, respect and trust (Kitwood, 1997, p8).

Building on this concept and also in acknowledgement of the part staff and the wider community play in good residential care, Nolan and colleagues (2004) have developed the idea of 'relationship-centred' care, adapting a concept originally devised for health care (Tresolini and the Pew-Fetzer TaskForce, 1994), but also drawing from Kitwood's definition of person-centred. The concept of relationship-centred care developed by Nolan and colleagues uses their own Senses Framework to describe how everyone involved in caring, including the resident, their families and care workers, should experience relationships that promote a sense of security, belonging, continuity, purpose, achievement and significance, 'to feel that 'you' matter' (p49).

A number of studies report the positive experiences and profound impacts that this type of care can have on both residents and staff (Daly et al., 2016, Stranz and Sorensdotter, 2016, Brannelly et al., 2017, Gjødsbøl et al., 2017). Theurer and colleagues (2015) have written about the need for a 'social revolution' in residential care to promote types of care which 'advance residents' social identity, enhance reciprocal relationships and increase social productivity', and move from a model of resident care to resident engagement (p201). New social movements have emerged to promote person-and relationship-centred approaches, including the Pioneer Network (Fagan, 2003) and Eden Alternative (Thomas, 1996) in the US and My Home Life in the UK (Bridges et al., 2006). For example, the aim of the My Home Life movement is to transform the lives of residents and support 'lives which have

meaning and purpose, if they wish, or simply to have peace of mind' (Bridges et al., 2006, p6).

Relationship-centred care is focused on the individual's needs and prioritises the quality of relationships between residents, staff and carers (Nolan et al., 2004, Walsh and Shutes, 2013). Studies consistently find that the positive experiences of older people in residential care stress the importance of familiarity between residents and their carers, leading to rapport, trust and a feeling of attachment (Bradshaw et al., 2012). Through continuity of staffing and spending extensive time with residents, care workers can learn to 'tune in to' the preferences of residents to provide appropriate care and mitigate against difficult reactions and even violence:

...a resident might be seen as 'incontinent' by those unfamiliar with her and continent "unless you make her wait too long" by those workers who know her well (Banerjee and Armstrong, 2015, p11).

Seen from this perspective, care is much more than completing tasks and calls on the individual skills and capacities of care workers to overcome the many indignities and humiliation involved in intimate care. The concept of relationship-centred quality also overcomes the criticism of paid care as creating an artificial dichotomy between the worlds of paid and unpaid care, by actively involving, and respecting the role of, the families and friends in the care and lives of the resident (Nolan et al., 2004). Without these 'genuinely caring and nurturing relationships', it is not possible to preserve the dignity of residents (Lopez, 2006, p136). This differs from home care where convenience and control over routines can be a higher priority for some service users and carers than long-term consistent relationships (Rodrigues and Glendinning, 2015).

A typology of provider quality

The idea that providers could take three different approaches to quality has close parallels with the typology of 'communities of care' developed by Davies (2003). Davies developed the typology to describe the patterns observed in comparing the experiences of residents, relatives and staff across three care homes and incorporated three types of model: 'controlled community', 'cosmetic community' and 'complete community'. The 'communities of care' typology sets out several characteristics for each model, for example, within the controlled community, care practice is characterised as 'control' and the work is described as task-centred and routine; within the cosmetic community, practice is described as a 'service' formed

of customer-centred and individualised work; and care in the ‘complete’ community is focused on enablement and nurturing, with work which is person-centred and relational. A major focus for Davies was the nature of the relationships between staff, residents, and relatives. There are also parallels with the work by Bowers and colleagues (2001) who identified three different types of care: care-as-comfort, care-as-service and care-as-relating.

The typology of care relationships set out by Wærness (1984, 1987) is also helpful in defining different types of provider quality. Centring on the power relationships between those involved, Wærness identifies three types of care: caring for dependents, caring for superiors and caring in symmetrical relations. In Wærness’s typology, power relationships are key. Where the relationship is between caregivers and ‘dependents’, or between caregivers and ‘superiors’, the relationships are asymmetrical and unequal. Wærness’s typology will be used in this study to frame three different conceptualisations of the resident: the resident as a dependent; as a consumer; and as an individual. These three different conceptualisations have parallels with the three different ways in which organisations might consider quality. Table 3.1 outlines the characteristics of the three different types of quality, linking the work by Davies, Bowers and colleagues and Wærness with theory from service marketing and quality management.

3.2 Information on quality

Discussions about ‘quality’ in the sector to some extent imply that differences in the quality performance of providers can be identified, expressed (usually quantitatively) and acted on. Developments in information technology and the growth of the internet mean that it is now much easier to gather, publish and disseminate quality information yet there is still considerable debate over how information should be used and for what ends. The purpose of this section is to set out the existing evidence on the place of quality information in government policy and regulatory regimes. It begins with a discussion of the challenges of measuring and expressing quality.

Table 3.1: A typology of provider quality orientations

	PROVIDER QUALITY ORIENTATION		
	Organisation-focused	Consumer-directed	Relationship-centred
Quality focus	<i>Internal processes</i>	<i>Consumer preferences and choice</i>	<i>Quality of life of residents, families and staff</i>
Conceptualisation of care	<i>Care as a process</i>	<i>Care as a service</i>	<i>Care as a relationship</i>
Organisation of work	<i>Task-centred and routine</i>	<i>Customer-centred and individual</i>	<i>Person-centred and relational</i>
Conceptualisation of the resident	<i>Passive patient</i>	<i>Empowered consumer</i>	<i>Individual with 'personhood'</i>
Power relationship	<i>Resident dependent on care worker</i>	<i>Resident superior to care worker</i>	<i>Resident and care worker in reciprocal and meaningful relationship</i>

Measuring and expressing quality

The challenges with measuring and expressing quality through indicators in long-term care have been discussed in some detail by Mor (2005), Castle and Ferguson (2010) and Malley and Fernández (2010). Identifying standard outcomes to be measured, attributing outcomes to care, the issue of small sample sizes, adjusting for different case mixes and the challenges of developing composite measures have all been identified as barriers to developing quality information in the sector. Much of the debate focuses on which of the structural, process or outcome measures set out by Donabedian (1966) most effectively articulate quality.

Both structural and process standards have been criticised for operating as a 'floor' or minimum standard and may present a disincentive for providers to improve their quality any further (Lathlean et al., 2006, Wiener et al., 2007a, Miller et al., 2010, Gawande, 2015). At the same time, the correct structural standards may be a necessary, but not sufficient, condition for good quality. Staffing is a good example of this, with both the ratios of staff to residents and their qualifications making a difference (Spilsbury et al., 2011), as well a link between staff turnover and resident outcomes (Bostick et al., 2006). While input standards might not guarantee good outcomes, Banerjee and Armstrong (2015) point out that neglecting the structural

issues of staffing and skills in regulation is unhelpful and may mean that insufficient resources are available to provide good care.

The advantage of process measures is that they ‘have the best chance of saying something about the nature of the important care relationship’ (Lewis and West, 2014, p4). In addition, they measure important aspects of social care, for example, the control the service user has over when and how services are delivered (Malley and Fernández, 2010). However, as with structural measures, attribution is still an issue, often showing weak links between care processes and outcomes (Donabedian, 1966). For many providers, particularly smaller, financially constrained providers, there is also a risk that they will have neither the resources nor the expertise to develop these processes.

Increasingly governments are turning to using outcomes indicators to measure the effects of care across a broad range of services and of different users and expectations. The appeal of outcomes measures is that they overcome the focus of process-related indicators as highly service specific, even though there are significant challenges with attributing outcomes to care processes (Malley and Fernández, 2010). Quality of life outcomes are also heavily influenced by the fact that care is ‘co-produced’ by individuals, and that much of the variation in quality of life outcomes can be better explained by the health and demographic characteristics of the individual resident than by the characteristics or quality of residential care (Shippee et al., 2015, Degenholtz et al., 2006).

Outcome standards have, however, been found to be more reliable than prescriptive input standards in inspections. Braithwaite and Braithwaite (1995) conducted a study comparing the reliability of the precise, prescriptive standards in inspections in the US with the outcome standards in place in Australia in the 1980s and early 1990s. Using ‘re-inspections’ of providers, Braithwaite and Braithwaite (1995) found that the broader outcome standards gave more reliable inspection results. They acknowledge how this is somewhat of a ‘reliability paradox’, showing that a focus on specific rules and input measures can undermine the understanding of the overall performance and quality of a provider. The authors conclude that the best standards are ‘simple and few in number’ and the regulatory process should be resident-centred and outcome-oriented (p336). There is, however, evidence from other sectors that a pure focus on outcomes may mean that organisations simply

neglect basic structural and process standards due to a lack of monitoring (May, 2003).

Responsibilities for gathering and publishing information

Quality information can come in a variety of forms. Fung and colleagues (2007) describe three different types of quality information. The first is ‘right to know’ information, focused on the basic safety and reliability of the product or service in question, where providers are obliged to disclose adverse events. The second type is the publication by providers of data which communicates differences in quality performance. The third generation is the concept of collaborative transparency, where consumers take an active role in both sharing reviews and demanding information.

Inspections and/or reviews form one mechanism for collecting and publishing quality information, but other avenues include information supplied by providers on a voluntary or mandatory basis; information from staff in the form of whistle-blowing; and information directly from residents and family members in the form of complaints, via surveys or online review mechanisms and ratings (Malley et al., 2015).

As well as gathering information themselves, governments can choose to mandate the publication of performance data and information to replace or complement information found through traditional inspection activity. The ‘mandatory disclosure’ of quality information is required to counteract the shortfalls of voluntary disclosure of information in long-term care. However, there is evidence that enforcing the mandatory disclosure of information can discourage organisations from seeking out the requested information internally, to avoid the risk that the information demonstrates poor quality and has to be published (Polinsky and Shavell, 2012). There is also the risk that organisations will simply present inaccurate or misleading information (Loewenstein et al., 2014).

Voluntary disclosure of information is also problematic, particularly because of the nature of the long-term care ‘market’. Voluntary disclosure relies on a process of ‘unravelling’, where the best quality organisation will disclose its quality performance voluntarily to differentiate itself from the competition, and this will be followed by other high-quality organisations until only the worst providers do not

disclose their information (Dranove and Jin, 2010). In theory, consumers will then assume that organisations which do not report their quality information are of poor quality and avoid them. However, unravelling requires several conditions that simply do not exist in long-term care, not least of which is that quality needs to be one-dimensional and well-defined, and consumer preferences need to be homogeneous. In addition, organisations may simply choose not to disclose their quality information if there is low public awareness or reporting or if consumers do not perceive non-disclosure as a sign of poor quality (Vukovic et al., 2017). The risk of non-disclosure can be high because purchasers are not ‘sufficiently skeptical about undisclosed information – they underestimate the extent to which no news is bad news’ (Jin et al., 2015, p1).

The concept of consumer ratings and reviews has gained traction in long-term care over recent years as a unique way of gathering the experiences of quality of residents and their families. There are however a number of issues which should provide a note of caution for their widespread use. Different residents may have different requirements and expectations of quality and their reviews may reflect these; the reviews may not be representative; residents and their families may be concerned about retaliation from the provider; and it is also generally not possible to verify whether the reviewer was actually a customer of the organisation reviewed (Dranove and Jin, 2010, Trigg, 2014).

Using information to promote quality improvement

Information on quality is used in a variety of ways in attempts to influence provider quality. The theory is that, if information on quality is published, provider organisations will be incentivised to improve their quality through one of two ‘pathways’: either directly through ‘activation’, where providers proactively use feedback and performance data to improve quality, or ‘selection’, where providers improve quality to attract and retain customers (Berwick et al., 2003). Using examples from other sectors, making it mandatory for restaurants to disclose their hygiene ratings has been shown to reduce the incidence of food-borne diseases (Jin and Leslie, 2003), and similar improvements were observed in water quality following the disclosure of contaminant levels (Bennear and Olmstead, 2008). There are, however, some difficulties in understanding whether any resulting quality improvement is due to the activation or selection pathways, including in residential care (Werner et al., 2016).

Most of the evidence around the ‘activation’ pathway is taken from health care. There are conflicting results on the links between the reporting of information and quality improvement behaviour. For example, DeCourcy and colleagues (2012) found that quality improvement was more likely to be linked to targeted campaigns than to the publication of quality information, for example, in campaigns around infection control or waiting times. Meanwhile, while the heads of hospitals in the US said that quality reporting had an impact on their public reputation and improvement efforts, their own quality improvement staff were much more sceptical, saying that reporting was unlikely to stimulate significant quality improvement (Lindenauer et al., 2014). This contrasts with two other studies with US hospitals where respondents said that quality reporting served to energise and focus quality improvement efforts (Hafner et al., 2011) and where the reputational effects of public reporting were believed to have had an influence on quality improvement (Hibbard et al., 2005). More broadly, the results of a UK study by Sheard and colleagues (2017) found that any quality improvement activity which results from reporting is likely to be linked to an existing culture of quality improvement and how the legitimacy of the improvements are seen internally. Similarly, a systematic review of the links between patient feedback and quality improvement in general practice showed that its use was highly dependent on a number of factors, including the perceived validity of the information for staff and the capacity of staff for change (Baldie et al., 2018). In studies where quality improvement has been identified as resulting from quality information, it tends to be through the effects of professionals and organisations becoming aware of how they compare with their peers (Hibbard et al., 2005, Kolstad, 2013).

The usefulness of public reporting for improving quality through the ‘selection’ pathway is based on two premises: firstly, that consumers will access and understand quality information and use this to choose safer and better-quality services; and secondly, that providers will be responsive to the potential changes in consumer behaviour based on quality. Where residents are viewed as consumers, then an important priority is how to express care quality in terms to allow these consumers to make informed and rational choices about care providers.

The idea that goods and services have different ‘search properties’ is a helpful concept here (Darby and Karni, 1973, Malley and Fernández, 2010). Some aspects of residential care have many of the characteristics of a ‘search good’, where the

attributes of a product can be easily reported. For example, a provider can publish structural information such as how many of its staff have attended a certain training course, how many rooms open onto gardens, whether wine is served with meals or how often a hairdresser is available. Residential care has, however, been described as an ‘experience good’ (Malley and Fernández, 2010, Trigg, 2014). Put simply, without experiencing care, it is not possible to fully assess or provide information on its quality.

However, residential care is even more complex than this suggests. The increasing frailty, co-morbidities and complex health conditions of the population of care homes mean that residential care is not merely an ‘experience good’, but a ‘credence good’. A credence good is one where the consumer trusts that they are being sold the appropriate product or service in situations where they cannot adequately judge quality because of a lack of technical knowledge (Darby and Karni, 1973). In certain aspects of the care received in residential care, the increasingly complex needs of residents demand specialist knowledge, whether it be in dementia care, end of life care or general clinical care (Eika, 2009). For families that have been struggling with the changing behaviours of older people with dementia, their understanding of good care may be as basic as a provider that can keep the resident safe, in a clean environment without unpleasant smells. The nature of care as a credence good means that the resident, and their families, may never know, even after the fact, that the resident received the care which would have optimally enhanced their health and quality of life:

We know a bad haircut when we see it. But we may never know that if only we had put our mother into a different nursing home she would have lived a longer and happier life. The mistakes that nurses, doctors, dieticians, social workers and physical therapists make in the care of our mother will mostly never be known to us in retrospect; in prospect it is even more difficult to judge where care would be best (Braithwaite et al., 2007, p262).

Potential residents and their families are unlikely - at least currently - to be familiar with the best practice psycho-social approaches which have emerged in dementia and end-of-life care over recent decades. In addition, the trend for the self-management of chronic conditions is difficult to apply to the later stages of dementia due to the nature of the symptoms and its impact on cognitive ability.

So, the question is whether better choices will be made by residential care users and their families if information on quality is available. Unfortunately, the evidence that

‘consumers’ make decisions based on quality information in the health and long-term care sectors is at best slim (Rodrigues et al., 2014). Studies in England and the US have found that residents and their families are unlikely to consult official quality information (Castle, 2009, CSCI, 2009a, Werner et al., 2012, Trigg et al., 2017), although professionals, for example, social workers and hospital discharge planners, are more likely to refer to them (Castle, 2009, CSCI, 2009a). Where consumers have used information to choose providers, one study in the US found that they still chose nursing homes which were geographically close and had high quality ‘hotel services’, but did not pay attention to the quality of clinical care. In practice, the individuals in the study made choices based on the ‘quality dimensions that are easy for them to observe, evaluate, and apply to their situation’ (Pesis-Katz et al., 2013 p.e31).

There are other barriers to the use of information. Reports may be difficult to access or to understand; individuals may not have the skills to interpret them; and the information may not be relevant to the person’s needs and/or preferences (Berwick et al., 2003, Gigerenzer et al., 2007, Dranove and Jin, 2010, Konetzka and Perraiillon, 2016, Schapira et al., 2016). The gap between the preferences of individuals and official information was demonstrated in a study where individuals were invited to construct their own composite measure of quality from NH Compare data, with the results differing from both the NH Compare five-star rating and from the ratings constructed by the other participants (Mukamel et al., 2016). Similarly, there were mixed results in a study comparing the star ratings given by CSCI with the social care-related quality of life outcomes captured through interviews and observations (Netten et al., 2012). Interestingly, the study by Netten and colleagues showed an association between the outcomes and ratings for residential care homes, but not for nursing homes. This finding possibly reinforces the idea that consumers can be better judges of quality where there are less clinical or technical credence good characteristics.

3.3 The relationship between policy interventions and quality

So far, the chapter has discussed how quality might be approached by providers, and the characteristics of different types of quality improvement. The next section explores an issue which vexes policymakers, that is, what is known about policy interventions and their impact on quality improvement.

The first challenge in understanding policy interventions is that there is a lack of research evidence from outside the US. Research into the effects of quality improvement mechanisms is predominantly (but not exclusively) US-based, mainly due to the extensive collection and publication of data to claim reimbursement from the government and for publication on the government's Nursing Home Compare website. More generally, understanding the impact of interventions is made more complex by the international lack of measurement for quality (Brennan and Berwick, 1996, Commonwealth of Australia, 2007). The fact that most countries implement regulation in one hit also means there is a lack of a counter-factual in each country with which to compare the effects (Walshe, 2001). Trying to identify the extent of a policy's impact is therefore problematic.

This issue is illustrated by a recent study in Australia which showed that care managers and staff thought that quality had generally improved in aged care since the implementation of the Aged Care Act 1997. However, interviewees were unable to disentangle the impact of legislation, policy, funding and accreditation – all implemented in tandem under the 1997 Act (Hogden et al., 2017). Participants in the same study also believed that some improvements were motivated by the increased expectations of consumers in residential care, but particularly in environmental design, something which supports the idea that consumers will drive improvements in 'search good' attributes. The study highlights that the potential impact of single policy mechanisms should not be considered on their own and instead should be assessed in relation to the broader picture in terms of funding and organisation.

It is also difficult to disentangle the different elements of inspection, for example, is change really due to the infrequent interaction between the inspector and the care home provider, or is it due to the simple act of setting standards in the first place (Walshe and Boyd, 2007), or alternatively drawing attention to specific quality issues via the use of themed reports (Walshe and Phipps, 2013)? Studies in England have suggested that improvements in the quality and consistency of services are as much due to setting and communicating a concrete set of minimum standards, as from the process of inspecting itself (Grenade and Boldy, 2002, Lathlean et al., 2006, Cherry et al., 2007, Furness, 2009).

Principles of regulatory design

The key to effective regulatory design is successfully predicting how regulated organisations will respond (Sunstein, 1990). As mentioned previously, early regulatory design assumed that ‘regulatees’ come in two forms, deterrence- or compliance-based (Reiss, 1984). Deterrence-based approaches assume that providers are ‘amoral calculators’ (Kagan and Scholz, 1984) or self-interested ‘knaves’ (Le Grand, 2003) who will only respond to regulation if the cost of not responding is greater than the cost of responding. Deterrence-based approaches see punitive regulatory styles with a higher risk of sanctions as a way to make it ‘rational’ for providers to comply with regulations (Baldwin et al., 2012). In contrast, compliance-based approaches presume that providers are altruistic ‘knights’ (Le Grand, 2003) or ‘political citizens’ (Kagan and Scholz, 1984). These knights are expected to respond positively to regulation for either social or normative reasons, from the ‘desire [...] to earn the respect and approval of significant others’ (Winter and May, 2001, p678), or simply because ‘it’s the right thing to do’ or a sense of moral duty (Nielsen and Parker, 2009, p378). Compliance-based approaches are considered to be appropriate for this type of provider, under the assumption that gentle persuasion is effective in convincing providers to comply with regulations and standards, and ultimately support providers in improving their quality.

A study of the motivation of care home providers (managers and owners) showed that many saw themselves as altruistic and driven by professional reasons, and to a certain extent this was reflected in the views of local authorities (Matosevic et al., 2007, Matosevic et al., 2008, Matosevic et al., 2011). However, Ayres and Braithwaite (1992) argue that it is impossible to assign a single motivational label to providers and individuals, as each has ‘multiple selves’. Organisations are not monolithic, and individuals may respond differently to different regulations and under different circumstances:

...the disorder we observe in regulatory typifications even of individual business actors arises because most business actors are bundles of contradictory commitments to values of economic rationality law abidingness, and business responsibility. Business executives have profit-maximising selves and law-abiding selves; at different moments, in different contexts, the different selves prevail (Ayres and Braithwaite, 1992, p31).

Responses to regulation are generally more nuanced, and consist of *motivational postures*, from willingly embracing the mission of the regulator to capitulation,

resistance, and game-playing and disengagement (Braithwaite et al., 1994, Braithwaite, 2009). These multiple responses have led to the development of more sophisticated approaches to regulation, often based on the principles of *responsive regulation* (Ayres and Braithwaite, 1992). The responsive regulation model builds on ‘tit-for-tat’ regulation and game theory (Scholz, 1984), proposing a strategy which combines elements of compliance- and deterrence-based approaches by outlining a pyramid of progressively more punitive actions depending on the response of the provider. ‘Regulation’ involves more than just inspections and standards-setting and should encompass a broader range of quality interventions and engage multiple stakeholders, for example, government, users, staff, providers and the general public (Gunningham and Grabosky, 1998, Black, 2002, Braithwaite et al., 2007). Instruments include the wide range of quality interventions, for example, inspections and standards-setting, certification, education and training, reporting, award schemes and economic incentives (Gunningham and Grabosky, 1998, Braithwaite et al., 2007).

When considering the design and implementation of regulatory regimes, policy makers have to be aware of the potential for unintended consequences and this is a particular issue for the use of quality information. Smith (1995) identifies a number of different forms of unintended consequences. These include *tunnel vision*, where an emphasis is placed on what is measured, at the expense of what is not; *myopia*, a focus on short-term objectives at the expense of longer-term benefits; *gaming*, where actual behaviour (rather than just reporting) is manipulated, for example, risk selection and cream skimming; and *measure fixation*, or ‘hitting the target and missing the point’ (Bevan and Hood, 2006, p521).

In regulatory terms, measure fixation resembles ‘ritual compliance’, the ‘acceptance of institutionalized means for securing regulatory goals while losing all focus on achieving the goals or outcomes themselves’ (Braithwaite et al., 2007). The risk of ritual compliance has been linked to the contemporary proliferation of rules, monitoring and oversight functions, or what Power (1999) refers to as the ‘audit society’. Ritual compliance has been observed in different forms in inspections of residential care in Australia, England and the United States (Braithwaite et al., 2007). For example, Anderson et al. (2003) observed that the priority for many providers in the US is to follow the regulatory rules to avoid being sanctioned or closed, creating an authoritarian and strictly hierarchical culture in many homes.

They suggest that this tendency to be authoritarian is exacerbated by the fact that homes tend to be staffed by potentially low-paid, unskilled employees. Other unintended and deleterious consequences of inspection have included cream skimming in Canada (Bravo et al., 2014) and the manipulation of care plans to reflect only activities and treatments that could be carried out in practice and therefore pass inspections in the US (Colon-Emeric et al., 2006). US studies have also highlighted the risk of tunnel vision, for example, the relative use of chemical and physical restraints where the use of one or the other is included in quality information (Bowblis and Lucas, 2012, Konetzka et al., 2014).

The key to successful policy design is therefore in choosing quality instruments which complement each other, with no single instrument having to solve every problem (Braithwaite et al., 2007). While these approaches have been discussed widely in other sectors, there has been no research in long-term care which has considered the combined effect of policies on provider quality behaviour.

The impact of regulation on quality improvement

Another challenging issue in regulatory design is understanding the precise ways in which inspection and regulation are linked to specific types of quality improvement. For nursing homes, it appears that quality is more likely to be improved by lower quality nursing homes. This has been observed in both the US (Clement et al., 2012, Chen, 2008) and Germany (Herr et al., 2016). This possibly backs up the observation by Coglianese and Nash (2006) that inspection is most effective at addressing 'low hanging fruit'. Alternatively, action by the poorest quality homes may just reflect that they have more room for improvement. However, while there is evidence to support a link between regulation and minimum standards, there are tensions between regulation and achieving quality over and above these levels. For example, conforming to prescriptive input standards may not result in a better outcome for the resident, and in fact, has been shown to impede quality improvement efforts (Lathlean et al., 2006, Miller et al., 2010). This phenomenon has been referred to as a 'regulatory paradox', where increasing the detail of regulation and oversight do not achieve commensurate increases in quality (Haines, 2011, Banerjee and Armstrong, 2015). For long-term care, this paradox has been attributed to the difficulties of describing what Kant referred to as 'imperfect duties', the elements of person-centred care which cannot be exhaustively described, such as compassion, concern, kindness and respect (McCormack, 2003). In fact, some

studies have found organisations where workers looking after people living with dementia regularly break overly prescriptive rules to provide better care (Kontos et al., 2010, Daly et al., 2016).

Banerjee and Armstrong (2015) argue that the nature of relational care is completely at odds with today's focus with prescriptive rules and measurement, or what they term 'neoliberal auditing', where:

...the dominant trend is to treat care as a commodity, workers as objects of control, and quality as something that flows naturally from market competition (p9).

Likewise, a criticism of inspection is that it takes time away from the delivery of care to focus on paperwork and documentation. This has been observed in several studies in long-term care, for example in Australia (Grenade and Boldy, 2002, Hogden et al., 2017), England (Warmington et al., 2014), the US (Cherry et al., 2007) and Canada (Banerjee and Armstrong, 2015). In Banerjee and Armstrong's view, the practice of 'auditing' in residential care fundamentally changes the practice of care and reduces it to a series of tasks which can be expressed in standards but neglect the quality of both the lives and the deaths of residents. The authors do not contest the need for oversight, but argue that regulation should work at multiple levels, and include regulations which better address structural issues to make sure that staff have sufficient skills and resources to provide what they call 'relational care' (Banerjee and Armstrong, 2015, p10).

One consequence of the implementation of inspection in many countries has been that many small providers have been forced out of the market due to the high costs of meeting regulatory standards, a phenomenon observed in Australia (Commonwealth of Australia, 2007), England (Lathlean et al., 2006), Canada (Bravo et al., 2014) and the US (Braithwaite et al., 2007). The loss of the poorest provision is generally considered to be a good outcome, but runs the risk of reducing diversity and choice, given that aspects of the regulatory regime are more easily negotiated by larger corporate providers, for example, meeting building regulations and standards (Lathlean et al., 2006). At the same time, other studies show that providers see regulation as a necessary and important intervention and gain value from the process. Studies carried out in England and Australia with care home managers regarding early experiences with inspections showed that the two most useful aspects of inspection were feedback and support from inspectors (Furness, 2009, Grenade and Boldy, 2002).

Organisational approaches to quality improvement

The three lenses through which quality can be viewed are, to a certain extent, mirrored by three different approaches to quality improvement. Quality improvement initiatives in organisations can be viewed on a spectrum, from basic (quality control and quality assurance) through to the more sophisticated approach of ‘systemic quality improvement’. When considering the potential and actual impact of government interventions on provider behaviour, it is important to assess whether certain interventions might deliver true systemic quality improvement and cultural change, or whether they represent a much more limited view of quality improvement which may or may not impact on the quality of life of residents.

In line with a focus on internal processes, the most basic quality improvement activities - quality control and quality assurance - are concerned only with the internal processes of the organisation. The purpose of ‘quality control’ is to identify defects and faults in services and products already produced (Watson, 2002, Zairi, 2013). While quality control can be viewed as a step on the path to implementing quality improvement, it is widely acknowledged that the presence of a quality control system does not in itself lead to the production of better quality products and services (Moullin, 2002). Quality assurance goes a step further than quality control in defining and documenting work processes and quality standards and often involves the implementation of external quality management systems and certification. There is fierce debate regarding the benefits of implementing quality certification processes. Some companies assert that quality certification improves customer service and the consistency of products and services, while others maintain that quality certification can be achieved even with poor quality output and no clear commitment to continuous quality improvement (Douglas et al., 2003, Terziovski et al., 1997).

The next level of quality improvement can be wholly focused on internal organisational needs or, alternatively, may have some consideration of the needs of consumers, often gathered through formal complaints and feedback processes. ‘Spotty’ quality improvement approaches address specific quality issues, but with little impact on the overall quality of the organisation (Moullin, 2002). These quality improvements might be relatively simple and involve matching the correct expertise and resources to a straightforward problem, for example, changing door handles to improve ease of access in a nursing home (Corazzini et al., 2015).

Delivering quality improvement which is externally focused, whether on the needs of residents as either consumers or individuals, requires a continuous approach to quality improvement, referred to in this thesis as *systemic quality improvement*. The defining factor of systemic quality improvement is that it is based on understanding and improving quality from the perspective of the ‘consumer’, or in this case, the resident, rather than from an internal focus on processes and procedures (Moullin, 2002, Watson, 2002, Dahlgaard and Dahlgaard-Park, 2006, Grol et al., 2007). There is little agreement on exactly what organisational behaviours and characteristics are needed for systemic quality improvement, but some of the common factors are a commitment to continuous improvement and a sense of quality ownership at all levels of the organisation, good leadership, participation from all staff, organisation-wide quality plans and goals, a proactive approach to identifying and avoiding potential problems, a willingness to invest in training and development, and team-work (Pollitt and Bouckaert, 1995, Powell et al., 2009, Zairi, 2013).

Quality improvement in residential care

A theme of this thesis is therefore the potential conflict between regulatory activity, which may be focused on narrow requirements, and the need to tap into broader, systemic and organic approaches to quality improvement.

Looking specifically at residential care for older people, several reviews have confirmed that successful improvement activity is linked to specific leadership behaviours and features of organisational culture (Masso and McCarthy, 2009, Low et al., 2015, Caspar et al., 2016). Studies of the ‘culture change’ phenomenon² in the US observed that systemic approaches which acknowledge the complexity of change are better for effecting and sustaining change in nursing homes (Corazzini et al., 2015, Shield et al., 2014). Similarly, ‘complex systems theory’ has been used to explain improvement in nursing home practices in Texas (Anderson et al., 2003, Colon-Emeric et al., 2006, Forbes-Thompson et al., 2007). Studies in Ontario nursing homes by Berta and colleagues (2005, 2013) have specifically shown the importance of making sure interventions fit the local context and being able to link outcomes to quality improvement interventions. To make change happen, there

² The term ‘culture change’ is used specifically in the long-term care sector in the US to refer to programs focused on the transformation of residential care, including the implementation of person-centred care (Doty et al., 2008).

have to be compelling reasons for both individuals and providers to change the way they do things (Kotter, 1996), yet there has been limited research into the motivations in the residential care sector to change. One exception is a qualitative study in the US into why organisations adopt ‘culture change’ practices. Nursing home administrators reported a variety of motivations, including the mission of the organisation, changes in their resident populations, market factors, satisfaction surveys, and state-driven quality improvement efforts (Shield et al., 2014).

There has also been limited research into the capability of providers to implement quality improvement. Shanley (2007) explored the ability of care home managers in Australia to manage change processes, finding that there was limited understanding or support of change management as a management responsibility. Heras and colleagues (2008a, 2008b) evaluated whether the adoption of external quality assurance and certification processes drove improvements in Basque nursing homes and found that there was no indication that certification improved quality of life or quality of care, particularly in very small homes (Heras et al., 2008a, Heras et al., 2008b).

3.4 Conclusion

The first goal of this chapter was to discuss the ways quality might be understood at the level of the provider organisation, as opposed to abstract or theoretical definitions. The chapter used studies from both long-term care and disciplines including quality management and service marketing to establish three different ‘quality orientations’: *organisation-focused*, where the priority is internal processes and where the resident is characterised as a passive and dependent patient; *consumer-directed*, where organisations focus on the needs and expectations of older people and their relatives as empowered consumers; and *relationship-centred*, where the resident is at the centre of a supportive and positive network of relationships and recognised by their ‘personhood’. These quality orientations will be used in both Chapter 6, which examines the link between quality understandings and regulatory interventions, and Chapter 8, which explores how the quality behaviour of providers is influenced by different policy interventions.

Next, the chapter turned to a discussion of the experiences of governments in using information to incentivise quality improvement. Governments have a range of options in how to incorporate information into their regulatory regimes. The

chapter identified different types of information related to quality – ‘right-to-know’ information about basic safety and failures; information produced by providers; and finally, information generated by ‘consumers’ themselves through ratings and online feedback. Communicating this quality information is, however, fraught with challenges, for example, determining which indicators best articulate quality and which avoid the unintended consequences of publishing information, for example, measure fixation and tunnel vision. This literature forms the basis for Chapter 7, which investigates the use of quality information by each country’s government.

Finally, the chapter discussed the response of organisations to regulatory interventions, using examples from both residential care and more generally. The section also examined the different ways in which provider organisations can view quality improvement, which has parallels with the quality orientations defined earlier in the chapter. This literature draws attention to the multiple behaviours which can be loosely defined as ‘quality improvement’; this adds complexity as responses to regulation can vary from ‘true’ quality improvement through to ‘ritual compliance’. This discussion provides the background for Chapter 8, which examines the effects of government quality policies on provider quality behaviour.

4 Methods: comparative analysis of regulatory frameworks in residential care

The chapter covers an overview of the methods used in the study and consists of seven sections. It begins by outlining the methods used in the study and the rationale for the research design, including the choice of England and Australia for comparison. This initial section also includes a discussion of the main ethical considerations for the design of the study and for how the results were reported. The chapter then has a brief description of how the initial background information was gathered, before describing how interviewees were sampled and recruited, and some of the key issues which emerged at this stage. It then moves to a discussion of the style and approach taken in the interviews. The chapter then describes how the process of analysis was carried out and finally discusses the main strategies used to assure the quality of the study.

4.1 A qualitative, comparative study

The purpose of this study was to gather new insights into how governments might design regulatory regimes for the residential care sector which encourage quality improvement over and above minimum standards. To do this, the study sought to examine:

1. What explains how and why the types of regulatory systems have developed?
2. How is quality understood in each country and how are those understandings reflected in the regulatory regimes?
3. How is information on quality used by governments to influence quality improvement?
4. How, and to what extent, do regulatory regimes influence providers to deliver quality over and above minimum standards?

The study required rich, complex, nuanced and possibly contradictory information from both countries on multiple aspects of the regulatory regimes and policy interventions, something for which qualitative methods are best suited (Miles and Huberman, 1994, Creswell, 2014, Dingwall et al., 1998). Understanding the local

context was also an important priority, as was the gathering of multiple perspectives from a range of stakeholders associated with the regulatory regime in different roles and at different levels. The flexibility and exploratory nature of qualitative approaches support a rich and nuanced understanding of a phenomenon, not least because they can capture different, ‘messy and contradictory’, perspectives, and also allow for the emergence of unanticipated issues and ideas (Braun and Clarke, 2013, p24). The primary form of data collection was semi-structured interviews, ‘a conversation that has a structure and a purpose’ (Kvale and Brinkmann, 2008, p3).

In using qualitative methods, the study takes an interpretivist position, acknowledging that facts and values are not entirely separate and prioritising the value of understanding the social world through each participant’s perspective (Snape and Spencer, 2003, Creswell, 2014). Rather than trying to pin down one corroborated picture of each system, interviews facilitated the exploration of a variety of perspectives, understandings and explanations.

The data required for the study can be split into two types, which led to two different sampling strategies. Table 4.1 shows which sample’s interviews were drawn on for each research question. The first type of data consisted of the ‘big picture’ information such as the features of each country’s system and the factors which explain the differences between the two systems. This data was used to answer Research Questions 1, 2 and 4, to understand features of system design and the factors which explain differences. For this data, a ‘General Sample’ was constructed, consisting of experts drawn from groups which included politicians and policymakers, regulatory organisations and arms-length organisations, industry associations and groups representing users and carers, and groups representing professionals. The second type of data consisted of the ‘micro’, detailed experiences of individual provider organisations, to answer Research Question 3. This data was gathered through interviews with a ‘Provider Sample’, consisting of ten provider organisations that deliver residential care, five in each country.

Table 4.1 Sample used for each research question

Research question	SAMPLE
1. What explains how and why the types of regulatory systems have developed?	General
2. How is quality understood in each country and how are those understandings reflected in the regulatory regimes?	General
3. How is information on quality used by governments to influence quality improvement?	General
4. How, and to what extent, do regulatory regimes influence providers to deliver quality over and above minimum standards?	Providers

Comparing the systems in England and Australia

Comparative research allows researchers to identify new and different underlying perspectives and insights about each of the systems under investigation (Hantrais, 1995). With a few exceptions, previous comparative research into quality improvement strategies in long-term care has taken the form of ‘stapled case studies’, where the authors have set out ‘how things work’ in whichever country they are writing about’ (Marmor et al., 2005, p342). These are often accompanied by an overview and comparison of the case studies (for example, Wiener et al., 2007b, OECD/European Commission, 2013, Mor et al., 2014). There are some notable exceptions, although again they are largely restricted to examinations of the nursing home inspection process rather than broader regulatory issues. These exceptions include a comparative study of nursing home inspection in the US and England in the 1980s (Day and Klein, 1987) and an extensive comparison of nursing home inspection styles in Australia, England and the US, conducted mainly in the 1980s and 1990s (amalgamated in Braithwaite et al., 2007). More recent research of relevance to this study is a comparison of how nursing home roles are prescribed and regulated in Canada, Denmark and Germany (Daly et al., 2016). However, most studies that analyse the impact of regulatory regimes on providers going over and above minimum standards have focused on other sectors, particularly on environmental regulation (for example, Gunningham and Sinclair, 2002, Gunningham et al., 2004).

In the past, the focus of cross-national comparative research has been on identifying generalisations that could be transferred from one country (often the US) to another. A past criticism of this approach is that these generalisations are not feasible because social phenomena and reality are so rooted in their national and

historical context. In answer to this, the purpose of cross-national research has evolved to somewhere between these two perspectives, acknowledging that ‘context’ is an important explanatory variable, rather than as a reason not to conduct cross-national studies (Hantrais, 1999).

One option for this comparative research would be to choose two systems of long-term care quality and regulation that have taken entirely different approaches. An example of this would be comparing England’s inspection-based approach to quality with, for example, the system in Japan where quality improvement strategies are focused on professional development and qualifications (Mor et al., 2014). Choosing England and Australia for comparison comprises what Przeworski and Teune (1982) describe as a ‘most similar systems’ design, where the number of common characteristics are maximised so that any differences can be easily identified and treated as explanatory variables. Lijphart (1971) positions this approach as a strategy for overcoming the ‘many variables, small N’ problem of comparative research. For research into regulatory regimes, Levi-Faur (2006) refers this to a ‘National Patterns Approach’ where the same sector is studied in more than one country to see what impact national level characteristics have on the system of regulation. Part of the appeal of choosing England and Australia therefore laid in their similarities, as set out in Chapter 2.

Consent and ethics

Every research study has ethical considerations, which range from broad questions around the societal value of the study through to upholding the rights of individual participants (Bulmer, 1982, Bryman, 2008). Qualitative research with primary subjects raises a number of issues, not least because the researcher is typically involved in a ‘sustained and intensive experience’ with participants (Creswell, 2014, p187). Part of the researcher’s obligations is to consider carefully the demands being placed on the participant and to ensure that no harm arises for individuals due to participation in research. Related issues concern informed consent and the approach to anonymity and confidentiality (Lewis, 2003, Social Research Association, 2003). These issues are considered below in the context of this study.

A separate obligation is to ensure the research benefits participants where possible and appropriate. A priority is therefore to disseminate the results of the study as broadly as possible. During this study I have presented the results at academic

conferences, but also shared the findings with policymakers in both countries. In England, this included meeting with senior staff at the CQC to discuss the emerging results. While in Australia, I presented twice to the Department of Health, specifically about consumer reviews and quality; given verbal evidence to the Review of Aged Care Regulatory Processes (Carnell and Paterson, 2017); and I have been invited to be a keynote speaker at the Quality Agency's annual conference in Sydney in August 2018.

Protecting participants from harm

Two major issues which can arise in much qualitative research are the power imbalances which can exist between the interviewer and the interviewee, and the importance of handling sensitive topics carefully (Moriarty, 2011). Power imbalances are inevitably present in interviews but equally can shift back and forth during the interview process (Nunkoosing, 2005). The focus on professionals in this study suggested that the bias of power towards the interviewer usually present in qualitative research was a lower risk in this study. Indeed, there were a number of participants who appeared to see the balance of power as completely reversed, something which was evident where participants attempted to deliver 'rhetoric' interviews, where the expert takes the opportunity to give a 'lecture' on the subject in hand (Flick, 2014).

How to deal with sensitive issues was considered as part of the ethics approval process. One important concern when conducting research in the social care environment is the possibility that the researcher becomes aware that the participant is at risk of harm (Lewis, 2003). This study did not include interviews with residents and families, primarily because the research was concerned with the detail of policy design rather than the direct lived experience of residents. However, the inclusion of providers in the study, and particularly site visits, meant that there was a risk I could become aware of the potential for harm to residents. Part of the informed consent process involved notifying participants that if this happened, I would be obligated to make the relevant third party aware.

Informed consent

Ensuring that participants receive transparent information is a vital part of study recruitment (Harvey, 2011). There are no 'universal rules' about how much information to provide to participants before obtaining informed consent and it is

the researcher's role to determine the correct balance of details (Social Research Association, 2003, pp27-8). The focus of this study on professionals and experts, and in two English-speaking countries, meant that providing information on the study to gain informed consent was a relatively straightforward process. All the participants were contactable by email and this was the primary method of recruitment. Each introductory email included details of my role, the reasons for the research and a brief outline of the study, how long I expected the interview to take, who else I was targeting and the source of funding for the study. The outline of the introductory email is included in Appendix 6. I customised each email to include the rationale for requesting an interview, for example, giving details where the individual had been recommended by another participant or if I had identified them because they held a specific role. Within the email to providers, this included an explanation of how their organisation had been identified as one which had gone over and above minimum standards of quality.

Attached to each email was a copy of a Study Information Sheet which gave further details including a 'Plain English' overview of the study, the intention to record and transcribe the interview, how the interview data would be used, and the results disseminated, and information on anonymity and confidentiality, which was slightly different for each sample (as discussed in the following section). All the participants signed consent forms at the beginning of the interviews, confirming that they were happy for the interview to be recorded and, in line with good practice (Lewis, 2003), with the understanding that participants could withdraw from the study at any time and ask that data already shared would be disregarded if this happened.

Anonymity and Confidentiality

Two separate, but related, issues regarding the identity of participants are important to consider as part of research projects: anonymity and confidentiality. The two terms, anonymity and confidentiality, are often conflated or used interchangeably (Saunders et al., 2015). Here, I use Lewis's definitions to distinguish between the two concepts. *Anonymity* in research projects is about making sure that the identity of participants is not known outside the research team, whereas *confidentiality* means avoiding the attribution of comments to identified participants in research findings (Lewis, 2003). Ethics guidelines tend to make implicit assumptions that anonymity is of central importance in research studies (Grinyer, 2002) and treat it as an 'ethical norm' (Tilley and Woodthorpe, 2011, p199). However, there are times

when anonymity is compromised due to the nature of certain studies and, in these cases, it is important to inform participants if others may be aware of their involvement in research (Lewis, 2003).

Three specific issues regarding anonymity applied to the General Sample in this study. Firstly, snowballing was the main approach used for sampling this group and this presents specific challenges to maintaining anonymity (Van den Hoonaard, 2003). Interviewees in the general sample for this research were aware of the participation (or potential participation) of other peers and contacts as they often recommended that I approach them. For some participants, this was as transparent as individuals discussing the research with each other to recommend that the second person participate in the study. Secondly, the inclusion of small stakeholder groups (for example, individuals in the regulatory agencies) meant that it would be quite straightforward to identify some of the individual participants within a reasonably close margin of error. This issue is exacerbated where issues under discussion could have come from a 'distinctive source in the researched community' (Van den Hoonaard, 2003, p143). A third issue related to the credibility of the study in terms of recruitment and reporting. Being able to say certain individuals had already been involved was a strong selling point for recruiting subsequent participants. This issue of credibility was also important in the findings, to demonstrate that the sample included key influencers and stakeholders in the sector.

A number of authors therefore contend that it is sometimes unfeasible (Van den Hoonaard, 2003, Silverman, 2013) or even inappropriate (Grinyer, 2002, Saunders et al., 2015) to maintain complete anonymity in research studies. Instead, levels of anonymity and confidentiality should be negotiated by researchers with their participants, and decisions will involve trade-offs between the importance of anonymity and maintaining the integrity of data (Saunders et al., 2015). During the informed consent process for the General Sample, nearly all the individuals in the study said they were happy for their identity to be disclosed. The decision was made therefore to include the names of those participants in the General Sample who had given consent to be named as an appendix to the study (see Appendix 7). Three participants asked that their participation be completely anonymous and where this was the case, their interview is included in the overall number of interviews for each stakeholder group (in table 4.2 below), but otherwise their names are not included anywhere in this report. However, when reporting the results, confidentiality was

preserved as much as possible by labelling and attributing quotations only to pseudonyms and stakeholder groups. As Vainio (2013) argues, even where participants are keen to be named, disguising the identity of respondents is not just a question of protecting the participant, but is also helpful to allow the researcher to report findings which may appear negative or positive.

For the Provider Sample, however, anonymity was treated differently. Providers were sampled on the basis of certain organisational characteristics, rather than through snowballing. Maintaining anonymity was also valuable to reassure participants that they could be open and honest in the interviews without facing any negative ramifications, either from inside their own organisation or from other parts of the sector. The names of all the providers and individuals identified for the Provider Sample have been pseudonymised. The job titles in the pseudonyms are generic to ensure that less common job titles cannot be used to identify the provider or the individual and are described below. The details of the provider such as the number of beds is rounded up or down, also to ensure that providers cannot be easily identified. Where interviewees have referred to residents, relatives, staff and colleagues by name, these names have been changed in any quotations included in the results chapters.

I created two different Information Sheets and two different Consent Forms, one of each for the 'General' sample and one of each for the 'Provider' sample. Having different Information Sheets and Consent Forms allowed me to include slightly different explanations on what information I was hoping to gather from each sample and the different options for anonymity and confidentiality. These documents are attached in Appendix 8. After each interview, I sent each participant an electronic version of the signed consent form with a personalised message thanking them for the interview. In many cases, participants subsequently supplied further information and documents. These documents often included historical policy documents which were not available online, and opinion pieces and books written by participants.

The study received approval by the NHS's National Social Care Research Ethics Committee (SCREC) as a condition of the funding from the National Institute of Health Research. This approval served as self-certification for approval from the LSE's Research Ethics Committee. I also reviewed the official guidelines for conducting research in Australia, the *Australian Code for the Responsible Conduct*

of Research (National Health and Medical Research Council et al., 2007), in line with the responsibility to ensure that overseas research and data collection is in line with the country's local legislation and research guidelines (Social Research Association, 2003). I corresponded with the Research Integrity and Compliance Manager at ANU regarding approval for my fieldwork in Australia and was advised that the LSE's approval for my project was sufficient and appropriate.

4.2 Policy background

The preliminary data collection for the project consisted of three main activities: reviews of policy documents, key informant interviews and meetings with academic experts. The purpose of this phase was to 'orientate' myself in the sectors in England and Australia, to refine my research questions, and to develop my sampling approach.

Policy documents

Official documents were used to understand the respective policy contexts in each country. These included the relevant acts and legislation; white papers; commissions and inquiries; Select Committee reports; reports and documents from the respective regulatory agencies; and policy statements and guidelines.

Documents here were used as resources and sources of evidence, that is, my research focused on what was 'in' the document, as opposed to analysis of how the documents came into being (Prior, 2008). These documents were treated as 'social facts', 'in that they are produced, shared and used in socially organised ways', rather than assuming that any single document depicted an absolute truth (Atkinson and Coffey, 2004, p58).

Key informant interviews

I conducted three, extended, interviews with key informants, one in England and two in Australia, to improve my understanding of the historical and institutional contexts of care for older people. All three key informants had worked in the care sectors since the 1980s and all three continue to be active in aspects of research and policy in the long-term care sectors. They were therefore able to provide rich and detailed accounts of developments of the sector up to and including recent reforms.

4.3 Sampling and recruitment

I adopted a purposive approach to sampling; identifying and recruiting a range of participants to gather specific information that they were particularly or uniquely well placed to provide (Patton, 2002). This approach has also been referred to as judgment sampling, where ‘you decide the purpose you want informants (or communities) to serve, and you go out to find some’ (Bernard, 2013, p176). A feature of purposive sampling is that the sample emerges during the course of the study, which increases the potential of discovering new findings and theories, rather than being constrained by existing assumptions (Flick, 2014). This approach allowed me to sample and recruit individuals who could fill in gaps, provide alternative views and enhance the data already gathered (Lincoln and Guba, 1985). The following sections outline the approach I took to sampling and recruiting the two sample groups in this study.

General Sample

For the participants in this first sample, I sought out individuals who were ‘expert’ in their field, as defined by Bogner and colleagues (2009a). According to their definition, identifying experts happens through two processes. In the first process, the expert is seen as a construct of the researcher, where the researcher assumes that the person has some specialised knowledge. This form of identification is different from the traditional idea of an elite in qualitative research in that experts could conceivably come from different levels of an organisation’s hierarchy and not be restricted to ‘leading figures who are the public face of an organization’ (Bogner and Menz, 2009, p49). The second way of identifying experts fits with the traditional notion of ‘elites’ in the literature by finding individuals with established reputations in the sector including those at senior levels. Bogner and Menz suggest that identifying experts through this latter approach can be a safer strategy, as it ‘provides researchers with a reasonable degree of certainty that these are the experts who ‘really’ possess a store of knowledge of relevance to their research’ (p50).

I took a ‘maximum variation approach’ to sampling participants for the General Sample (Patton, 2002). I identified separate stakeholder groups at the beginning of the study which would provide a broad range of perspectives. The maximum variation approach helped to ensure that all the key groups are included, and to increase the range of different perspectives in the study (Rubin and Rubin, 2005,

Ritchie et al., 2014). The approach also helped to identify whether there were themes and patterns that were common to different stakeholder groups or across each country's system. Snowballing was then used to identify 'information-rich' participants and 'critical cases' (Patton, 2002, p237). At the end of each interview, I asked the participant to suggest other individuals who could be helpful to the study. Patton suggests that the chain of recommendations will diverge as initially new sources are mentioned, but then 'converge as a few key names get mentioned over and over' (p237). In Australia, this convergence happened much more quickly than in England, with many of the same names mentioned in most interviews from early in the study. Another notable difference was that in Australia, the names included more senior individuals in provider organisations. A benefit of using the snowballing approach was that the support of participants in one interview made it easier to get access to other experts in each country, as suggested by Bogner and colleagues (2009b). There were several interviews where it was clear that the support of individuals already interviewed was instrumental in gaining access to additional participants, with many study participants offering their assistance with contacts and access. This was encouraging, as the readiness of participants to suggest their peers and contacts can be a good sign of how well the interview went and how positively the interviewer is regarded (Harvey, 2011).

In Australia, it became clear that, even though I had aimed to achieve maximum variation in the sample, the overwhelming sense was of a consensus view among the participants, particularly about the role of the active consumer and markets in affecting the quality of provision. Therefore, I actively sought out 'deviant cases', using news articles and websites. I also took advantage of opportunities to improve my understanding of the sector and its dynamics and attended one of the Quality Agency's Better Practice Conferences as well as a Quarterly Meeting of the National Aged Care Alliance (NACA) (discussed in more detail in Chapter 5).

The make-up of the general sample for each country to some extent reflected differences in the governance of the long-term care system, the size of the sector in each country and aspects of the overall political and social context. The number of participants in each stakeholder group is included in Table 4.2. In the results, each participant is identified with three labels: the country in which they were interviewed; the stakeholder group to which they were assigned (see below); and a participant number within that group (for example, Australia, regulator, P1). The

participant numbers were assigned in a way to avoid identification through a defined pattern, for example, by seniority or alphabetical order.

In Australia, there were participants with roles on formal committees involved in the governance of the sector, for example the Aged Care Sector Committee. Many of the participants in the sample had multiple roles, for example, Chief Executives from provider organisations serving on committees and working groups. In this case, they are included in only the most relevant stakeholder group.

Table 4.2 General Sample: Stakeholder groups, Participants and Interviews

STAKEHOLDER GROUP	ENGLAND		AUSTRALIA	
	Participants	Interviews	Participants	Interviews
POLITICIANS AND POLICYMAKERS (NATIONAL AND LOCAL)	10	8	14	10
QUALITY REGULATORS	5	5	7	5
ARMS-LENGTH BODIES AND GOVERNMENT-FUNDED PROGRAMMES	5	5	3	3
INDUSTRY ASSOCIATIONS	6	6	8	5
USER AND CARER GROUPS	2	2	5	6
PROVIDERS	1	1	2	2
CARE WORKERS	0	0	2	2
CONSULTANTS	3	3	6	5
TOTAL	32	30	47	39

a. Government

Elected politicians and non-elected government officials participated in both countries and are both included under the label of 'Government'. Using one label for both types of participant is primarily to protect the attribution of comments as there were only a small number of politicians in the study. In terms of non-elected government officials, the make-up of the sample reflected the structural differences in the governance of social care in each country. In England, the sample included representatives from local government departments and associations, whereas in Australia the sample was dominated by representatives from the Australian Government.

Two other organisations included here are the organisations which represent commissioners and local government, the Local Government Association and the Association of Directors of Adult Social Services (ADASS). These have no similar group in Australia, given that the Australian Government contracts with providers via the state offices of the Department of Health.

b. Quality regulation groups

The sample included individuals currently working for the quality regulators, the CQC and the Quality Agency, as well as ex-staff and staff from the predecessors of the organisations, CSCI and the Accreditation Agency. This group includes both senior individuals and a regional inspection manager in each country. In England, this group also includes two participants who were responsible for programmes associated with the regulator, that is, Experts by Experience and Healthwatch.

c. Industry associations and providers

In England, there are four national industry associations, as well as many small industry associations at the regional and local authority level which are often run by volunteers from local providers. All four of the national associations were included in the sample, as well as a local organisation. In Australia, two main national bodies (LASA and ACSA) are dominant, with a third, the Aged Care Guild set up in 2001 to represent the largest providers (the Guild has nine members as at June 2017). There are further layers of industry groups in Australia, especially of the NFP, mainly faith-based, sector. As well as being members of ACSA or LASA, religious groups also have their own umbrella organisations which participate in

policymaking. For this reason, I included an interview with a large faith-based industry association. I also conducted interviews with two leaders from large provider organisations in each country, on the recommendation of other interviewees.

d. User and Carers Groups

The sample included groups representing users and carers. Involving residents and their families directly in the study was considered, but discounted due to the focus of the study on policy, rather than on the front-line practice of care providers. The views of residents and their carers are essential in judging provider quality, however, including representative groups was likely to be more productive as these groups have a broad view of the sector and not just any one provider.

In England, no dominant group was suggested in the interviews, despite the presence of large non-government organisations in the sector. The three participants in the sample in England were suggested by other interviewees. In Australia, the groups were more obvious due to the higher profile of ‘consumer’ organisations in the sector.

e. Care workers

One feature of the sample is the different representation of care workers. The unions in Australia feature more highly than the unions in England, partly reflecting different employment conditions, with the rights of Australian workers underpinned by negotiated agreements, legislation and ‘awards’ (Fair Work Ombudsman, 2016). For this reason, I conducted interviews with representatives from two of the main unions, both members of NACA.

f. Arms-length bodies and government-funded programmes

Arms-length bodies were unique to the sector in England and included arms-length bodies associated with quality. For Australia, the sample included funded government programmes such as the Community Visitors Scheme and the National Aged Care Advocacy Program.

Securing interviews with the sample of experts in the General Sample did not pose any major difficulties. Many authors have written about the difficulties with recruiting elites or experts (Aberbach and Rockman, 2002, Mikecz, 2012), but this

did not reflect my experience. Almost all the people I approached for this sample responded positively. This could be for several reasons; experts are motivated to participate in research for altruistic reasons and to make a difference, professional curiosity or the opportunity to share their thoughts and ideas (Bogner et al., 2009b). These explanations have salience for my study. The issue of poor quality in residential care is high profile, has been much-discussed and has proved difficult to resolve. Likewise, the policy question of how (and if) governments should intervene in the long-term care sector is one much discussed in both academic and the mainstream media, so none of the participants questioned the rationale for the study. Many of the questions from participants concerned my strategy for making the findings available to policy makers at the end of the study, rather than any need to justify the research.

Using a purposive and theoretical sampling approach in a comparative study led to differences - as would be expected - in the make-up of the sample in each country, for example, there were more providers and union representatives in Australia, and alternatively, local government representatives and arms-length bodies in England. There are valid reasons for this. Firstly, there are structural differences in the respective sectors, and secondly, the sample was focused on identifying 'experts', using Bogner and Menz's definition. This presented a dilemma, which was whether to seek out the equivalent role in each country to try to 'match' the sample more neatly (for example, by seeking out a union representative in England to match the inclusion of a union representative in Australia). The approach was a mixture of the two approaches, with the multiple phases of the data collection allowing some 'matching' but led mainly by the recommendations of participants.

Provider Sample

The purpose of sampling provider organisations was to explore the extent to which government interventions influence quality improvement behaviour. The aim was to uncover what happens in practice, so it was necessary to gather data from the operational level. The original plan for the sample was to identify ten providers in each country, with single interviews at each provider. However, the need to gain a deeper understanding of the overall response of the provider organisation to external factors merited identifying a smaller number of providers, but multiple participants in each organisation. These included roles such as Chief Executives, Operations Managers and Quality and Training Managers. Four characteristics

were initially used to form and stratify the sample at the organisational level, with varying levels of success, as discussed below. The four characteristics are (a) organisations with a track record in delivering quality over and above minimum standards, (b) organisations located in the same single geographical area in each country, (c) a mix of ownership types, and (d) a mix of different sizes. The make-up of the provider sample is shown in Table 4.3.

Table 4.3 Provider Sample and Interviews

Provider	Ownership and size	Interview	Participants
ENGLAND			
Silver Birches	Not-for-profit, medium	Interview 1	Operations Director
		Interview 2	Care Home Manager
Chestnut	For-profit, large	Interview 1	Care Home Manager
Maple	For profit, medium	Interview 1	Care Home Manager
		Interview 2	Quality Manager
Poplar	Not-for-profit, medium	Interview 1	Care Home Manager
Hawthorn	For-profit, medium	Interview 1	Chief Executive Operations Director Senior Manager (Shared Services)
TOTAL ENGLAND		7	9
AUSTRALIA			
Acacia	Not-for-profit, medium	Interview 1	Chief Executive
		Interview 2	Operations Director
		Interview 3	Quality Manager Senior Manager (Shared Services)
		Interview 4	Care Home Manager
Waratah	For-profit, medium	Interview 1	Chief Executive
		Interview 2	Senior Manager (Shared Services)
		Interview 3	Care Home Manager
Eucalyptus	Not-for-profit, medium	Interview 1	Senior Manager (Shared Services)
		Interview 2	Quality Manager
		Interview 3	Care Home Manager
Banksia	For-profit, large	Interview 1	Chief Executive
		Interview 2	Care Home Manager
		Interview 3	Operations Director
Hibiscus	Not-for-profit, large	Interview 1	Operations Director
TOTAL AUSTRALIA		14	15
TOTAL STUDY		21	24

a. Quality over and above minimum standards

The goal of the sampling process was to identify five organisations which delivered over and above the minimum standards of quality in each country. The process of trying to identify these providers was in itself highly informative. The task was easier in England than Australia. The system of CQC ratings described in Chapter 2 was formally introduced in April 2015. By the end of July 2016, 16,000 out of 25,000 care providers (both residential and community-based) had been rated (CQC, 2016d). I was therefore able to make use of the ‘Good’ and ‘Outstanding’ ratings to identify providers for the fieldwork which took place in early 2017.

In Australia, the system of accreditation is limited to measuring compliance or non-compliance against the Accreditation Standards, and the vast majority of providers are compliant with all standards. In 2016-7, 96.2 per cent of providers were subject to an accreditation period of three years, the maximum granted by the Quality Agency (Productivity Commission, 2018). Identifying a comparable sample in Australia therefore proved to be difficult due to the lack of visibility of quality differences. The lack of visibility of quality achievement was in itself instructive and is discussed in more detail in Chapter 7. Eventually, in the absence of publicly-available information on quality, I asked contacts within the Quality Agency and Department of Health if they could help me create a list of potential organisations from which I could draw a sample.

Two providers were included, one from each country, which are held up as role models by the regulator in each country in terms of the quality of their care, particularly for people living with dementia. In England, this provider was one of the few to have received an overall ‘Outstanding’ rating. In Australia, the provider was one which was mentioned by many of the interview participants as a leading organisation in dementia care.

b. Geographical area

An important learning from research in other sectors is the importance of understanding the local regulatory ‘eco-system’ when conducting a study of this type. While differences in approach in Australia would be explained by inconsistencies between quality assessors (given that a national system of funding and regulation is in place), in England this is a more difficult issue due to the variation in practices between local authorities and county councils. The initial solution to this was to

identify a single geographical area in each country. However, after conducting a number of interviews with participants at a local authority in England, when it came to recruit providers in their area, I encountered several difficulties. I had started with targeting providers in their authority, using the CQC ratings and cross-checking these with quality ratings awarded by the local authority inspection teams. However, despite multiple emails and phone calls to each provider, this local authority area elicited a positive response from only one provider organisation. This situation was made more complex by the fact that some of the providers were part of national and regional chains, and I was seeking the participation of both the local care home manager and head office staff, but it is not clear why more organisations were not interested in taking part. Due to these difficulties, I took a more opportunistic approach to sampling in England, and targeted provider organisations in other local authorities. Two providers responded to an email forwarded by colleagues in the Personal Social Services Research Unit to care home groups which had previously taken part in other research. The final provider in the sample responded to an email I sent to provider organisations who had recently been awarded 'Good' ratings from the CQC. In Australia, it proved easier to recruit providers from a single 'regional planning area', identified with advice from the key informant in Australia and senior staff at the Quality Agency as a region with a broad range of providers in terms of ownership, size and quality.

c. Ownership

Several studies have looked at the relationship between the structural characteristics of provider organisations and quality, and particularly between ownership type and quality. Harrington and colleagues have found that, in the US, NFP homes have more staff, higher quality, better safety and less adverse events (Harrington, 2001, O'Neill et al., 2003, Harrington, 2013). However, while many studies suggest that, at least in the US, NFP facilities generally deliver higher quality care, other studies highlight no significant trend (Comondore et al., 2009, Stevenson and Grabowski, 2008). In England, Forder and Allan (2014) identified that NFP organisations deliver better quality, findings confirmed by a review of CQC data, with FP homes delivering lower quality than NFP homes across all five Fundamental Standards (Barron and West, 2017). Studies in Australia have also found that FP providers tend to receive more sanctions from the regulators than NFP providers (Ellis and Howe, 2010, Baldwin et al., 2014). The potential links between ownership and quality highlighted the importance of including organisations with both types of

ownership, particularly given the differences in the market share of the FP and NFP sectors in England and Australia. The sample therefore included a mix of FP and NFP organisations, as shown in Table 4.3.

d. Size

There is evidence from other fields that regulatory design should be based on the size of the regulated organisation (Gunningham and Sinclair, 2002). The response of small and medium enterprises may be limited by a lack of resources and capital, higher compliance costs and smaller margins, and lower public profiles than large corporations, meaning that they are less likely to attract attention and publicity if they perform poorly. Regulation is difficult because of the sheer numbers of small and medium enterprises when compared to larger businesses. This is borne out by a Canadian study which found that nursing home chains were nearly three times more likely to apply for and achieve voluntary accreditation for quality than smaller organisations (McDonald et al., 2015). The authors challenge the idea that this is purely due to economies of scale and access to expertise but is more about information sharing and the promotion of standard practices across chains.

The size of the organisation was therefore seen as potentially important and initially positioned as a sampling criterion. However, this had to be abandoned for two reasons. The first reason is the structural differences in how the sectors are made up in each country. While there has been consolidation in the sectors in both countries, this is particularly true of Australia, where the proportion of facilities with more than 60 places increased from 56% to 72% of facilities between 2007 and 2014 (Australian Institute of Health and Welfare, 2014). In contrast, 45 per cent of the market in England remains with 'independent, single home small businesses' (Laing & Buisson, 2011). The second issue relates to the points already made about the lack of transparency around variation in quality. When I asked for suggestions for provider organisations for the study in Australia, all the provider organisations were medium and large organisations, and no small organisations were mentioned. In England, the challenge arose simply because of the overall problems with recruiting providers.

In summary, while the intention was to achieve a small but similar sample in each country, this was limited by barriers in the sampling and recruitment process. In England, the biggest problem was having to spread the sample over different local

authority areas. In Australia, the main problem arose because of the lack of transparency around quality performance. In Australia, the recruitment of providers was much more straightforward than in England, with all five providers approached agreeing to participate. It was not clear why this was the case, although some potential explanations might be that providers in Australia have been under less financial pressure recently than those in England; Australian providers do not have research ‘fatigue’; or there was interest in participating in comparative research and/or in meeting a researcher from England and/or the London School of Economics.

Each provider organisation has been given a pseudonym for the reporting of the study results. All senior operations staff are labelled ‘Operations Director’ and all the managers in individual homes are labelled ‘Care Home Manager’, regardless of the type of home or facility. ‘Senior Manager (Shared Services)’ is a generic label for a range of managers, with responsibilities for accommodation, marketing and sales, finance and learning and development. ‘Quality Manager’ includes staff with responsibility for Quality Assurance and in one case, for Complaints.

4.4 Conducting the interviews

I conducted the interviews over five phases between January 2015 and April 2017, three phases in England and two in Australia. In total, I spent two periods of ten weeks in Australia, with a Visiting Fellowship at the Australian National University (ANU) in Canberra. These periods of fieldwork allowed me to immerse myself in all things aged care-related in Australia to provide the ‘local groundedness’ described by Miles and Huberman (1994, p10). Being based in Canberra and at ANU also had logistical advantages. Many of the interview participants were based in Canberra, particularly politicians and policy makers, and the heads of the industry associations and other representative bodies. The ANU was a convenient location for hosting a small number of interviews. Finally, being based in Canberra made it relatively easy to travel to interviews and meetings in the other major cities in Australia.

Logistical arrangements were subsequently made directly with the participant, or with their personal assistants or support staff. Almost all the interviews took place at the offices of the individual participants; except for four of the General Sample interviews held at the LSE, two at ANU, and four in cafes for the convenience of the participants. All the Provider Sample interviews were conducted on the

organisation's premises and all included an informal tour of one or more of their care homes. Across both samples, I requested an hour with each participant and at the start of the interview I checked that this was still convenient. As it turned out, many of the interviews ran over the allotted time, despite always alerting the participant to the overrun and trying to bring the interview to a close. In many cases, the richness of the data justified extending the interview; however, in a few of the interviews with the General Sample there were overtones of 'rhetoric' interviews.

I used semi-structured interviews with an outline structure in the form of a topic guide. This enabled me to adapt, modify and add questions and alter their sequencing dependent on the flow of the interview and the responses given by the participant (Robson and McCartan, 2016). The interview guides, one for each sample, are included in Appendix 9. The interviews with the General Sample ranged from 42 minutes to 2 hours 8 minutes. The duration of the interviews with the Provider Sample was similar in the two countries. In England, the interviews ranged from 38 minutes to 1 hour 24 minutes, in Australia, from 37 minutes to 1 hour 30 minutes. One interview in Australia with a senior operations manager had to be cut short so that the individual could attend a resident's funeral and so this interview was excluded and is not reported here.

While all the interview participants were invited individually, some chose to participate with colleagues in groups. In England, this applied to two interviews with a local authority and one interview with a provider organisation. In Australia, however, this happened in several interviews, with staff from government departments, the regulator and industry associations, as well as in one provider organisation. Holding group interviews had both benefits and drawbacks. In some instances, participants built on each other's contributions by both confirming and contradicting each other's answers. At the same time, there were three interviews where the most senior staff members took the lead and junior staff were less vocal. However, the value of having the participation of senior stakeholders balanced out the disadvantages of conducting the interviews in groups.

In the interviews, I adopted as conversational a style as possible. The aim was to achieve a 'fluid and flexible structure' to maximise the chances of uncovering new themes (Mason, 2002, p62). My approach followed an 'active' interviewing style, a process where knowledge is produced as part of an active process between the interviewer and interviewee in what Holstein and Gubrium call 'meaning-making

work' (1995, p4). The questions in the interview guides were used as 'a set of starting points for discussion' (Mason, 2002, p62). How closely I followed the interview topic guide then varied depending on circumstances and the flow of the interview.

Reassuring participants that I had done my groundwork and did not need to be 'brought up to speed' on easy-to-access information was important to enhance my credibility (Richards, 1996, Harvey, 2011, Mikecz, 2012). Before each interview I sought out information on each of my participants and their organisations. For some individuals, the information available was very limited, particularly for government officials and for staff in provider organisations. At the other end of the spectrum, many participants in the General Sample had published their own material about the sector and quality and I spent some time reviewing this material before our interviews. This material included books and book chapters, reports and formal inquiries, peer-reviewed articles, newspaper articles, and blog posts. Preparation for the interviews also included reviewing organisational websites, for example, of the industry associations and provider organisations. As well as enhancing my credibility, this in many cases helped me to formulate more targeted and relevant questions and enhance the quality of the data collected and move from the 'hypothetical or abstract to the very concrete' (Holstein and Gubrium, 1995, p77). Using data collected in earlier interviews to inform questions and guide the interview also helped to demonstrate my knowledge and enhance my credibility, which in turn helped to generate rich data in the interviews (Richards, 1996).

In the interviews, I used a range of strategies with the aim of developing rapport, depending on the individual's role and experience. It was helpful in some of the interviews in Australia to refer my time living in Australia and my dual nationality. It was also helpful in some interviews (in both countries) to refer to my background in quality improvement and change management in other sectors. This exchange of information elicited some comments about the potential benefit of having an 'outsider' conduct such research. In the interviews with providers I also drew on my previous experience in managing quality and change programmes to probe the participants, particularly providers, on their approaches to quality improvement and particularly, in exploring gaps between the rhetoric in the interviews and the reality of implementation.

The interviews with the General Sample followed three different styles, as described by Bogner and Menz (2009). The first type of interview was exploratory, to accumulate basic knowledge for the study. In this study, this took two forms. Firstly, the interviews with key informants served to provide insights into the sector. Secondly, there were aspects of some interviews with the owners of government programmes which elicited mainly technical information, for example, details about the size and reach of advocacy programmes. The second type of interview, the 'systematizing' interview, focused on exploring the 'exclusive knowledge' of the expert on different aspects of the regulatory systems. The third type of interview is the 'theory-generating' interview, where the interview elicits 'interpretative knowledge', from getting the expert to open up about their subjective views and opinions.

It is tempting to categorise each of the interviews in the study into one of the three types. I have avoided this for two reasons; firstly, most of the interviews included different types of data which could be categorised under more than one category; and secondly, any participant interested to read this thesis might disagree to the category to which their interview has been ascribed. In several cases, it only became clear which type of interview it was after the interview began, especially as some interviews elicited relatively little theory-generating material. In some cases, the individual was someone focused heavily on the detail of their role or programme; in a handful of cases, I suspected that the lack of theory-generating material was due to reticence on the part of the individual to express potentially controversial views.

As mentioned earlier in this chapter, a small number of interviews had overtones of 'rhetoric interviews'. The preparatory research before each interview in many cases alerted me to participants who were very vocal about certain points of view, and I prepared questions around these perspectives to avoid them taking the opportunity to sermonise or lecture on their chosen topic. In some cases, my strategy was one suggested by Berry (2002), which is simply to 'use the interview for what it is':

If you've got an ideologue or someone who isn't going to be terribly helpful in a particular area because of their bias, think about where you can spend the time most profitably. Move more quickly to questions that might have a higher payoff (p680)

All but three of the interviews were recorded. The three exceptions could not be recorded for practical reasons, as they were conducted in relatively noisy environments. Where the interviews were recorded I took minimal notes to avoid

interrupting the flow of the conversation, and my notes served mainly to prompt me to return to issues and questions raised during the discussion. However, where interviews could not be recorded, I took detailed notes. The interviews were professionally transcribed, verbatim. There were six interviews which were interviews not transcribed (listed in Appendix 7); these were omitted as I had reached data saturation and judged that transcribing them would be a costly exercise which would not add to the findings of the study. These interviews were excluded from the analysis.

After each interview, I made field notes using the template included in Appendix 10. The field notes featured what Miles and colleagues (2014) refer to as ‘jottings’, ‘the researcher’s fleeting and emergent reflections and commentary’ (p94). Having a field notes template acted as an aide memoire to help me to structure my thoughts on different aspects of the interview, particularly on the key points and observations and any broader themes or questions to think about. I wrote analytic memos throughout the data collection and analysis phases to capture my developing ideas and observations, both in conventional Microsoft Word documents and in the form of mind maps.

4.5 Analysis

Analysis of my data started early in the process, reflecting the need to use emerging findings to purposively sample further participants, to focus the interviews on certain topics and gaps, and to test emerging conclusions (Maxwell, 2009). Initially, this took the form of simply thinking through how to make sense of the interview data, rather than formal coding (Basil, 2003). As Pope and colleagues (2000) observe:

Such continuous analysis is almost inevitable in qualitative research: because the researcher is ‘in the field’ collecting the data, it is impossible not to start thinking about what is being heard and seen (p114).

The approach I took to data analysis was thematic analysis: ‘searching across a data set [...] to find repeated patterns of meaning’ (Braun and Clarke, 2006, p86). My initial approach was to use codes derived from my interview guides. However, I found that this approach was encouraging me to narrow down my analysis prematurely and ‘shoehorn’ my observations into the existing themes. Instead I changed my strategy and generated inductive, ‘bottom-up’ codes, then comparing

them to the *a priori* categories. I used NVivo 10 to store, organise and code the transcripts.

In line with a constructivist approach, no single participant account was viewed as any more or less ‘true’, although as would be expected, some interviews were more enlightening than others (Guba and Lincoln, 1998). There were many reasons for this. Some informants were closer to the process or policies under discussion; some were better informed or had better memories of events; some seemed more open and more prepared to share their opinions and ideas.

For the initial coding for the interviews from the General Sample, I created an initial sub-sample of ten transcripts. After re-reading the transcripts I selected one transcript from each group of stakeholders in each country, selecting those transcripts which seemed most promising in terms of theory-generating material. The criteria identified by Kvale and Brinkmann (2008) to assess the quality of interviews were helpful here. These criteria include the extent to which the interview includes short questions with longer ‘spontaneous, rich, specific, and relevant answers’ from the interviewee, and how well I probed and verified the answers to generate ‘a self-reliant story that hardly requires additional explanations’ (p164). By taking the approach of using a spread of transcripts from across the groups and from both countries, it meant that my initial ‘first cycle coding’ was based on a range of interview data.

For the initial coding of the Provider interviews, I coded a single transcript from each provider organisation, and then coded the transcripts from additional participants until I reached saturation, ‘the point in data collection and analysis when new information produces little or no change to the codebook’ (Guest et al., 2006, p65). This strategy was helpful to address the imbalance between the different number of individual participants in England (10) and Australia (15) across the ten provider organisations.

The next stage of the analysis process for both samples was to organise the codes into themes. This was an iterative process consisting of many phases of grouping, aggregating and re-organising the codes and themes. Each sample was coded separately, resulting in two different sets of themes. For the General Sample, the themes which eventually emerged were *explaining regulatory design, quality and standard-setting*, and *information: collection and use*. These themes form the

basis of three of the empirical chapters (Chapters 5, 6 and 7). The themes identified for the Provider Sample were *regulation and quality improvement, funding and quality improvement, choice and quality improvement, ratings and quality improvement* and *intrinsic motivation and support for providers*. These themes are reported in Chapter 8.

Reporting the findings of international comparative research on long-term care is made complex because different terms are used, sometimes to describe the same phenomenon. In this thesis, the generic term *long-term care* is used when referring to the combination of community and residential care services. The term *social care* is also used in relation to these services in England, with the term *aged care* in Australia. The terms *residential care* and *care homes* will be used to refer to all types of residential care, including nursing homes. To differentiate between the paid and unpaid carers supporting older people, I follow the definitions set out by King (2007b), where the term *care worker* refers to care staff formally employed within provider organisations, while *carer* refers to unpaid caregivers, often family or friends. A more extensive Glossary of Terms is included for reference at the front of this thesis.

4.6 Quality assurance

Researchers have an ethical responsibility to maintain high standards of quality across all aspects of research studies (Social Research Association, 2003, p13). Notwithstanding this, there is much debate over how best to assess the quality of qualitative research. Reliability and validity are common concepts in quantitative methods and some authors have treated these as the benchmarks of quality which should be transferred to qualitative methods (for example, Silverman, 2011, Lewis et al., 2014). Silverman argues that dismissing these concepts increases the potential for research to be viewed as essentially ‘anecdotal’ and to undermine its potential value. Meanwhile, others have argued that the criteria of reliability and validity are too closely aligned with the positivist concepts of quantitative methodologies and do not sit well with research knowledge which is socially constructed (Mason, 2002, Lincoln and Guba, 1985). Instead, there have been attempts to develop criteria specifically for assessing qualitative research, such as the criteria proposed by Lincoln and Guba (1985), namely *trustworthiness*, which includes credibility, transferability, dependability and confirmability; and *authenticity*.

One strategy for assuring the credibility of the study was the use of a maximum variation sampling approach. The maximum variation approach meant that I had a broad spread of participants, with no one group dominating in either country. Seeking out deviant cases at the data collection stage was also an important part of this, to include different perspectives on the issues covered in the study, and to counteract the potential issue of participants referring only to like-minded individuals as part of the snowballing process. This was a more active part of the process in Australia. Where in England, the interviews organically generated conflicting views and more ‘noise’, there was much more consensus across the different constituent groups and less questioning of some of the assumptions around quality in the sector in Australia. Another aspect of assuring the credibility of the study was spending extensive time in both countries conducting all the interviews face-to-face in order to maximise the potential for collecting rich and insightful data (Maxwell, 2009).

Throughout the study, I continued with the use of the constant comparative method (Silverman, 2014), going back and forth between data as it emerged (from both countries) to find cases to test new and emerging hypotheses. This involved checking across transcripts, but also using the information from interviews to frame questions in subsequent interviews. This process was also invaluable for triangulating my data.

A challenging aspect for a small, single researcher-conducted study, is the question of confirmability. The nature of the interview as an active process of co-producing knowledge means that neutrality (or replicability) is not possible (Mason, 2002). The characterisation of the interviewees as ‘experts’ presents particular challenges, as flexibility and fluidity are an even more important feature of the data collection process (Berry, 2002). However, to ensure that the data collection process did not become too unstructured, I spent time making an outline plan before each interview, using the topic guide, the information I had gathered on the respondent beforehand, and the data I had already collected from other participants. A systematic approach to coding, supported with NVivo, was also important here.

Lincoln and Guba’s criterion of dependability has parallels with the concept of reliability (Bryman, 2008). Silverman (2011) suggests a number of strategies for ensuring reliability in qualitative studies, however many of these were impractical for this study, such as through the training of multiple interviewers and the use of

inter-rater reliability. Silverman's suggestion of using fixed choice answers was also inappropriate for this study because of the limiting effect this would have on the richness of the data. Instead, the three strategies I deployed were firstly, to record all interviews where possible; secondly to have all the interviews professionally transcribed, rather than relying on notes on what I judged to be significant 'in the moment'; and thirdly, by including verbatim extracts of data within the empirical chapters.

This chapter has set out the research design and methods for the study. The following four chapters report the findings of the study. Chapters 5, 6 and 7 draw on data from the interviews with the 'General Sample'; Chapter 8 draws from the 'Provider Sample'.

5 Explaining the differences between the regulatory regimes

Part of the value of conducting this comparative study laid in identifying the underlying explanations for either convergence or divergence in the design of the respective regulatory regimes. Understanding the context around policy design is essential to understand the opportunities for policy transfer or policy learning. An unanswered question in long-term care is why, when systems share many features in terms of resident characteristics, ownership and services, the design of regulatory systems develops differently, both between and within countries. Some trends in national inspection styles have been identified, for example, a highly deterrence-based, legalistic approach in the United States when compared to the UK (Axelrad and Kagan, 2000, Kagan, 2001), and a regulatory environment in Australia which is generally characterised by a more conciliatory style (Grabosky and Braithwaite, 1986). These trends have also subsequently been observed in the inspection of the residential aged care sector in Australia, England and the US (Braithwaite, 1998, Braithwaite et al., 2007). However, the empirical chapters which follow this one highlight several differences in the regimes for quality in England and Australia. These differences include how quality has been defined in policy; the place of ‘rights’ in the system; how regulatory and funding mechanisms influence different types of policy; and how information is used in the regulatory regime.

This chapter examines possible explanations for why each regulatory system has developed differently over recent times. The chapter begins with an overview of the explanations by Hood and colleagues (2001) and Haines (2011) regarding the development of regulatory regimes. This is followed by an overview of the wider context for regulation in each country, and particularly the overarching political ideologies which have influenced regulation. The chapter then analyses the influences behind the design of the regulatory regime for residential care, using data gathered from the General Sample of participants connected with policymaking at the central level, both currently and in the past, including regulators, government staff and industry associations and user and carer groups. The chapter explores three explanations for the differences in the systems for residential care in England and Australia, as developed in the following section.

5.1 Explaining regulatory regimes and system differences

The aim of the following section is to introduce the theories which may explain the differences in the approaches of each country to the design of regulation for the residential care sector. The outsourcing of public services over recent decades has resulted in a sharp increase in regulatory activity and there have been many theories developed to explain this increase, for example, the expansion of the ‘regulatory state’ (Majone, 1994), ‘regulatory capitalism’ (Levi-Faur, 2005), and the rise of the ‘audit society’ (Power, 1999). However, there has been less attention on explaining variation in specific aspects of regulatory design.

To move from the ‘macro’ analysis cited above to a more specific understanding of what influences regulatory design is relatively under-researched. Two notable exceptions are the analysis of the development of regulatory regimes by Hood and colleagues (2001)¹ and Haines (2011)². Their studies identify three explanations for the design of regulation: the rational economic argument of market failure; ‘opinion responsive’ regulation, closely aligned to interest group theory; and finally, regulation put in place for political motives³.

Market failure

Market failure – the rational economic explanation – is the most dominant explanation for putting regulations in place (Baldwin et al., 2012, Mor, 2014). In the market failure argument, the implementation of regulation is based on a rational calculation of how likely it is that a ‘mischief’ will happen (Baldwin et al., 2012). Haines describes this positivist rational approach to regulatory design as being driven by ‘actuarial risk’: ‘the physical, environmental and financial impact that is highlighted by the event and calculated as likely to occur in the future’ (2011, p4). This raises difficulties for the designing of a system around actuarial risk for social regulation as it is more often concerned with values and goals such as quality, social

¹ The study by Hood and colleagues compared nine regulatory regimes linked to dealing with various types of risk, for example, the regulation of pesticide levels in food and drinking water; attacks on children by convicted paedophiles released from prison; and injuries and deaths from road accidents.

² Haines studied the design of regulation implemented following three ‘disasters’: an industrial explosion and the collapse of a large insurance company in Australia, and the terrorist attacks in New York on 11 September 2001.

³ Haines refers to these three explanations as controlling the ‘actuarial’, ‘political’ and ‘socio-cultural’ risks respectively.

solidarity and human rights than with concrete, quantitative objectives (Feintuck, 2010, Prosser, 2006). Hood and colleagues also contest that, if the only driver of regulatory design was market failure, then regulatory systems in different countries would look remarkably similar.

Political motives and ‘never again’ events

The political explanation for regulatory design concerns the attempts of governments to deal with events which resonate particularly negatively with the public. Haines (2011, p4) calls these ‘never again’ events, reflecting the habit of politicians of proclaiming ‘this must never happen again’ following catastrophes or scandals. The suggestion is that more regulation will be the answer; this is then followed by a burst of regulatory activity before it becomes clear that preventing the same risk will be almost impossible. This phenomenon is often observed in residential care (Banerjee and Armstrong, 2015).

Within the care sector, and more broadly across social welfare, scandals and catastrophes often act as ‘focusing events’ which serve to put regulation on the agenda in the first place (Birkland, 1998)⁴. These focusing events act as the ‘little push’ for issues to get the attention of politicians and policymakers (Kingdon, 2003, p94). To have an impact, these focusing events need to be reflected in some sort of ‘policy strain’, be ‘capable of catching a tide that is already beginning to run in a fresh policy direction’ (Butler and Drakeford, 2005, p238), and to occur in policy domains which are well-organised to begin with (Birkland, 1998). What differentiates scandals from ‘everyday’ tragedies is more difficult to ascertain, but generally involves intervention or ‘scandal generation’ by the media (Butler and Drakeford, 2005). A bigger question is whether they subsequently lead to meaningful policy change. Downs’s issue-attention-cycle theory suggests that interest will wane as soon as it becomes clear that the problems under the spotlight are far more difficult to resolve than it first appears (Downs, 1972).

Opinion responsive

Private interest theory has traditionally served as the key explanation of regulatory design (Wilson, 1980, Baldwin et al., 2012, Carpenter and Moss, 2013b). In this explanation, regulatory design reflects the interests and preferences of the ‘best-organized group in the policy domain’ (Hood et al., 2001, p65). Understanding the

distribution of power and who stands to benefit from regulatory change in what Hancher and Moran (1989) refer to as the 'regulatory space'⁴ is a core part of explaining the development of regulatory regimes. Research in the US has highlighted the sophisticated lobbying and political power of providers of long-term care, although this has been partially offset by the ability of residents and advocates to form coalitions with other groups (Hawes, 1997, Edelman, 1997, Weisskopf and Weisskopf, 1997). Most notably for this study, an account of how the nursing home sector in Australia influenced the move to a less demanding model of accreditation in 1997 is given by Braithwaite and colleagues (2007).

The dominant issue with regulatory design which is driven by business interests is the risk of 'regulatory capture'. Originally focused on how regulated organisations worked to exclude competitors from markets, regulatory capture is now viewed more broadly as:

...the result or process by which regulation, in law or application, is consistently or repeatedly directed away from the public interest and toward the interests of the regulated industry, by the intent and action of the industry itself (Carpenter and Moss, 2013a, p13).

Capture can take many forms in long-term care. A common form is the situational capture highlighted in Chapter 6, where inspectors feel they cannot recommend the closure of a provider which continuously fails to meet standards, because of a shortage of beds in the vicinity (Makkai and Braithwaite, 1992).

However, while considering the role of interest groups is essential to understanding the development of regulation, it does not in itself explain why similar groups are able to influence policy differently in different national contexts. For this reason, it is important to consider how the actions of interest groups are shaped by institutional factors (Thelen and Steinmo, 1992) and, in doing so, acknowledging that change is complex and driven by more than just 'mere aggregations of individuals' preferences' (Baldwin et al., 2012, p53). In addition to interest groups, individual actors can also take an active and important role in shaping regulatory design, and, as this chapter will show, the interviews identified the specific impact of 'policy entrepreneurs', individuals who play an important part in all stages of the policy cycle and are adept at taking advantage of 'politically propitious events'

⁴ The 'regulatory space' is an analytical approach which considers all of the different dimensions of a regulatory regime and the actors – both minor and major – who occupy the 'space' (Hancher and Moran, 1989).

(Kingdon, 2003, pp165-6). These policy entrepreneurs can be motivated by different issues - personal interest, certain policy priorities and values or simply the satisfaction of being involved in the policy action. These individuals pay close attention to how problems are defined and framed in order to convince people of a crisis, finding ways to highlight policy failures and gaining support from actors from outside the immediate policy space, and mobilising supporters and building coalitions (Mintrom and Norman, 2009, Béland and Cox, 2016). A common characteristic of policy entrepreneurs is in their readiness to invest their resources in the hope of a future change (Kingdon, 2003).

5.2 The broader regulatory context in each country

To shed light on why the regulatory regimes in residential care have developed differently within England and Australia, it is important to understand the wider regulatory contexts for decisions regarding regulatory design for long-term care.

The biggest changes in the regulatory environments for long-term care in each country have been broader shifts linked to political ideology. The role of regulation in England has increased under both Conservative and Labour governments since the 1980s, paradoxically caused by the inclusion of the use of choice and markets as a mechanism to improve efficiency. In long-term care, the Conservative government in power between 1979 and 1997 introduced the purchaser-provider split with the NHS and Community Care Act 1990, placing an obligation on local authorities to contract with the independent sector (both FP and NFP) for the provision of the bulk of services. Both these moves reflected the Conservative Government's strong ideological belief that markets were the way to introduce efficiency and cost containment (Lewis and Glennerster, 1996). The increased reliance on the market for care provision in turn increased the need for regulation, what Osborne and Gaebler (1992) refer to as 'steering, not rowing'. Subsequent reforms by the Labour government retained the principles of markets and choice, but with increased control in the form of national quality regulation, broadly in line with other reforms described under the banner of 'New Public Management' (Lathlean et al., 2006).

In Australia, ideologically-based change is apparent in the residential care sector in two phases of legislation and reform, the first phase under the Australian Labor Party (ALP) in power between 1983 and 1996 and the second under the Liberal (Conservative) government in power between 1996 and 2007. The reforms in the

1980s and 1990s, referred to as the *Aged Care Reform Strategy*, were designed and implemented within the ALP's Social Justice Strategy. The policies reflected the Strategy's priorities of fair and equal access to essential services; equality of rights; equity in the distribution of economic resources; and participation in society (Howe, 1997). On coming to power in 1996, the right-leaning Liberal government implemented a new set of reforms for aged care, although not on the same scale as the Aged Care Reform Strategy. Pro-business ideology played a large role in the 1997 legislation, most notably for this thesis, in explaining the shift from government inspection to a system of accreditation administered by an arms-length body (Braithwaite et al., 2007). The changes formed the Aged Care Act 1997 and the accompanying Aged Care Principles, the underlying legislation which still governs the sector today.

5.3 The impact of 'never again' events and political triggers

The regulatory system in England has undergone multiple changes since inspection was first centralised in 2000, with three different regulators set up within less than a decade; three different approaches to quality standards; and the implementation (and then re-implementation) of a ratings system. This contrasts with the situation in Australia where there has been relative stability. The Quality Agency changed its reporting lines in 2014 and took over responsibility for quality in community care, but the same Accreditation Standards have been in place since 1997. Interviews in England communicated a strong sense that the amount of change was almost always due to political reasons, and the triggers for changes were usually the periodic scandals in the form of neglect and poor care - the 'never again' events described by Haines (2011), rather than a widely held belief that inspection can in itself improve quality. As a senior participant from the regulator commented:

P: ...I think a lot of the abuse that took place in care homes and in hospitals in the late 90s really sent a shock through Government about how do we stop this happening again. I'm not sure you'll ever stop this happening again, but in many respects when we have these child abuse crises, abuse in residential care crises, politicians say, oh we've got to make sure this never happens again, but then, I think the only thing that is certain is it *will* happen again somewhere. [...] So I almost see the history of regulation as being a reaction to events that have happened, and Government needs to be seen to do something at a national level and a systemic level, quite properly has to do something, and they reach for the regulatory level in order to do that. (England, regulator, P4)

In social care in England, the scandal that was ‘pivotal’ (England, regulator, P4) in the development of centralised regulation was the scandal at Longcare, a residential care provider. A leaked 1994 report revealed that the owner had been beating, raping and ill-treating its residents, adults with learning disabilities, for more than ten years⁵.

P: So [Longcare] was an example of an event that led to a political response because of the public outcry, that led to changes in regulations, changes in the structures of what we did. (England, regulator, P4)

The events at Longcare led to the commissioning of the Burgner Report on inspection and regulation (Burgner, 1996), which in turn informed the approach to regulation described in the then incoming Labour Government’s White Paper *Modernising Social Services* (Department of Health, 1998).

Another pivotal moment in regulation in England was the merger of the Commission for Healthcare Improvement and CSCI to form the CQC in 2009. Again, this was described as a top-down decision that participants attributed to a cost-saving exercise by Gordon Brown, with apparently little attention to the logic of the decision. The early emphasis for the CQC Mark I was on compliance with standards, and was more focused on integrating the regulator and regulations for health and social care standards than on quality itself:

P: And actually, when CQC was set up, I’m not sure that it was about quality, it was more about integration. It was more about we should have the same set of standards whether you’re a two-person care home, or a 14-bedded hospital, which actually meant that somebody was going to miss out somewhere. Some people were going to be over-regulated and other people not – or people’s services not, rather than people. (England, regulator, P7)

The decision to assign the task of developing quality standards for social care to NICE was also seen by a senior policymaker in the study as a somewhat random decision led by the then-Secretary of State, Andrew Lansley, a decision which had not been discussed with policymakers outside the Department of Health. A senior regulator expressed the opinion that the tendency of Secretaries of State to involve themselves in regulation has seemingly been independent of their political leaning

⁵ More information in Pring (2005).

and has been more a measure of how involved they have been in the health and social care portfolio (England, regulator, P4).

The crisis at Mid Staffordshire NHS Foundation Trust⁶ heralded an increase in the influence of health care on the regulation of social care in England, even though the health care and social care functions were subsequently separated in the CQC.

Following the recommendations of the ‘Francis Report’ into events at the hospital, new, rights-based, Fundamental Standards were developed in consultation with the public and a number of stakeholder groups. Applying the learning from Francis has involved some re-engineering:

P: So that’s where we started off, and I think there was a – we then thought about we had that template provided and to be perfectly honest, it was pretty much developed with an acute hospital frame of mind, because that’s what came first at CQC. So we had to from the social care perspective a bit of thinking that said how can we make this apply in social care without compromising some of our core you know, values really, around social care? (England, regulator, P2)

The penchant for regulatory design to go through fads in England was also something commented on by participants.

P: We’ve had an unfortunate history in England and the UK, of playing with regulation – it’s been a bit of a political football I think – so well-intentioned, but the politicians can’t seem to leave it alone. (England, industry association, P5)

One participant described a ‘regulatory pendulum’ which swings between light-touch, sector-led improvement approaches and intense regulatory activity.

In contrast, changes in policy direction in Australia have been almost entirely driven on the back of reforms to address financial or supply issues. To date, scandals have certainly not played a large role in the development of the Australian approach. One participant suggested that this was because of a lack of scandals:

P: Now, Australia is fairly new to the world of care. [...] They don’t have the baggage of the Ely Hospital scandal particularly. They don’t have the baggage of mid-Staffs and all Bristol, and Winterbourne View, all the myriad of scandals that we could list. (England, consultant, P4)

However, there have been (and continue to be) scandals happening in the aged care sector in Australia. The fact that scandals have not taken on the same relevance in Australia as in England is illustrated by the lack of impact on policy of the Kerosene

⁶ See Chapter 2.

Baths scandal, a scandal that came to light in Australia in 2000⁷. The Minister for Health at the time, Bronwyn Bishop, made a statement in Parliament effectively taking responsibility for the issues at the home, thus, according to participants in this study, forming a link between the government and provider quality which had previously not existed. However, even with such a high-profile incident, only minor changes were made to the quality accreditation process.

This is not to say that there is not an awareness of the potential for scandals and wrongdoing to emerge from the sector, referred to by one participant as ‘unexploded ordnance’ (Australia, government, P4). The fear of negative press is seen to be a major driver for the bipartisan support which underpins change and reform in the sector:

LT: But all through all of [the Aged Care Reform Strategy], there seems to have been bipartisan support. It seems to be one policy area that isn’t very contested. [...]

P: Um, yeah. Yeah. Almost.

LT: Why is that?

P: Well, I think people understood, one: it was a – because aged care is a headline waiting to happen. (Australia, government, P7)

The first major change in terms of a national approach to quality regulation was as part of the Aged Care Reform Strategy, launched in the 1980s. Based on the recommendations of the McLeay Report into both community and residential care (House of Representatives Standing Committee on Expenditure, 1982), the initial priority of the Strategy was to reduce the reliance on residential care by both improving community care programmes and by having better assessment of older people’s needs before they entered residential care. Up until this point, a need for residential care could be approved by family doctors, with no formal needs assessment. Subsequently however, the Giles Report (Senate Select Committee on Private Hospitals and Nursing Homes, 1984) provided the motivation for adding quality improvement to the reform programme. With its graphic and shocking photographs of physical neglect, the Giles Report drew attention to the poor care practices in place in the industry. The exposure of poor quality allowed the

⁷ The Kerosene Baths incident refers to a case where older people in a care home in Victoria developed blisters after being given baths of diluted kerosene, an outdated practice to cure an outbreak of scabies. The baths allegedly led to the death of one of the residents. The incident became a ‘scandal’ when it emerged that the Minister of Health had previously been informed about long-running quality problems at the provider organisation (Reynolds, 2000, Cauchi, 2002).

policymakers of the time to add in quality measures to the reforms, and in addition, were supported by the focus of the ALP administrations under Bob Hawke and Paul Keating on equity and social justice.

However, like the Aged Care Reform Strategy of the 1980s, the recent LLLB reforms in Australia were driven more by concerns about the financial sustainability of the system than about quality:

P: Yeah, look the Productivity Commission Report really did focus on the financing of aged care, rather than anything else. In terms of what it did in the area of quality, was basically say that 'it's pretty good, and a pretty good system. You know, in excess of 90% of facilities pass accreditation and have done so for a few years now. And you know, even though there are some bodies that say that it's not so great, we think that it's pretty good. In fact, we have a world class aged care system'. I think they said in one part of the report.

LT: Right. And would you agree with that?

P: No. No, of course not. (Australia, Users and Carers, P2)

Another stark difference between regulatory policy making in the two countries is the level of bipartisanship present in the political system in Australia, at least on this issue. When participants who were involved with the major reforms of the 1980s and the recent LLLB Reforms - were asked about why this was so, they often expressed surprise that it could have been any different. In discussing the reforms of the 1980s, one participant declared:

P: None of these things met with political opposition.

LT: Why not?

P: Because who could argue against them?

LT: Well ...

P: No, they weren't. And Labour had a big majority. (Australia, consultant, P3)

Many participants who had been in the sector for a long time commented that being able to take such a far-reaching approach with the Aged Care Reform Strategy was facilitated by a coming together of a group of individuals' both in the Department and the Government, who were able to put together a strategic and comprehensive plan of reform, which 'transcended' the election cycle.

This level of bipartisanship was slightly less in evidence when John Howard's Liberal-National government came to power in 1996 after thirteen years of ALP rule.

One of the politicians in the study suggested that this was due to a lack of preparatory work with both providers and consumers:

P: ... they didn't do the political ground work. The sector was heavily divided. Consumers – consumers, well the provider sector itself was divided. So the not-for-profit, the church and charitable sector didn't support bonds going into high care. [...] So I just don't – I think they underestimated the level of grunt work that needed to be done to get consensus before you started to chart the path. (Australia, government, P4)

On balance, bipartisan support has prevailed through the recent reforms and through a change of government. In a speech to an annual conference of one of the industry associations, Mitch Fifield, the incoming Minister with the Liberal government, explained how he had embraced the Productivity Commission reforms inherited from the Labor Government:

When we were in Opposition we broadly supported that work, and the response of the previous government. Why did we do that as an Opposition? It's not something Oppositions always do. We did, simply because the evidence in the Productivity Commission report was compelling. We knew that change was needed. (Fifield, 2015)

How much of this is due to a culture of cooperation is less clear. Participants explained that at the heart of the LLLB reforms is the principle that consumers will gain the perceived benefits of choice but in return will have to pay more. One participant described this as a 'grand bargain':

P2: The grand bargain is that consumers want increased choice, control and responsiveness. If they're given that, those who can afford to, agree to pay more. So long as they get value for their money. [...] The benefit for the government is that consumers are paying more, therefore it's making the system more sustainable and less expensive for the tax payer. (Australia, industry association, P7)

The opportunity to cut public spending through transferring more to consumers undoubtedly has appeal to both political parties, as well as to providers. Notably, the one part of the LLLB reforms rejected by the incoming Liberal Government was the implementation of a Workforce Supplement, an additional government payment to pass onto care workers, where provider organisations fulfilled certain conditions of employment (Butler, 2013). A participant from one of the trade unions described the extensive lobbying for this measure to be included in the reforms and the intense disappointment its omission had caused them. This was the only element of the reforms which would increase costs to providers. The level of provider

dissatisfaction with the Supplement was summed up by the leader of one of the industry associations:

P: There are also some quite, you know [pause] unpalatable aspects like the Workforce Supplement... Another thing which the government was trying to force providers to pay more money. Those sorts of things left a very bad taste in the mouth of industry as well, so, nobody disagrees that our workforce isn't paid adequately. Nobody disagrees that we don't need to do better, but forcing it upon an industry through a policy position is just not tenable. (Australia, industry association, P6)

5.4 Provider power and the organisation of the sector

The interviews suggested that providers and their industry associations have more power in Australia, and this is backed up by some of the developments in the sector, for example, a more aggressive approach to de-regulation, and the lack of teeth of the regulator in comparison to the CQC in England. To set the scene for this section, it is helpful to reiterate some critical differences in the policymaking 'space' in the two countries.

An important feature of the system in England is its fragmentation, when compared with the highly centralised system in Australia. In England, the Department of Health is responsible for legislation and policy design for social care. Delivering social care policy is then the responsibility of 152 local authorities, which differ in size, demographics, financial strength and strategic competence. Between the Department of Health and the local authorities is the Department of Communities and Local Government which not only sets the budget for local authorities but also has influence over the extent of local authority responsibilities and the level of oversight by central government and its agencies. Further complicating policymaking around social care in England is the fact that around half the older people in residential care are self-funded residents. Until the passing of the Care Act 2014, local authorities had limited obligations in regard to self-funded residents. Now they have, at least in theory, responsibilities regarding the provision of information regarding quality and to ensure that there is a supply of good quality services available.

The policymaking context in Australia could not be more different in terms of the degree of centralisation. As described in Chapter 2, residential aged care has formed a single policy area since the implementation of the first measures under the Aged Care Reform Strategy in the 1980s, although Aged Care has moved between

different departments, including during the life of this study. Aged Care now sits in the Department of Health, and crucially, the Department of Health also owns the licensing of providers, the allocation of provider places *and* the assessment of individual need for residential aged care (although the day-to-day operation of the Aged Care Assessment Teams is delivered by State government teams). The Quality Agency is also now part of the Department of Health. What this means in terms of lobbying groups is that the routes to influencing policy design, implementation, and purchasing, are relatively obvious and direct when compared to England. In addition, all Australians are entitled to government funding for the care component of their funding and therefore providers are heavily incentivised to lobby the federal government as it is the sole monopsony purchaser of care. This is set within the broader context of the emergence of an increasingly professionalised lobbying in Canberra (Sheehan and Sekules, 2012, Warhurst, 2014, Menadue, 2015). The centralised nature of policymaking in aged care, combined with the culture of lobbying, has led to the emergence of a body of high profile stakeholder groups in aged care of mostly, but not exclusively, provider CEOs. This body is loosely but widely referred to as ‘the sector’, the relevance of which is discussed later in this chapter.

One of the differences in the organisation of the sector is the relative fragmentation of provider interests in England compared to a much greater degree of organisation in Australia. As Table 5.1 shows, four national industry associations exist in England, but these are supplemented by many small industry associations at the regional and local authority level, often run by volunteers from local providers. In contrast, two main national bodies (LASA and ACSA) are dominant in Australia. Until recently, both organisations had a federated structure: the national offices based in Canberra to lobby the government on behalf of provider members; the state offices providing member services such as training and legal services.

Table 5.1 Industry Associations in England and Australia

	MEMBERSHIP	COVERAGE	ACTIVITY
ENGLAND			
CARE ENGLAND	For-profit providers	National only	<ul style="list-style-type: none"> • Lobbying • Training and knowledge exchange
NATIONAL CARE FORUM (NCF)	Not-for-profit providers	National only	<ul style="list-style-type: none"> • Lobbying • Training and knowledge exchange
REGISTERED NURSING HOME ASSOCIATION (RNHA)	Nursing homes (small)	National only	<ul style="list-style-type: none"> • Lobbying • Training and knowledge exchange • Professional services*
NATIONAL CARE ASSOCIATION	Care homes (small)	National only	<ul style="list-style-type: none"> • Lobbying • Training and knowledge exchange • Professional services*
LOCAL TRADE ASSOCIATIONS	Mix of providers	Local authority/regional	<ul style="list-style-type: none"> • Varied
AUSTRALIA			
AGED CARE GUILD	Nine largest for-profit providers	Largest providers only	<ul style="list-style-type: none"> • Lobbying
AGED AND COMMUNITY SERVICES AUSTRALIA (ACSA)	Not-for-profit providers	National, with federated state offices	<ul style="list-style-type: none"> • National: <ul style="list-style-type: none"> ◦ Lobbying • State-based: <ul style="list-style-type: none"> ◦ Training and knowledge exchange ◦ Professional services*
LEADING AGED SERVICES AUSTRALIA (LASA)	Mainly for-profit providers, some not-for-profit	National, with federated state offices	<ul style="list-style-type: none"> • National: <ul style="list-style-type: none"> ◦ Lobbying • State-based: <ul style="list-style-type: none"> ◦ Training and knowledge exchange ◦ Professional services*

* For example, legal and employment advice

It is also important to note the extra layers of sector organisation in Australia, especially of the NFP, mainly faith-based, sector. As well as being members of ACSA or LASA, religious groups also have their own umbrella organisations which participate in policymaking. Catholic Healthcare is by far the largest of these, but

other groups include Uniting Care, Baptist Care and Anglicare. Finally, the Aged Care Guild is an organisation set up in 2001 to represent the largest providers. In Australia, if the lack of reach of the industry associations (referred to as ‘peak bodies’) is an issue, it was not raised in interviews. This is partly assisted by the scale of the sector in Australia, with the industry associations attempting to reach a much smaller number of providers in Australia (2,672) versus England (11,300) (Department of Health, 2017d, CMA, 2017b). This is partly due to the smaller size of the population, and also because the average home in Australia is bigger than in England (78 beds in Australia, when compared to 40 in England) (Department of Health, 2017d, CMA, 2017b).

The fragmentation of policy design and implementation in England does not easily allow lobbying groups to influence every element of the policy design process. The most important weapon the sector has is the threat that providers will hand back contracts and in doing so adversely affect the supply of care. One participant in England explained that this was paramount in shifting the position of the Department of Health in enforcing the National Minimum Standards in 2002. However, the power of this threat to influence policy change appears to have diminished in the intervening period with the reduced prices paid by local authorities undermining the supply of care. Between 2015 and 2017 alone, the number of nursing home beds in England has declined by two per cent, with some areas suffering losses of up to 20 per cent (CQC, 2017d).

In general, the fact that policy design, budget-setting and the purchasing of care are fragmented over so many different bodies places structural limits on the extent to which interest groups can organise to lobby the government and affect policy. The potential upside of this situation in England is the noise and chaos - or as a senior regulator, simply referred to it, ‘democracy’. There are additional stakeholders involved in policy design and implementation in England, the equivalents of which do not exist in Australia, for example, ADASS, the Local Government Association, and the County Councils Network.

While the noise in the sector in England could in some ways be said to serve policymaking well, the lack of both a figurehead and a single voice - across both providers and other interest groups - is at the same time seen as a weakness of the sector. A senior policymaker in England, compared the situation to the NHS where

having a named individual in charge means that the NHS has an identifiable champion in policy and funding decisions:

P: The weakness of that [the lack of a single leader in social care] is that it allows the state to play one part of the sector off against another. It means that at crucial moments such as Spending Reviews, there isn't a face or a sufficiently coherent articulation of the case, you know, there isn't a Simon Stevens [Chief Executive of NHS England] figure for social care... (England, Government, P2)

The same policymaker also raised the issue that the lack of a unified sector was also problematic in terms of public perceptions and support for the sector. Whereas the NHS is something people 'cherish and value', even though they may not understand its operations, social care is different:

P: They don't have a real idea of what social care is and to the extent they do, they don't cherish, they dread. [...] Most of the images that you have about social care is not positive. And that I think is its biggest weakness and why it's been so spectacularly bad at winning an argument when it comes to resources in public expenditure. (England, government, P2)

Pinning the national industry associations in England down to how much of the sector they represent was difficult, but one industry association leader estimated that two-thirds of the sector is not represented by the national industry associations:

LT: So there's a large swathe of providers that are completely unrepresented?

P: Absolutely, about two-thirds. Whatever anybody tells you, the truth of the matter is that as trade bodies and provider organisations, we only collectively represent one-third of the sector. So there's twenty-four thousand businesses out there and we don't touch anything – and it's the ones that are not represented that, you know, we ought to be thinking about when we look at quality. (England, industry association, P4)

Despite the lack of coverage, consulting with the large industry associations in England was conflated by one senior participant with having consulted with the entire industry. In general, however, many study participants commented on the lack of reach of industry associations in the sector. A government participant observed that when consultations are held with 'the sector', this does not include many providers as 'a significant proportion of the providers are not affiliated to any trade association' and cannot be reached (England, government, P1). This is a position which is widely acknowledged:

P: I don't think the organisations ever really claimed to be able to deliver the provider sector. They always were honest enough to say you know, our, our membership is only a minority of actual providers, but we've got the providers who are sort of articulate and interested in standards and want to work with government. (England, consultant, P2)

Industry associations representing the smaller organisations in England felt that their involvement was much more about sorting out the detail than setting the overall direction:

LT: ...how have people like you and the other organisations been engaged in the policy process around quality?

P: Not often in the policy process. We typically get brought in at the back end. So policy making, very unusual. You might get asked about this or that going through parliament or these ... Yeah. And you respond to the consultations. But mostly the policy making is the policy making. Yeah. And it's a matter of us saying, 'hang on if you do that, this is gonna happen, or if you do that, that's gonna happen'. (England, industry association, P3)

In Australia, the power of providers was highly visible for the first time during the Aged Care Act 1997 reforms. Braithwaite et al. (2007) have written about the power of one particular nursing home operator, Doug Moran, in influencing the reforms of John Howard's Liberal government in 1997. Moran's influence was confirmed by several interview participants. For the first time, the industry associations and providers were instrumental in the introduction of two major changes, brought in in the face of stiff opposition from consumer groups, particularly, the Combined Pensioners and Superannuants Organisation (CPSA). The two changes were the introduction of accommodation bonds⁸ into low care and the move to a system of accreditation. The evaluation of the outcomes standards in place since the 1980s had shown the standards to be valid and reliable. However, the process of monitoring them by the States was highly unpopular among providers due to what they perceived to be inconsistencies and unnecessarily punitive:

P: ...So accreditation put a far more positive framework in place for quality improvement, rather than nurses going around checking to see that this was done properly and that was done properly. You know, nurses judging other nurses is um, goes down like a lead balloon. [...] So there was a – the sector was receptive to the idea of moving to something which the sector could adopt and build on and be proud to be proactive about rather than being bashed around with a stick. (Australia, industry association, P5)

In both countries, there is a recognition that providers could influence the policy process more effectively as a group, but this has been much more successful in Australia. Providers and other stakeholder groups have collaborated to form the National Aged Care Alliance (NACA), discussed below in more detail. In England, there have been several attempts to set up an organisation to represent the interests

⁸ Replaced by the current system of Refundable Accommodation Deposits/Contributions and Daily Accommodation Payments/Contributions in 2014.

of providers in the sector in order to form a united voice, although nothing on the scale of a ‘social movement’ suggested by one government participant (England, government, P2). The Care Provider Alliance (CPA) was set up in 2009 under the leadership of Des Kelly, the Chief Executive of the National Care Forum, to provide a unified voice for care providers. The CPA has eleven members, however it lacks resources and receives no formal funding and this is seen as a major hindrance to its ability to influence policymaking in any significant way. While the CPA has reportedly helped with policy discussions with the CQC and the Department of Health, there is no evidence that it has either the reach or the impact of NACA in Australia. As one participant from the regulator observed:

P: ...the capacity to speak as a collective just simply doesn't exist (England, regulator, P3)

The role of the large corporate providers in policymaking in England is more opaque. At the level of co-production of legislation and policy, the large providers appear to be no more influential than the smaller organisations:

LT: And do any of those, not just the providers, but any of the organisations, are any more influential ...? And we haven't talked about the large providers, the Four Seasons and the BUPAs and the Barchesters and ...?

P: And we did engage with some of them as well. Some were sort of closely involved, others were more, it was more sort of consultation than co-production. [...] I don't think really, any of the provider organisations, of themselves, stood out as being the one you would go to for everything, because none of them were big enough. (England, government, P2)

However, it would be naive to expect that large corporate organisations are not active at higher levels in policy formulation and in trying to set the agenda regarding care and regulation. Participants spoke of the close relationship that large providers have with Ministers, and how this certainly affects the tone of initiatives such as the Red Tape Challenge and policy regarding the reach of regulation.

Turning to Australia, NACA was set up by a small group of providers following the Kerosene Baths incident to address the lack of provider influence with the Department and the government. It now has 48 members, including industry associations, user advocacy groups, allied health organisations and unions. To qualify for membership, organisations must be ‘peak national organisations’, that is, an organisation that represents the interests of other groups across the whole country (National Aged Care Alliance, 2016b). The organisations providing

advocacy services to the National Aged Care Advocacy Program formed a national network partly so that they would be eligible to participate in policymaking forums.

NACA now meets on a quarterly basis to discuss policy developments and set its policy position on different aspects of aged care policy. It took some years for the Alliance to gain momentum, but senior members attribute the setting up of the Productivity Commission Report and the subsequent reforms to NACA, due to NACA's lobbying of politicians on the back of a NACA vision paper for aged care reform *Leading the Way: Our Vision for Support and Care of Older Australians* (National Aged Care Alliance, 2009). NACA also raised its profile in lobbying Ministers and Shadow Ministers before the 2007 election:

P1: Yeah and the 2007 – during the 2007 election period, or just before it, the National Aged Care Alliance formed some lobby groups, comprising of, you know, a provider, consumer, a union person, a professional... And met with all the ministers and the shadow ministers to talk about aged care. So, that became a principal, direct lobbying approach for the election. (Australia, industry association, P5)

NACA also acts as an intermediary for the Department of Health for recruiting volunteers for government working groups from the NACA membership, therefore potentially eliminating the participation of any groups which sit outside NACA. In addition, the Department now provides funding for the Secretariat functions of NACA which are carried out by the consumer group, COTA, and COTA's Chief Executive is widely regarded as the dominant voice in NACA. However, even though COTA is at the helm, NACA was viewed by some participants as an organisation with an emphasis on representing provider interests. Balancing the needs of all the constituents can result in a watered-down version - the 'lowest common denominator' - in policy recommendations. The opinions of dissenting voices are managed through allowing members to opt out of specific statements. As well as the issues raised about consumer representation in NACA, reconciling the views of the union members with that of the industry associations is particularly problematic. The subject which best illustrates the dominance of providers in the NACA discussions is related to workforce. This is an area where the union members (the Australian Nursing and Midwifery Federation, United Voice and the Health Services Union) break ranks to lobby for their members. The unions are often (unsurprisingly) in conflict to the providers who are opposed to what they perceive to be the expensive union agenda of increased staff and nursing ratios and improved terms and conditions. A manifestation of this conflict is included in the NACA response to the 2016 Senate Inquiry on the Future of Australia's Aged Care

Workforce⁹, setting out the issue that a consensus position could not be reached within the NACA membership (National Aged Care Alliance, 2016a).

Another notable difference between the two countries is how user and carer representative groups are organised. In England, there is a plethora of organisations offering both advocacy and practical support and advice, some having equivalents in Australia, for example, Carers Australia and Alzheimer's Australia. However, in England, these groups appear to have a greater role in policy development. According to one government participant in England, a large group of people was consulted during the 'co-production' of the Care Act with an emphasis on user groups. This was also the approach in how the Fundamental Standards were put together. An interviewee from the CQC positioned it as of central importance to use co-production to make regulatory design work for all stakeholder groups, including service users, their family and carers, staff, providers, commissioners and other partners including SCIE, NICE, Skills for Care, Healthcare Professionals Council, Local Government Ombudsman and the Equalities and Human Rights Commission. The focus has been on balancing the needs of the different groups, at the same time making the providers and industry associations aware and accountable for their decisions during the process:

P: [...] So yes, the trade associations will ask for certain things – of course they will. That's the dance that they've got to dance, but they're sat in a room with somebody who's going, 'Yeah, but my mum – you know, this is what happened to her, and actually I want this bunch to make sure that that doesn't happen again.' (England, regulator, P2)

The key difference between the two countries is how two of the main organisations representing users in Australia are mainly focused on the rights of (usually wealthy) 'consumers', as opposed to broader issues of human rights, such as equity. The study suggests that this has resulted in a policy direction which is arguably skewed towards the needs of wealthy constituents. Three key organisations exist: The Council of the Ageing (COTA) which, like LASA and ACSA has a federated structure, with a national office in Canberra for lobbying, and state offices which offer a range of services to older people, for example, insurance products. National Seniors is a national organisation based in Queensland which labels itself 'the consumer lobby for older Australians' and is targeted at wealthier Australians and has a large focus on financial issues. Only the third body, the Combined Pensioners and

⁹ Senate Community Affairs References Committee, 2017

Superannuants Association (CPSA), exists solely to represent ‘pensioners’, understood as people on low incomes in the Australian context. The role and influence of COTA and its Chief Executive is considerable as shown later in this chapter. COTA represents the interests of its membership base, and actively and widely promotes the concept of the resident as the ‘consumer’. This is demonstrated by COTA’s development of an on-line system for consumer ratings and reviews of long-term care providers to facilitate CDC policies.

The dominance of providers in Australia is also demonstrated by the fact that neither National Seniors nor the CPSA¹⁰ are members of NACA. The CPSA, in its national body, the Australian Pensioners and Superannuants Association withdrew from NACA some time ago because ‘we felt that the policies espoused by NACA, or pushed by NACA, were very watered down and didn’t comply with what we were advocating at the time’ (Australia, Users and Carers, P2). The same participant observed how the voices of many groups were submerged due to the dominance of provider groups:

LT: So everybody has become part of NACA and is ...?

P: Yeah. Yeah.

LT: And your view on that is ...?

P: Well, it just means that there are very few voices which aren’t toeing the line of NACA. I mean, obviously when you have a large Alliance like that, which has a lot of provider representation, you’re not going to get a, you know, [pause] a very in-depth view of what’s happening with consumers, or what’s happening with staff, you know. (Australia, Users and Carers, P2)

While it is still a member, Alzheimer’s Australia opted out of the ‘Election Platform’ statement prepared by NACA to lobby politicians in the run-up to the Australian general election in July 2016.

Issues around how different groups are represented in lobbying can be illustrated by the example of how the CPSA campaigned against the introduction of bonds into aged care under the 1997 Aged Care Act and as a result had its funding stripped by

¹⁰ The CPSA’s membership of NACA was previously held through the national body, the Australian Pensioners and Superannuants Association.

the Howard Government. The CPSA has continued to be marginalised. Answering a question about the role of the CPSA in the LLLB reforms, one senior participant commented:

LT: What about the dissenting voices, the CPSA is in there?

P: Oh, the CPSA were just ... I mean the CPSA I think had some views about ... I just ... Yeah, no. I think they were outliers. Well-intentioned but outliers. You know, and I think their views about what we should have done were just so far out of the ball park in terms of our financial capacity to do that, that they ended up not being serious participants in the debate. (Australia, government, P4)

Detractors of NACA suggest that it has become a convenient mechanism for government and politicians to demonstrate that they have consulted and secured support from the entire aged care sector:

P: [...] the great thing with NACA for governments is that government can say 'well this is supported by NACA, this is supported by consumer, industry and union groups. Therefore, everyone should accept it'. That's where the power lies, for both NACA and the Minister. (Australia, Users and Carers, P2)

In Australia, the interviews suggested that providers have largely captured the policy design process through the National Aged Care Alliance and through bodies such as the Aged Care Sector Reform Committee. Many of the principal actors in policymaking in Australia are the Chief Executives of what are generally regarded as the best or most important providers. The findings in Chapter 6 regarding the lack of transparency on variation in quality show that membership of these committees is not based on provider quality, but more strongly connected to the personality and reputation of the individual Chief Executive. The provider 'lobby' in Australia, have been successful in challenging the role and value of the Quality Agency through the presence of Chief Executives on sector committees, the activities of industry associations and through the responsibilities and actions of NACA. The lobbying power of providers in Australia appears to have resulted in a more stable system of accreditation but a process which appears to have lost its teeth in the process. Instead, there is evidence of 'corrosive capture' in the sector, where the regulated parties are able to convince the government that regulation no longer serves the public interest and could easily be replaced (Carpenter and Moss, 2013a). This phenomenon is illustrated by the plan of the Australian government, now on hold, to introduce 'contestability' in the accreditation process.

However, while NACA presents itself as the face of the sector, its work is supplemented (or potentially undermined) by the highly professional lobbying

conducted by the industry associations. The leader of one of the industry associations described how Chief Executives of providers were organised to lobby politicians during the run-up to the 2016 election:

P: Well, NACA is just another lobby group. It's a frustrating one for me, one I have to be a part of and have a watching brief of cos it's forty national entities like me, but some are small, even though you may say they're important. [...] I advocate and lobby separately in respect of my members. So next week, we've got two days up on the Hill¹¹ here, I've got twenty-seven CEOs flying in and we've got forty-five meetings with polities [politicians] over two days. And we've got our set script and our issues that fit in to what our policy – national policy agenda is pushing. (Australia, industry association, P4)

Even so, NACA has become dominant (at one level) in policy, particularly design, which the government has in some ways outsourced to the sector. NACA is supported by a government-funded member of staff from COTA, and COTA and the industry associations are the most vocal in its ranks. Its dominance is difficult to articulate simply using the interview data; this impression was gained as much from my other experiences in Australia such as attending the NACA Quarterly Meeting and discussions outside of the interviews. Virtually every interview participant in this study in Australia recommended contacting industry 'players' for interview, and many of these individuals are on government policy bodies. This phenomenon was largely absent in the interviews in England. When policymakers were asked to comment on who was influential in policy in England, the names offered were representatives from the industry associations, and advocacy and other groups. Individual Chief Executives and senior managers from provider organisations were never mentioned.

5.5 Ideas and policy entrepreneurs

So far, this chapter has examined the impact of two factors in regulatory design in each country, the role of 'never again events' and political triggers, and the influence of interest groups. However, these factors do not entirely explain two differences between the two regimes which are discussed in later chapters, namely the role of human rights-based approaches in England, and the dominance of the consumerist narrative in Australia. This section refers to the concept of the 'policy entrepreneur' to highlight some of the individual influences which emerged frequently in both countries. In England, while rights-based approaches have been driven by many

¹¹ Referring to Capital Hill in Canberra, where the federal parliament is located.

legislative and cultural factors, interviewees spoke frequently of the influence of two individuals, Denise Platt (the Chairman of CSCI) and David Behan (the Chief Executive), in positioning the rights of the individual as a central part of the focus on quality. On the demise of CSCI in 2009, David Behan had moved into the Department of Health. When responsibilities for social care moved from the CSCI to the CQC and a generic model of inspection and standards was established for health and social care, the CQC was criticised by the Health Select Committee for its lack of purpose (House of Commons Health Committee, 2011). David Behan was brought back in to the CQC in 2012 to turn it around and made significant changes, as described in Chapter 2. This dimension of the regulatory approach in England was perceived by interviewees as having been strongly shaped by these two individuals, or ‘policy entrepreneurs’.

Despite the absence of a focus on human rights in the Australian system today, this has not always been the case. As part of the Aged Care Reform Strategy, a human rights lawyer, Chris Ronalds, was commissioned to review the state of the sector from the perspective of resident rights. Her report, commonly referred to as the Ronalds Report, led to the drawing up of a Charter of Residents’ Rights and Responsibilities. This charter is still in place today, although it has never been formally linked to any legislative requirements for providers despite recommendations to do so by the Law Reform Commission (Australian Law Reform Commission, 1995). The Ronalds Report also led to the set-up of three support programmes for residents and relatives: the Aged Care Advocacy Program, the Community Visitors Scheme and the Aged Care Complaints Scheme. The individual who commissioned the Ronalds Report, explained his rationale for bringing rights into policy as part of the government’s social justice agenda: ‘because to me it’s was an obvious thing because it was part of quality and the whole concept of the resident’. The publication of the Ronalds Report presented a milestone in how it invoked residents as individuals:

P: Yeah. So Ronalds was really important, really important... because it did – it basically for the first time – didn’t codify it, that came later, but actually again took the standards and converted them from a – this is some – these are the principles – these are headlines – and turned them into people. (Australia, government, P7)

Interviews and study visits suggested that the Charter, along with the Aged Care Advocacy Program and Community Visitors Scheme, appear to have lost traction.

As one provider of advocacy services commented:

P: Everything should focus on what does it feel like to be a resident living in this place? How do I speak up for my rights? How is it my rights can be so quickly taken away and so easily taken away? Twenty-five years ago we had the report from Chris Ronalds, which said you know, residents' experience is loneliness, it's boring, they have no way to speak up. All of this was documented - which is why we had all these safeguards in place - and here we are twenty-five years later and it's the same... (Australia, Users and Carers, P3)

There are many potential explanations for this, including a subsequent lack of focus on the voice of the resident, and also the policy 'drift' which seemed to have inflicted aged care policies in Australia up until the latest set of reforms.

The first issue, the lack of focus on the voices of residents, could potentially be partially attributed to the effect of the reforms under the Howard Government, for example, through the defunding of the CPSA. Running up to the 2011 Inquiry by the Productivity Commission, the concept of the consumer was promoted by key influencers, most notably, Ian Yates of COTA and Glenn Rees, formerly of the Department of Health and Alzheimer's Australia, and also, for example, by Mark Butler, former Minister of Aged Care. The frustration of one of the smaller user and carer organisations about the lack of representation of less powerful consumers was clear, as this participant described:

P: The Productivity Commission, you know, that campaign was a bit of a turning point, I'd say, because it became clear then that COTA was not representing the views of older people. That was pretty clear [...] And they also didn't really discuss the issue of quality very much. And they've kind of always taken that line that, you know, 'quality's pretty good, so it's not so much of an issue with people not having basic care needs met. We're not really that worried'. And for us, you know, it's a big loss really, because we certainly know that that's not the case. But if an organisation like that is kind of saying, 'it's okay' that immediately takes pressure off the government to actually *do* something about it. (Australia, Users and Carers, P2)

Another reason for the diminishing presence of human rights in the system could be ascribed to the 'drift' in policy and can be seen as the lack of institutional memory which has afflicted policymaking as a whole since a large reduction in the public service in Canberra when John Howard came to power in 1996 (Tingle, 2015).

Interviews suggested that there is little knowledge among today's policymakers of previous aged care reforms, including the extensive work which was conducted around validating the quality monitoring standards. One former policymaker commented on how this could be explained by changes in the culture of policymaking in the intervening period. The new tendency for Australian departments is to look to external sources for advice and problem-solving, to what

he called ‘the plastic folder consultant brigade’, rather than nurture departmental talent and intellectual capability, resulting in a ‘paucity of the intellectual talent to do serious policy work within government as opposed to outsourcing it’. One participant expressed frustration at the number of bureaucrats over recent years who ‘blew in on a MOG [Machinery of Government change]’ as the responsibility for Aged Care moves between departments and individuals. Indeed, current staff in the Department themselves acknowledged how little time they had to proactively research and prepare policy positions and how much of policymaking was just being responsive to ad hoc ministerial requests.

Stepping into the gap left by this institutional amnesia are the CEOs of provider organisations in Australia who have taken on leadership roles in many levels of policymaking bodies. The most important body is the Aged Care Sector Committee, which was tasked with producing the Aged Care Reform Roadmap (Aged Care Sector Committee, 2016) for the future strategic direction of government policy in the sector. At the time of writing half of the sixteen-member Committee was made up of providers or industry associations, as well as Ian Yates from COTA, the Chief Executive of National Seniors, the head of the Australian Nursing and Midwifery Federation, and representatives from Alzheimer’s Australia and Carers Australia. The relevance of providers in policymaking is not disputed; after all, it is the providers who are most familiar with both the opportunities and challenges of delivering care. However, it raises questions over how much influence the provider sector has in both policy direction and design in Australia when compared to England. While there is no equivalent body in England, the presence of so many providers on the committee in Australia is in stark contrast to the list of independent experts identified by the government in England for its upcoming 2018 green paper. Of the list of 12 independent experts, not one is a provider of residential care, although the list does include the Chief Executive of a large insurance company (Cabinet Office, 2017).

In Australia, virtually all the participants in the study, including all three politicians, highlighted the influence of Ian Yates in all areas of aged care policy and particularly

in the formation of the LLLB reforms. The following comments from a politician in Australia illustrate this well:

P: You know, I think both major parties would prefer not to have a political stouch [punch-up] over services to the most vulnerable, unless there's a very good reason to do that. [...] But also it lifts the pain threshold for an Opposition to step out and say, cos they're not just saying I'm a dickhead and got it wrong, they're saying Ian Yates is, you know, the nurses' union is, all the big providers are, the AMA is, you know, that's a very different proposition. (Australia, government, P4)

5.6 Conclusion

The purpose of this chapter was to set out the reasons for the differences in regulatory design in the two countries, discussed in more detail in the following chapters. Chapter 2 described the national systems in place in each country for the governance of long-term care and its regulation. There are several aspects of these national contexts which merit attention when considering how policy is forged in each country. An important contextual difference between the two countries is the level of fragmentation or centralisation of the two systems. The fragmented nature of the sector in England means that there is more 'noise' in the system, both in the policy making process and in the monitoring of providers. However, the fragmentation of the policy space means that there is a lack of sufficient cohesion and unity between providers to disrupt what has traditionally been a top-down policymaking process driven by a series of interventionist Secretaries of State for Health, often in line with short term political responses to crises rather than ideological goals.

Regulation in England has been subject to continuous change, and appears to be more susceptible to 'never again events' such as the incidents and scandals at Winterbourne View and Mid Staffordshire Hospital. The downside of never again effects is that they can continually 'ratchet up' the reach and style of regulation without necessarily having any positive effects (Haines, 2011). The following empirical chapters show how the system in England has a much greater legislative reach in terms of provider quality, and the regulator is also more inclined to expose poor care and variation in quality than in Australia. On the upside for the system in England, one positive side effect of this continuous change is that it may have protected the CQC and its predecessors from the risks of regulatory capture, a phenomenon which is much more apparent in Australia.

The continuous change in England compares with the system in Australia which has been, until recently, relatively protected from the impact of scandals and largely unchanged between 1997 and 2014. However, this lack of change can be linked to a much higher level of capture in the sector than in England, and particularly the phenomenon of ‘corrosive capture’, where the role and value of the regulator is dismissed by key stakeholders. As the following chapters demonstrate, the form and style of regulation in Australia consequently has less ‘teeth’ than in England. The role of the Quality Agency also differs from the CQC in that it is neither perceived as the ‘arbiter’ of quality, nor does it present itself as taking this role.

Regulatory capture in Australia is also enabled by the centralisation of the system in Australia. This centralisation of the system has made it more susceptible to capture by provider organisations and by policy entrepreneurs, reinforced by a professionalised lobbying system which is more predominant generally in Australia. This monolithic, monopsony purchaser of care is far more targetable by providers than the myriad of different policymakers and purchasing bodies in England.

The interviews suggested an aura of quiet collusion in the sector in Australia: the lack of dissenting voices combined with the fact that it is in neither the providers’ nor the government’s interests to expose poor quality in the system. In general, the providers do not want to support exposing poor provision; the government would not want to foot the bill for additional budget to improve quality. In terms of regulation, the provider view of regulation and accreditation as unnecessary red tape has prevailed, and the hot topic for discussion by NACA and others during this study was the introduction of ‘contestability’ (Australian Government, 2015), where accreditation in the sector could be carried out by multiple agencies. What contestability means remains unclear, and the Department of Health had asked NACA to provide feedback on several options, the most radical of which was to create an open market for accreditation. Less accreditation visits would also be an attractive option for the government, given the high costs associated with the process. The concept of granting longer periods of accreditation is one supported at the organisational level by COTA and Alzheimer’s Australia (COTA and Alzheimer’s Australia, 2014), although there was some debate among the NACA members about the policy.

In England, policy entrepreneurs such as Denise Platt of CSCI and David Behan of both CSCI and the CQC have become instrumental in driving a rights-based, person-centred agenda, and for establishing more continuity in the regulatory regime than is at first obvious. In Australia, the more extensive influence of provider interests and certain policy entrepreneurs in setting policy direction, especially Ian Yates of the Council of the Ageing consumer group, has produced a dominant consumerist policy paradigm, with a focus on the ability of wealthy, baby boomer consumers to demand and drive quality in the sector.

This consumerist theme is much stronger in residential care in Australia than in England, as demonstrated in the following empirical chapters. The discussion in Chapter 9 returns to this topic, drawing attention to the extensive influences on the regulatory regimes from broader historical and cultural issues, for example, the respective roles of the state in the funding and delivery of care.

6 Approaches to quality in the regulatory systems

As discussed earlier, defining quality in residential care is notoriously difficult. The academic discussion has been dominated by two issues: the differences between quality of life and quality of care, and the debate about which indicators best articulate good quality. This thesis shifts the examination of quality to the level of the provider organisation, something which has received less attention in academic studies (King, 2007b). This chapter uses the three different ‘quality orientations’ set out in Chapter 3 (organisation-focused, consumer-directed and relationship-centred) to explore the different stakeholder understandings of what ‘good’ quality means at the provider level in Australia and England, and how these understandings have been influenced by different policy interventions in the respective countries.

The chapter draws on existing policy documents and on the interviews from the General Sample for their views on what is meant by ‘quality’ in terms of provision. The chapter first examines how quality is expressed in the regulatory systems of each country and highlights three areas of difference, namely, whether there is a single definition of quality, whether regulatory standards are expressed in terms of outcomes or processes, and whether ‘rights’ in the system are restricted to the protection of ‘consumers’ or are constructed using a view of human rights more broadly. This is followed by a section regarding the participants’ views on the challenges with incorporating definitions of quality into the respective regulatory regimes.

The chapter then explores how the three quality orientations relate to the understandings of quality in each country and in turn, how these understandings are linked to the interventions of each government. The analysis showed that the understanding of quality is impacted by multiple policy interventions and not just by regulation. Links were identified between *regulation and organisation-focused quality*; *funding and organisation-focused quality*; *consumer choice policies and consumer-directed quality*; and *regulation and relationship-centred quality*. These links between policy interventions and different types of quality include the unintended consequences of government policies. As the chapter will argue, there were some striking differences between systems of the two countries. Where England has adopted a person-centred, rights-based approach to quality in

regulation, the focus in the Australian regime is on processes and consumer protection. The emphasis in Australia on processes, combined with the impact of the ACFI (for the reimbursement of providers), results in a more prominent understanding of quality as having an organisational focus, whereas the intended focus of the regulatory system in England is towards relationship-centred quality. Another key difference highlighted in this chapter is the greater emphasis in Australia on the potential for consumer behaviour to determine quality in the sector.

6.1 How quality is expressed in the regulatory system

The purpose of this section is to compare how quality is expressed in the regulatory standards of each country. While they are both centralised quality bodies, the CQC and Quality Agency have different powers, responsibilities and reporting lines, as described in Chapter 2. Another area of difference is the nature of the standards used in each country, with England adopting standards which judge the quality of provision from the perspective of the user, and Australia using standards based on the quality of provider processes. In England, there is a single definition of quality based on the idea of person-centredness, underpinned by an approach called the ‘Mum Test’ (described below). However, in Australia, there is currently not a similar vision of quality for residents in aged care – instead, accreditation is focused on the quality of provider processes.

In April 2015, CQC Mark II introduced the *Fundamental Standards* in England and a new rating system was developed and implemented. The five key questions (shown in Table 6.1) underpinning the Fundamental Standards are scored as ‘Outstanding’, ‘Good’, ‘Requires Improvement’ and ‘Inadequate’. Ratings had previously been in place during the life of CSCI in the form of star ratings, but the CQC had dropped the system of allocating star ratings to providers on its launch in 2008. More detail on the questions used during inspections, the ‘Key Lines of Enquiry’ is included in Appendix 3. Part of the launch of the new standards included a shift towards a person-centred approach and the lived experience of the

resident. At this point the CQC introduced the ‘Mum Test’, explained by the Chief Inspector of Social Care, Andrea Sutcliffe:

On their visits, I will ask our inspection teams to consider whether these are services that they would be happy for someone they love and care for to use. If they are, then we will celebrate this through our ratings. If they are not, we will take tough action so that improvements are made. Above all else, my priority is to make sure people receive care that is safe, effective, high-quality and compassionate. (CQC, 2014b)

Table 6.1 Key Questions for CQC Fundamental Standards

KEY QUESTION	DEFINITION
<i>IS IT SAFE?</i>	People are protected from abuse and avoidable harm.
<i>IS IT EFFECTIVE?</i>	People’s care, treatment and support achieves good outcomes, promotes a good quality of life and is evidence-based where possible.
<i>IS IT CARING?</i>	Staff involve and treat people with compassion, kindness, dignity and respect.
<i>IS IT RESPONSIVE?</i>	Services are organised so that they meet people’s needs.
<i>IS IT WELL-LED?</i>	The leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Source: *How CQC regulates. Residential adult social care services. Provider handbook* (CQC, 2016a)

The Accreditation Standards in Australia have been in place since 1997. The standards are shown in Table 6.2. They differ from the standards in England in two ways. Firstly, they are focused on processes and secondly, they take a pass/fail approach to accreditation, rather than being linked to ratings as in England. The emphasis for the standards is on checking that providers have processes in place for internal quality improvement. The standards explicitly stop short of prescribed ways of working and the Quality Agency simply assesses whether providers have passed or failed each standard, rather than apply a rating. A recognised issue with the pass/fail nature of the accreditation standards is that the system is effectively concerned with setting minimum standards in the sector (Commonwealth of Australia, 2007, O'Reilly et al., 2007).

In parallel with this study, the Australian Government has been developing a Quality Framework for the sector, and a new set of standards were published for consultation in early 2017 (Department of Health, 2017e). The new standards are expressed with three different perspectives: a statement of outcome for the ‘consumer’, a statement of expectation for the organisation, and the organisational requirements to demonstrate that the standard has been met¹. However, these new standards still stop short of defining a single view of quality and are still subject to a system of compliance/non-compliance, an approach previously rejected by the CQC when it replaced the Essential Standards of Safety and Quality with the current Fundamental Standards.

Table 6.2 Accreditation Standards

STANDARD	PRINCIPLE
1. Management systems, staffing and organisational development	<p>Within the philosophy and level of care offered in the residential care service, management systems are responsive to the needs of care recipients, their representatives, staff and stakeholders, and the changing environment in which the service operates.</p> <p>This standard is intended to enhance the quality of performance under all Accreditation Standards, and should not be regarded as an end in itself. It provides opportunities for improvement in all aspects of service delivery and is pivotal to the achievement of overall quality.</p>
2. Health and personal care	Care recipients’ physical and mental health will be promoted and achieved at the optimum level in partnership between each care recipient (or his or her representative) and the health care team.
3. Care recipient lifestyle	Care recipients retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.
4. Physical environment and safe systems	Care recipients live in a safe and comfortable environment that ensures the quality of life and welfare of care recipients, staff and visitors.

Source: *Australian Aged Care Quality Agency Assessor Handbook* (Australian Aged Care Quality Agency, 2014b)

¹ The new standards are due to be implemented in July 2018 (Australian Aged Care Quality Agency, 2018).

The ability or inclination of each government to settle on a single, formal, definition of quality for use within their own regulatory system appears to be partly influenced by decisions about the trade-off between quality and sustainability. The trade-off is between a regulatory system which sets challenging quality requirements, but which at the same time ensures that the provision of care is sustainable and affordable. In England, participants from the regulator were clear that the standards should be independent of any financial constraints facing the sector. The standards have been designed to focus on the delivery of person-centred care and the assessment against the standards is, in theory, identical across the country. The CQC sets expectations for services, and these are in place regardless of the financial ability of local authorities or in the self-funder to fund this level of quality.

In Australia, government participants were clear that the definition of quality would be influenced by the sustainability of a given level of quality. Interviews with Australian government staff revealed that the sustainability of the sector is a critical factor into the design of the future Quality Framework:

P: This is a 'what people want' piece against 'what is the appropriate engagement by government to fund this as a system in terms of sustainability into the future' and then how do we measure against both those things together. (Australia, regulator, P1)

This approach implies a more explicit trade-off with the setting of regulatory standards and the fiscal implications of requiring quality improvement. The interviews highlighted the difficult position of the Australian Department of Health, in that it has direct responsibility for both funding and for setting standards. If the government actively highlights poor quality, it will face calls to close providers down (which may result in supply issues) or to become involved financially or practically in turning providers around.

The rights of the person or of the 'consumer'?

A major finding of this study is whether quality is shaped by if and how rights-based approaches are woven into each system of quality in residential care. In England, a rights-based approach shapes a focus on person-centred care in the regulatory system, compared to Australia where the issue of 'rights' is restricted to the protection of consumers.

In England, the role of rights-based approaches in health and long-term care has accelerated since the introduction in 2000 of the Human Rights Act 1998. The Act covers most of the rights protected under the European Convention on Human Rights and under the legislation, bodies delivering publicly-funded care have a duty to protect the human rights of the people for whom they care (Curtice and Exworthy, 2010). Disability groups in the UK have been instrumental in campaigning for rights-based approaches across different aspects of social care and social services (Glasby and Littlechild, 2009).

Using a rights-based approach, the *National Service Framework for Older People* (Department of Health, 2001, p.i) advocated a ‘cultural change so that all older people and their carers are always treated with respect, dignity and fairness’ and rights have since been embedded in the care system through the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards legislation, commonly referred to as ‘DoLS’. Safeguarding is defined by the Department of Health (2017b) as ‘protecting an adult’s right to live in safety, free from abuse and neglect’ while also promoting their wellbeing. Providers and local authorities have extensive responsibilities under the DoLS legislation and the Mental Capacity Act (Law Commission, 2015). Part of the responsibilities of the CQC is to check that providers are following safeguarding processes. In terms of quality, these formal safeguarding processes effectively introduce an additional layer of monitoring and oversight to the care provision, even though it is focused on what are essentially minimum standards of quality.

In the system in Australia, the focus on ‘rights’ has in recent times been more concerned with the issue of consumer protection, rather than broader questions around human rights. This focus on consumer protection has most recently taken the form of mandating providers to publish price information on the MyAgedCare website (as described in Chapter 2), and more broadly in measures to regulate prices in the sector. The Aged Care Act sets out detailed rules around charging and prices, under the Fees and Payment Principles (Commonwealth of Australia, 2015). A maximum rate for the RAD is set by the responsible Minister², and providers also have to apply to the Aged Care Pricing Commissioner for approval to charge for ‘extra services’, for example, a higher standard of accommodation or additional

² At the time of writing \$550,000 (Aged Care Pricing Commissioner, 2017)

services (Aged Care Financing Authority, 2016b). These rules contrast with the situation in England, where the lack of protection of consumer rights in the sector is an ongoing issue of concern. In 2016 the Competition and Markets Authority (CMA) launched an investigation into the workings of the care home market (CMA, 2016), following earlier reports by both CSCI and the predecessor of the CMA, the Office of Fair Trading (Office of Fair Trading, 2005, CSCI, 2007, Office of Fair Trading, 2011). The CMA's interim report highlighted a range of issues associated with consumer protection for self-funding residents in England, including a lack of indicative pricing information on websites, the charging of large upfront fees and deposits, the ability of care homes to ask residents to leave, and the charging of fees for extended periods after the death of residents (CMA, 2017a, p2).

This consumer protection focus is dominant in Australia despite the presence in Australia of a Charter of Residents' Rights and Responsibilities and the programs which were set up alongside it. As Chapter 6 described, these programs appear to have fallen into disrepair: an example is how both the National Aged Care Advocacy and the Community Visitors Scheme have been outsourced to the same providers for the past 25 years, largely without major reviews of their effectiveness. A recent review of the National Aged Care Advocacy Program was largely focused on the organisation of the supply of services, did not re-examine the criteria for accessing the service, and without linking to the recent state reviews of guardianship legislation (Australian Healthcare Associates, 2015). When approached about an interview about the Community Visitors Scheme, an anonymous government source commented 'I don't know what it has to do with quality'. Discussion about the need for extra support and advocacy has tended to focus on a number of 'target groups'³, without special recognition of the extra needs for older people with, for example, cognitive impairment or dementia.

³ The Aged Care Act 1997 defines 'people with special needs' as people from Aboriginal and Torres Strait Islander communities; people from culturally and linguistically diverse backgrounds; people who live in rural or remote areas; people who are financially or socially disadvantaged; veterans; people who are homeless or at risk of becoming homeless; care-leavers; parents separated from their children by forced adoption or removal; lesbian, gay, bisexual, transgender and intersex people; and any groups subsequently identified within the Act (Commonwealth of Australia, 2016).

6.2 Understandings of quality in the regulatory systems

In both countries, policymakers and other groups are grappling with similar issues in terms of how quality should be defined in the regulatory systems, issues which are already well covered in the academic literature. These issues included how to define quality when it is subjective and multidimensional; the relationship of minimum standards to safety and quality; and balancing quality of life outcomes with quality of care processes. Another important question is how the trade-off between quality and sustainability is viewed. These difficulties were raised more often in interviews in Australia, where it seemed that efforts to define quality had been derailed by the debate around these issues. On this note, participants in Australia frequently gave similar examples of subjective issues with quality, often centred on the choice of services, such as the provision of cable TV or wider food choices. Less frequently, the interviews in Australia acknowledged the multidimensional issues with quality, for example, how to prioritise between different care processes and activities:

P: And deciding what is really good practice is a very vexed question anyway, because is it best practice – are they really good in activities, really good in dementia, really good in clinical care? What are they good at? Do they have to be good at everything to be high quality? (Australia, consultant, P1)

A view which was common in both countries was that quality should be viewed as being distinctly different from the idea of minimum standards, and some participants rejected the notion that basic standards of safety represented ‘quality’ in any sense. For many participants in both England and Australia, inspection and accreditation activity should focus solely on minimum standards of safety and risk minimisation and should probably not be referred to as ‘quality’ at all. Participants referred to other sectors to illustrate this differentiation between quality and safety. In England, one participant used the analogy of information on hygiene and safety standards and how these help consumers to make decisions about whether it is safe to eat in a restaurant, but then how these consumers could make their own subjective decisions about the quality of the cooking and food. In Australia, a popular analogy among participants was how safety standards in the airline industry

are governed by regulation, but differences in terms of the quality of services should be a matter for the airlines and individual consumers:

P: What does the Australian community and the consumer want comfort about? [...] What's my analogy to that? I'm comfortable I can fly in a plane in Australia. Cos there's a regulatory framework that gives me satisfaction as a consumer of air services, that it's safe to fly in Australia. I don't want them to have any comment to me about consumer choice or quality issues, in terms of my assessment about whether I choose Qantas, Jetstar or Virgin. I don't want the government to have any say in that. (Australia, industry association, P4)

The view, that regulation should focus on safety (and not quality) was far more dominant in interviews in Australia than in England. In Australia, the government's role is perceived by interviewees, particularly in the Department of Health and in industry associations, as being firmly in the safety space. In the eyes of the Department, accreditation is 'sort of a pass/fail or a met/unmet thing' which is essential for accessing government funding (Australia, government, P10). The view of many interviewees was that, if providers are registered and/or funded by the government, that the 'community' expects the government to check the 'take for granted' components. However, where these two layers of quality separate is far from clear:

P: So, I guess, I think, probably what's showing up a little bit through the standards process is where does the *take for granted* stop and where does the *differentiate above and beyond that* start and where does the line ...? (Australia, government, P1)

In contrast, the CQC's new approach, based on CQC's Fundamental Standards and the Mum Test, aims to make quality of life aspects as important as safety. As one participant from the regulator commented:

P. You can't just do patient safety – that's in a kind of health service context, you know, and think that you've cracked quality, because actually you could be keeping people safe but you'll have wrapped them up in cotton wool and then actually their experience is really poor because they're not being involved and they're not being – you know, they might be safe but they might be not being treated with dignity and respect and actually, the impact on them is just as bad as if their safety had been compromised (England, regulator, P2).

More generally, the discussion in England focused more on topics around person-centredness and quality of life, even though there was some scepticism that all providers, and even inspectors, had grasped the concept of 'doing with', as opposed to 'doing to', a principle at the core of person-centred care.

In both countries, there was discussion of the tension between quality of care processes and quality of life outcomes, and a view that, while regulation might have some impact on the former, it was less useful for supporting improvements in quality of life outcomes:

P: I think there's only so far you can go with regulation to deliver quality, so I think you can put some things into regulations, you can put some things in legislation, but the – in more recent years I've become more interested in quality of life, rather than just of quality of care. So I think you can use regulation to improve quality of care. I am not sure you can use regulation to improve quality of life. (England, industry association, P5)

In Australia, the interviews suggested that the understanding of quality at the policy level has become firmly entangled with the market narratives of CDC. When asked to name the best providers in the study area, participants, including from the Department of Health, often explained quality using tangible, 'search good', characteristics of providers such as the attractiveness of the location of the home, the availability of satellite TV or being able to have a glass of wine every night. Some, but not all, policymakers and regulators in the study were sceptical that a focus on these characteristics could improve quality of life outcomes and were primarily the concern of providers seeking wealthier residents.

Discussions about other aspects of quality, particularly relationship-centred quality, were less common in Australia at the policymaking level. Interestingly for this thesis, however, this relative lack of discussion is not mirrored in the interviews with providers. These interviews are reported in Chapter 8 and suggest that relationship-centred quality is being delivered by some providers in both countries, although it is difficult to say on what scale. The presence of relationship-centred quality suggests that, to some extent, good quality develops independently of the policy mechanisms in place and is more related to the intrinsic motivation of providers than the regulatory regimes of either country.

Nonetheless, achieving a balance between quality of life and safety was viewed as challenging in both countries because of the increasingly complex care delivered in nursing homes which is, as one provider in England observed, more akin to 'sub-acute care'. It is therefore difficult to balance important clinical governance issues, particularly infection control measures, with the goal of providing a homelike environment. A provider in Australia referred to this as the 'Triple H Dilemma', referring to the tension between designing homes as hospitals (to deliver safety and

better clinical outcomes), hotels (for relatives and to meet the increased expectations of wealthy baby boomer⁴ consumers) or homelike environments (with the best chance of contributing to the quality of life of residents). These three approaches to describing the environment reflect the concepts of quality as organisation-focused, consumer-directed and relationship-centred and as such a way of categorising the physical environment for the typology of quality approaches.

6.3 Links between government interventions and definitions of quality

The following section reports the views of the General Sample in terms of how different policy interventions are linked to quality in the sector. The interviews identified three separate features of the systems that have an impact on understandings of quality: regulation (including ratings), which mainly impacts on organisation-focused quality but also on relationship-centred quality; the ACFI funding mechanism in Australia and organisation-focused quality; and, how the appeal of wealthy self-funding clients provides a high-powered incentive to focus on consumer-directed quality, leading to the emergence of two tiers of quality.

The relationship between quality and policy interventions differed in the two countries. As Chapter 3 showed, previous research has demonstrated that regulation is most associated with quality in terms of processes and documentation. Even so, the design of the regulatory regime in Australia (which is process-focused and based on a system of pass or fail) drives more of an organisational focus on quality than the system in England. The following section argues that the ACFI also contributes to this focus by providers on specific processes in Australia. In both countries, consumer-directed quality arises from the desire of providers to appeal to wealthy individuals. However, the large sums of money available in the form of RADs in Australia appear to exacerbate this focus in Australia⁵.

⁴ The term 'baby boomer' is used to refer to the generation born in the 'baby boom' after the Second World War. The precise period differs between countries: in England there were two 'baby booms' in the period between 1945 and 1960 (Ready for Ageing Alliance, 2015), in Australia, a single 'boom' continued for longer, from 1946 to 1965 (Quine and Carter, 2006).

⁵ In 2017 the average RAD holding per provider was reported as being 89 RADs with a value of \$22 million (Department of Health, 2017d). This is approximately £12.2 million as at 19 March 2018 (www.oanda.com).

Regulation and organisation-focused quality

The first theme that emerged was that inspection can drive an understanding of quality that is focused on safety, processes and the internal needs of provider organisations. This organisation-focus appeared to be much more dominant in Australia than in England, mainly due to the process-focused nature of the Accreditation Standards. Several participants in Australia commented that it is possible to pass accreditation with little consideration of the quality of life of the older person. The Accreditation Standards promote an internal, process-focused view of quality, more concerned with internal checks and balances than with quality of life. The fact that the standards are compliance-based also allows them to be viewed as ‘minimum’ standards.

An example of this prioritisation of process quality over quality of life outcomes concerns the policies and practices around antipsychotic medication in Australia. The over-use of antipsychotic medication has implications for both mortality and quality of life (Lee et al., 2004, Schneider et al., 2005). Research projects have recently been exploring ways to address this issue in Australia (for example, Westbury et al., 2009, Jessop et al., 2017). Despite this, there was a view that Australia is lagging behind the UK on policies on antipsychotic medication:

P: The other thing that I feel passionate about but we’ve totally failed with in Australia – and you’ve done better within the UK and the US – has been the use of antipsychotics and restraint. There’s been absolutely no sympathy for responding to that in Australia. (Australia, consultant, P4)

Even so, a participant from the Department of Health in Australia explained how it steers clear of assessing whether providers are administering appropriate medication, focusing instead on whether organisations have appropriate processes for medications management. One participant in Australia referred to the overuse of antipsychotic medication as ‘the canary in the goldmine’ for poor care, where the excessive use of medication could mask the fact that residents with dementia were unnecessarily bored, agitated or distressed. Another participant highlighted how a provider could pass the standard for medications management, while at the same time it was apparent that the provider was overusing antipsychotic medication:

P: This home was, in my view, very border line... And a lot of the residents were sleepy, and doing the sample showed a lot of people were actually on Risperidone, they were drugged. There’s nothing in the Standards that says you can’t drug people. (Australia, Consultant, P1)

This situation is exacerbated by the lack of ownership taken of this issue by providers in Australia. Many providers, including participants in this study, blamed doctors' prescribing practices for excessive use of antipsychotic medication, rather than acknowledging a responsibility for providers to address the issue by working to improve the quality of life of residents. The lack of attention of the Accreditation Standards to quality of life issues also means that there are still dubious practices in place in provider organisations in Australia, something raised by several participants, but notably, not by any industry associations or providers. One participant raised the issue of preserving the dignity and privacy of residents and commented that he had never heard of anyone failing accreditation because of them, despite having seen providers use inappropriate processes, such as wheeling naked residents to shower rooms covered only in sheets (Australia, consultant, P3).

The process focus in the Australian regime means that the system is more exposed to practices of ritual compliance. One participant described how many providers were more concerned with the quality of processes and paperwork, rather than the quality of life for the resident:

P: [...] there's this myth in providers around what is – what the accreditors want to see. So they're very *driven* to producing all those beautiful graphs about falls and what not. [...] And then sometimes you'll see the falls go up and then you'll see audits and training and protocols and assessments and then they'll check the lighting and the flooring. There's this huge effort goes into falls. But somebody's in their room crying and withdrawn and it doesn't rate on the quality management system. (Australia, Consultant, P1)

Similarly, there was evidence of providers in Australia showing 'tunnel vision' and hitting the target but missing the point: a participant in Australia described how, when a new head of quality arrived to work at a provider organisation, the new manager asked to see the 'red file where you keep your police clearances'. When advised that documentation was held on line, the person expressed concern that not having a 'red file' meant that they were not compliant with the legislation, rather than focusing on whether processes were being carried out effectively (Australia, consultant, P2).

Another issue specific to Australia was a tendency to equate the existence of good corporate governance processes with good quality. Participants explained that the introduction of accreditation was seen to be one way of improving quality in the sector, through 'professionalising' the sector. This understanding can be seen to

stem from the measures (standards and funding mechanisms) introduced under 1997 Aged Care Act with the goal of ‘professionalising’ what was perceived as a ‘cottage industry’:

P: [one of the] objectives in the reform of the ‘90s was to take it from a cottage industry to a proper, professionalised industry. Because one of the ways you drive proper scale and quality, is actually having scale. Because then you can run your systems over multiple services, you can put proper training in place, you can create career progression for people, etc, etc... (Australia, Government, P13)

The interviews suggested that organisational size and apparent ‘professionalism’ at the senior management level are often conflated with good quality by many in Australia, even though this professionalism may not translate into quality at the resident level. While good leadership has been identified as a prerequisite of high-quality provision, there is no evidence that good governance processes alone will trickle down to result in high quality (person-centred) care.

The link between regulation and organisation-focused quality was much more apparent in Australia than in England. Even so, despite the intended focus of the CQC on quality of life, interviewees reported that for many providers in England the basic requirements of inspection also continue to have a focus on ‘good’ paperwork. The challenge for providers is to adapt this paperwork to a more person-centred approach which continues to support the complex health care needs of individual residents, rather than the clinical, task-oriented approach to meet the requirements of the inspector:

P: Well, the two things that they actually failed on were not having a quality system implemented and formats of care plans. Because they were in the old sort of, slept well, good day, yeah. Very – very nurse, nurse, very task orientated, not written as ‘I’ statements, not written personalised, not individualised to the individual. (England, industry association, P3)

Funding and organisation-focused quality

The interviews showed that a major driver of organisation-focused provider quality in Australia is the ACFI or, more specifically, the goal of maximising ACFI revenue. The approach of the Australian government to the funding of care also impacts on how providers manage care provision and, implicitly, manage quality and quality improvement. This revenue maximisation activity is supported by a thriving market in benchmarking and consulting in ‘ACFI optimisation’.

A common criticism of the ACFI is that, because higher needs attract higher payments, there is no incentive to rehabilitate the resident. There are also built-in perverse incentives, as the following example shows:

P: ...so it's um, so one of the things under ACFI, a really big thing is if you give a person a hot pack, you get paid for it.

LT: A hot pack as in?

P: Hot pack. Warm pack.

LT: For muscle pain and ...?

P: Yeah, yeah. So for some reason the government picked on three or four different pain treatments and you get funded for that. So that's generally all that people treat the residents with.

LT: So there are other things they could treat them with but they just stick to the things in the ACFI?

P: Yeah, cos they get funding for it ... (Australia, consultant, P3)

One ex-government participant commented on how the ACFI also increases the fixation on documentation in the form of care plans. This fixation is exacerbated by the need to ensure that the care plan is consistent for accreditation and for ACFI claims (Australia, government, P12).

The industry associations in Australia were consistent in saying that providers 'maximise' ACFI revenue to fund good quality care and as Chapter 8 shows, there are providers in Australia who are focused on relationship-centred quality regardless of the perverse incentives bound up in the ACFI funding process. A number of participants described examples where ACFI revenue had been maximised with poor attention to the actual quality of care. One participant argued that the tool was not fulfilling its original goal to provide another, indirect, check and balance for quality in the sector. So, for example, if the provider was claiming for a large number of residents having depression through the ACFI, this should be a signal for the accreditation team to review the provider's approach to managing depression.

Providing further evidence of the impact of the ACFI, the sector is characterised by the proliferation of roles within provider organisations specifically focused on maximising revenue and in government for auditing ACFI claims. The Australian government has more recently recognised the perverse incentives in the ACFI in terms of quality but more urgently the moral hazard they present in terms of the supply of care and growing care budgets. In the mid-year budget in 2016, the ACFI

was the subject of a government attempt to clamp down on rorting (gaming) and to claw back fraudulent claims (Morrison MP and Cormann, 2016) and this has subsequently been the subject of ongoing debate and conflict in the sector. The government subsequently commissioned research on the potential replacements for the ACFI, the results of which were reported in 2017 (McNamee et al., 2017, Rosewarne et al., 2017).

Consumer choice policies and consumer-directed quality

For some participants in both countries, the main driver of provider behaviour was consumer choice and profitability. Several participants observed that, in reality, revenue was the key driver for many to improve quality, and the compelling reason for change in both countries was low occupancy:

P: ...I mean there is an element of competition and that, in the end, will force people through. The best thing that forces them to change is low occupancy. Right. Cos that hits them in the pocket.

LT: And low occupancy, so the local authority, this is local authority funded or self-funded or anything.

P: Either. (England, industry association, P3)

However, supply issues in the sector in both countries would reduce the motivation of providers to improve quality, diluting the desired effects from consumer choice and marketisation policies:

P: I think it's unrealistic to expect the industry to improve in quality, just by giving people more opportunity in terms of being able to move a facility. And that's *also* assuming that there is space available in facilities. At the moment most homes run at 90% plus occupancy. (Australia, Users and Carers, P2)

However, the extent to which market mechanisms are perceived as being the 'be-all and end-all' manifests itself differently in policy discussions in the two countries.

On several occasions in both countries, participants commented that the relationship between money and quality is stronger than the relationship between inspection (or accreditation) and quality. In the Australian system, government funding is contingent on providers being accredited and this is where the real motivation for passing accreditation lies, rather than seeing the importance of meeting the standards in the pursuit of better quality. This is compounded by the fact that all Australians are entitled to government funding to pay for their care costs, so the government is a powerful monopsony purchaser of care.

Because of this situation, participants in England at the national level raised the need to have visibility and oversight of local authority commissioning to ensure that local authorities are setting prices and negotiating contracts that are not undermining quality. In England, this situation is changing as providers are no longer allowed to receive local authority funding if they are rated ‘inadequate’. The predecessor of the CQC, the CSCI, had a responsibility to monitor how councils were using commissioning in relation to the quality of provision. This oversight responsibility was reduced when the CQC came into being, although it can still conduct special reviews with permission from the Secretary of State or when commissioned by the Secretary of State⁶. Clauses to empower the CQC to monitor commissioning practices were originally included in the draft Care Act, however these were blocked by the Minister for Communities and Local Government at the time – a major error in the opinion of one study participant.

In England, there is plenty of policy rhetoric around consumer choice and the importance of the market in shaping quality (see, for example, Department of Health, 2005, Department of Health, 2007, Department of Health, 2012a). At the same time, there are several mechanisms in England which implicitly recognise the limitations of residents and families to exercise consumer sovereignty. These mechanisms include access to advocacy (although this may be limited in practice) and safeguarding processes, and the duty on local authorities to supply information on providers. The public also has access to information on quality through the provider ratings, although interestingly one senior participant from the regulator explained that the goal of using ratings is more to improve quality through the ‘activation’ pathway, rather than selection and customer choice. This topic is explored in more detail in Chapter 7.

⁶ In 2017, the Secretary of State commissioned the CQC to conduct system reviews of 20 local authorities, as described in Chapter 2.

The planned implementation of CDC in residential care in Australia is a radical change to the current process of central planning and the allocation of bed licences. The idea that consumer choice is a key driver has been widely embraced, as illustrated by the Aged Care Roadmap (discussed in more detail in Chapter 5):

Greater consumer choice drives quality and innovation, responsive providers and increased competition, supported by an agile and proportionate regulatory framework. (Aged Care Sector Committee, 2016, p3)

The notion of the consumer in the aged care sector, and more specifically, a ‘consumer focus’ across government programmes was first floated in Australia in a pamphlet entitled *A consumer focus in the Department of Community Services and Health* in 1990. However, the tone of this pamphlet and how ‘consumers’ are conceptualised is centred on the social justice priorities of the then-ALP government, that is, equity, equality, access and participation, and ‘to ensure that the basic objective of social justice is met, that is giving all consumers a ‘fair go’ (Department of Community Services and Health, 1990, foreword). In later reports, however, the meaning of ‘consumer’ was firmly embedded within the idea of a functioning market, particularly in the Hogan Report (Hogan, 2004) and more recent Productivity Commission Report (Productivity Commission, 2011). A strong theme in the interviews concerned the expectations surrounding the power of the demanding baby boomer consumer and how they will influence and direct quality in the aged care sector.

This idea that members of the baby boomer generation would be more ‘effective’ consumers than their predecessors was shared by participants across almost every stakeholder group in the study in Australia. There was a strong view, shared equally by representatives from all stakeholder groups, that unlike the ‘stoics’ before them, the baby boomers will be considerably more demanding. Participants saw the baby boomers as empowered and vocal and as already active in the quality of aged care, through their role as children of current users of residential care:

P: So, I think the baby boomers will be bitching a bit more, because they’re not gonna put up with it. And on behalf of their parents or themselves. [...] I mean my mum is part of that generation of course, at ninety-four, whatever she got she just took. [...] She accepted it, that was just how her whole life’s been. But I think where we’re currently a little bit ahead of the game, the baby boomers will just not put up with that and they’ve got the money to back it (Australia, industry association, P3).

Only one participant, from a consumer group, disagreed with this view, raising the issue that residents may not be in a position - physically, mentally or financially - to make demands, or that care could be broken down in the manner of consumer goods. In this vein, it was interesting to note that when individuals spoke about the choices baby boomers would be able to make, the examples they gave were frequently tied up with the idea of residential care as a service with optional extras and interventions. For example, one participant spoke about how 'my generation' would not tolerate poor food; another spoke about purchasing extra time with a carer for his mother.

In both countries, the presence of consumer-directed quality is driven by the decisions of providers to market themselves to wealthy, and potentially more profitable, clients. This marketing activity often stresses the quality of the physical environment in terms of aesthetics, often with more attention to the preferences and opinions of relatives, rather than to the physical needs and preferences of the residents themselves. As a result, the emergence of luxury nursing homes has happened in both countries. In England, this development is aimed at affluent self-funders; in Australia, it is directed at residents with large RADs and DAPs. This trend appeared to be more marked in Australia, possibly because of the large sums of money available through RADs and DAPs. A participant who had worked across both Australia and England commented specifically about the link between bonds (the precursor to RADs and DAPs) and the provision of luxury accommodation:

P: I think in Australia where you see a lot of the homes with these facilities, you will find that they've been trying to attract big bonds and so you know, it's – they'll have a plush sort of foyer and they'll have various facilities. It's the same in Spain, you know, swimming pools but no-one ever uses the swimming pool. And so I mean, you know, it's part of the marketing. (England, consultant, P4)

In both countries, participants spoke of the tendency to design care homes to appeal to relatives, given that they often make the decision regarding the choice of provider. Many commented on how the need to appeal to the preferences of relatives often supplanted the needs of residents, often living with dementia, as two government officials in Australia explained:

P: We've got 70% now, of residents, with a cognitive impairment. 70% and climbing. [...] So we've got this struggle between, what is homelike and person-centred and what looks like real estate that these people's sons and daughters will feel comfortable coming and visiting. (Australia, regulator, P3)

The clash between the hotel-like aesthetics of new homes and the preferences and needs of older people was also evident in England. Local authority staff highlighted how some older people preferred older buildings because of their homelike environments, despite the buildings often being objectively viewed as potentially of lower quality because they lacked features such as en-suite bathrooms. This friction was also highlighted by a representative from a carers' group in England:

P: So you can have a – you know, you can have a beautiful-looking care home, but if the care assistant or care worker doesn't treat you well, it doesn't matter. If you have a bit of a shabby care home but the quality of the relationship is great, actually that will compensate. But it won't compensate the other way around. (England, users and carers, P1)

Regulation and relationship-centred quality

The chapter so far has found that far stronger links were identified between policy interventions and organisation-focused and consumer-directed quality in Australia. The links with policy interventions and relationship-centred quality were largely

absent in Australia. There is a strong intent at the policy level to focus providers on person-centred behaviours. At the same time, participants in England cast some doubts over whether regulation could drive person-centredness and relationship-centred support. In addition, one participant in England pointed out how the understanding of what constitutes 'person-centredness' can be limited in its interpretation by inspectors and providers:

P: Well, I think what I would say is, it depends upon your understanding of person-centredness, cos a lot of person-centredness is just around kind of relabelling you know, care planning documents and things like that, in different ways. Sorry if that sounds slightly cynical. But true person-centredness actually involves a shift of power from staff to the person themselves. And, you know, I'm not convinced that most CQC inspectors understand that power shift paradigm. (England, users and carers, P3)

Despite this, in England, there is a single definition of quality which is guided by a person-centred approach. The principles underpinning the CQC standards are derived from the definition of person-centred care linked to the notion of personhood and put forward by authors like Kitwood (1997) and Brooker (2007). This definition permeates across the Fundamental Standards of the CQC, the Quality Standards produced by NICE, the Adult Social Care Outcomes Framework and runs through the guidance on the commissioning of services through to the output of bodies such as SCIE and Skills for Care. Most recently, person-centred

approaches feature in the *Quality Matters* initiative launched by the Department of Health and other major stakeholders in the sector (Department of Health and Care Quality Commission, 2017). A large part of the clarity around the definition of quality in England is that, in designing and implementing the ratings, the CQC has had to explicitly set out what is involved in delivering different levels of quality, that is, what counts as outstanding, good, requires improvement or inadequate. In England, selecting providers for the study who had been rated ‘outstanding’ or ‘good’ by the CQC implicitly suggested that there was evidence that the provider had not only understood, but had implemented, the CQC’s priority of ‘person-centredness’.

Reinforcing the importance of person-centredness, the Fundamental Standards are also framed from the view of the resident. The notion of quality as being about the experience of the person was first introduced when the CSCI was set up, as recalled by a participant who had previously held a senior role at CSCI:

P: And it felt to me that it had to, and that you had to start in that place, and you had to understand what the experience was, of the people who received care as it was currently delivered, and really focus on that and your standards had to be focused on that, and what you had to do was try and change the focus of the organisations that you inspected, that they focused on it as well, so that the people you were inspecting were absolutely clear that you were coming in, looking at those systems through that lens. (England, regulator, P7)

The CQC is prolific in its public role as the champion of quality in the sector and positions itself, at least publicly, as very much on the side of the user. On launching the new standards in October 2014 in the form of provider handbooks, the Chief Inspector of Social Care, Andrea Sutcliffe emphasised this point:

Our new regulatory model has people right at its heart. We will ask the questions that matter most to people who use services, listen to their views, take action to protect them, and provide them with clear, reliable and accessible information about the quality of their services (CQC, 2014b).

The CQC’s desire to promote a definition of quality which recognises relationship-centred care goes further than the Fundamental Standards. As one senior manager at the CQC observed, regulatory standards in themselves do not necessarily bring a vision of quality to life. To address this issue, the CQC promotes the ‘Mum Test’ to both internal CQC inspectors and external stakeholders, directing inspectors to ask themselves whether they would be prepared to have a loved one living in the home. The Mum Test reflects the intention of the CQC to focus its efforts on the ‘lived

experience' of residents and is aimed at overcoming the potential for ritual compliance and framing quality from the perspective of the day-to-day experience of the resident:

P: And you can be meeting all Fundamental Standards but still require improvement, because you're not good. And I was very struck when I came to the organisation with a conversation that I had with a group of our inspectors, who said that they were very concerned that they sometimes went to services which were compliant but they wouldn't want to leave their Mum there. (England, regulator, P2)

6.4 Conclusion

The aim of this chapter was to explore the different stakeholder understandings of what 'good' quality means at the provider level in Australia and England, and how these understandings have been influenced by different policy interventions in the respective countries. In order to examine quality at the level of the provider organisation, the chapter drew on three different 'quality orientations', organisation-focused, consumer-directed and relationship-centred. The interviews identified two new domains for this typology, namely around the approach to accommodation (the 'Triple H Dilemma') and how the 'rights' of the individual are conceived, as shown in Table 6.3.

The study found that while the abstract discussion of quality is very similar in both countries, understandings of how the specific characteristics of quality are discussed and operationalised vary between stakeholders in each country. The different understandings of quality in the two countries were influenced by differences in the design of the regulatory regimes, most notably, whether a single definition of quality exists to drive quality or whether standards are more concerned with management processes and governance; how the resident and rights are positioned in the regulatory process (human rights versus consumer protection); and the respective impact and regulatory clout of regulatory standards and payment mechanisms.

First, quality is defined differently in each country's regulatory system. In England, the CQC has developed and promotes a single definition of quality, based on person-centred care. While the idea of consumer choice is regarded as being a major influencer of policy in both countries, the policies which have emerged in England suggest that this idea is more nuanced in practice, for example, in the CQC's implementation of a top-down, rights-based view of quality based on the lived

experience of the person. This definition of quality is operationalised in the ‘Mum Test’ and also in the recently introduced ratings. In comparison in Australia, there is no single, stated, definition of quality in residential care, and very little sign in the interviews of an appetite to agree one. The current accreditation standards are primarily concerned with the quality of processes, and this process quality can ‘trump’ resident outcomes, as shown by the example of antipsychotic medication. The new standards published for consultation as part of the development of a Single Quality Framework are framed as outcomes, but stop short of any form of ranking to differentiate levels of quality performance (Department of Health, 2017e).

Table 6.3 An enhanced typology of quality orientations

	PROVIDER QUALITY ORIENTATION		
	Organisation-focused	Consumer-directed	Relationship-centred
Quality focus	<i>Internal processes</i>	<i>Consumer preferences and choice</i>	<i>Quality of life of residents, families and staff</i>
Conceptualisation of care	<i>Care as a process</i>	<i>Care as a service</i>	<i>Care as a relationship</i>
Organisation of work	<i>Task-centred and routine</i>	<i>Customer-centred and individual</i>	<i>Person-centred and relational</i>
Conceptualisation of the resident	<i>Passive patient</i>	<i>Empowered consumer</i>	<i>Individual with ‘personhood’</i>
Power relationship	<i>Resident dependent on care worker</i>	<i>Resident superior to care worker</i>	<i>Resident and care worker in reciprocal and meaningful relationship</i>
‘Rights’ focus	<i>Patient safety and quality of care</i>	<i>Consumer rights and choice</i>	<i>Human rights and quality of life</i>
Accommodation	<i>Hospital-like</i>	<i>Hotel-like</i>	<i>Home-like</i>

The 'resident' is also perceived differently in each system. In Australia, the emphasis in the regulatory system is on the baby boomer 'consumer' and consumer protection, where in England, regulation is based on a broader definition of rights. Arguably consumer protection is an area where Australia is ahead of England, where the lack of information on contracts and pricing for residential care has been consistently highlighted as an issue (CSCI, 2007, Office of Fair Trading, 2005, Office of Fair Trading, 2011, CMA, 2017a). Tellingly, however, the absence of a rights-based approach in aged care in Australia has been highlighted in state and federal government reports (for example, Victorian Law Reform Commission, 2012, Australian Law Reform Commission, 2017) and also by academics (Barnett and Hayes, 2010, Lacey, 2014). The lack of focus on human rights in the aged care system was also noted by the Australian Human Rights Commission in 2012 (Australian Human Rights Commission, 2012, p3), and more recently by a Law Reform Commission review into elder abuse (Australian Law Reform Commission, 2017).

Identifying the differences between the two countries has highlighted the issue of regulatory 'clout'. The differences demonstrate that the impact of regulatory regimes can be diluted or undermined if stronger, 'high-powered' incentives⁷ are in place, for example, through the unintended consequences of funding models. The relative strength of policy interventions is different in each country. In Australia, definitions of quality are influenced by three factors (accreditation, the ACFI and RADs/DAPs); the respective strength of these appears to be dependent on the motivation of the provider. This issue is examined in more detail in Chapter 8.

In England, the legislative powers of the CQC provide some 'regulatory clout', although this is potentially undermined by the fragmented nature of commissioning. Some policymakers and regulators in England commented that the visibility of commissioning practices was an essential factor in a fully functioning regulatory regime. In contrast to Australia, while the inspector in England is viewed as having stronger 'teeth', there are weak links between inspection and local authority commissioning. Study participants in national roles commented on how the real

⁷ 'High-powered' incentives overwhelm other, less valuable, 'low-powered' incentives for changing provider behaviour (Dixit, 2002).

power to influence quality improvement lies with local authority commissioners and self-funders.

In Australia, there is also evidence that some, if not all, of the adherence to the standards is driven by the fact that government funding for care is contingent on providers passing accreditation, given that most residents qualify for government funding for their care. This regulatory clout however, is overtaken by financial incentives from two directions in Australia: the financial incentives provided by the ACFI which have several unintended consequences and perverse incentives for provider behaviour (for example, neglecting rehabilitation), and by the market incentives to appeal to wealthy RAD and DAP-paying residents, which can also result in unintended consequences (for example, designing homes in the style of upmarket hotels). In England too, there is evidence of the emergence of these ‘two tiers’ of quality, where upmarket accommodation and services are marketed to self-funders.

The potential impact of these policy instruments on provider understandings and quality behaviour is explored in more detail in Chapter 8. The next chapter examines and compares the differences in the use of quality information in each regulatory regime.

7 The use of quality information in regulatory regimes

This chapter examines the different strategies of each government regarding the use of information on quality in the respective regulatory regimes. Existing research has tended to focus on the type of indicators used, for example, whether reports are based on structural, process or outcome indicators, or how publishing information has impacted on the behaviour of provider organisations, individuals and government purchasers. This study looks at other aspects of the use of quality information, for example, responsibilities for the collection and publication of data and some of the features of the information published, such as whether poor performance is reported.

Chapter 6 highlighted several differences between understandings of quality and their links with policy actions in each country. Three important differences have implications for the use of quality information in each country. Firstly, there is a person-centred definition of quality in England, as opposed to the process-based definitions in Australia, which will affect how quality is expressed. Secondly, where the ratings system in England allows the differentiation of different levels of quality, for example, Requires Improvement versus Outstanding; in Australia the pass/fail system only highlights whether providers have acceptable processes – a standard passed by virtually all providers. Finally, the biggest difference for the potential use of information is the emphasis in Australia on the consumer as the driver of quality, suggesting that the information on quality ought to be more extensive and transparent in Australia than in England.

The interviews in this chapter show how the use of quality information by each government differs. The chapter is structured in three sections. The aim of the first section is to set out the responsibilities and policies around official quality reporting in each country, including where information is published. The second section reports on three themes which emerged from the interviews regarding the differences between the national regulatory bodies: *differentiating and communicating performance, acknowledging and highlighting poor care*, and

process compliance or the lived experience of the resident. The final section of the chapter examines what the policy intent is in each country with regard to quality information and quality improvement, using the activation and selection pathways described by Berwick and colleagues (2003).

7.1 Gathering and publishing quality information

The first section of this chapter compares how the gathering and production of quality information is organised. The ‘official’ sources of quality information are shown in Table 7.1.

Table 7.1 Official sources of publicly available information

ENGLAND		AUSTRALIA	
Source	Format	Source	Format
Care Quality Commission (website)	Inspection Reports Ratings	Quality Agency (website)	Accreditation Reports Consumer Experience Reports (since June 2017)
NHS Choices website (Department of Health)	Consolidates information from other sites, including: <ul style="list-style-type: none"> • CQC Ratings • Food hygiene ratings • Consumer reviews (if available) 	MyAgedCare website (Department of Health)	Pricing information Planned: <ul style="list-style-type: none"> • Voluntary Quality Indicators • Provider ratings
Local authorities	Varying content, through a variety of channels including websites and brochures)		

Sources: Department of Health and Ageing, 2012, NHS Choices, 2013, Department of Health, 2016d, Independent Age, 2016, Australian Aged Care Quality Agency, 2017a, Australian Aged Care Quality Agency, 2017b, CQC, 2017a, Department of Health, 2017a

In both countries, recent legislation includes provisions for how information on quality should be made available to the public. In England, the Care Act 2014 includes legislation which specifies that local authorities should ensure that information on quality is available for potential users of care (HM Government, 2014a). A significant development is that this duty extends to supporting self-

funded residents for the first time. However, the responsibility to provide information stops short of allowing local authorities to make recommendations about providers:

LT: The local authority can't comment on the respective quality of care homes, can they?

P: No, they can't. Obviously the NHS Choices ratings are empirically robust, objective, because they're based on CQC assessments, but no, it's a bit like they can't direct you to whatever plumber or electrician, no. (England, government, P1)

In Australia, the LLLB reforms of 2012 included the set-up of MyAgedCare and the development of a Single Quality Framework, which included the project to develop voluntary quality indicators (Department of Health and Ageing, 2012). The MyAgedCare website and contact centre was launched by the government in 2013 to help consumers access aged care. MyAgedCare is intended to provide 'a clear entry point to the aged care system' and includes information about aged care and aged care providers, as well as a central client record for use for assessment and referral (Department of Health, 2017a). One of the initial mandatory requirements was that providers publish their rates on the website, to bring transparency to the process and to prevent providers from setting prices based on the wealth of the potential resident.

Both the CQC and the Quality Agency publish the results of inspections and accreditation reviews on their websites. However, there are several differences in other aspects of each country's approach. In England, the government takes an active role in both producing and publishing information with the results of inspections and the ratings published on the CQC's website, information which is also accessible through the NHS Choices website. In contrast, the Australian government is arguably taking a more passive role in the provision of quality information, placing priority on the gathering and publication of quality information by providers and consumer reviews. At the time of conducting the fieldwork, the information published by the Australian government consisted of the mandatory publication of provider prices on the MyAgedCare website, and accreditation reports and the list of providers receiving sanctions, both available on the Quality Agency's website. The accreditation reports in Australia are based on whether the provider passed or failed each of the 44 accreditation standards (see Appendix 4) and are highly focused on the quality of processes and documentation. All inspection

reports are available on the Agency's website which also includes details of the small number of providers who are facing sanctions following accreditation reviews.

In England, the CQC gathers a range of data directly from providers to inform and plan inspections. This data covers a range of incidents and comes from several data sources. For example, the CQC tracks any whistleblowing incidents and is notified of incidents such as the lack of a registered manager, a high rate of deaths, assaults or serious injuries, and staff ratios (see Appendix 5 for a list of data and sources). Providers also have to complete extensive Provider Information Returns before inspections, linked to the five key questions which form the basis of CQC inspections (CQC, 2016a). The CQC refers to this as 'intelligent monitoring', and it is a main feature of its five-year strategy for planning its inspection activity (CQC, 2016c, p18). However, this data gathered for intelligent monitoring purposes is not published. The CQC gives the reasons for this as the need for confidentiality and the risk of identifying individuals, but also because of concerns about the consistency and availability of quality data in the sector (CQC, 2016c).

The role of providers and information

A policy focus which differs between the two countries is the emphasis in Australia on encouraging providers to generate and publish their own quality information. The efforts to differentiate quality and provide information on MyAgedCare is all part of 'building this framework that supports consumer choice' (Australia, government, P1). In response to criticism in the Productivity Commission inquiry that it was impossible to discern quality in the sector due to the lack of measurement, part of the LLLB reforms was the setting up a 'Quality Indicator Reference Group'. This group included individuals from across the sector, including from provider organisations and from stakeholder groups put forward through NACA (covered in more detail in Chapter 5).

After the group's first three years elicited no firm recommendations on quality indicators, the Minister responsible for aged care, Mitch Fifield, chose three quality indicators which were already in place in state-run nursing homes in his home state, Victoria, reportedly 'to get the thing rolling' (Australia, government, P2). The indicators are the prevalence of pressure injuries, the use of restraints and the prevalence of unexpected weight loss. The lack of a scientific approach to the

selection of these three indicators was commented on by several participants, for example:

P: We don't know how he [Mitch Fifield] made the decision, but they are based on what's been collected in state run nursing homes in Victoria. [...] And he chose those three. We don't know why. We don't know how he came to those three. And why three? Why not the five that they collect in Victoria? Why not ten? (Australia, industry association, P2)

The important indicator which is missing is a measure of the use of antipsychotic medication - the 'canary in the coal mine' for the quality of dementia care, as referred to in Chapter 6, a decision that has been criticised by both COTA and Alzheimer's Australia (COTA and Alzheimer's Australia, 2014).

Indicators to measure the quality of life of residents and user experience were subsequently included in the list of indicators, following recommendations from the Reference Group. The Department of Health in Australia then launched a trial of three measures which focus on the experience and quality of life of the resident: the Adult Social Care Outcomes Toolkit to measure quality of life, and two customer experience tools¹ - one developed for mental health and a tool developed by the World Health Organization (KPMG, 2017).

One key difference between the sectors in each country is the extent to which the funding mechanisms have driven different approaches to the internal use of data by providers in Australia. The ACFI has generated a need for detailed data for providers and all the providers in this study in Australia made use of one of two external benchmarking systems². These benchmarking systems were developed after the introduction of Resident Classifications Measures (the precursor to the ACFI) and mainly focus on tracking financial and clinical measures, but also include modules for tracking human resource utilisation and for administering and reporting satisfaction surveys, allowing providers to implement approaches in their organisations based on a balanced scorecard approach. Even so, there is still criticism that the sector in Australia lacks a consistent approach to collecting quality information, particularly clinical information. There is some support in Australia

¹ The three tools were the Adult Social Care Outcomes Toolkit (ASCOT SCT4), the WHOQOL-BREF (OLD), and the Your Experience of Service (YES) Survey.

² QPS Benchmarking (www.qpsbenchmarking.com) and MOA Benchmarking (www.moa.com.au)

for the use of the Minimum Dataset-Resident Assessment Instrument (MDS-RAI) in place in the US (Courtney et al., 2010, Davis et al., 2015), even though this tool has been criticised for its emphasis on clinical care and a neglect of quality of life issues (Kane, 2001, Stevenson and Bramson, 2014).

The lack of quality data in England was commented on by two participants who had worked for providers and who were supporters of the idea of introducing measures which could be used by providers for benchmarking. For these two participants, the point of reference was also the MDS-RAI. Both participants recognised the issue that in isolation these measurement approaches had flaws, for example, spikes in certain adverse events may not be a sign of an overall deteriorating trend, as well as issues with case mix adjustment. But for these participants, the most important issue is a pressing need for quantitative data to enable providers to assess and benchmark their performance:

P: ...if you measure falls in a care home and suddenly they go up, the immediate *'Oh well, they're not doing very well at quality this year.'* It might be nothing to do with that. It might be to do with one or two people who are just more... But you don't know, because you've no data. (England, Consultant, P3)

The role of the public and information

Chapter 3 described some of the challenges with residents providing feedback and reviews on their care. One issue is that the 'credence good', or technical nature, of many aspects of residential care mean that it is difficult for a non-expert to judge whether the care experienced was of high quality even after it has been delivered. However, at the same time, the 'experience good' properties of residential care mean that valuable feedback will be available only from those who experience the service, that is, the residents and their families and friends. There is therefore an increasing focus on capturing direct feedback, through online reviews and ratings; surveys of residents and their families and friends; and through managing complaints. One related way of capturing resident feedback is using lay assessors in inspections and accreditations – this is discussed later in the chapter.

A clear difference between the interviews in England and Australia is how positively the potential of consumer reviews and ratings is perceived, and what they might contribute to filling the quality information gap. The major difference is that, in England, the policy of using online consumer reviews as a major source of feedback

for residential care (launched in 2011 (Samuel, 2011)) was largely dropped once it became clear that this channel had significant limitations. In contrast, the idea of using online reviews was mentioned many times by participants in Australia, including in the Department of Health and the regulator, as an important source of quality information. Many of the interview participants stressed how resident and relative reviews would be a major plank of the MyAgedCare website.

Despite the shift in emphasis from reviews produced by consumers to ratings produced by the regulator, some participants in England suggested that online reviews could still be valuable for helping people to choose between providers - these participants included a representative of a user and carer group and staff at a local authority. However, there was some scepticism in the Department of Health in England that reviews could be of real value, due to the limited comments and activity which had been captured on the NHS Choices website in the five years leading up to the study. Functionality for users to leave reviews was incorporated into the main NHS Choices website in 2012 and the site pulls information from several sources of data, including the ratings from the CQC. However, a participant from the Department of Health in England explained how consumer reviews and ratings were the 'weakest' part of the quality information strategy. The lack of resident turnover in the sector is recognised as a major challenge to generating reliable user reviews and feedback, particularly when compared to the health sector. As one government official commented:

P: ...the last hospital I worked in had a hundred thousand people a year – some of them were the same person – but 100,000 visits a year through that outpatients' department – like an airport. And so you can sit down with somebody and say, oh would you mind five minutes to go through this? I mean, how do you do that in a care home? No-one's going anywhere – they're just there. Very, very difficult to do.
(England, government, P1)

In contrast, in Australia, much of the discussion in the interviews (and in political speeches) is on putting the onus on consumers to judge the quality of care through online reviews and ratings. The dominant opinion expressed by most of the participants in Australia was that making consumer reviews available on the MyAgedCare website would provide *the* most valuable source of information for consumers to make decisions about providers. This very positive view of 'TripAdvisor' type reviews was shared by many across the sector, including government officials, providers, industry associations and particularly COTA, a

consumer group. COTA had launched a ratings system product in conjunction with the NRMA (National Roads and Motorists' Association³) called the 'Owls' system for consumers to score retirement villages and which would be developed for use in aged care. The Owls system was under consideration by the government for use on the MyAgedCare website. However, despite the frequent positive representations in interviews and several high-profile political speeches by Ministers, interviews with the Department of Health suggested that many questions remained for how this mechanism might work, for example, whether the reviews would be managed or published by one or several third-party organisations, and how the content would be moderated and by whom.

Only one participant picked up on the issue that the Aged Care Act prohibits the sharing of information which may allow individual residents to be identified, thus creating potential barriers for the use of reviews. There are strict limits in the Act around information which can be made public. Part 6.2 of the Aged Care Act sets out how much of the information which is related to the affairs of a provider is regarded as 'protected information' (Commonwealth of Australia, 2016). Only basic information about providers can be legally disclosed, unless it has been otherwise specifically deemed in the public interest.

Much of the discussion in Australia centred on the apparently consensus view that the new cohort of older people, the so-called baby boomers, would be active and critical regarding the quality of care. A participant from the regulator commented that this new 'generational cohort' will be predisposed to rate residential care because they have more experience of social media and of rating services such as cafes and hotels (Australia, regulator, P5). There was almost no acknowledgement of how aged care does not fit many of the characteristics of consumer products, particularly in reference to the generation of adequate quantities of reviews (Trigg, 2014). In fact, in Australia, interviewees went as far as suggesting that the

³ Similar to the Automobile Association or Royal Automobile Club in the UK.

introduction of reviews might allow the government to rein in the amount of regulation applied to providers:

P: But also even from the Minister's office, they're saying, well, look if you really did have excellence in a whole range of TripAdvisor type things, and you really did have really good consumer, well, consumer accessible, sort of quality information, we'd even consider, actually on a red tape reduction agenda... [...] the government would probably, you know, take, bear some of the risk of reducing some of the formal sort of standards and quality accreditation. Or the number of visits we might make or whatever... (Australia, government, P9)

Even given the challenges with online reviews, there is clearly value in capturing the views of users and carers, and the immediacy of online reviews has positive benefits. One advantage of consumer reviews identified in both countries, is that the governments see feedback from consumers as a way of addressing the delays in providing government information regarding the quality of care. In Australia, Department of Health officials commented on the fact that consumers were likely to pick up new quality issues in provision well before accreditation visits took place:

P: ...because information's up there, if they don't do the right thing, by the time we get out that clipboard, the place is almost going out of business. (Australia, government, P9)

Similarly, in England, a local authority participant commented on how making consumer feedback available was helpful to keep information on providers current. The participant's local authority awarded an annual quality rating but, like the Department of Health official in Australia, commented that consumer feedback might better reflect if there had been rapid changes with provider quality.

There are important reasons to harness consumer information, particularly regarding poor care, but it is also important to recognise the limitations of online reviews. Relying on online reviews for immediate feedback is problematic, particularly for complaints where feedback may not be routed to the provider effectively or at all (Trigg, 2011). The lack of clarity for making complaints about care is consistently acknowledged in England, where up to five different formal channels for making complaints have been identified (House of Commons Public Administration Select Committee, 2014). In Australia too, there is still confusion about how to make complaints, despite the existence of a federal complaints channel in the form of the Aged Care Complaints Commissioner (Australian National Audit Office, 2012).

7.2 Characteristics of ‘official’ reporting

This section now turns to the differences in how quality is expressed in information in each country. Discussions about quality and information in interviews in the two countries identified differences in the following characteristics of reporting: *the lived experience of the resident or process quality, communicating differences in quality, and acknowledging and highlighting poor care.*

The nature of the information in each country is linked to some of the features of the regulatory systems already discussed in Chapter 6. For example, in England, there is a single definition of person-centred quality which runs through legislation and policy, and the CQC has developed a ratings system which is intended to assess how well providers are delivering person-centred care and services. In Australia, however, quality is measured with a compliance-based – or pass/fail – system which assesses whether providers have adequate processes in place as required by the accreditation standards. The ratings system allows the government in England to communicate differences in provider quality. In addition, the government has legal obligations under the Health and Social Care Act (HM Government, 2014b) to publish information on quality achievement at both the provider and at the system level, for example, through the annual State of Care reports. In Australia, however, legislation under the Aged Care Act 1997 explicitly prevents the publication of information which can be linked to provider organisations (see above).

The lived experience versus process quality

Chapter 6 showed how the accreditation system in Australia focuses more on processes, and how this leads to more of an emphasis in the system on organisation-focused quality, while the intended emphasis of the inspection approach in England is on the lived experience of the resident and the ‘Mum test’. The following section examines how this difference is reflected in how quality is articulated in the inspection and accreditation reports in each country.

Inspection reports in England set out to tell the story of what it is like to live in the home, with both good and bad aspects. The inspection process in England prioritises the views and experiences of residents and their families as part of the policy of putting the person at the heart of regulation, an approach which was first implemented by the CSCI. The goal was to move away from descriptions of the

physical aspects of homes and concentrate on the issues relevant for potential residents:

P: We had some beefs about the national standards because they – if you read an inspection report, it felt like an estate agent's report. It started off by describing the building, the surroundings, and how you entered it, and those sorts of things. All of which is important, but it didn't tell you, 40 people live here who need this sort of support, and these are the surroundings and this is the sort of care you would get. It didn't start with the people. (England, regulator, P7)

Figure 7.1 contains excerpts from inspection reports from each country to illustrate these differences in style. The following section explores these differences in more detail.

Figure 7.1 Excerpts from inspection and accreditation reports

England: a focus on 'the lived experience'	Australia: a focus on processes
<p>There was a lively and energetic atmosphere in the service. We saw people being involved in the running of their home laying tables, folding laundry, and dusting.</p> <p>The service had a stable staff team, the majority of whom had worked at the service for a long time and knew the needs of the people well. The continuity of staff had led to people developing meaningful relationships with staff. We observed a person peeling potatoes with the cook. They informed us that they enjoyed doing this each morning and would have a good chat with the cook.</p>	<p>Lifestyle staff plan daily activity programs in both groups and individual settings and offer a range of activities including the celebration of special occasions. Lifestyle staff evaluate and redesign programs as necessary based on resident feedback and participation. Information from resident meetings and surveys also assists lifestyle staff in planning programs. Residents and representatives said they are satisfied with leisure interests and activities offered for residents.</p>

Sources: CQC, 2015d, Australian Aged Care Quality Agency, 2014c

Inspections in England place a large emphasis on talking to residents and their relatives, and 'Experts by Experience' are employed to assist in this process:

P: But I think it [the Experts by Experience programme] has made a difference and I think if you look at a CQC report that's got an expert's voice in it and one that hasn't, you can see the difference. [...] It'll say experts by experience. You know you can see the richness, because the expert is there to talk to those who use the service and to get their voice. (England, Regulator, P5)

The concept of 'experts by experience' was first implemented under the CSCI to ensure that inspections were conducted from 'a user perspective' (CSCI, 2009b, p6). Experts by experience are people who use services and their family carers, and these are the people regarded as 'best placed to assess [the] appropriateness and quality'

of services. This programme was re-introduced by the CQC and two external organisations are contracted to provide trained individuals to support CQC inspections. The CQC also uses SOFI2, the short observational framework for inspection, developed by the School for Dementia Studies at the University of Bradford, to 'capture the experiences of people who use services who may not be able to express this for themselves' (CQC, 2015f).

In Australia, historically the emphasis of reviews has been on checking care plans and other documentation. The value of the accreditation reports is questioned because of the focus on processes in the accreditation process. As Chapter 5 highlighted, providers can pass accreditation with little regard to the outcomes for residents. Recently however, the Quality Agency has introduced new information-gathering processes which incorporate the views of residents and relatives into the accreditation process, extending the number of relatives and residents it meets with, and experimenting with postal and online surveys with relatives. A recent change is the introduction of Consumer Experience Reports. In order to improve the 'resident voice' in accreditations, in 2017 the Quality Agency introduced a resident survey, surveying at least ten per cent of residents in each accreditation review (Australian Aged Care Quality Agency, 2017a)⁴.

As in England, reviewers have started gathering more feedback from residents and relatives through interviews and surveys and have also introduced the use of the SOFI2 tool to gather information on quality of life for people living with dementia or cognitive impairment. The Agency in Australia is also experimenting with tools to capture quality of life and user experience data. Much of this new practice has been directly inspired by the work of the CQC, according to a senior manager at the Quality Agency. A government official commented that with the Quality Agency's new approach, 'the bar has lifted, even though the standards are the same' (Australia, government, P10).

The Quality Agency also carried out a short-lived, small experiment of the CQC's experts by experience approach in its previous incarnation as the Accreditation Agency. However, the results of the trial were mixed, and the idea was shelved.

⁴ The Consumer Experience Reports were introduced after the conclusion of this fieldwork and so receive limited attention in this thesis.

Participants in the study reported that this was due to a number of issues, particularly around role clarity and the skills of the small group of ten experts.

The CQC uses information from two other avenues of feedback to support its inspection activity. The CQC in its Mark II incarnation has set up and promotes its own complaint call centre, as well as partnering with other organisations for the collection of additional complaint data. A representative from a user and carer group in England spoke positively of the organisation's relationship with the social care team at the CQC, and how their own advisors could discuss with them emerging patterns and trends they identified through complaints to the user and carer group (England, User and Carers Organisation, P1). HealthWatch, which is part of the CQC but with a local office in each local authority, also provides information on quality from the user perspective, and this information is used both by the CQC and by local authorities.

Communicating differences in quality

One of the most notable differences between the two systems is the extent to which each government makes available information on the quality performance of providers. In England, the regulator uses ratings to mark each provider's performance, and these ratings are made available on both the CQC site and on NHS Choices. Poor quality is highlighted directly in inspection reports and in the rating of providers by the CQC. The ratings are calculated by the inspector rating the provider against each of the five key questions and then use a ratings aggregation tool to set a rating for the overall quality of the service (CQC, 2015b). Providers are legally obliged to display these ratings, both on their websites and in the physical location of the care home (CQC, 2015a).

While ratings were initially introduced by CSCI 'in the teeth of opposition' from providers, this attitude changed markedly over the life of the ratings and when they were withdrawn by the incoming Coalition Government in 2010, 'the private sector was in outrage' (England, regulator, P7). The ratings were re-launched in 2015 on the instruction of the Secretary of State of Health, Jeremy Hunt, and emulate the four ratings (Outstanding, Good, Requires Improvement and Inadequate) which

were already in place for Ofsted, the inspector of schools and children's services in England:

P: I think it's just as important we know what 'good' and 'outstanding' looks like, because we know what 'poor' looks like. Because we've got to rate and you can't rate something unless you know what 'good' and 'outstanding' looks like. I think this is to the point about we are no longer just a regulator assessing compliance with minimum standards, we've got a job to rate what good and outstanding is. (England, regulator, P4)

In Australia, most providers pass the process-focused accreditation standards, meaning that is almost impossible to identify which providers are good quality. This is a problem which was openly acknowledged in the 'Let's Talk about Quality' consultation document which the Agency published at the end of 2015 to launch its work on the Quality Framework. As the document explains, nearly all providers of residential care now meet all the Standards with only one per cent of homes failing any standards and asks:

So does that mean our aged care services can be described as being of high quality? Inevitably, the answer to this question is... 'it's hard to say'. Complying with standards whilst essential does not guarantee high quality. (Australian Aged Care Quality Agency, 2015, p13)

Government officials in Australia acknowledged that the standards and current level of reporting fall short in supporting consumer choice, with the compliance system of pass or fail presenting particular issues.

A bigger challenge with using accreditation reports in the new consumer-directed environment in Australia stems from the fact that they do not include commentary on anything over and above whether the provider is compliant with the accreditation standard:

P: That's right so, in terms of differentiating performance ... I mean, because our system is about pass and fail or met, strictly speaking, met and unmet there's no need or incentive for the assessors to comment about, you know, superior performance and excellence and those sorts of things. And so that's not reflected in the accreditation system, it's not reflected in accreditation reports, it's not really reflected anywhere. And so the consumer is blind to variations in performance unless they drop beyond, you know, into the unmet category. (Australia, government, P2)

The idea of official ratings for the sector has been floated on multiple occasions in reports on residential aged care in Australia: first in the Hogan Report (Hogan, 2004); in the Campbell Report (Commonwealth of Australia, 2007); in the

Productivity Commission report⁵ (Productivity Commission, 2011); and, most recently, in the first review of the incidents at Oakden by Carnell and Paterson (Carnell and Paterson, 2017). However, there has been resistance to ratings historically, partly from the Accreditation Agency itself. Similarly, a government official expressed some reservations about official ratings due to the 'purely subjective' nature of quality (Australia, Government, P3). This theme was consistent in many of the interviews in Australia - as reported in Chapter 6, there is a widely held view that it is not possible to have a definition of quality which meets everyone's needs and preferences, and therefore it is impossible to construct a reliable system of ratings.

Differences in how 'quality' is defined and reported in each country were partly exposed by the difficult process of sampling providers to interview for this study. The objective was to identify providers who strive to go over and above minimum standards in each country. Identifying the good providers in Australia is, as the head of one industry association and proponent of CDC admitted, apparently without irony, that the process of finding a home was 'breathlessly impossible' and 'unbelievably difficult', after the challenges he encountered when looking for a nursing home place for a parent (Australia, industry association, P4).

Even so, examples in the interviews and visits to providers suggested that there is just as many differences in provider quality in Australia as in England, even though the high rate of accreditation may suggest higher standards. Identifying providers who pass the Accreditation Standards is largely meaningless because the Standards are rarely failed, as an interview with representatives from a different industry association suggested:

LT: And given that the accreditation process is pass or fail, what's the evidence that says that they're high quality?

P7: Oh, based on the fact that they generally would all meet forty-four outcomes, standards outcomes.

LT: Right. How do you differentiate if everybody passes? Is it 95% now pass all of the standards?

P7: Near enough. Something like that.

⁵ Ironically the Productivity Commission report recommended that a ratings system be designed based on the CSCI star ratings which had been - almost concurrently - thrown out by the incoming Coalition Government in England in 2010.

LT: So how do you differentiate between ...?

P5: Ah, you can't.

P7: It's hard. (Australia, industry association, P5/P7)

In Australia, Department of Health officials, both in the national and state offices, were unwilling to identify providers as high or low performing, even though the state office gathers information from several different sources, including accreditation, complaints and ACFI audits, and regards itself as having a day-to-day working knowledge of what is going on in provider organisations. In the absence of meaningful data, people used several signals to identify high-quality providers and these were reflected in advice on the recruitment and sampling of providers for this study. At the State branch of the Department, a participant suggested 'providers that are providing projects outside their expectation' or which 'pick up services that are falling and [...] who have arms extended towards regional, rural'. (Australia, government, P3). A Department of Health official commented on how they regarded high quality providers as the organisations which are most innovative (Australia, government, P2). Suggestions from the Department and from the Quality Agency on how to identify good providers focused on identifying providers who had ever won a Better Practice Award, even though awards often apply only to specific programmes or therapies.

In England, the availability of CQC ratings meant that this process of identifying good providers was relatively straightforward, although their use involves making assumptions about the objectivity and reliability of ratings. In Australia, the challenge of identifying 'good' providers for this study was formidable, and the sampling process was in itself instructive.

Acknowledging and highlighting poor care

As the section above shows, the extent to which poor care is acknowledged in each system is very different. In England, not only are issues regarding provider quality raised at the individual levels, but systemic issues are also highlighted in several ways. As part of its legislative duties, the CQC is tasked with publishing an annual State of Care report. The report sets out the quality performance of health and social care providers at a system level. The CQC also publishes periodic themed reports such as 'Cracks in the Pathway', a report which drew attention to the

difficulties experienced by people moving between hospitals and care homes (CQC, 2014a).

More informally, examples of both good and poor care are also discussed on the CQC's website, for example, through a blog by Andrea Sutcliffe, the Chief Inspector of Social Care. For example, a post in February 2016 focused on cases of assault and neglect being prosecuted in court, and the first conviction for corporate manslaughter relating to a care home (Sutcliffe, 2016). By the same token, however, a benefit of the re-introduction of the ratings is that it can also draw positive attention to improvements and good practice in care provision, something which is often neglected:

P: ...if you took what gets reported in the media, you'd have a pretty jaundiced view about the quality of care in general. I mean, all the evidence suggests that things are improving and have been improving, and when we get the quality ratings back in place we'll have the evidence that supports that general proposition that things are getting better all the time. (England, industry association, P5)

Some concerns were shared about the implementation of the ratings in England and, in particular, 'requires improvement' and 'inadequate' standards and it is important to acknowledge the potentially deleterious effects of poor ratings. Some provider participants in England talked about the danger of using a snapshot of the provider to make an assessment, when care standards can slip - or improve - so rapidly, especially with leadership changes in the organisation. For poor providers, the danger of an 'inadequate' rating, or even 'requires improvement' was explained by one local authority participant as a self-fulfilling prophecy: once a provider is labelled as inadequate, staff start to leave, and no new residents enter the home and the home quickly goes downhill:

P: It's not just about quality and one of the issues with quality in the care sector is that there's a very real impact of CQC inspection. If CQC goes and inspects somewhere and rates it as 'inadequate', unless swift action is taken that organisation can spiral very quickly downwards and go out of business. (England, government, P1)

In contrast, in Australia, apart from the very small number of providers who are sanctioned, poor care is only discussed openly when exposed by media coverage. As the previous section explained, the reports from the accreditation visits only describe whether the providers complied with each of the process-based accreditation standards. It emerged during the study that there are two separate reports prepared by the Quality Agency. The first is the 'real' report supplied by the

reviewer team. The report which appears on the website however, is one which has anything controversial in terms of comments stripped out. One government participant commented on how a provider who had passed accreditation could simultaneously be under investigation for multiple complaints, a situation which calls for requesting the ‘real’, detailed report from the Quality Agency.

The inclusion of negative information in the reports in Australia is limited by the legislation in the Aged Care Act 1997 limiting information disclosure (see above). The lack of negative information in the accreditation reports means that they are largely toothless when it comes to addressing poor behaviour and certainly lack relevance for alerting consumers to poor quality:

P: I’d have better information so that it actually makes those organisations, through naming and shaming, so that no one will want to go. But if they saw the *real* report, the *real* picture would they want to go there? (Australia, consultant, P1)

7.3 Quality improvement pathway

The aim of the final section of this chapter’s findings is to assess the rationale behind the publication of information in each country, using the theory developed by Berwick and colleagues (2003) that the use of information is linked to quality improvement either through ‘activation’ or ‘selection’. The interviews showed that the overarching goal for the quality information under development in Australia is to enable consumer choice and ‘selection’. In England, the goals are more nuanced. The challenges facing residents and their families were seen as the limiting factor for using selection as an improvement pathway by a Department of Health official in England:

P: But in theory, if this was a kind of like a proper market, then that user part of it would be really important, because that’s what’s gonna drive quality [...] People aren’t able to make those sorts of choices, as you know. How do you do it? I mean, if you’ve got a parent who’s got dementia and they need to go into care, who’s making the choice? It’s you. Not them. Or it’s you and them. (England, government, P1)

While the stated focus of the CQC ratings in policy documents is on facilitating consumer choice (Department of Health, 2017c), interviews with CQC participants suggested that the ratings were intended to be a more direct influence on provider quality. The regulator observed that, while legislative measures were helpful for

providers not meeting basic standards, for providers who were better than this, 'softer' mechanisms like ratings had more potential:

P: The softer 'carrots' don't work down at the bottom. If they were going to work they'd have worked by now and this lot wouldn't have been at the bottom of the standard distribution. But as you move through a standard distribution you have softer measures, so promoting good practice, sharing good practice, putting people that are outstanding in touch with people that are good, to pull them through. The less legal, the less interventionist, will be much more about learning and improvement. (England, regulator, P4)

The regulator explained that the ratings are based on a 'push-pull' strategy: poorly performing providers are 'pushed' to improve their ratings due to effects of *Inadequate* and *Requires Improvement* ratings on their businesses. At the other end of the scale, the top-performing providers 'pull' up the overall quality of providers in the sector by appealing to the intrinsic motivation of other providers to compete for reputational and competitive advantage.

Previously, research into CSCI's star ratings (the predecessor to the CQC) showed that they were much more likely to be consulted for 'selection' purposes by local authority staff than residents or their families (CSCI, 2009a). Instead, the CSCI found that the response of providers to the ratings was driven by other factors which are related to the concept of activation. Providers realised that the ratings gave them some leverage for negotiating rates with local authorities, and some providers also used the ratings for internal performance management:

P: ...some of the big providers put the achievement of particular ratings into their managers' performance contracts, so they saw the quality ratings as a way in which they could lever quality in their organisation and had it as a quality system. Which was an unexpected development. We felt it was about information for the public (England, regulator, P7)

On one hand, the regulator acknowledges that it is not possible to improve quality solely by inspection – this is firmly the responsibility of the provider:

P: [...] I don't think you can regulate quality into services. I think the only thing you can do in regulation is check that quality is there in services and describe it. The people that put quality into services are providers, commissioners and professionals. (England, Regulator, P4)

At the same time, the regulator is in a unique position to identify where quality exists, and to highlight this for providers, as well as commissioners and other

professionals, to undertake quality improvement activities. As one participant in England put it:

P: I think the role of the CQC is to mandate adequacy and shine a light on excellence. I don't think it's their job – so I think the job of a regulator can't be to mandate greatness. (England, local government, P3)

In Australia, the message which underpins the work around the Quality Framework is the need to provide information to support a fully functioning market in aged care:

P: ... To me what we're doing, is all aged care policy is about, is creating a consumer driven market-based system. [...] So we're developing quality indicators so they can differentiate quality through quality indicators.[...] We may be able to differentiate quality better by considering the accreditation ratings and not just having pass/fail, you can differentiate. So all of a sudden, consumers have more improved information on which to make choices. (Australia, government, P2)

The theme which came through in almost every interview in Australia is the drive to implement a 'consumer-driven, market-based system' (Australia, government, P2). Safety is a 'given' but 'quality above that seems to be contingent on consumer choice'. The development of quality indicators is heavily geared towards the provision of information for consumers to make choices about providers, as part of the selection pathway.

The main tenet underpinning the LLLB reforms was that consumers could expect to make higher contributions towards their care but would be able to choose their own provider. This was referred to many times in the interviews, for example:

P: ...the very explicit quid pro quo when the reforms were announced in 2012 was, if consumers are going to pay more, then they deserve more choice to go with it. And that was a very explicit sort of deal struck I guess between the government at the time and the consumer representative organisations. (Australia, government, P1)

Despite this, an important gap in the process is the education of consumers, or the development of 'consumer literacy' (Australia, government, P8) to be able to not only use and interpret this information, but also to have 'conversations' with providers about issues of quality, for example, about what actions the provider was taking to reduce, say pressure sores in either the person's relative, or more generally. An industry association representative explained how they viewed consumer education as an area on which the government had failed to deliver. The only government support for consumer education has been made available through

COTA, but as one participant said, the support for consumers has fallen way short of the support for provider organisations:

P: ...there's almost been no support to the consumer in this reform process. [...] you should be funding them, that whole sector, with education, information, in all sorts of forms. [...] In order to make sure, as you say, when it comes to them having to make a decision about quality of care or what they should be looking for, they actually are informed. (Australia, users and carers, P1)

However, only two participants in Australia spoke at any length about the problems consumers might encounter in using information about quality in aged care. One participant in an industry association was concerned about how lay people would be able to interpret the quality indicators as this would inevitably require an understanding of case mix of each provider's resident population. Another participant, from a user and carer group, spoke about how being a consumer in the aged care sector was not like being a consumer in other markets:

P: You know, by the time someone reaches a nursing home, they're extraordinarily frail, they may have dementia, they may not. There may be family issues. There are so many ... There's so much stuff going on. It's not like you're going out and buying a fridge and you can just go to Harvey Norman or Good Guys [well-known electrical retailers in Australia], or whatever, and choose. (Australia, Users and Carers, P2)

At the same time, there is concern outside the sector that the 'average' person, whether it is the person themselves, a guardian or a professional such as a lawyer, may not have the knowledge and skills to make decisions about care providers, as 'they don't know what they don't know' (Office of the Public Advocate (Queensland), Undated, p2). The recent investigation by the Australian Law Reform Commission (2016) into elder abuse commented that the introduction of more choice, flexibility and control may also expose older people to 'new risks' (p39).

7.4 Conclusion

The goal of this chapter has been to examine how information on quality is used by governments to influence quality improvement. The interviews exposed differences between the approaches of the two countries, in how responsibilities for information are organised; the characteristics of reporting in each country; and the rationale behind each government's use of quality information.

Despite the emphasis on consumers driving better quality in Australia, there is less information available on differences in provider quality. MyAgedCare includes

information on the prices charged by providers and will eventually include quality indicators. However, in Australia, the only government-produced information is on whether the provider is compliant with the accreditation standards. There is arguably more information available to consumers in England because of the use of the CQC rating, especially as there is a legal requirement for providers to display their ratings both at their location and on their organisation's website. Highlighting poor quality is also a statutory requirement of the CQC, both at the provider and the system level, for example, through the annual State of Care report. Information signalling quality is impossible to find in Australia, as demonstrated by the problems encountered in the sampling of providers for this study. Knowing that a provider has passed accreditation is also largely unhelpful, given that less than one per cent of providers fail their accreditation review (Australian Aged Care Quality Agency, 2015). The sector, supported by the Quality Agency in its previous incarnation, has resisted any use of official ratings even though they have been consistently recommended in successive inquiries into the sector.

Despite these issues, the priority of the Australian government is to enable the selection pathway with the provision of information to consumers. There is also a greater focus on incentivising quality improvement through the choices of empowered 'baby boomer' consumers. To support this, the Australian government is looking to providers and consumers to be the main drivers of information on quality, rather than take a lead role itself in gathering and publishing information on differences in quality. One of the principles of the new Quality Framework is that the government will turn to providers and consumers to voluntarily generate quality information through the quality indicators project and via the MyAgedCare website. The interviews highlighted a common view in Australia that quality information from providers and consumers could facilitate a move towards earned autonomy and lighter touch regulation.

In England, the strategy is more nuanced, with both activation and selection seen as pathways for improvement. Publishing ratings is positioned in policy documents as a strategy to support choice of provider in England, but interviews with participants at the regulator identified an intent to influence provider behaviour more directly through the activation pathway. From the CQC's point of view, the use of the ratings forms a strategy which attempts to appeal to the intrinsic motivation of providers –

by appealing to providers trying to protect or improve their reputation in terms of quality.

There is therefore some dissonance between the intentions and actions of each government regarding quality information. In England, the onus is on the activation pathway and appealing to the intrinsic motivation of providers, whereas in Australia, the focus is on consumer choice and the selection pathway. Conversely however, the government in England takes a much more active role in gathering and publishing information than the government in Australia and publishes information which is much richer as it attempts to communicate the lived experience of the resident and it is far more enlightening in terms of signalling different quality performance and drawing attention to poor care at both a provider and a system level.

8 The effects of government quality policies on provider quality behaviour

The previous two chapters have identified a range of possible links between policy interventions and how quality is understood in the sector, and how quality information is used within regulatory regimes. However, the most important question is arguably whether the efforts of either government have a tangible impact on provider behaviour. This chapter reports the findings of the interviews with provider organisations and explores the relationship between external interventions and provider approaches to quality improvement.

This chapter first reports on how the government interventions in each country are linked to different types of quality behaviours in provider organisations. Four policy interventions were identified as having an impact on different types of quality, namely, regulation, funding mechanisms, consumer choice policies, and ratings. The chapter will then argue that the most influential factor for relationship-centred quality in both countries was the intrinsic motivation of individuals working in care homes at all levels to provide a better quality of life for their residents. Taking this into account, the final section of the chapter draws on the interviews with industry associations about the potential opportunities to help providers with quality improvement. The final part of the chapter then examines the other tools which could be used by governments to encourage providers to embark on systemic quality improvement.

8.1 Providers in the study

Five provider organisations were identified in each country. The characteristics of the providers are included in Table 8.1.

Table 8.1 Characteristics of the Provider Organisations

ENGLAND	Silver Birches	Chestnut	Hawthorn	Poplar	Maple
Ownership	Not-for-profit	For-profit	For-profit	Not-for-profit	For-profit
No. of homes	11-20	50+	6-10	20-49	20-49
Home(s) visited in study	Residential	Residential/nursing	Residential/nursing	Residential	Residential/nursing
Local context	Village/rural	Suburban	Rural	Suburban	Suburban
Environment and feel	Converted Victorian home	Purpose-built, modern	Purpose-built, homely	Converted Victorian home, slightly dilapidated	Purpose-built, modern
Interviews	<ul style="list-style-type: none"> • Operations Director • Care Home Manager 	<ul style="list-style-type: none"> • Care Home Manager 	<ul style="list-style-type: none"> • Chief Executive • Operations Director • Senior Manager (shared services) 	<ul style="list-style-type: none"> • Care Home Manager 	<ul style="list-style-type: none"> • Operations Director • Quality Manager

AUSTRALIA	Acacia	Waratah	Eucalyptus	Banksia	Hibiscus
Ownership	Not-for-profit	For-profit	Not-for-profit	For-profit	Not-for-profit
No. of homes	1-5	6-10	11-20	50+	6-10
Home(s) visited in study	Residential	Residential/nursing	Residential/nursing	Nursing	Residential
Local context	Rural	Suburban	Suburban	Suburban	Suburban
Environment and feel	Large estate with a number of services	Purpose-built, modern	Large estate with a number of services	Large estate with a number of services	Large estate with a number of services
Interviews	<ul style="list-style-type: none"> • Chief Executive • Operations Director • Quality Manager & Senior Manager (shared services) 	<ul style="list-style-type: none"> • Chief Executive • Senior Manager (shared services) • Care Home Manager 	<ul style="list-style-type: none"> • Senior Manager (shared services) • Quality Manager • Care Home Manager 	<ul style="list-style-type: none"> • Chief Executive • Care Home Manager • Operations Director 	<ul style="list-style-type: none"> • Operations Director

A mix of FP and NFP providers was sampled for each country. The providers varied in other ways. The three voluntary sector providers in Australia could be labelled as ‘ageing in place’ models, in its Australian interpretation. All three were on large estates and provided different care services in different settings in the same location, including residential care and independent living units where community-based care was made available. These ‘ageing-in-place’ locations included services such as community pharmacies and GP surgeries. The other two providers in Australia were FP chains (one large, one medium) and the homes I visited were primarily occupied by people with complex health needs, including dementia. In England, two providers, one FP, one NFP, offered a handful of independent living units but for one of the providers this was a legacy from an existing arrangement; for the other it was a previous model which they had subsequently had to cease due to property and land prices.

There were some issues with the recruitment of the provider sample, as discussed in Chapter 4. These issues included the challenges of recruiting providers from a single geographical location in England, problems with stratifying the sample according to size of provider, and also the issues with identifying ‘good’ providers in Australia (as discussed in Chapter 7). The use of quality performance as a criterion for selection was problematic in Australia since almost all providers pass accreditation and there is no other form of rating for signalling quality. In the final sample, there were two providers in Australia which appeared, at least from my visits, to be providing a lower level of quality when compared to the other providers in the study in both Australia and England.

In addition, in England, there has been a recent trend (reported in Chapter 2) in providers exiting the market for local authority-funded residents due to the stagnation in rates. Effectively the only way many providers see they can carry on delivering quality is by exclusively accepting higher fee-paying clients. In England, four out of the five providers in the sample had stopped accepting local-authority-funded residents, something which only became clear once the interviews were underway. Where local authority-funded residents lived in these four homes, they were ‘wealth-depleters’, residents who had depleted their wealth and assets and were now relying on local authority funds. All four of these providers would only continue to support wealth-depleters if their relatives were prepared to pay top-up payments to make up the difference between the local authority and the self-funder

rate. In Australia, providers are obliged to take a certain number of low means residents, otherwise they are paid reduced rates of accommodation supplements (as explained in more detail in Chapter 2). Including homes in the study in Australia which were obliged to accept both RAD/DAP-paying and low means residents might explain the more visible polarisation between standards of accommodation within individual properties and facilities than in England, where providers can simply decide not to accept local authority-funded clients.

A number of observations should be made about the quality of accommodation in each country. In both countries, the sample included providers who were running homes which emulated many characteristics of hotel-like accommodation. These features included reception desks at the entrances, high quality decoration and furnishings, restaurant service and menus and touches like fresh flowers. In England, this standard of accommodation was the preserve of providers exclusively supporting self-funders. In Australia, there were differences between and within homes belonging to the same provider, especially where provider differentiated between the standard of accommodation available to RAD/DAP-funded residents and 'low means' residents.

These differences between the quality of care providers dependent on the fees and clients they attract, or 'two tiers of care' has previously been highlighted in research. Research suggests that more expensive providers in England are more responsive to quality, and paying higher prices is normally the preserve of self-funders rather than local authority commissioners (Forder and Allan, 2014). In the US too, this phenomenon has also been observed, with Grabowski et al. (2014) establishing that nursing homes which adopt culture change tend to have fewer publicly-funded residents. Similarly, Clement et al. (2012) found that nursing homes with more private paying residents were more likely to improve quality, but also more likely to increase their charges to private payers to fund these improvements, safe in the knowledge that long-term residents are unlikely to change providers. Mor et al. (2004) observed that the nursing homes that serve predominantly Medicaid residents generally tend to have fewer nurses, lower occupancy rates, and more health-related quality issues.

8.2 Links between government policies and provider approaches to quality

The following section addresses the question of how formal government policies are linked to changing provider quality behaviour. The findings suggest that these external interventions can incentivise quality improvement, but that the type of quality improvement tends to be limited to quality assurance and ‘spotty’ quality improvement, rather than the systemic quality improvement which would be needed for relationship-centred quality. The links between regulatory policy and relationship-centred care are much weaker and appeared to be more associated with the intrinsic motivation of provider managers and staff. However, there are still opportunities for governments to influence this type of quality. Following this section, the chapter covers some of these policy ideas in more detail.

Regulation and quality improvement

As reported in Chapter 1 and reiterated in the interviews with other stakeholders in this study, it is widely acknowledged that inspection and accreditation in each country have generally improved the minimum standards of quality in the sector. All the providers in the study agreed with this view. At the same time, there was agreement that, in quality terms, the main impact of the core activities of inspection and accreditation is linked only to basic quality assurance activity, and not to more sophisticated forms of quality improvement. The possible exception to this is where ratings are used to signal inspection findings, a subject covered later in the chapter.

In Australia, the focus of the accreditation system on processes also restricts the system to the achievement of minimum standards only. Even though ‘continuous improvement’ is included in each of the four domains of the Accreditation Standards, the test for the accreditation reviewer for this standard is merely whether a provider has a process in place for continuous improvement, rather than how effective the process is in terms of the outcomes for residents. While all providers in the study in Australia used logs and processes to document ‘continuous improvement’ activity to be highlighted for accreditation reviews, providers ‘operationalised’ this continuous improvement standard in different ways. For the best providers, continuous improvement logs reflected quality activity which would be underway regardless of whether accreditation was in place.

However, for two providers in Australia, quality improvement activity resembled what John Braithwaite and colleagues have referred to as ‘continuous improvement ritualism’, that is, ‘the ritual of achieving outputs to demonstrate continuous improvement but not on the underlying system that produces better outcomes for quality and care of residents’ (Braithwaite et al., 2007, p208). The interviews suggested that, for these providers, the logging of continuous improvement actions was more geared towards satisfying the accreditation process than driven by a mission to improve quality in the organisation. When speaking about quality, these two providers focused on the documentation and management of quality improvement processes, rather than how quality improvement activities served to improve the lives of their residents and staff at a systemic level.

For these providers, ensuring that the subject of quality was discussed in meetings took on more importance than the act of improving quality itself. For example, the continuous improvement log of one of these providers focused on mostly technical or ‘spotty’ quality improvements, rather than on addressing systemic issues that could significantly enhance the quality of life of residents. Examples of these improvements included changing the types of trays used for mealtimes, organising re-painting and resolving issues with air conditioning. Other quality improvement activity was focused on improving the efficiency of the organisation, rather than on meeting the needs of residents. One of the providers explained how they had recently improved their shift handover processes. Handovers play an important part in enabling continuity of care and reducing the risks of omitting important care processes or identifying where a resident’s condition has deteriorated (Moriarty et al., 2017). However, the purpose of the improvement for this provider was purely on internal efficiency, and in part driven by a reliance on agency staff who were not familiar with residents, rather than being linked to an explicit desire to improve the quality of life of residents through a more resident-centred handover process:

P: And then these are care ones that we’ve recently done, so we’ve redone our handover sheets to be more comprehensive. So there was a need that when we have agency staff or casual RNs [Registered Nurses] that are coming that don’t know the residents very well, we needed a lot more information on those handovers about the residents. We’ve just done all that and that’s been really positively taken on board. It really cuts down the time it takes for handover and especially if you’re orientating a new person in as well. (Care Home Manager, Waratah, Australia)

This does not mean that all Australian providers concentrate exclusively on organisation-focused quality, even though the Accreditation Standards are heavily process-focused. The behaviours of the best providers transcend the policy activities of either government, as discussed later in this chapter. But in both countries, the standards can unfortunately lead to an unnecessary focus on paperwork and bureaucracy. The leading Australian provider in the study explained how the priority often placed on documenting resident preferences can be misguided and can displace what is needed to achieve a feeling of ‘normal’ life in residential care. The interviewee gave the example of documenting preferences for tea or coffee:

P: Accreditation, we’ve had discussions, one of my favourites was around food preferences and they wanted to see the list that we had of what tea and coffee people have. I said ‘oh, we don’t have a list.’ And they said ‘oh, but you need to be able to demonstrate whether people like tea or coffee.’ And I said, ‘no we actually don’t have to demonstrate that. What I have to do is demonstrate that that person has received what they’ve chosen. And they may choose coffee today but they may choose tea tomorrow. Once I have a list, I’m actually removing that daily choice.’ ‘Oh, but what if you have a casual staff member?’ I said, ‘yeah, same rule applies, ‘would you like a tea or a coffee?’’. It’s not hard. (Operations Director, Hibiscus, Australia)

Therefore, despite ‘continuous improvement’ being a feature of the accreditation standards in Australia, there was no evidence to suggest that this in itself motivated systemic quality improvement, with one senior manager commenting on how ‘true quality’ was not linked to the accreditation system:

LT: The other, the most important question I should ask you is about accreditation and whether that hinders or supports your approach to quality?

P: ...look I think it needs to be set in context I think it’s a compliance system, not a quality system. So it’s establishing a base line. [...] So once you accept that it’s working as a minimum compliance type of system, the issue it then becomes is there is nothing that’s actually, from a government perspective, encouraging innovation and development. And true quality. And that’s really having to come from the providers. (Operations Director, Banksia, Australia)

For providers in both countries who claimed and appeared to be delivering relationship-centred care, inspection and accreditation activity was important but not central to the provision of excellent care. Where the improvements met the requirements of the regulator, this was a positive outcome, but not seen as the be-all and end-all. Instead, these ‘real’ quality improvements were being driven day-in,

day-out, by the needs of residents and families. As this provider in England explained:

LT: So, to what extent does it [the CQC] improve your quality and to what extent is it a distraction?

P: Okay. Does it improve our quality? I don't believe it does. I believe we improve our own quality and we do not do things for CQC. We do things because they enhance the well-being of the residents who live with us. [...] we need to comply with the regulations, that's a responsibility that we have, but we don't do things just because it's says in the CQC regulations, we look at, okay what are we doing and can we make sure that the residents' lived experience is a positive one? And isn't that wonderful that it happens to dovetail with what CQC are looking for. (Operations Director, Maple, England)

This view was reflected in interviews with the wider sample, including representatives of the CQC. There was a strong view that 'true', that is systemic, quality improvement has to be led internally by providers.

Similarly, a participant in Australia (Hibiscus, Operations Director) explained that the key to managing the accreditation process was 'to know the regulations better than the regulator', and that ultimately the activities of the provider in relation to quality were driven by outcomes for their residents, rather than the requirements of the Quality Agency. In contrast, all providers in England saw process quality as important but as only one of multiple aspects of good quality. This difference should be treated with caution, however, as the Provider Samples varied between the two countries.

Something that was common to nine of the ten providers in the study was the use of specific teams to manage quality assurance and learning and development. Apart from one provider in Australia (Waratah), every provider had dedicated staff whose responsibility was quality and compliance activity. All the providers in the study were medium or large organisations, so are more likely to have the economies of scale to run shared services, such as quality assurance teams. A common responsibility of these teams was to conduct internal quality audits and set priorities for clinical and technical improvements, and usually the primary role was to ensure that homes were always ready to pass inspection or accreditation. There was some scepticism among local managers that these quality audits contributed to better quality, although all accepted that they were useful for ensuring that their processes and policies were adequate and up-to-date. At the same time, two providers (one in each country) did see additional value in inspection and accreditation activity, seeing the standards as providing a useful framework for checking that quality

improvement activities were spread sufficiently across all aspects of running the home, at least to the extent of the areas reviewed by the inspectors or accreditation teams. This was a view expressed by providers in both England and Australia, for example, as the following provider explained:

P: And also it might be that perhaps we're looking at all in one area of the service and there is a part of the service that's not having any improvement undertaken and so it gives us an opportunity to look back and think, okay, well we're not actually having any improvement in say Standard 1. (Care Home Manager, Eucalyptus, Australia)

A theme which came up with all providers in both countries was the inconsistency of inspectors and reviewers and outcomes. Providers in both countries commented on the variation in the size of inspection and accreditation teams, the length and depth of each visit, the skills and experience of the CQC and Quality Agency staff, and in England, variation in the style of inspection reports. Some inspectors in England were much more interested in process documentation and care plans, others were more likely to spend time 'out' in the homes with residents and staff. Variation in inspection and accreditation was frequently mentioned by providers in both countries and should be remembered when considering future development of regulatory activity for quality improvement. For providers in England, this inconsistency was also problematic as it increases the subjective nature of inspector ratings, a pressing issue because of the deleterious effects poor ratings might have on occupancy and profitability.

Providers in England were also specifically concerned about how inspectors were not always as knowledgeable as they would expect to be about people living with dementia. For example, the following provider explained how inspectors did not always understand the balance between risk and quality of life, and prioritised safety and risk minimisation:

R: Depending on that person's experience, especially when you are talking about homes where we've got a lot of people living with dementia. We will see some distress, we will hear someone calling out, we will see all of that. Now, some inspectors, view that as negative and don't understand actually that it's probably a good sign that you've not got everyone in bed in their rooms, sedated. And that actually it's good that you've got people moving around, but because people do lack that knowledge ... (Group Interview, Hawthorn, England)

Funding and quality improvement

Chapter 6 highlighted some of the issues about how the ACFI funding mechanism drives certain unintended consequences and quality behaviours among providers in Australia. Some of the examples included how the ACFI incentivises the supply of excess care to individuals and how it does not reward rehabilitation and reablement. There have been accusations that providers ‘game’ the system to maximise their ACFI revenue. For one provider in this study, staffing was a precise science to be managed using ACFI data. The profitability of the business, the Chief Executive’s stated main priority, was key and supplanted all other goals, including quality. There were numerous comments about ‘ACFI optimisation’ and also ‘uplifting’ to claim extra funding. One provider shared a similar view to those reported by interviewees in Chapter 6, in that the ACFI contained built-in disincentives to invest in rehabilitation or reablement, or to focus on improved quality of life. The lack of consistency between the views of the providers and the views of policymakers could be for a number of reasons, for example, the fact that the sample was focused on better quality providers, or even an unwillingness to acknowledge to an external researcher that the ACFI resulted in negative behaviours. There were sufficient examples in the interviews with the General Sample to suggest that the perceived problems with the ACFI and unintended consequences are real, even though some of the participants in Australia argued that the ACFI was simply a vehicle for calculating and securing appropriate funding from the government.

Choice and quality improvement

The findings reported in Chapter 6 regarding the relationship between funding and consumer-directed quality were borne out by the provider interviews, including increasing the focus on the needs and preferences of family members, possibly at the expense of the needs and preferences of the resident. The overarching issue with markets and funding is their ‘regulatory clout’, that is, that they may form more powerful incentives for behavioural change by providers than inspection or accreditation activity. The ‘quality improvement’ which then ensues is likely to be more focused on consumer-directed quality and the tangible features of the service, rather than on quality that is relationship-centred. The interviews highlighted three types of activity which were implicitly linked to attracting consumers: *approaches to environmental design*, *the formal packaging of activities and services* and *the use of resident feedback*.

Approaches to environmental design

The ‘Triple H Dilemma’ described in Chapter 6 helps to explain the most visible impact of consumer-directed quality, that is, the phenomenon of accommodation resembling luxury hotels. The quality of the environments in the study varied greatly, and at the most expensive end, many aspects of homes resembled upmarket hotels. One provider in England was about to embark on a renovation, to update the home. The current home was in relatively good condition, but the provider had decided that it needed updating to appeal to the relatives of potential residents:

LT: So, you were telling me about [your] refurbishment. How does that ... what triggers the priority, if you like, why did that become a priority here?

P: It becomes a priority when you look at what state the home's in. [...] It's one of our older homes. [...] And whilst our residents love, perhaps, potentially a shabby chic look, their sons and daughters don't, they want something that's a bit more 'in the moment' for mum or dad. So, we're trying to create that homely environment that's a little bit lighter and brighter. (Operations Director, Maple, England)

The phenomenon of providers designing environments to attract family members, rather than the residents themselves, was present in both countries. This focus on the needs and preferences of the families was seen as an explanation for the luxurious design features of many homes. In fact, many of them were decorated and furnished in ways which were often unsuited to supporting people who were living with dementia¹, for example, isolated rooms, bright white bathrooms and softly-lit dining rooms. The ‘hotel’ approach extended to how food and dining were arranged, with the high-end homes having features such as printed menus and silver service in their dining rooms. Several participants in both countries commented on how this heightened interest from relatives, and particularly adult children, in aspects of quality, was often driven by the guilt they felt at placing their family member in a home. Even so, participants acknowledged that the quality of the environment and quality of life did not go hand in hand:

P: And that's [good quality] just not whether you've got five-star accommodation or three-star accommodation because ultimately what we've found is that you can have a beautiful facility but very inadequate care and it's not a nice place to be. (Operations Director, Banksia, Australia)

A theme in both countries was the emergence of two tiers of provision for different socio-economic groups, effectively driving two different levels of quality in the sector. In England, as reported earlier in this chapter, four out of the five provider

¹ See, for example, Bowes et al., 2016

organisations had stopped accepting local authority-funded residents and were also setting rules about how they would treat ‘wealth-depleters’. In doing so, it demonstrates a shift to the better quality – or at least, more expensive – homes being available only for those with sufficient funds.

In Australia, approved providers are obliged to take low means residents as a condition of certain levels of government funding. It became clear during this study that each of the provider organisations in Australia took different approaches to the resident experience for low means residents. The quality which is expected for all residents, regardless of funding source, focuses only on the quality of care processes detailed in the Accreditation Standards. An area which is not governed is the standard of accommodation, and the differences in the standards of accommodation between low means residents and RAD/DAP-paying residents were particularly visible during the study visits in three of the provider organisations (two FP and one NFP). In these providers, RAD/DAP-paying residents generally lived in single rooms while many low means residents shared rooms of up to four people. These shared rooms resembled small hospital wards rather than homelike bedrooms. Shared rooms are rarely seen in England except for, for example, married or cohabiting couples, but the guidelines in Australia allow providers to accommodate low means residents at an average of 1.5 residents per room (Productivity Commission, 2011). This situation was not seen as unfair by these providers. One provider commented that low means residents were likely to have lower expectations regarding accommodation. The participant likened the situation to being able to afford different classes on an airline:

P: Some people are lucky, get on a jumbo jet and turn left, most of us turn right and sit down the back. [...] So yeah, some people will choose and have the means to sit up in first. But if it's the government paying for your seat that you're not surprised if you're down the back. (Senior Manager, Waratah, Australia)

The ability to charge RADs and DAPs for high care since 2014 has meant that many providers are now re-designing their environments so that they can attract wealthier residents, as this provider explained:

P: So nearly two years ago, July two years ago, the government changed that. So that people that were coming into high care paid bonds. So we were able to change the design of the high care unit to have twenty single rooms. Cos if I'm paying four or five hundred thousand dollars to come in, I want a room on my own. (Operations Director, Acacia, Australia)

At the same time, two providers in Australia, both NFP, said that they tried to deliver the same overall experience to all residents, regardless of funding, however it was not possible to verify this.

Formal packaging of services and therapies

For some providers, a focus on the consumer led to increased attention on the use of activities as a marketing tool. All the providers in the study provided formal therapies for their residents to enhance their physical and mental wellbeing, for example, music therapy and pet therapy, and these formal therapies should be treated separately from ‘activities’. However, for providers focused on the resident as a ‘consumer’ rather than an individual, the emphasis was on packaging these activities as formal services, rather than incorporating them as informal day-to-day interactions – an approach McCann (2013) has referred to as ‘cruise ship living’. Many providers are thinking about how to market their care to residents and relatives and the availability of formal activities and ‘activities coordinators’ (in England) and diversional therapists (in Australia) were central to this. For one provider in Australia, the formalisation of activities was illustrated by the past fad for ‘Snoezelen¹ rooms’. For the interviewee, it was much more important to provide a ‘normalised environment’ where care workers understood the needs of individuals rather than use tools such as Snoezelen rooms to ‘overstimulate you to the point of catatonia’ (Operations Director, Hibiscus, Australia). Similarly, a provider in England spoke about their concerns for the ‘Namaste Care’² programme, which requires moving residents to a prescribed location in the home, rather than give them care and attention in the place which works best for them.

Marketing and market research

The regulatory standards in both countries include a requirement to capture formal feedback for quality improvement and complaint handling. For some providers, the goal of collecting feedback is to improve quality, but very much with future marketing opportunities in mind. What differentiated the quality approaches of

¹ ‘Snoezelen’ is a multi-sensory environment for people living with dementia to stimulate primary senses through the use, for example, of lighting and tactile surfaces (Chung and Lai, 2002).

² ‘Namaste Care’ is a program for people living with the advanced stages of dementia who are unlikely to be engaged in other activities due to the effects of the disease (Simard, 2007).

organisations was the extent to which formal feedback (through surveys and complaints mechanisms) was prioritised over day-to-day, continuous, informal feedback from residents and relatives. One phenomenon for providers more focused on profitability was the use of formal feedback to drive ‘spotty’ quality improvement, for example, for improvements to the process for handling new resident enquiries.

Relative satisfaction surveys were important to providers to make sure that relatives recommended the home to others. On one level, this feedback is helpful for planning future improvements. For relationship-centred providers, formal feedback plays a less important role as understanding the feelings of families and friends of residents is be a normal part of their day-to-day interactions. These providers prioritised constant, ongoing feedback from day-to-day interactions in the home, taking a ‘bottom-up’ approach to quality improvement. They talked about the best ideas for quality improvement coming from their own residents. While formal market research was helpful for these providers to identify longer-term trends, they felt that the information did not contribute to the day-to-day business of improving the lives of residents.

Ratings and quality improvement

Chapter 7 reported how the regulator viewed the main purpose of the CQC ratings as appealing to the intrinsic motivation of providers to achieve higher ratings. It appears that the CQC ratings might have had an impact on quality behaviour which extends past the requirements of the minimum standards, and this is where some of the CQC’s ‘regulatory clout’ comes from. For example, for one provider in England, even the possibility of relatives consulting the CQC website meant that the ratings were important:

LT: You’ve done really well lately with the CQC ratings ... what does that mean to you?

P: Everything. And it means everything because it is an area where families go and look at. So, what do the, you know, what do the regulators say about this home? We don’t know if families are put off, if they look on the website and they see a ‘requires improvement’ but if I was looking and I had a list of care homes, it wouldn’t be my first care home to go, regardless of how old that report was, if that’s what they found on that particular day (Operations Director, Maple, England)

However, providers in England had nuanced views on the importance and benefits of achieving an ‘Outstanding’ rating, which in theory should be the lever for quality over and above minimum standards. Only one provider had received an overall

rating of Outstanding and felt that the ratings were not particularly important, especially as ratings only reflect the outcomes of ‘one day, one person’s view’ (Group Interview, Hawthorn, England). A theme through this interview was that the provider would be focused on outstanding quality regardless of whether the ratings existed. To this provider, being outstanding was not about structured processes or practices and better CQC ratings but flowed naturally from prioritising the quality of relationships and the quality of life of residents. Outside the interview one of the participants commented how ‘you either get it or you don’t’, when it comes to understanding relationship-centred quality. This view rang true as participants in this study who had not received outstanding ratings were not easily able to articulate what ‘Outstanding’ meant, as the following exchange demonstrates:

LT: ...what would you have to do to get outstanding?

P: I think it’s going the extra mile. Um, [pause]

LT: In what way?

P: [pause] In everything, I think. Everything that you do, I think has to be that you’ve just got that bit more to it than what other homes have got.

LT: [...] So, what would you have to do, what would it look like, what would you be doing for your residents that ...?

P: I don’t know. I think sometimes you know, that if they wanted a bar in the home or something, then put in different things or, you know, I don’t know. (Care Home Manager, Silver Birches, England)

Conversely, two provider interviewees commented how ‘outstanding’ ratings might be a curse, rather than a blessing, due to the pressure for providers to maintain their outstanding performance.

For some providers, the idea of an ‘Outstanding’ rating from the CQC is appealing - this is demonstrated by the phenomenon of independent training providers selling training courses in England on how to achieve better ratings. However, it is not clear whether these courses are attracting providers who need to improve the most. A care home manager commented on how one course she had attended was poorly attended by providers who might be struggling with quality and dominated by providers with better ratings. While the ratings may motivate good and competent providers to seek ways to improve further, those providers who lack basic skills or resources have more fundamental issues around their approach to quality improvement, for example, issues around leadership, skills and staff retention.

8.3 Additional support for providers to deliver relationship-centred care

The chapter has so far found some evidence that external interventions have had a generally positive effect on raising the minimum standards within the sector in both countries and in establishing quality assurance processes and responsibilities. This quality improvement has, however, been largely associated with addressing quality assurance and ‘spotty’ quality improvement. The evidence presented in Chapter 3 of this thesis suggests that prescriptive regulation is at odds with the behaviours required to deliver relationship-centred quality and this was reinforced by the interviews with providers. The question remains, then, of how governments can influence providers in the implementation of relationship-centred quality, and whether current regulatory efforts help or hinder this type of quality improvement.

The provider interviews painted a picture of how the culture and practices associated with delivering relationship-centred quality are entangled with the intrinsic motivation of the individuals involved in the organisation. There were aspects of relationship-centred practice described in the interviews which appear to be incompatible with rigid, prescriptive regulation, either because of the flexibility required to adapt to individual needs, or because certain ‘practices’ such as compassion are difficult to articulate in formal rules and regulations. The interviews uncovered five key aspects of provider behaviour which supported relationship-centred quality, and which were present in providers in both countries. These behaviours are briefly described in Table 8.2, in order to illustrate the difficulties with including these in regulatory standards and inspection activities.

Table 8.2 Relationship-centred provider behaviours

Behaviour	Description
The impact of leadership	<i>Interviews with and about leaders in relationship-centred organisations highlighted passion and energy around the quality of life of their residents.</i>
The organisation's mission	<i>The best providers communicated a strong sense of 'how we do things around here' and the ethos which guided the way they ran the homes.</i> <i>Two NFP providers in Australia also spoke about their 'mission' in the sense of its meaning as a vocation, to extend help to people who would otherwise not have access to it.</i>
How providers perceived residents	<i>The managers who were most vocal about relationship-centred care saw even the frailest residents as having distinct personalities, skills and experiences, and also spoke knowledgeably and affectionately about their residents.</i>
Staff roles and wellbeing	<i>Staff wellbeing was of paramount importance. Staff retention levels varied across the different provider organisations, but the organisations most focused on relationship-centred care reported staff turnover being low.</i> <i>Providers prioritised continuity and familiarity between care workers and residents. Part of this involved accepting that boundaries between work and life would be blurred.</i> <i>Providers spoke about the importance of more fluid and flexible roles in the homes where all staff were expected to spend time with residents and not just focus on their 'primary' role.</i>
Homelike environment	<i>Providing a homelike feeling was not just about the environmental design but about being relaxed about what happens in the home and a lack of structure around day-to-day activities, such as meals. This included flexibility and creativity about what others may regard as risks to the health and safety of their residents (for example, having kettles available or keeping pets and animals) or risks to corporate branding (for example, accepting messiness and untidiness where it reinforced the relaxed and homelike feeling of the environment).</i>

Overall, the interviews highlighted that delivering relationship-centred quality often requires careful negotiation of the regulatory processes. Providers in both countries remarked on aspects of inspection and accreditation which could restrict the provision of relationship-centred care, although providers in England said that the new CQC regulations were less restrictive and more focused on outcomes than the previous regulations. A provider in each country described how they, in some interactions with inspectors and reviewers, in effect 'went into battle' where they felt that the requirements of the inspector were not in line with relationship-centred

practices. The best providers believe that decisions should be made by front-line staff, even when these would be perceived by many providers as increasing risk. One provider gave the example of a staff member who realised why a resident was finding it difficult to sleep and took actions which in other providers could have triggered concerns about the level of physical contact:

P: They're great in that we had a gentleman come in here and he'd lived with his wife forty years, no, forty-five years they'd been married and he'd be very distressed in the evenings, we couldn't get him to want to settle, he didn't wanna go to sleep and one of our guys just thought, you know what, I need to lie in the bed and hold him, because that's what happens with his wife. Got on the bed, held him, five minutes, sleeping soundly, all night long. Other people would medicate. (Group Interview, Hawthorn, England)

While this is consistent with the principles of relationship-centred quality, it sits less well with a culture of inspection and accreditation. This example highlights the tensions between encouraging providers to take a pragmatic and caring approach and their responsibilities to manage risk and protect the safety of residents.

While one participant in England commented that staff are often cautious about perceived risks because of the safeguarding and 'best interests' legislation, this contrasts with a provider who explained the benefits of the legislation in enshrining real choice for residents in their everyday lives. Respect for the resident's wishes is a theme which came up more often in England than in Australia. One provider highlighted the Mental Capacity Act having been the largest influence on provider practice due to the radical shift from a focus on 'the nurse knows best' to giving more control to residents. This is an area which requires more research in terms of the impact the MCA has had on provider behaviour.

What was noteworthy about this type of quality is that it was neither generally seen as being connected with external interventions nor implemented with the goal of attracting new clients. The other striking feature was that relationship-centred quality largely transcended the national systems. Due to the small size of the sample, it is not possible to say whether relationship-centred quality is more prevalent in one country or the other. What can be said is that relationship-centred quality was observed and discussed in England and Australia, suggesting that it is largely independent of the regulatory systems and mainly stems from self-motivated provider behaviour.

The question is then, if policy interventions such as regulatory and funding mechanisms do not directly incentivise quality improvement, how do governments tap into the intrinsic motivation required for a focus on relationship-centred care. In the interviews with the providers, I explored the range of support and influence accessed by managers and identified five forms of external support which managers felt could assist them in improving quality and carrying out their jobs in general. These were *skills and capacity-building; networking with other managers; access to externally tested models of care; practical interventions*; and, to a lesser extent, *awards and prizes*.

The interviews with industry associations highlighted the needs of small and medium organisations, which needed external support to supplement sparse internal resources.

Skills and capacity-building

In general, the managers in the study who were most positive about improving quality also spoke about how they actively sought out information and inspiration. The participants who spoke extensively of quality improvement and relationship-centred quality explained how they took responsibility of doing their own research for new ideas, including reading, attending conferences and training programmes and visiting other provider organisations. In Australia, providers spoke about how ACSA was an important source of information and advice, and also on-line training companies, particularly the Aged Care Channel, an Australian company which also operates in England. One provider in Australia spoke about how she looked internationally for advice, including to SCIE in England.

While these information tools were very helpful for building the knowledge base for providers, the study did not find any evidence that these tools were the sources of motivation for provider organisations to invest in quality improvement - instead they were useful repositories of information which providers could access proactively.

Networking with other managers

The idea of providing support directly for managers to network with each other and provide peer support was more commonly raised in England. All the Care Home Managers in England spoke of the benefits of networking with their peers, either

within their own organisation or in local forums and networking groups. The networking and support groups took different forms. One provider described a local network of about 25 managers for which she organised events and which brought in guests to present different aspects of running care homes which had been seen as highly valuable by the participants, in part for the moral support it provided:

P: If you ask the managers, they say it's been the most valuable thing they've ever had. And I can't tell you why except that they value the fact that you've got the opportunity to talk openly, without fear of being criticised. It's time out, you know, cos we all need that. (Care Home Manager, Poplar, England)

In England, there was particular praise for the My Home Life programme², to the extent that participants felt the programme merited government funding. The programme aims to instil the principles of relationship-centred care in residential homes and does this by bringing managers together for training events and to provide peer support (Owen et al., 2012). The value of this programme was commented on by a range of stakeholders in this study, including local authorities and various stakeholders at the national level. However, these programmes are becoming less and less viable with the cuts in social care funding and participants commented on how efforts to fund them both locally and nationally have been pared back.

As discussed briefly in Chapter 4, there is ongoing debate over whether there is a difference in the quality delivered by FP providers, when compared to NFP providers. The tentative conclusion of this study is that, while if there are differences at the aggregate level, it is difficult to assert that one set of providers is better than the other based on ownership. This is mainly due to the pivotal part played by the manager and their staff, as described above, something which is not necessarily linked to ownership. However, the higher propensity of NFP providers to collaborate with each other was a theme which emerged in both countries. Both providers and industry associations in the NFP sector described instances of where they had sought help or inspiration from other providers. This collaboration was not exclusive to the NFP organisations, but it was more explicitly referred to by NFP providers and NFP industry associations. This collaboration extended to providers looking to other countries for best practice and the two main NFP industry

² The My Home Life movement is led by City University in England and funded by a charitable grant. The movement is 'a UK-wide initiative that promotes quality of life and delivers positive change in care homes for older people' (My Home Life, 2018).

associations from England (the National Care Forum) and Australia (Aged and Community Services Australia) have conducted joint study tours and have a Memorandum of Understanding in place regarding the sharing of information. In Australia, one of the striking features of the South Australia Hub Trial to test the concept of earned autonomy eventually exclusively consisted of NFP providers. A leader of one of the industry associations for FP organisations in Australia had a slightly different view which was that size was more important in terms of levels of innovation. In his opinion, medium-sized organisations are more likely to innovate, with larger providers more likely to concentrate on standardising processes and practices across their chains.

Externally accredited models of care

The My Home Life movement was also mentioned in discussions about the availability of government approved models of care. What would be useful, according to a staff member at a local authority in England, was an official view on which of the various models available for care were the best. The local authority had provided training on a specific trademarked model of dementia care, but the participant was also aware that the model was one of many, undermining the legitimacy of recommending the approach. The participant suggested that the review and recommendations on specific models of care would be a helpful role for NICE to take.

Other providers in the study in England shared the view that the government had a role in developing operational guidance, for example, in testing the My Home Life programme. So, for example, a participant from one of the industry associations which represented smaller providers talked about the role of the government in testing and publicising concepts which would be useful at the provider level, rather than high level guidance on quality. The participant commented on how the sector needed a body like the NHS Improvement Agency to test concepts and come up with practical help to implement them:

P: We need somewhere in the system, I'm not sure where it should be, something that's a bit like NHS Improvement Agency ... or whatever ... that actually says, okay, this is an issue we'll set the academics off researching this and this and this, yeah? We'll create a project to actually pilot this and this and this, yeah, and then we'll decide which is going to be best and we'll get ADASS to adopt it as formal policy. Nobody ever does that. (England, industry association, P3)

It was important to this participant, and others that this guidance was grounded in the day-to-day operations of care homes. The NICE quality standards were not considered to be particularly useful for providers, although one individual who managed quality commented about referring to them to develop internal quality guidance for her organisation. The industry associations representing smaller provider organisations in England identified a gap between the academic, output from NICE and SCIE and what providers need in practice. Only one provider participant, a Quality Manager, mentioned the NICE's Quality Standards, which they used as a resource to write their processes and policies. However, a caveat needs to be made here which is that the quality standards had only been recently launched when the fieldwork for this study was conducted.

Practical interventions

In both countries, provider organisations mentioned hands-on projects as being more helpful to them. In England, an example was a project set up between the local authority and Clinical Commissioning Group (CCG) to provide regular district nurse and pharmacist visits to monitor resident health and medication.

The value of practical 'how-to' interventions was demonstrated in Australia by the use of the Dementia Behaviour Management Advisory Service (DBMAS). DBMAS is a service funded by the Australian government to support professionals and carers in a number of different care settings. The service is staffed by multidisciplinary teams including clinicians, social workers and allied health professionals who provide support by telephone. The government also offers residential care providers face-to-face support through the national Severe Behaviour Response Teams (SBRT) with addressing the needs of people with 'severe and very severe Behavioural and Psychological Symptoms of Dementia (BPSD)' (Dementia Behavioural Management Advisory Service, 2017). In Australia, all the providers in the study had accessed the DBMAS for advice on how to deal with difficult situations with residents living with dementia. For some providers, however, this service was positioned as a tactical intervention, as opposed to exposing the provider to practices which could be transferred for the benefit of other residents in the pursuit of systemic quality improvement. It is notable that hands-on interventions like the CCG project and DBMAS were viewed by providers as more helpful than traditional training events.

Prizes and awards

Some, but not all providers commented on the value of prizes and awards for motivating staff and was mentioned by a handful of providers. For providers focused on staff wellbeing, awards were all about rewarding individuals:

P: I think it's important that we give them that respect and give them the opportunity to actually recognise what they do, because carers are not good at blowing their own trumpet. [...] So, it's the staff that win the award, not the entry. (Care Home Manager, Poplar, England)

These prize and award ceremonies and events are run mainly by private organisations to promote other services such as industry publications and market analysis. In Australia, however, Quality Agency organises better practice conferences, training, education and state-based awards to recognise individuals and providers for examples of innovative and leading quality practices. It was unclear how effective these awards were in practice in pulling poorer providers up in terms of quality or whether the awards were simply a showcase for already high-quality providers.

8.4 Conclusion

Interviews with staff at five provider organisations exposed differences in how policy interventions influenced quality behaviour, both within each country and between England and Australia. A finding common to both countries is that, while inspection and accreditation have generally had a positive effect on raising minimum standards in the industry, the type of quality improvement activity they directly incentivise can be categorised as having an inward, organisation-focus on quality, and result in improvements limited to quality control and assurance, rather than systemic quality improvement. In both countries, the need for documentation for inspection and accreditation means that providers can become focused on paperwork and lose sight of resident outcomes.

In both countries, the presence of residents who pay for themselves (self-funders in England, RAD/DAP-paying residents in Australia) has created a market for consumer-directed quality, manifested in high-end hotel-like accommodation, sophisticated marketing, and activities organised in the style of 'cruise ship living'. The introduction of consumer choice and markets have generated both 'spotty' and systemic quality improvement, but the emphasis here is very much on consumer-

directed quality. In both countries, this is driving two tiers of quality although in subtly different ways. Where there are providers in England who now only take self-funders, the system in Australia means that providers are effectively obliged to take a percentage of low means residents. The result of this is that some providers have two tiers of accommodation quality with shared rooms for these publicly-supported residents.

The study has found that the delivery of relationship-centred quality is driven by the intrinsic motivation of providers. The development of relationship-centred quality does not even easily fit with definitions of systemic quality improvement and is not easily translated into standards for regulatory regimes. In both countries, the wellbeing of residents and staff is at the heart of relationship-centred quality and 'improvements' are made continuously within the interactions and activities of daily life, and usually do not involve the formalised goals and plans which would normally be associated with models of systemic quality improvement.

In England, one possible benefit of the ratings introduced by the CQC is that providers who are delivering relationship-centred quality can be identified as role models to inspire others. Whether this inspiration is effective is still unclear and requires further research: the nature of relationship-centred quality is characterised by many intangible characteristics and the study showed that it can be hard for providers who are not 'Outstanding' to understand quite what is involved with being 'Outstanding'. The effect of the ratings in terms of changing consumer behaviour is even less clear, but at least one provider spoke of how even just the possibility of ratings affecting consumer decisions already meant the organisation was focused on achieving better ratings for its care homes.

What this study has also found is that providers are rarely focused on one type of quality or on one type of quality improvement. The regulatory standards in both countries, along with the changing needs of residents, mean that, to a certain extent, organisation-focused quality assurance must be considered by all providers. Consideration of safety and the quality of clinical processes should still be paramount, while balancing these considerations with the quality of life needs of residents and in the context of delivering relationship-centred care. Similarly, the delivery of relationship-centred quality and consumer-directed quality are not mutually exclusive. Many wealthier residents may expect hotel standards of accommodation as they better reflect the standards of their own previous homes.

Homes need to meet the expectations of different residents, some of whom will be quite affluent, some of whom are used to less extravagant homes. Where this might be concerning is where the providers are focused purely on aspects of consumer-directed quality and neglect the important elements of relationship-centred quality.

This chapter focused on the views of provider organisations about what influenced their approach to quality. The interviews in both countries highlighted an important issue, which is how difficult it is for smaller providers to assess best practice, and how there is a perceived need for government support in this area. Participants in England commented on the disparity between the money and effort invested in this type of improvement activity when compared to the NHS. Participants also commented on the gap between the academic, high level activity of organisations like NICE and what providers need in practice, as well as the limited resources to disseminate information and support providers. There was less mention of this issue in Australia, but the medium-sized NFP providers in the study in Australia did talk about how ACSA, their industry association, was a useful source of training and ideas. At the same time, it is worth noting that none of the interviewees in Australia, including at the Department of Health, mentioned the Encouraging Better Practice in Aged Care Program described in Chapter 2.

However, at the end of each interview (with both samples), I asked participants for their thoughts on what their governments could do to help improve quality in the sector. Funding was frequently mentioned, especially in England. Many participants, in both countries, saw the main responsibility of government as supporting a supply of skilled workers for the sector, mainly through immigration policy and training and education. Both countries are facing the prospect of chronic shortages of skilled workers, particularly of qualified nurses (for example, Cavendish, 2013, Kingsmill, 2013, Senate Community Affairs References Committee, 2017, Health Committee, 2018). Several participants in England, from a range of stakeholder groups, also pointed out the gulf between the investment in training for the NHS and social care and many participants commented that training and development for the sector was severely underfunded. The need for further research on the impact of labour policies on the sector in different countries is highlighted in the following chapter.

9 Discussion and conclusion

The purpose of this study was to gather new insights into how governments might design regulatory regimes for the residential care sector which encourage quality improvement over and above minimum standards. To do this, I compared the regulatory regimes of England and Australia, examining the following questions:

1. What explains how and why the types of regulatory systems have developed?
2. How is quality understood differently in each country and how are those understandings reflected in the regulatory regimes?
3. How is information on quality used by governments to influence quality improvement?
4. How, and to what extent, do regulatory regimes influence providers to deliver quality over and above minimum standards?

Previous studies into quality and long-term care have focused mainly on three aspects: inspection styles; the type of standards; and the effectiveness of standalone policy interventions. Underpinning these are studies exploring the complex and difficult conceptual issues around the definition and measurement of quality. This thesis instead sought to explore understandings of quality at the level of the provider organisations, and how these are linked to regulatory and policy actions. To do this, I developed a typology of three types of provider quality drawing on both social policy literature (most notably, Wærness, 1984, Bowers et al., 2001, and Davies, 2003), and literature from fields including service marketing and quality management. The three types of quality were organisation-focused, consumer-directed and relationship-centred and were described along a range of dimensions (see Table 6.3). The interviews identified two additional dimensions to be added to this typology: the design of accommodation and how providers prioritise the needs and preferences of the resident.

My research uncovered a complex picture both in differences in regulatory design and the extent to which government actions shape both the understandings of quality and provider behaviour, with both intended and unintended consequences. Towards the end of this research, issues concerning quality in aged care in Australia were laid bare by the exposure of poor care and mistreatment of older people with dementia at Oakden in South Australia, a scandal which resulted in an independent review into regulatory processes in Australia (Carnell and Paterson, 2017) and an

ongoing inquiry into the sector at the time of writing (Standing Committee on Health, 2017). At the same time, quality in the sector in England continues to deteriorate and this has been largely attributed to insufficient funding (Burns et al., 2016, CQC, 2017d). Quality in each country is therefore a 'live' issue.

The first section of the chapter summarises the findings of the four sub-research questions. It explores and discusses the differences identified in the regulatory regimes and reported in Chapters 6 to 8, before turning to a discussion of the explanations of these differences which were reported in Chapter 5. The chapter then turns to the overall findings of the thesis and the main contribution of the study, namely, how the design of each system has been guided by broader institutional differences related to the history of the sector; and how these institutional factors have informed the design of the 'regulatory space' in each country, and the implications for policymakers. I then highlight how the findings of the study might be transferred to other sectors. Finally, I highlight some of the limitations of the study and the opportunities to extend this research.

9.1 Summary of findings and discussion

The differences between the regulatory regimes of the two countries are summarised in Table 9.1 and discussed in this section in the context of the research questions. The regulatory regimes varied along several dimensions: these included differences in the understandings of quality, the nature and use of quality information, and how policy interventions influence provider behaviour. This section explores these key differences before considering the explanations for the divergence between the sector in each country.

Approaches to quality in the regulatory systems

As Table 9.1 shows, the two countries varied in terms of how quality is expressed and understood in policy and by different stakeholders in the system. Many of the interviews in both countries included discussions about the difficulties of defining quality for residential care due to its multidimensional and subjective nature, something already well covered in the literature (for example, Qureshi et al., 1998, Sloane et al., 2005, Malley and Fernández, 2010). These problems with definition

Table 9.1 Quality and the regulatory regimes in England and Australia

	ENGLAND	AUSTRALIA
QUALITY AND THE REGULATORY SYSTEM		
Standards	<i>Person-centred</i>	<i>Process-based</i>
Priority	<i>Upholding the rights of the individual</i>	<i>Protecting the consumer</i>
Expression of quality	<i>Ratings (Outstanding/Good/ Requires Improvement/Inadequate) The 'Mum Test'</i>	<i>Compliance-based Pass/fail</i>
INFORMATION IN THE REGULATORY SYSTEM		
Role of the regulator	<i>Publish inspection reports based on 'lived experience' of residents Publish ratings Publish 'state of care' and thematic reports Highlight poor care at provider or system level</i>	<i>Publish accreditation reports based on process compliance Publish information on resident experience gathered through surveys (since April 2017)</i>
Provider reporting	<i>Display government ratings at location and on own website (mandatory)</i>	<i>Publish quality indicators (voluntary) Publish prices on government's MyAgedCare website (mandatory)</i>
Resident ratings and reviews	<i>Consumer review functionality included on main systems (NHS Choices, CQC) but very low volumes of reviews</i>	<i>Consumer review and ratings capability to be developed</i>
Government strategy for information for improvement	<i>Combination of activation and selection</i>	<i>Emphasis on supporting selection</i>
PROVIDER QUALITY IMPROVEMENT: EXTERNAL DRIVERS		
Drivers of organisation-focused quality	<i>CQC inspections, through the requirements for documentation</i>	<i>Accreditation reviews, through the requirements for process compliance ACFI funding mechanism</i>
Drivers of consumer-directed quality	<i>Market of self-funders</i>	<i>Market of RAD- and DAP-paying residents</i>
Drivers of relationship-centred quality	<i>Largely independent of external drivers but potential for ratings to identify role models – but this still needs to be tested</i>	<i>Largely independent of external drivers</i>

have prevented straightforward and meaningful discussion about links between quality and government actions. Through the development of a new typology of quality, one of the contributions of this thesis is to identify the links between different regulatory interventions and specific understandings of quality. This thesis identified links between the three different types of quality in the typology and different features of the regulatory systems: the design of inspection and accreditation approaches; the impact of payment mechanisms (particularly the ACFI); and the tensions between these policy features and the impact of consumer choice and competition. While consumer choice would not normally be considered as part of the regulatory regime, it became clear in the study that the ‘high-powered’ incentives introduced by choice and competition result in different understandings of quality and distinct types of provider behaviour (discussed later in the chapter).

Regulatory regimes and understandings of quality

In terms of the design of the respective regulatory regimes, the study identified some fundamental differences between the two countries. First, the CQC in England has developed a single, person-centred definition of quality, and the expectations of quality are set out in detail through the ratings and the ‘Mum Test’. At the heart of this is a human rights-based definition of quality complemented by legislation around safeguarding and mental capacity. The emphasis, at least in policy, is on co-production, and the concept of ‘doing with’ the resident instead of ‘doing to’ the resident. This positioning is strengthened by legislation which promotes the rights and autonomy of individuals, for example, in the Mental Capacity Act and Deprivation of Liberty Safeguarding legislation. The impact of how ‘rights’ of residents are expressed and understood on what quality means has been previously highlighted by Manthorpe and Samsi (2016b). This thesis confirms a link between how the understanding of rights is linked to whether residents are seen primarily as ‘patients’, ‘consumers’, or as individuals with ‘personhood’.

This person-centred definition of quality in England contrasts with the situation in Australia where the emphasis in the accreditation standards is on the quality of processes and documentation, albeit including a standard requiring that the provider show evidence of continuous improvement. Interviewees in Australia expressed much stronger views than in England that a single definition is impossible and unhelpful to develop an ‘official’ view of quality. Much attention has been paid in previous studies to the type of standards and regulation in place (Coglianese and

Lazer, 2003, Coglianese et al., 2003, May, 2007), but this thesis finds that the application of standards will have a limited effect on quality improvement if they are not set in the context of what ‘good’ looks like, as has been outlined in the system in England. Determining what quality looks like is therefore a vital ingredient in assessing how well providers are providing care. The system in Australia also places emphasis on consumer protection rather than a broader human rights approach.

Behind these design issues is the question of whether standards are set at a level most providers will surpass (as in Australia) or whether they are an absolute level of quality which may result in providers failing to meet the required standard (as in England). These decisions can be undermined anyway at the inspection stage where inspectors must make difficult decisions about poorly-performing providers. The dilemma in both countries is whether it is better to have poor providers who ‘bounce along the bottom’ or to take care availability out of the sector – an example of the ‘situational capture’ described by Makkai and Braithwaite (1992), where inspectors avoid recommending the closure of providers to avoid creating supply issues in the local area.

Underpinning these questions of regulatory design were the fundamental differences in the role of the CQC and Quality Agency discussed in Chapter 2. The CQC has significant legislative powers, including the ability to bring manslaughter charges, where the Quality Agency refers decisions around provider sanctions to the Department of Health in Australia. Related to this, participants in each country perceived the CQC and Quality Agency quite differently in terms of their respective roles and value, an issue discussed later in this chapter.

While both countries have ostensibly adopted consumerist approaches to the provision of care, the two countries position the ‘resident’ differently in the regulatory regime. Linked to this, the involvement of local authorities in safeguarding processes introduces an extra layer of oversight into the sector in England. Although problems have been identified with how these processes have been implemented (Ash, 2015, Law Commission, 2017, Turner, 2017), the presence of safeguarding serves an additional purpose for quality by introducing other stakeholders into the oversight of homes, and therefore introducing additional checks and balances to the quality process. Local authority reviews of residents also form a channel for quality oversight where they happen for local authority-funded

residents, offering an opportunity to residents and relatives to comment on the quality of care with someone outside the care home (Scourfield, 2010).

In Australia, there was much less formal involvement than in England from external organisations in terms of the wellbeing of the individual resident, even though the value of the involvement of multiple stakeholders was formally highlighted in the ‘Ronalds Report’ in 1989 (Ronalds et al., 1989). The programs set up following this report, as well as the establishment of a mandatory Charter of Residents’ Rights and Responsibilities, were developed with the express purpose of introducing more transparency in the sector and protecting and promoting resident rights and quality. However, these programs have lost their impact since their implementation in the early 1990s¹. Interviews with organisations contracted to deliver the Advocacy Program and Community Visitors Scheme uncovered programs which seemed to have lost their way in terms of their value in supporting resident rights.

Payment mechanisms and understandings of quality

This study also uncovered a number of issues with the impact of payment mechanisms on understandings of quality, for example, the unintended consequences of the ACFI in Australia and the low levels of public funding in England. The study found that the ACFI in Australia is linked most closely with the concept of organisational-focused quality, and the instrument appears to undermine the goals and practices associated with relationship-centred quality or indeed concepts such as reablement or prevention. As one participant pointed out, Australia and the US (which also uses an activity-based pricing model or Resource Utilisation Group (RUG)) are characterised by the need for large auditing functions to manage claims and payments. The use of this type of RUG payment mechanism and their impact on quality is under-researched within the long-term care sector, when compared to the amount of research conducted in the context of health care. Until recently, the existing research on economic incentives in residential care has mainly been restricted to the use of pay-for-performance and targeted reimbursements to incentivise improvement in the US (for example, Norton, 1992, Harrington and Hyer, 2008, Hyer et al., 2013). An exception is a recent comparative study which identified that the activity-based funding system in place

¹ The Australian Government has expressed an intention to reinvigorate the Advocacy Program, however, the recommendations of a recent government report on the program mainly concern its administration (Department of Health, 2016b).

in Ontario, similar to the ACFI, was highly restrictive for delivering relational care, when compared to Germany and Norway where global funding allows providers more flexibility to respond to changing resident needs (Daly et al., 2016, Armstrong et al., 2017). The activity-based funding model in Ontario was found to promote a medical model and standard interventions, did not adequately support questions surrounding quality of life, and also undermined relational care because of the focus on specific work or care tasks (Armstrong et al., 2017). The reliability and measurement of data were also problematic.

Studies on payment mechanisms in health care provide some salutary lessons in how RUG-based payment mechanisms like the ACFI can incentivise unwanted provider behaviours (Robinson, 2001, Rice and Smith, 2002, Busse et al., 2006, Jakobsen, 2010), and many of these lessons are relevant for long-term care. Busse and colleagues (2006, p212) highlight issues which include the potential ‘dumping’ of high-dependency patients; cream-skimming, where providers only accept patients for whom reimbursement is likely to exceed the costs of treatment; ‘up-coding’ of conditions to increase reimbursement; the potential to provide unnecessary treatment; and most notably for this study, payments based on RUGs do not in themselves carry any incentives for care providers to maintain or improve quality and they may, in fact, provide incentives for ‘quality skimping’. Many of these same issues arose during my study in the context of the ACFI.

Questions should therefore be asked around how a tool designed for a clinical environment might encourage and support the move of providers to deliver relationship-centred quality, or whether in fact, the payment mechanism has inbuilt disincentives to invest in this type of care. The unintended consequences of these payment mechanisms are of vital importance given that discussions about funding approaches are underway in both countries. The findings around the ACFI and provider quality behaviour reinforce the need to understand the unintended consequences of implementing such a system and the links with quality behaviour.

Choice and understandings of quality

The emphasis on consumer protection in the system in Australia was linked to a dominant theme in the interviews that residents and their families will eventually assume the role of empowered consumers, and that these individuals would ultimately be the key influencers for quality in an open market. The role of government is therefore to protect the consumer rights of residents. This view

reflects a broad tendency for policymakers internationally to assume that quality problems in long-term care will be solved in the future because ‘baby boomers’ will expect and demand better standards of care than the ‘silent’ generation who went before them, despite a lack of evidence to back this theory up (Jönson and Jönsson, 2015). However, this reliance on third age baby boomers is at odds with the description some authors have used of older people in residential care being in their ‘fourth age’, and therefore holding limited consumer sovereignty (Scourfield, 2007a, Lloyd et al., 2013, Higgs and Gilleard, 2016).

Limits of the typology

While the typology of provider quality is helpful, it is important to stress that, whichever of the three types of quality is dominant at the provider level, organisations must still pay attention to all three types of quality, albeit with different priorities. So, for example, aiming for quality which is relationship-centred does not exempt providers from ensuring that they have high-quality internal processes or from considering the quality of accommodation or hospitality services. Good internal processes are essential in all providers and are a necessary, but not sufficient, condition for excellent care. Inspection and accreditation are important to make sure that providers understand the minimum expectations of quality and are addressing internal processes. The increasingly complex health needs of older people in residential care means that all providers must have robust processes which assure the safety of the people they are caring for, particularly in clinical governance and procedures. The problem for policymakers is to achieve a balance which avoids focusing providers solely on internal ‘organisation-focused’ quality, and treating the resident as a passive, dependent patient and prioritising safety and risk minimisation over supporting residents to lead meaningful and fulfilling lives. This happens both on a day-to-day basis, for example, the overuse of antipsychotic medication to restrain people ‘for their own safety’ and, for example, in shifting residents to hospital for unnecessary treatment at the end of their lives.

At the same time, even relationship-centred providers have to cater for different ‘consumer’ preferences in terms of services and accommodation. While a theme throughout my study is the notion that consumer-directed quality should not be viewed as a route to supporting quality of life outcomes, it is also important to acknowledge that older people will continue to have their own priorities and preferences in terms of the tangible features of care provision such as the quality

and choice of food or the physical features of accommodation. For some individuals, a luxurious hotel-like environment may form what Maslow (1943) might refer to as a 'hygiene factor', where the life experiences of the family mean that a luxurious environment might be seen as a basic requirement. However, a disproportionate focus on consumer-directed quality potentially neglects the more important aspects of quality of life for older people who have multiple conditions, are frequently living with dementia and who will usually spend the end of their lives in residential care.

The use of quality information in regulatory regimes

Chapter 7 identified several differences in how the respective governments and regulators perceive their responsibilities in terms of information. The most notable differences between the systems of the two countries were the transparency around poor provision and how quality is communicated, whether through describing the lived experience as in England or commenting on compliance with processes as in Australia. The transparency around quality information was informed by a number of factors, including the underlying legislation and respective roles of the CQC and the Quality Agency. The CQC has a responsibility in legislation to highlight poor care at both the provider and system level, where the Quality Agency is restricted to what it can say under the Aged Care Act 1997. The extent of these differences was reinforced by the challenges experienced when trying to identify provider organisations to include in the study. The ratings system in England, with all its potential flaws, at least provides a starting point for separating low- and high-quality providers. In Australia, there is no information to help individuals identify differences in quality between providers. Even participants in the study who were familiar with the sector as professionals described the problems they encountered when trying to navigate the system as private individuals.

The approaches of the two countries also differed in terms of the overarching rationale for how quality information is gathered and used, that is, whether the respective governments saw the purpose of the publication of quality information as encouraging quality improvement through the activation or selection pathways. The Australian government's reliance on the selection pathway reflected the assumptions around residents as consumers, where the government in England saw opportunities for improvement through both pathways. The stated strategies (of activation versus selection) were somewhat at odds with how each government

approached the use of information, with much more information on quality available in England than in Australia.

Activation in England

In England, despite the dominance of the consumer choice narrative, the CQC maintained that the use of information and ratings was expected to inform the actions of providers directly, through reputational effects and the activation pathways. Ratings appear to be a good way of shining the light on good provision, to allow *copying* and reward *innovation*, an approach recommended by Brennan and Berwick (1996) for good regulatory design. There are signs from the experiences in England that the combination of ratings with inspections might have promise for future quality improvement, although this is an area which requires further research. There is some evidence that some providers in England are looking to the providers awarded 'Outstanding' for inspiration and ideas which will help them improve their care and/or reputation in the sector. At the same time, the effect of ratings in England is still not entirely understood, and the study participants specifically highlighted the deleterious effects that negative ratings can have on already struggling providers. In addition, while previous research explored the links between quality of life outcomes and the CSCI star ratings in place from 2008 to 2009 (Netten et al., 2012), there has not been any similar research conducted on the relationship between outcomes and the CQC's ratings against the Fundamental Standards. More research is therefore needed on ratings, and how other similar, positive, mechanisms might be used, for example, to promote best practice in dementia or end of life care. This approach would also have the effect of de-linking assessments of the accommodation and the assessment of the provider's delivery of relationship-centred care. This suggestion in some way echoes a review of the residential care sector in England which recommended that the quality of housing be separated from the regulatory responsibilities to monitor the quality of care (Demos Commission, 2014).

Selection in Australia

The emphasis on the use of information in Australia was on the idea that quality would be driven through the selection pathway. The selection pathway is underpinned by the idea that consumers will make informed decisions about providers based on quality, and that providers will adjust their behaviour accordingly (Hirschman, 1970). However, as discussed multiple times in this thesis,

the ability of the resident to act as the empowered consumer is restricted by a number of issues, not least the stressful circumstances under which choices have to be made and the influence of poor health and/or cognitive status.

Part of the issue with the use of quality information for selection arises from the difficulties the general public has in interpreting the information provided on health and long-term care (Gigerenzer et al., 2007). Information is also subject to 'misinterpretation' (Smith, 1995), not least because of the issues associated with case mix, but also because potential residents and their families struggle to interpret this type of granular and technical information (Trigg et al., 2017). In addition, without a definition of what quality should look like (as in Australia) it is difficult to articulate the level of quality performance, therefore adding little clarity for the consumer. Policymakers therefore have two choices: either to work on making the information easier to understand and more accessible; or alternatively to work on the 'demand' side, by improving the skills and support provided to the general public (Peters, 2017). The exception is where providers are marketing their services to 'institutional consumers', for example, local authorities or health care providers, who are more likely to make use of quality information (Castle, 2009, CSCI, 2009a).

In terms of their use of information, potential residents and their families may also be less aware that the aspects of quality which ultimately lead to better quality of life, particularly for residents living with dementia, are those which fall under the banner of 'experience' and 'credence' goods (as described by Darby and Karni (1973)). Consumers may well have the skills to assess the quality of consumer-directed aspects such as accommodation but are less likely to have the knowledge to assess 'experience' and 'credence' goods such as complex clinical, dementia and end-of-life care. The importance of specialist knowledge becomes clearer when we consider what some of the pressing issues are in residential care, particularly related to people living with dementia. One issue which has been discussed already in the thesis is the over-use of antipsychotic medication in the treatment of dementia and how this is related to failures to deliver person-centred care. Another which emerged during discussions in the study is the extent to which pain is under-treated in people living with dementia and how this can be the source of changes in behaviour, something confirmed in a systematic review by Achterberg et al. (2013). These are aspects of care which could be considered as 'credence' goods. So, while lay people can judge the consumer-directed quality components of residential care, such as the standard of accommodation and the number of activities, an appropriate

role for government might be to signal the presence of both safe processes and relationship-centred quality, as these are the types of quality which are most difficult for lay people to assess. An alternative to taking the primary role in quality would be for governments to actively encourage and incentivise the setting up of intermediaries to help consumers and compensate for information asymmetries (Issacharoff, 2011).

Sources of information

Another difference between the two countries is the respective roles for government, providers and consumers in the generation and publication of information on quality. The CQC in England takes an active role in gathering information and publishing ratings, underpinned by a single person-centred vision of quality. The government in Australia has instead turned to providers and consumers to publish quality information voluntarily, although the Quality Agency began to publish the results of Consumer Experience Surveys in 2017.

As Chapter 3 set out, the successful voluntary disclosure of information by providers relies on ‘unravelling’ effects (Dranove and Jin, 2010), something which is problematic when applied to the care sector due to both the complex and multidimensional nature of quality and the varying motivations of providers to supply information. A recent evaluation of the customer experience and quality of life indicators piloted in Australia’s Quality Framework acknowledged that there could be inherent issues in voluntary provider participation, referring to it as ‘volunteer bias’ (KPMG, 2017). There are also issues with the quality of data collection with a study of reporting from nursing homes in Victoria identifying suboptimal levels of adherence to measurement guidelines and indicator definition, considerable heterogeneity in the personnel, sources, and tools used to gather the QI data, and limited data checking (Ibrahim et al., 2014).

In Australia, the interviews suggested that participants had high hopes for how consumer reviews would form the lynchpin of quality information. In England, the idea that ‘consumers’ can be a major provider of reviews of quality has lost traction since the government first proposed a focus on online reviews in 2011. This planned reliance on consumer information is problematic, as shown by experience in England. Generating the volume and quality of reviews is likely to be challenging, as well as their use and interpretation by consumers (Trigg, 2011, Trigg, 2014).

How well consumer ratings and reviews accurately reflect actual quality is also unclear (Gao et al., 2012, Greaves et al., 2012, Segal et al., 2012, Okike et al., 2016, Gaudet Hefelet al., 2017).

The effects of government quality policies on provider quality behaviour

In this study, I have established that inspections and relationship-centred quality are not closely connected, but that relationship-centredness instead stems more from the intrinsic motivation of providers to maximise the quality of life of their residents. This finding is reinforced by the fact that there were providers in both countries which were delivering relationship-centred quality and this behaviour appeared to be largely independent of the respective regulatory regimes. This confirms a common finding of previous studies that inspection and accreditation in both countries has been largely effective in generally increasing the basic standards of care rather than quality over and above this level (Lathlean et al., 2006, Commonwealth of Australia, 2007). There is something inherently different about providers who deliver relationship-centred quality when compared with other organisations in the sector. Relationship-centred providers have a different view of staff roles and staff wellbeing and, most importantly, they perceive residents as individuals with ‘personhood’. Those providers who spoke about relationship-centred quality emphasised the importance of leadership behaviours and a culture of empowering and devolving responsibility to front-line workers; characteristics which were seen as essential for staff loyalty and retention. This reinforces the findings of other studies that the role of leaders and managers in residential care is central to whether relationship-centred care can flourish (Lopez, 2006, Meagher, 2006, King, 2007b, Killett et al., 2016). These characteristics appear to be more linked with the intrinsic motivation of individuals than with a response to external policy actions by governments. For providers who focus on relationship-centred quality, the key to quality improvement is nurturing a culture of ‘bounded emotionality’ (King, 2007a) and empowering residents, staff and families in the pursuit of quality of life and wellbeing.

The potential for inspections and accreditation reviews to directly trigger the delivery of relationship-centred quality on their own is therefore questionable. Indeed, the interviews confirmed previous studies where regulation has been seen as conflicting with person- and relationship-centred approaches (Stone et al., 2009, Banerjee and Armstrong, 2015, Daly et al., 2016). The experience with ritual

compliance with the Accreditation Standards in Australia demonstrates that poorer providers will often ‘hit the target, but miss the point’, confirming the potential for unintended consequences of process measures (Smith, 1995, Bevan and Hood, 2006). This phenomenon extends to the standards around continuous improvement, where the ‘ritual continuous improvement’ observed by Braithwaite et al. (2007) takes the form of being focused more on the need to be seen to be identifying and delivering ‘spotty’ quality improvement, in contrast with the ongoing and constant quality improvement which happens continuously where providers are engaged in delivering relationship-centred care. These improvements may be as simple as making different decisions with a resident about the structure of the day, about their surrounding environment or who they would like to spend time with. As Brannelly et al. (2017) observed, this type of quality develops in an ‘organic’ way, produced through ‘the synthesis of ideas, energy, and talents of the staff’ (p2), rather than through rigid and prescriptive regulatory rules.

The interviews also suggested that the main impact of ‘choice’ policies in residential care is to motivate providers to focus on improving consumer-directed quality, but these policies are less likely to affect other forms of quality. The phenomenon of consumer-directed quality was apparent in both countries but far more apparent in the interviews in Australia. Consumer-directed quality is most visible in providers delivering high standards of hotel-like services, accommodation and ‘cruise ship living’ approaches to activities. Providers leverage consumer-directed quality to attract residents who are paying for all or part of their own care and accommodation costs. One consequence of this behaviour is the emergence of two tiers of quality. The danger is that provision becomes polarised, with the sector separating into a set of underperforming organisations with poor demand and unable to attract good staff, alongside a set of high-performing providers who can effectively choose which residents to accept – a phenomenon highlighted in previous studies (Perri Six, 2003, Grabowski and Town, 2011).

In England, this polarisation takes the form of providers who accommodate solely or mainly affluent self-funders in preference to publicly-funded residents. There is significant geographical variation in supply as providers target affluent parts of the country, a phenomenon which should be of interest to the Australian Government to inform its planned shift from centralised allocations of residential care places towards a market-based model. As local authority rates stagnate, care homes in England are increasingly only taking self-funders or residents with top-up

payments; indeed, four out of the five provider organisations participating in this study in England had stopped accepting new local authority-funded residents. Previous research has shown that this ‘segregation’ can be exacerbated by private providers selecting risks by turning away ‘difficult, confused, very frail, aggressive or obese clients’, and people dependent on public funding effectively have little real choice of provider (Hayashi, 2013, p33). At the same time, self-funders experience their own difficulties, most notably with selecting care providers in the first place due to the considerable difficulties around the availability and accessibility of information (Miller et al., 2013, Baxter et al., 2017, CMA, 2017a, Tanner et al., 2018).

Visits to providers in Australia as part of this study suggested that, for residents reliant on public funding, quality can be biased towards an organisational focus, with patient safety and clinical care having a far higher priority than relationship-centred care and quality of life. Low means residents are, in theory, provided with the same standards of care as RAD and DAP-paying residents, however, an equivalent standard of accommodation is not required by the Australian government. My study visits highlighted providers in Australia which still had low means residents sharing rooms, often three or four residents to a room, something which has largely disappeared in England except to accommodate married or cohabiting couples. This observation highlights the potential need for regulations to protect the rights of the most frail and vulnerable residents.

Another characteristic which differentiates the two countries is that, in Australia, the system has been largely unchanged for 20 years. It appears that providers are now highly adept at meeting the same Accreditation Standards and accreditation activity has effectively become disconnected from the idea of quality. The opportunity for gaming and ritual compliance with different standards was exacerbated by the fact that until March 2018, inspections in Australia were announced and arranged with providers in advance (Australian Ageing Agenda, 2018). As Bevan and Hood (2004) observe, a key way of preventing gaming (and therefore ritual compliance) by providers is to introduce an element of unpredictability into regulatory systems. While some of this is through holding unannounced inspections, other strategies include making changes in targets and rating systems, changes which are not too disruptive but reduce the potential for ritual compliance. One approach which may be appropriate in the residential care sector is to have a focus on specific areas of improvement, an approach taken by the

US government with its 'Quality Improvement Organisations' (Rollow et al., 2006, Stevenson and Mor, 2009). Programmes in residential care could focus on specific items for improvement such as reducing the use of antipsychotic medication in the sector or improving end-of-life care. This approach is supported by recent research in the NHS in England which showed that quality improvement gains are more likely to result from the implementation of targeted campaigns, for example, on infection control (DeCourcy et al., 2012).

Explaining the differences between the regulatory regimes

Chapter 5 examined the reasons why the regulatory regimes for residential care have developed differently in England and Australia, using the theories put forward by Hood et al. (2001) and Haines (2011). These theories propose that regulatory regimes are shaped by three main factors: market failure, political 'never again' events, and 'opinion responsive' (driven by business interests). The role of 'policy entrepreneurs' was also identified as a factor in how the regulatory regimes had developed. All of these played a part in the development of the regimes in each country, although in different proportions.

The role of 'never again' events was much more dominant in England than in Australia, where the role of providers was much more apparent, not least through the influence of industry associations and NACA. Interestingly however, the incidents at Oakden mentioned earlier in this chapter have had a major impact on discussions about regulation in Australia, described by one official report as 'A Shameful Chapter in South Australia's History' (Lander QC, 2018). The extent to which this scandal will influence the long-term development of the sector is however unknown although, as mentioned below, it appears that strategies such as contestability in the accreditation space in Australia have been abandoned.

There is more evidence in Australia that the regulatory regime has been captured by provider interest groups than England. This situation could also explain (and be explained by) the 'life-cycle argument' theory for regulatory regimes (Bernstein, 1955, described by Baldwin et al., 2012, Lodge and Wegrich, 2012). The first stage of the life cycle, *gestation*, is the creation of the regulatory body in response to a problem or situations of heightened public attention. In England this is a familiar scenario, with the scandals at Longcare, Mid Staffordshire Hospital and Winterbourne View all mentioned as triggers for changes in the regulatory regime. The regulatory body then experiences a stage of *youth*, in which it operates with

‘crusading zeal’ (Baldwin et al., 2012, p47), even though it may be outmanoeuvred by the regulated organisations. The energy behind the launch of CQC Mark II with the Fundamental Standards and the new ratings places the CQC in this stage of the life-cycle, as does the support for it from both politicians and providers (National Audit Office, 2017). In the life cycle argument, as initial political support wanes, the regulator moves into a period of *maturity* and starts to pay more attention to the needs of the sector. At this stage, politicians also become more responsive to industry. Having lost interest in the reasons why the regulator was set up in the first place, they become susceptible to the ‘corrosive capture’ described in Chapter 5 and become hostile to the regulatory regime. This seems to be the stage of regulatory development for the Quality Agency in Australia. Finally, *old age* arrives, characterised by ‘debility and decline’ (Baldwin et al., 2012, p47).

The position of the Quality Agency in the ‘maturity’ stage, combined with the past influence of interest groups, might explain why the Agency appears to have fallen into the ‘compliance trap’, as described by Parker (2006). The compliance trap refers to the situation where there is little support for the regulatory system and the regulator chooses to avoid conflict with business interests which may result in businesses lobbying government ‘to emasculate the regulatory enforcement agency’ (p593). In doing so, the regulator has a minimal effect on quality. The evidence for this is seen in the lack of exposure of different levels of quality and the fact that almost all providers pass accreditation. As Parker highlights, the only way out of the compliance trap is through action by politicians and policymakers. This is not a problem which regulators can solve, as their role is already undermined. The potential opportunity for addressing this may be as a result of the fall-out from the Oakden scandal as one discussion which has ceased to appear in policy discussions is introducing contestability into accreditation.

The applicability of the life-cycle theory to the regulatory regimes in England and Australia appears to offer some lessons for policy makers. Regulation has gone through almost continuous change and disruption in England, but the theory suggests that this constant change might be an advantage in terms of effectiveness, particularly in countering the risk of regulatory capture. In contrast, in Australia there are signs of ‘corrosive capture’ and hostility to the idea of regulation. This observation was reinforced by the strong sense in the Australian interviews that levels of basic quality have been achieved and that reaching levels of quality above this level is the concern of providers themselves, rather than a matter for

government involvement. Many participants spoke about the idea that the sector had ‘matured’ in Australia, and therefore it could be assumed that providers were achieving - and would go on to achieve - higher levels of quality, and that providers would also be more responsive to the needs, preferences and decisions of consumers. For policymakers then, it is important to recognise the points at which regulatory activity might become stale and in need of reinvigoration, either through fundamental changes in the organisational design or alternatively through changes in the strategy and approach.

9.2 Overarching findings and policy implications

This thesis suggests that there are more fundamental differences between the two national systems than simply how regulatory standards are formed or the extent to which the regulator is deterrence- or compliance focused. The first difference concerns the overarching theme which characterises each regulatory regime, with a ‘welfare’ theme in England and a ‘consumerist’ theme in Australia. Linked to this is the second difference, concerning how each regime’s ‘regulatory space’ is organised, and the roles and functions played by different stakeholders and groups.

Welfare or consumerism?

The wholesale adoption of consumerism and choice as an effective mechanism for quality is widely accepted to reflect a global trend (Fine, 2013, Tronto, 2017). The findings of this thesis indicate that the ‘consumerism’ label conceals the broad range of ‘consumerist’ ideas and how they might stem from historic institutional ideas over and above recent trends. While both the governments England and Australia are ostensibly focused with providing choice for individuals, this thesis identified a much stronger emphasis on the role of the consumer in Australia than in England. The theories put forward by Hood et al. (2001) and Haines (2011) provided a useful basis for analysing the development of the regulatory regimes in each country, but potentially neglect the far-reaching historical influences of the institutional contexts in each country.

While the policy rhetoric in England is based around consumers and choice, the regulatory regime continues to be influenced by the ‘welfarist’ heritage of the care system in England. Local authorities continue to play a major role in terms of oversight and safeguarding and at the centre of this is the role of the social worker in supporting the older person and their family. Oversight of the system in England is

supplemented and heavily influenced by legislation concerning the mental capacity and ‘best interests’ of residents, supported by the Deprivation of Liberty Safeguards legislation. The CQC is positioned as a key arbiter of quality with significant legislative powers, with a remit which includes ‘scoring’ providers using the ratings and drawing attention to poor care practices at the provider level and at the system level through the annual State of Care reports, themed investigations and reports and, most recently, the reviews of health and care systems in local areas. The CQC also has a role in safeguarding to ensure that providers follow processes appropriately. The state here has a strong role in protecting the welfare of residents and promoting human rights. While industry groups and providers lobby both central and local government, this thesis suggests that these groups have much less power than in Australia where they form a strong and coordinated lobby.

In Australia the role of the ‘consumer’ was generally seen by participants in the study as central to improving the quality of care provision. The state had a role to play in checking the basic levels of safety and quality of clinical processes, and in supporting consumer protection. However, many participants were sceptical about a larger role for the Quality Agency and were also largely positive about alternative options for accreditation (through ‘contestability’). Participants generally expressed the view that the residential care sector had ‘matured’ and this meant that there was less need for quality oversight in the sector than previously. The impact of consumerist ideas was more apparent in the interviews in Australia than in England.

The differences in the approaches of the two countries highlight the impact of the institutional history of the sector as having a much greater effect than is obvious from previous studies. The system in England continues from what is essentially a welfare model, informed by a history of state intervention, first through the Poor Laws, and then through the National Assistance Act. This contrasts with a longstanding mixed economy of supply in Australia, where philanthropic and faith-based provision has transitioned into a highly organised and professionalised system, still dominated today by non-profit providers.

The appeal of CDC in Australia is therefore partially driven by historical reasons over and above the recent global trend towards consumerism in other countries. The embeddedness of the consumerist view could explain why policymakers in Australia appear to have ignored previous research on the views and preferences of older people regarding choice. The favourable views of ‘choice’ at the policy level

discount, for example, studies in community care in England which have found that older people generally had less positive experiences with choice in the form of individual budgets when compared to younger adults (Glendinning, 2008, Woolham and Benton, 2013, Woolham et al., 2018). The evaluation of direct payments in residential care conducted into the ‘Trailblazers’ sites in England found that the benefits of direct payments for older people in residential care were more limited than had been claimed (Williams et al., 2017), with residents having limited capacity to exercise choice and control, and a lack of meaningful choices in terms of services (Ettelt et al., 2018). More positive findings emerged from a study of older users of direct payments in community care (Rodrigues and Glendinning, 2015), where some, though not all, individuals and their carers appreciated the increased control they had over timing and tasks, as well as the increased opportunities to develop close and reciprocal relationships with the individuals they appointed as personal assistants. In Australia, there was a general lack of discussion about the risks involved with this highly consumerist approach. The consistent message through the interviews was that older people simply need better information on quality to enable them to act as empowered consumers, although recent Australian research has drawn attention to some of the challenges and flawed assumptions in CDC policies (Gill et al., 2017, Cardona, 2017).

Design of the regulatory space

This theme, of welfare versus consumerism, is reflected in the design of the ‘regulatory space’, a concept which acknowledges that regulation encompasses a broad range of resources, relationships and perspectives, and is not restricted to the activities of a single body (Hancher and Moran, 1989, Scott, 2001). Previous studies have focused on the importance of the type of standards used (for example, structural, process or outcomes indicators) and the approach of the regulator (deterrence-based, compliance based, or based on responsive regulator). This thesis has established that the type of standard used is only one part of regulatory design, and the success and influence of the regulator depends on several other factors, including the extent of the legislative powers of the regulator, a need to articulate a vision of what good quality looks like, how payments mechanisms are designed, what and how information is gathered and published, and by whom. The success of quality oversight is also influenced by factors such as the relative power of providers, the stage of the regulatory life cycle and the level of government support. This last point is illustrated by the evidence in this thesis of the acceptance and approval of

the CQC's role in England when compared to the corrosive capture apparent in the Australian context.

In considering how to improve quality in long-term care, policymakers should pay attention to the design of the overall regulatory space, paying attention to the full range of policy options regarding regulatory design, complementary policy instruments and the opportunity to involve multiple stakeholders. Specifically, policymakers should:

- **Consider the relative impact of policy mechanisms**

The interviews in the study suggested that the respective regulatory 'clout' of different policy mechanisms has changed the balance between the different types of quality in each country, with both intended and unintended consequences. The imbalances caused by these 'low-' and 'high-powered incentives' (Dixit, 2002) should therefore be considered in policy design. So, for example, the presence of wealthier self-funding residents in England and residents with large RADs and DAPs in Australia are likely to drive a focus on consumer-directed quality which may trump aspects of organisational-focused quality or more likely, simply neglect the quality of life benefits which come with relationship-centred care.

- **Design pluralistic approaches**

The approaches of England and Australia were markedly different in how they engaged a range of actors in the regulatory space. In England, the system, influenced by the longstanding role of local authorities, involved a range of stakeholders in the oversight of quality. The involvement of multiple stakeholders in the regulatory process has long been recognised as a way of avoiding issues of ritual compliance and regulatory capture and copes with the varying capacities and motivations of individuals and provider organisations. Usually based on the theory of responsive regulation from Ayres and Braithwaite (1992), these types of multi-stakeholder, multiple intervention approaches have been developed under the banner of, for example, 'smart' regulation (Gunningham and Grabosky, 1998), 'decentred' regulation (Black, 2002) and 'really responsive' regulation (Baldwin and Black, 2008).

In residential care, the involvement of multiple stakeholders can potentially have a dual effect. Firstly, it improves connections between residents, their homes and the

community and therefore the quality of lives of residents, staff and relatives. Secondly, it is the most effective way of achieving the lighter touch regulatory goal which is so appealing to many policymakers. As one Australian policymaker in the current study commented:

The easiest hands-off regulation is when you have lots of people coming in and out every day. (Australia, Government, P11)

Involving extra stakeholders is, as Day and Klein (1987) argued, a way of making regulation into a continuous process, ‘to find ways of increasing the visibility of what goes on in nursing homes by exposing their activities to more eyes for more of the time’ rather than the ‘episodic’ process of formal inspections (pp340-1). Authors pay specific attention to the need to formally involve the public and empower consumers (Ayres and Braithwaite, 1992, Schwarcz, 2013).

- **Provide better information on quality**

In England, there was an acceptance that information on quality was important for motivating providers to improve but flawed in terms of its value for supporting choice. In contrast, in Australia, the approach of the government to information was inconsistent with how it gave precedence to the role of the consumer in provider quality improvement. If governments elect to choose ‘choice’ as a mechanism for incentivising quality improvement, then it is important that they take an active role in ensuring that appropriate quality information is made available to help individuals to make informed decisions about providers. This recommendation echoes the recommendations of Fung et al. (2007), who argue that governments need to play an active role in managing the flows of information particularly where information on risks or service failings are hidden from view, a salient issue in residential care. The authors see a very clear role for government as the ‘steward’ for managing and shaping the quality of the information itself, including overseeing the publication of reviews and user feedback, but particularly in compelling the disclosure of information and promoting common definitions and accurate measurement and data. The importance of this role is reinforced for long-term care due to its properties both as an experience and a credence good, and because of the profound impact care can have on quality of life.

9.3 Lessons for other sectors

A further question is the extent to which these findings can be transferred across other parts of long-term care. A contentious issue in qualitative methods is whether it is appropriate to assess the ‘generalisability’ of research studies, given that the concept of generalisability is a concept more accurately associated with the probabilistic sampling approaches used in quantitative research (Lewis et al., 2014). However, the comparative and policy-focused nature of this study provides opportunities to transfer conclusions to areas outside the remit of residential care for older people in Australia and England.

In terms of the three definitions of quality, there are more similarities between residential and community-based care than differences. The critical aspect of residential care in both countries which explains the findings of this study is not necessarily the specific care setting, but instead the fact that each country relies on a mixed economy of supply for care provision. The notion that there are three types of quality orientation could apply to any care setting where the private sector plays a part in provision and profitability is a factor.

The concept of organisation-focused quality can be easily applied to community-based care, in the form of a priority on well-documented processes and procedures and a focus on efficiency, for example, in how staff are rostered to achieve optimal numbers of home visits. Potential examples of consumer-directed quality in community care could include a focus on ‘branding’, such as sophisticated websites, expensive uniforms and innovative use of technology for providing care and managing care plans. For relationship-centred quality, the focus of home care companies would be on the recruitment of staff for their interpersonal skills, as well as designing rosters and schedules which provide continuity of staff and which allow staff the space and time to develop meaningful relationships with users of home care and their families. Studies in home care confirm that the quality of relationships and the innate characteristics and attitudes of staff are also important for users and their families (Francis and Netten, 2004, Kampanellou et al., 2017, Manthorpe et al., 2017, Chester et al., 2018). The model of different types of quality would require some re-design to be transferred to community-based models of care, but the presence of a mixed economy of care in the sector means that some of the same issues with policy decisions might still be present.

There are also relevant findings for other forms of social regulation, for example in education, health care and housing. The study confirms the theories put forward in models such as responsive regulation (Ayres and Braithwaite, 1992) and smart regulation (Gunningham and Grabosky, 1998), specifically in that it is the mix of policies, including aspects such as funding, which influence different types of quality, rather than inspection or accreditation alone. The study also reinforces the idea of ‘market ritualism’ put forward by Braithwaite et al. (2007), demonstrating that a reliance on the market to drive quality will incentivise a narrow focus on consumer-directed quality.

9.4 Limitations and further research

As with any research project, it is important to highlight the limitations of the study. As discussed in Chapter 4, there were problems with recruiting providers according to the original plan and the makeup of the final sample also differed between the two countries. The nature and size of the provider sample means that it is not possible to analyse the impact of the structural characteristics of provider organisations on their quality orientation, for example, the relative influence of NFP provision or the size of the organisation. The interviews with providers suggested that larger organisations are better resourced to manage the inspection and review processes, as they can provide dedicated quality staff and programmes to deliver internal ‘organisation-focused’ quality assurance and to manage inspection and accreditation processes. Yet, at the same time, in England, the State of Care report shows that larger nursing homes often struggle more with quality (CQC, 2017c). In terms of ownership, the study included both FP and NFP organisations, but the sample was not big enough to be able to draw conclusions about how ownership affected the provider’s approach to quality.

The impacts of size and ownership on quality and whether this varies in different countries is therefore an area which merits further research. The relationships between structural characteristics may be much more nuanced than current research in the long-term care sector shows; for example, different quality responses to information in the environmental sector are heavily influenced by factors such as how well established embedded organisations are in their local context or by the proximity of branches to head office (Doshi et al., 2013).

An unanticipated issue in the study was that the sample in England was skewed towards providers who are taking self-funders only, due to the corporate decisions to stop taking local authority-funded residents. This raises the issue of bias for the study, and more worryingly, reinforces the observation regarding the emergence of two tiers of quality. Linked to this, the size and nature of the sample in England also did not allow the assessment of variation between local authorities. Analysis of this variation was outside the scope of the study, but merits further investigation to see whether this was a pattern nationally, but also because of the large amount of work being done by local authorities on monitoring and improving quality, part of the market shaping responsibilities assigned to local authorities under the Care Act 2014.

This study has highlighted several differences in the design and potential impact of the policy mechanisms in each country. However, the lack of clear and comparable measurement in both countries meant that there is little opportunity to assess whether either system had any benefits over the other. Future research which compares different regulatory, quality and funding approaches might involve setting in place agreed quality measurements in a sample of similar providers and then tracking changes, something which this thesis has identified as a challenging task.

Further research is also recommended for three issues related to wider questions about the overall sectors: workforce issues; health care and clinical governance; and the impact of funding levels. The first concerns the links between the supply of a skilled workforce and quality and was mentioned at the end of Chapter 8. It is difficult to compare England and Australia in terms of whether the workforce is better equipped to provide good quality care because the skills and supply vary on so many different dimensions. These differences include the demographic makeup of the workforce, training and qualifications and employment legislation. The second issue concerns the relationship with health care in each of these countries. Much of the work on quality interventions in residential care are focused on managing health care, which is clearly a high priority issue in a sector where so many residents have complex health needs. The interviews with providers highlighted many areas where they benefited from support for various aspects of care and more research is needed in this area.

The last of the three issues is the underlying funding levels for the sector in each country. Without further research it is not possible to determine exactly how the

financial health of the sector is related to the different types of quality outlined in this thesis. There are two challenges with moving this forward. Firstly, there is no agreed measurement of quality, as discussed above. Secondly, there are differences in how the funding of providers in each country is organised. One difference is the use of the ACFI in Australia, but another concerns the ability of providers to make large capital investments in Australia, due to the large holdings held in deposits through RADs and their predecessor, accommodation bonds². Government spending in the sector in Australia also continues to grow year on year and providers also benefit from a large holding of accommodation deposits from residents. This contrasts with the sector in England, where austerity policies have seen significant cuts in government spending in the care sector since 2010, with a demonstrable impact on quality (Burns et al., 2016, CQC, 2017c, Healthwatch, 2017).

Finally, for a more rigorous evaluation of the influence of institutional factors affecting national regulatory regimes, it would be necessary to include other regulatory regimes in the study (for example, residential care and education or residential care and social housing) in the two countries (Levi-Faur, 2006). This would provide the opportunity to more clearly identify whether difference in design and implementation is driven by broader national characteristics or by the specific demands and characteristics of the sector being regulated.

9.5 Conclusions

At the outset of this study, the similarities between the quality systems of the two countries for residential care appeared to outnumber the differences. Existing literature and policy documents described two systems heavily reliant on market-based mechanisms, but with a strong safety net for quality provided by inspection and accreditation. In theory, the compliance-based, process-focused accreditation approach in Australia has been delivering better results than the deterrence-based inspection approach in place in England, according to the evidence published by the CQC and the Quality Agency. In Australia, virtually all providers pass accreditation (Australian Aged Care Quality Agency, 2015), while in England, around a fifth of social care providers were rated as ‘inadequate’ or ‘requires improvement’ by the CQC between 2014 and 2017 (CQC, 2017c). At the same time, the study also

² As at June 2015, providers in Australia held \$18.2 billion (approximately £11.4 billion as at January 2018) in deposits (Aged Care Financing Authority, 2016b), in a sector roughly a third the size of the sector in England.

suggested that the actual levels of provider quality in each country are much closer than suggested by the published results of inspections and reviews.

One contribution of my thesis is the development of a new typology to separate out three different ‘quality orientations’ in the sector and understand better how these different types of quality are linked to external policy interventions. This new way of looking at quality might help policymakers to design regulatory systems with a more informed understanding of what type of quality (organisation-focused, consumer-directed or relationship-centred) is likely to result from different interventions, and additionally, what the unintended consequences of certain policy choices might be. The study found that the pursuit of relationship-centred quality by provider organisations is largely independent of the regulatory system, demonstrated by existence of this type of quality in providers in both countries. However, this does not mean that the government does not have a role in relationship-centred quality; to promote relationship-centred care, it is vital that governments first set out a vision of quality, and that this vision of quality puts the resident at the centre. This vision should then be consistently communicated in policy documents for the sector, as well as in the standards and review process and policies around the publication of quality information.

To date, research on regulatory models and quality in long-term care has tended to focus on specific aspects of policy interventions and there have been limited comparative studies. By exploring and comparing a broad range of characteristics of the regulatory regimes of England and Australia, this study has highlighted how the extent of differences between regimes go much further than the style of inspection or nature of regulatory standards. This thesis identifies that regulatory design is informed by much bigger questions concerning institutional context and the history of the sector in England and Australia. This finding should be helpful in future research, to avoid overly simplistic comparisons of regulatory regimes which do not adequately acknowledge cultural and historical influences. In addition, the design of regulatory regimes needs to take into consideration the entirety of the ‘regulatory space’ governing the care sector, and consider the interplay between policy interventions, legislation and the involvement of multiple stakeholders, to fully understand how regulation works in practice.

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Appendices

- 1. The Aged Care Funding Instrument**
- 2. Funding Mechanisms in Australia**
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Appendix 1: The Aged Care Financing Instrument

From McNamee et al., 2017, pp15-6

The aged care funding model consists of three components – accommodation, basic services and care. This project is concerned only with the care component. The core of the design of the current funding model for the care component is that each resident is funded at a basic daily subsidy rate based on their ‘usual’ needs in each of the three ACFI domains - Activities of Daily Living (ADL), Behaviour (BEH) and Complex Health Care (CHC). Section 3.5.1 provides more detail on these domains.

For illustrative purposes, the current rates are shown in the table below. The daily subsidy paid for each resident for the care component is the sum of these three daily subsidies.

Level	Activities of daily living (ADL)	Behaviour (BEH)	Complex Health Care (CHC)
Nil	\$0.00	\$0.00	\$0.00
Low	\$36.65	\$8.37	\$16.37
Medium	\$79.80	\$17.36	\$46.62
High	\$110.55	\$36.19	\$67.32

There are also a range of subsidies and supplements. These include, for example, an oxygen supplement, enteral feeding supplements and supplements for veterans and homeless residents. Some of these supplements (such as those just listed) relate to the needs of individual residents. Others address structural issues such as the geographic isolation of some care homes. While these subsidies are an important feature of the overall design of the aged care funding system, they are supplementary rather than the core model.

Appendix 2 Funding Mechanisms in Australia

	Payment mechanism	Government or resident-funded	Revenue 2014/15 (\$ millions)	GBP equivalent* (£ millions)	Overview
All residents	Basic care subsidy	Government	\$7,917.2	£3,726.7	<ul style="list-style-type: none"> • Calculated using the Aged Care Funding Instrument • Dependency-based, against three domains: Activities of Daily Living; Behaviour; Complex Health Care • Needs assessed as Low, Medium or High against each domain
	Basic daily fee	Resident	\$2,855.8	£1,344.3	<ul style="list-style-type: none"> • Set at a maximum of 85% of the old age pension (pension \$404.15 (£193) per week in 2017**) • Covers living expenses such as laundry, meals and utilities
Supported residents only	Accommodation supplements	Government	\$762.4	£358.9	<ul style="list-style-type: none"> • Means-tested against assets (and income since July 2014) • Rate calculated on a combination of factors including the standard of the building and refurbishment • Rate reduced by 25% for providers for whom supported residents represent less than 40% of their total residents
Other residents	Means-tested care fee	Resident	\$314.2	£147.9	<ul style="list-style-type: none"> • Means-tested against income and assets since July 2014 • Accounted for less than 4% of revenue in 2014/15
	Refundable Accommodation Deposit (RAD)	Resident	\$18.2 billion held by providers as at June 2015	£8,567.0	<ul style="list-style-type: none"> • Essentially interest-free loan to providers • Capped at \$500k since LLLB reforms (can be raised with permission from the Aged Care Pricing Commissioner) • In 2014/15, sole form of payment by 42% of residents who paid for their own accommodation
	Daily Accommodation Payment (DAP)	Resident	\$643.2	£302.8	<ul style="list-style-type: none"> • Regular payments, similar to rent • Paid in place of, or as well as, RADs • In 2014/15, sole form of payment by 34.5% of residents who paid for their own accommodation • Combinations of RADs and DAPs were used by 23.5% of residents who paid for their own accommodation
	Extra services	Resident	\$194.8	£91.70	<ul style="list-style-type: none"> • Additional payments for extra services, for example, a higher standard of accommodation or additional services • Accounted for less than 1% of revenue in 2014/15

* Calculated using OECD Purchasing Power Parities as published on 21 April 2017

** From Department of Human Services at 21 April 2017

Sources: Aged Care Financing Authority, 2016b, Department of Health, 2016c, Department of Human Services, 2017, OECD, 2017

Appendix 3: CQC Fundamental Standards

Source: CQC Residential Care Provider Handbook (CQC, 2015b)

Safe	
By safe, we mean that people are protected from abuse and avoidable harm. In residential care this means that people are supported to make choices and take risks and are protected from physical, psychological and emotional harm, abuse, discrimination and neglect.	
S1	How are people protected from bullying, harassment, avoidable harm and abuse that may breach their human rights?
S2	How are risks to individuals and the service managed so that people are protected and their freedom is supported and respected?
S3	How does the service make sure that there are sufficient numbers of suitable staff to keep people safe and meet their needs?
S4	How are people's medicines managed so that they receive them safely?
S5	How well are people protected by the prevention and control of infection?

Effective	
By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence. In residential care, this means that people are supported to live their lives in the way that they choose and experience the best possible health and quality of life outcomes.	
E1	How do people receive effective care, which is based on best practice, from staff who have the knowledge and skills they need to carry out their roles and responsibilities?
E2	Is consent to care and treatment always sought in line with legislation and guidance?
E3	How are people supported to eat and drink enough and maintain a balanced diet?
E4	How are people supported to maintain good health, have access to healthcare services and receive ongoing healthcare support?
E5	How are people's individual needs met by the adaptation, design and decoration of the service?

Caring	
By caring, we mean that staff involve and treat people with compassion, kindness, dignity and respect. In residential care, this means that people, their families and carers experience care that is empowering and provided by staff who treat people with dignity, respect and compassion.	
C1	How are positive caring relationships developed with people using the service?
C2	How does the service support people to express their views and be actively involved in making decisions about their care, treatment and support?
C3	How is people's privacy and dignity respected and promoted?
C4	How people are supported at the end of their life to have a comfortable, dignified and pain free death?

Responsive	
By responsive, we mean that services are organised so that they meet people's needs. In residential care this means that people get the care they need, are listened to and have their rights and diverse circumstances respected.	
R1	How do people receive personalised care that is responsive to their needs?
R2	How does the service routinely listen and learn from people's experiences, concerns and complaints?
R3	How are people assured they will receive consistent coordinated, person-centred care when they use, or move between, different services?

Well-led	
By well-led, we mean that the leadership, management and governance of the organisation assure the delivery of high-quality, person-centred care, supports learning and innovation, and promotes an open and fair culture. In residential care, this means that management and leadership encourage and deliver an open, fair, transparent, supporting and challenging culture at all levels.	
W1	How does the service promote a positive culture that is person-centred, open, inclusive and empowering?
W2	How does the service demonstrate good management and leadership?
W3	How does the service deliver high quality care?
W4	How does the service work in partnership with other agencies?

Appendix 4: Accreditation Standards

Source: Australian Aged Care Quality Agency Assessor Handbook (Australian Aged Care Quality Agency, 2014b)

Standard 1: Management systems, staffing and organisational development	
Principle: Within the philosophy and level of care offered in the residential care service, management systems are responsive to the needs of care recipients, their representatives, staff and stakeholders, and the changing environment in which the service operates.	
Intention of standard: This standard is intended to enhance the quality of performance under all Accreditation Standards, and should not be regarded as an end in itself. It provides opportunities for improvement in all aspects of service delivery and is pivotal to the achievement of overall quality.	
1.1 Continuous improvement	The organisation actively pursues continuous improvement.
1.2 Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards and guidelines.
1.3 Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
1.4 Complaints and complaints	Each care recipient (or his or her representative) and other interested parties have access to internal and external complaints mechanisms.
1.5 Planning and leadership	The organisation has documented the residential care service's vision, values, philosophy, objectives and commitment to quality throughout the service.
1.6 Human resource management	There are appropriately skilled and qualified staff sufficient to ensure that services are delivered in accordance with these standards and the residential care service's philosophy and objectives.
1.7 Inventory and equipment	Stocks of appropriate goods and equipment for quality service delivery are available.
1.8 Information systems	Effective information management systems are in place.
1.9 External services	All externally sourced services are provided in a way that meets the residential care service's needs and service quality goals.

Standard 2: Health and personal care	
Principle: Care recipients' physical and mental health will be promoted and achieved at the optimum level in partnership between each care recipient (or his or her representative) and the health care team.	
2.1 Continuous improvement	The organisation actively pursues continuous improvement.
2.2 Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about health and personal care.
2.3 Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
2.4 Clinical care	Care recipients receive appropriate clinical care.
2.5 Specialised nursing care needs	Care recipients' specialised nursing care needs are identified and met by appropriately qualified nursing staff.
2.6 Other health and related services	Care recipients are referred to appropriate health specialists in accordance with the care recipient's needs and preferences.

2.7 Medication management	Care recipients' medication is managed safely and correctly.
2.8 Pain management	All care recipients are as free as possible from pain.
2.9 Palliative care	The comfort and dignity of terminally ill care recipients is maintained.
2.10 Nutrition and hydration	Care recipients receive adequate nourishment and hydration.
2.11 Skin care	Care recipients' skin integrity is consistent with their general health.
2.12 Continence management	Care recipients' continence is managed effectively.
2.13 Behavioural management	The needs of care recipients with challenging behaviours are managed effectively.
2.14 Mobility, dexterity and rehabilitation	Optimum levels of mobility and dexterity are achieved for all care recipients.
2.15 Oral and dental care	Care recipients' oral and dental health is maintained.
2.16 Sensory loss	Care recipients' sensory losses are identified and managed effectively.
2.17 Sleep	Care recipients are able to achieve natural sleep patterns.

Standard 3: Care recipient lifestyle	
Principle: Care recipients retain their personal, civic, legal and consumer rights, and are assisted to achieve active control of their own lives within the residential care service and in the community.	
3.1 Continuous improvement	The organisation actively pursues continuous improvement.
3.2 Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about care recipient lifestyle.
3.3 Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
3.4 Emotional support	Each care recipient receives support in adjusting to life in the new environment and on an ongoing basis.
3.5 Independence	Care recipients are assisted to achieve maximum independence, maintain friendships and participate in the life of the community within and outside the residential care service.
3.6 Privacy and dignity	Each care recipient's right to privacy, dignity and confidentiality is recognised and respected.
3.7 Leisure interests and activities	Care recipients are encouraged and supported to participate in a wide range of interests and activities of interest to them.
3.8 Cultural and spiritual life	Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered.
3.9 Choice and decision-making	Each care recipient (or his or her representative) participates in decisions about the services the care recipient receives, and is enabled to exercise choice and control over his or her lifestyle while not infringing on the rights of other people.
3.10 Care recipient security of tenure and responsibilities	Care recipients have secure tenure within the residential care service, and understand their rights and responsibilities.

Standard 4: Physical environment and safe systems	
Principle: Care recipients live in a safe and comfortable environment that ensures the quality of life and welfare of care recipients, staff and visitors.	
4.1 Continuous improvement	The organisation actively pursues continuous improvement.
4.2 Regulatory compliance	The organisation's management has systems in place to identify and ensure compliance with all relevant legislation, regulatory requirements, professional standards, and guidelines, about physical environment and safe systems.
4.3 Education and staff development	Management and staff have appropriate knowledge and skills to perform their roles effectively.
4.4 Living environment	Management of the residential care service is actively working to provide a safe and comfortable environment consistent with care recipients' care needs.
4.5 Occupational health and safety	Management is actively working to provide a safe working environment that meets regulatory requirements.
4.6 Fire, security and other emergencies	Management and staff are actively working to provide an environment and safe systems of work that minimise fire, security and emergency risks.
4.7 Infection control	An effective infection control program.
4.8 Catering, cleaning and laundry services	Hospitality services are provided in a way that enhances care recipients' quality of life and the staff's working environment.

Appendix 5: CQC Intelligent Monitoring Indicators (CQC, 2016b)

Theme	Indicator description	Data source
Context and cross key question indicators	Whistleblower in previous 12 months	Care Quality Commission received whistleblowing alerts
	Multiple whistleblowers in previous 12 months	Care Quality Commission received whistleblowing alerts
	Warning notice in previous 12 months	Care Quality Commission (internal data)
	Concerns and complaints received by CQC in previous 12 months	Care Quality Commission (internal data) – Complaints received directly by CQC about a service and concerns received about a service via CQC's Share Your Experience webform
Safe indicators	High rate of serious injury notifications (regulation 18-2 a&b) per bed compared to the rate of similar residential social care services	Statutory notifications submitted to the Care Quality Commission
	High rate of death notifications (regulation 16) per bed compared to the rate of similar residential social care services	Statutory notifications submitted to the Care Quality Commission
	Low rate of serious injury notifications (regulation 18-2 a&b) per bed compared to the rate of similar residential social care services	Statutory notifications submitted to the Care Quality Commission
	Low rate of death notifications (regulation 16) per bed compared to the rate of similar residential social care services	Statutory notifications submitted to the Care Quality Commission
	High rate of abuse or allegations of abuse notifications (regulation 18- 2e) per bed compared to the rate of similar residential social care services	Statutory notifications submitted to the Care Quality Commission
	Safeguarding in residential social care	Care Quality Commission received safeguarding incident data
	Ratio of all staff to beds	This indicator is constructed from data from the Skills for Care National Minimum Data Set for Social Care (NMDS-SC); in the absence of a completed and up-to-date NMDS-SC, data from the Provider Information Return (PIR) is used.
	Vacancy rate for all staff	This indicator is constructed from data from the Skills for Care National Minimum Data Set for Social Care (NMDS-SC); in the absence of a completed and up-to-date NMDS-SC, data from the Provider Information Return (PIR) is used.
Well-led Indicators	Turnover rate for all staff	This indicator is constructed from data from the Skills for Care National Minimum Data Set for Social Care (NMDS-SC); in the absence of a completed and up-to-date NMDS-SC, data from the Provider Information Return (PIR) is used.
	There is a registered manager in place	Care Quality Commission (internal data)
	Multiple changes in registered manager in previous 12 months	Care Quality Commission (internal data)
	No serious injury, abuse/allegations of abuse or death notifications submitted since their registration	Care Quality Commission (internal data)

Appendix 6: Sample introductory email for recruitment (customised for each participant)

Dear XXXX,

I work in the Personal Social Services Research Unit at the LSE and I am writing to ask if you would be prepared to be interviewed for my PhD research. I am investigating how governments should intervene in the social care sector to improve quality over and above minimum standards. I would like to interview you because...

My research is a comparative study of the approaches taken by the governments of England and Australia, focusing on residential care. You may be aware that Australia has adopted a slightly different approach from England in terms of regulation in the residential care sector. The purpose of my study is to investigate how and why the approaches differ and to identify the advantages and disadvantages of each country's approach from the perspectives of government, regulators, providers, researchers and of groups who represent users, carers, care professionals and providers. My research is funded through a Doctoral Research Fellowship funded by the National Institute for Health Research. I have attached an information sheet with details of the project.

I would be very grateful if you would agree to a face-to-face interview of approximately one hour. I am aiming to capture a broad range of perspectives and experiences, and as part of the interview I would appreciate any advice you can provide on suitable people to interview at the next stage of the study.

Please let me know if you would be happy to meet me and, if so, where and when would be most convenient for you.

I look forward to hearing from you.

Kind regards,
Lisa

Lisa Trigg
NIHR Doctoral Research Fellow

Appendix 7: General Sample Organisations and Interviews

ENGLAND	
INDIVIDUAL	ROLE AND/OR ORGANISATION
NADRA AHMED	Chair, National Care Association
SHARON ALLEN	Chief Executive Officer, Skills for Care
CAROLINE BARIA	Strategic Commissioning, Access & Safeguarding, Nottinghamshire Local Authority
DAVID BEHAN	Chief Executive, Care Quality Commission
CLIVE BOWMAN	Independent Consultant
DON BRAND	Independent Consultant
PAUL BURSTOW	Former Minister of State for Care Services (2010-12)
JANE CASHMORE	Commissioning Manager, Nottinghamshire Local Authority
GILLIAN DALLEY	Independent Consultant
JOANNA DAVID	Assistant Director Social Care Reform, Local Government Association
GLORIA DOWLING	Regional Inspection Manager, Care Quality Commission
AMANDA EDWARDS	Deputy Director, Social Care Institute for Excellence
MARTIN GREEN	Chief Executive, Care England
ROB GREIG	Chief Executive, National Development Team for Inclusion
HELENA HERKLOTS	Chief Executive, Carers UK
SARAH HOWARTH	Commissioning Officer, Nottinghamshire Local Authority
RHIDIAN HUGHES	Chief Executive, Voluntary Organisations Disability Group
DES KELLY	Former Chief Executive, National Care Forum
JOHN KENNEDY	Director of Care Services, Joseph Rowntree Foundation
GILLIAN LENG	Deputy Director, National Institute for Health and Care Excellence
JAN LOCKYER	My Home Life Programme, Essex Local Authority
SARAH MAGUIRE	Director of Quality, Choice Support (Experts by Experience)
ALAN PEARCE	Chair, Nottinghamshire Care Association
DAVID PEARSON	Immediate Past President, Association of Directors of Adult Social Services
DENISE PLATT	Former Chair, Commission for Social Care Inspection
PAUL RICHARDSON	Department of Health
SUSAN ROBINSON	Acting National Director, HealthWatch
ALAN ROSENBACH	Strategy Lead, Care Quality Commission
RASCHEL SANGHERA	Quality and Market Management, Nottinghamshire Local Authority
ANDREA SUTCLIFFE	Chief Inspector of Social Care, Care Quality Commission
IAN TURNER	Chair, Registered Nursing Home Association
ROSAMUNDE WILLIS-READE	Quality and Market Management, Nottinghamshire Local Authority

AUSTRALIA	
INDIVIDUAL	ROLE AND/OR ORGANISATION
CHRISTINA BOLGER	Executive Director Programs and Education, Australian Aged Care Quality Agency
ELSY BRAMMESAN	Department of Health (State Office)
MARK BRANDON	Former Chief Executive, Aged Care Standards and Accreditation Agency
ROSS BUSHROD	Director (Quality & Standards), Australian Aged Care Quality Agency
MARK BUTLER	Former Minister for Mental Health and Ageing (2010-13)
TRACY CLERKE	State Director, NSW/ACT, Australian Aged Care Quality Agency
MELISSA COAD	National Office Development and Industry Coordinator, United Voice
ANDREA COOTE*	Chair, Aged Care Quality Advisory Council
DAVID COX	Consultant, Ansell Strategic
MARILYN CRABTREE	Chief Executive, Aged Care Advocacy Service (South Australia)
CHARMAINE CROWE	Senior Advisor, Research and Advocacy, Combined Pensioners & Superannuants Association
MICHAEL CULHANE	Department of Health
MARY ANN FISHER	Department of Health
RICHARD GRAY	Aged Care Policy, Catholic Health Australia
JUDY GREGURKE	National Manager Aged Care Reform (NACA)
IAN HARDY	Chief Executive, Helping Hand
JAN HERBERT	Independent Consultant, National Seniors
ANNA HOWE	Independent Consultant
STEPHEN JUDD	Chief Executive, Hammond Care
JOHN KELLY	Chief Executive, Aged and Community Services Australia
RAE LAMB	Aged Care Complaints Commissioner
LISA LANGLEY	Policy Manager, NSW Council for the Ageing
JOSH MALDON	Department of Health
NICK MERSIADES	Director, Aged Care, Catholic Health Australia
MARY MURNANE	Formerly at Department of Health
ANNETTE PANZERA	Health Care Policy, Catholic Health Australia
ELIZABETH PRINGLE	Independent Consultant (formerly Accreditation Agency)
ALMA QUICK	Formerly at Department of Health
CATERINA RACCOSTA	Manager and ACT/NSW State Representative, Community Visitor's Scheme
LISA RALPHS	Community Policy Advisor, Aged and Community Services Australia (state office)
JOANNE RAMADGE	Former Senior Clinical Advisor in Aged Care, Department of Health
GLENN REES	Independent Consultant (formerly Department of Health and Alzheimer's Australia)
PATRICK REID	Chief Executive, Leading Aged Services Australia
KAY RICHARDS	National Policy Manager, Leading Aged Services Australia
COLLEEN RIVERS	Manager, Policy Advice & Consultancy, Aged and Community Services Australia (state office)
RICHARD ROSEWARNE*	Chief Executive, Applied Aged Care Solutions Pty Ltd
NICK RYAN	Chief Executive Officer, Australian Aged Care Quality Agency
RACHEL SIEWERT	Senator for Western Australia (2005-)

AUSTRALIA	
INDIVIDUAL	ROLE AND/OR ORGANISATION
ELLEN SKLADZIEN*	National Policy Advisor, Alzheimer's Australia
PETER STAPLES	Former Minister: Housing and Aged Care (1988-90), Aged Family and Health Services (1990-93)
LEE THOMAS	Federal Secretary, Australian Nursing & Midwifery Federation
RUSSELL WESTACOTT	Chief Executive, The Aged Care Rights Service (NSW)
ANN WUNSCH	Executive Director – Operations, Australian Aged Care Quality Agency
IAN YATES	Chief Executive, Council for the Ageing

* Conducted in public places and not transcribed due to sound quality

Interviews which were not transcribed due to data saturation and excluded from the analysis:

Name	Country	Role
John Burton	England	Independent Consultant
DAVID CULLEN	Australia	Principal Economist, National Disability Insurance Agency
MARY LYTTLE	Australia	Chief Executive, Elder Rights (Victoria)
GEOFF ROWE	Australia	Chief Executive, Queensland Aged & Disability Advocacy
ANDREW LARPENT	Australia	Chief Executive, Southern Cross Care (South Australia)
MIKE RUNGIE	Australia	Chief Executive, ACH Group

Appendix 8: Study Information Sheets and Consent Forms

- 1. Participant Information Sheet (General)**
- 2. Consent Form (General)**
- 3. Participant Information Sheet (Providers)**
- 4. Consent Form (Providers)**

Best practice and the regulation of quality of residential care for older people

Participant Information

Investigator: Lisa Trigg

I would like to ask you to take part in a research project. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what you will be asked to do. Please take time to read this information carefully and discuss it with others if you wish. Only participate if you want to. Choosing not to take part will not affect you in any way. Please ask me if there is anything that is not clear or if you would like more information.

What is the research about?

The purpose of this study is to look at what governments have done, and should do, to encourage providers to deliver care which is better than just the basic level of quality. Sometimes this is described as 'excellent' care, or as 'best' or 'better' practice. The study will look at the different ways governments might be able to influence quality improvement and which approaches might be most successful. To do this, I am going to compare the approaches taken by the governments of England and Australia for residential care for older people (referred to as 'aged care' in Australia). The care systems in these two countries have much in common, but the governments have taken different approaches to promoting best practice.

Why is this research happening?

Most governments have found it difficult to encourage providers of care to improve their quality. Many approaches have been tried, but it is not clear which are the most effective. These approaches include conducting inspections, encouraging competition between care providers and publishing performance data and star ratings. Many of these are used to make sure that providers deliver basic levels of care.

The main contribution of this study will be to inform the future design of policies to improve care for older people over and above basic levels. Its main value will be to policy-makers in England and Australia, however it will also seek to develop understanding which can be used by other countries.

Who am I?

I am a researcher from the Personal Social Services Research Unit at the London School of Economics and Political Science (UK). The National Institute for Health Research (NIHR) in England is funding this research through a Doctoral Research Fellowship (DRF- 2013-06-091). The research forms part of my PhD in Social Policy.

Why have you been approached?

I am approaching you because of your current or past professional role within the adult social care or aged care sector and your expertise about this subject. I am aiming to capture a broad range of perspectives and experiences, from people in government, in regulatory bodies, care providers, researchers and from groups who represent users, carers, care professionals and providers.

What do you need to do?

I would like to conduct a face-to-face interview with you to discuss different aspects of the research. The interview will take place at a location which is convenient for you. It will take approximately 60 minutes. I will record the interview if you agree, so that nothing is missed. The interviews will be typed up by a transcriber, who has signed a confidentiality agreement.

Will taking part in this research be kept confidential?

I will use anonymised data and quotations to illustrate points in written publications. I will make every effort to ensure quotes are non-attributable, although this cannot be guaranteed because of the small number of people in each group. I would like to include your name in the list of people I spoke to for the study, but you can let me know if you would prefer your participation in the study to be confidential. All of this will be explained at the beginning of the interview and you will be asked to sign a form indicating what you would prefer.

In the unlikely case of professional negligence, harm to vulnerable adults or criminal behaviour being disclosed or observed, I may have to break confidentiality and contact the relevant authorities. This is a condition of all research approved by the Social Care Research Ethics Committee in England to ensure that the interests of users of care and other individuals are prioritised and protected.

What will happen to the results of the study and how will you know about them?

I will present the findings of the research at conferences, seminars and other events. I will also publish the findings in journals and reports. I will send all participants an article with the final results, as well as any reports or articles which are freely available.

What are the possible benefits of taking part?

There may be no or few short-term benefits for you, but the study will provide recommendations for policy-making and I hope the study will contribute to a better understanding of how to improve quality in care in the future. I will share the results of the study with everyone who has been interviewed.

How can you withdraw from the study?

You can withdraw from the study at any time. You do not have to give any reason for changing your mind. Withdrawing from the study will have no effect on you. I would retain the information from your interview unless you tell me or one of my colleagues that you would prefer it to be destroyed.

What will happen to your personal information?

All the information I collect will be kept securely. This data will be stored on a password protected computer and university network and any paper material will be stored in locked filing cabinets within university offices. Only the transcriber and I will have access to the data collected. Data will be stored for one year after the end of the study and then deleted.

What if something goes wrong?

If you wish to complain or have any concerns about any aspect of the research and the way you have been approached or treated, please contact me or David Coombe, Director, Research Division, London School of Economics and Political Science, Houghton Street, London, WC2A 2AE. Telephone: 020-7955-7114. Email: d.coombe@lse.ac.uk.

Ethics

The study has been approved by the Social Care Research Ethics Committee in England (Study Identification Number: 14/IEC08/1021) and by the Research Ethics Committee of the London School of Economics and Political Science.

For information, questions and concerns please contact:

Lisa Trigg, tel: +44 (0)20 7852 3733, email: l.j.trigg@lse.ac.uk

Consent Form

Best practice and the regulation of quality for older people

Thank you for considering taking part in this research. If you have any questions please ask the researcher before you decide whether to take part. You will be given a copy of this consent form to keep and refer to at any time.

	Please tick if you agree
I confirm that I have read and understood the Participant Information (General) dated 2/12/14 (Version 1.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my employment or legal rights being affected.	
I know personal information such as my contact details will be kept private.	
I understand that if I withdraw from the study my personal details will automatically be destroyed and I can request that any written or recorded information collected through an interview be destroyed.	
I agree to take part in the study.	

	Please delete as appropriate
I agree to the interview being audio recorded.	Yes/No
I agree to be identified in the following way within research outputs. Full name included in list of participants Full name included in study results Pseudonym (e.g. generic job title or role) Complete confidentiality	Yes/No Yes/No Yes/No Yes/No

Name of participant (please print) _____

Signed _____ Date _____

Name of researcher (please print) _____

Signed _____ Date _____

For more information, contact: Lisa Trigg, Personal Social Services Research Unit, London School of Economics and Political Science, Houghton St, London, WC2A 2AE Telephone: +44 (0)20 7852 3733 Email: l.j.trigg@lse.ac.uk

Best practice and the regulation of quality of residential care for older people

Participant Information

Investigator: Lisa Trigg

I would like to ask you to take part in a research project. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what you will be asked to do. Please take time to read this information carefully and discuss it with others if you wish. Only participate if you want to. Choosing not to take part will not affect you in any way. Please ask me if there is anything that is not clear or if you would like more information.

What is the research about?

The purpose of this study is to look at what governments have done, and should do, to encourage providers to deliver care which is better than just the basic level of quality. Sometimes this is described as 'excellent' care, or as 'best' or 'better' practice. The study will look at the different ways governments might be able to influence quality improvement and which approaches might be most successful. To do this, I am going to compare the approaches taken by the governments of England and Australia for residential care for older people (referred to as 'aged care' in Australia). The care systems in these two countries have much in common, but the governments have taken different approaches to promoting best practice.

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The main contribution of this study will be to inform the future design of policies to improve care for older people over and above basic levels. Its main value will be to policy-makers in England and Australia, however it will also seek to develop understanding which can be used by other countries.

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Why have you been approached?

I would like to interview you because of the knowledge and experience you have of managing residential homes for older people. I would like to find out more about how you go about changing and improving the way you do things and whether you receive help or advice from other organisations or individuals.

I am also going to speak to people with a range of other experiences, from people in government, people from regulatory bodies, researchers, and from groups who represent users, carers, care professionals and providers.

What do you need to do?

I would like to conduct a face-to-face interview with you to discuss different aspects of the research. The interview will take place at a location which is convenient for you. It will take approximately 60 minutes. I will record the interview if you agree, so that nothing is missed. The interviews will be typed up by a transcriber, who has signed a confidentiality agreement.

Will taking part in this research be kept confidential?

Everything you say/report is confidential unless you tell me something that indicates someone is at risk of harm. I would discuss this with you before telling anyone else.

Otherwise, your information will be treated in the strictest confidence and kept securely. I will not list your name in any reports or articles or when talking about the study. I will use anonymised data and quotations to illustrate points in written publications.

What will happen to the results of the study and how will you know about them?

I will present the findings of the research at conferences, seminars and other events. I will also publish the findings in journals and reports. I will send all participants an article with the final results, as well as any reports or articles which are freely available.

What are the possible benefits of taking part?

There may be no or few short-term benefits for you, but the study will provide recommendations for policy-making and I hope the study will contribute to a better understanding of how to improve quality in care in the future. I will share the results of the study with everyone who has been interviewed.

How can you withdraw from the study?

You can withdraw from the study at any time. You do not have to give any reason for changing your mind. Withdrawing from the study will have no effect on you. I would retain the information from your interview unless you tell me or one of my colleagues that you would prefer it to be destroyed.

What will happen to your personal information?

All the information I collect will be kept securely. This data will be stored on a password protected computer and university network and any paper material will be stored in locked filing cabinets within university offices. Only the transcriber and I will have access to the data collected. Data will be stored for one year after the end of the study and then deleted.

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Ethics

The study has been approved by the Social Care Research Ethics Committee in England (Study Identification Number: 14/IEC08/1021) and by the Research Ethics Committee of the London School of Economics and Political Science.

For information, questions and concerns please contact:

Lisa Trigg, tel: +44 (0)20 7852 3733, email: l.j.trigg@lse.ac.uk

Consent Form

Best practice and the regulation of quality of care for older people

Thank you for considering taking part in this research. If you have any questions please ask the researcher before you decide whether to take part. You will be given a copy of this consent form to keep and refer to at any time.

	<i>Please tick if you agree</i>
I confirm that I have read and understood the information sheet dated 2/12/14 (Version 1.0) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my employment or legal rights being affected.	
I know my personal information will be kept private and that my name will not be used in anything that is written about the study.	
I understand that if I withdraw from the study my personal details will automatically be destroyed and I can request that any written or recorded information collected through an interview be destroyed.	
I agree to take part in the study.	
I agree to the interview being audio recorded.	Yes/No

Name of participant (please print) _____

Signed _____ Date _____

Name of researcher (please print) _____

Signed _____ Date _____

For more information, contact:

Lisa Trigg, Personal Social Services Research Unit, London School of Economics and Political Science, Houghton St, London, WC2A 2AE Telephone: +44 (0)20 7852 3733 Email: l.j.trigg@lse.ac.uk

Appendix 9: Interview Guides

- 1. General Interview Guide**
- 2. Provider Interview Guide**

Interview Guide: General Semi-structured Interviews

[Information in square brackets is a note to the researcher. Where information will vary between each country, it is shown in italics.]

Thank you for agreeing to take part in my study and for agreeing to an interview. My name is Lisa Trigg, and I'm from the London School of Economics *in the UK*. All of my research is in *adult social care/aged care* and I'm particularly interested in quality and residential care.

This research is looking at what governments should – or indeed shouldn't – do to encourage or help care home providers deliver excellent care.

I'm exploring the full range of approaches governments might take to improve quality. This might include inspections and standards-setting, *commissioning/bed allocation* processes, government-provided training and information, complaints schemes, or interventions to do with staff such as minimum wages or qualifications. However, I'm particularly interested in the interventions where the goal is to improve quality over and above a basic level, under banners such as 'best (or better) practice' or 'excellence'.

I'm interviewing a number of different people in the *social care/aged care* sector in England and Australia. This includes the regulatory bodies, the relevant government departments, academics and people who represent users and carers, and providers and professionals. This includes people who are currently in these roles or previously in these roles. The reason I'm comparing these two countries is that, while the systems have many similarities, the way in which quality is managed is slightly different, with different actions and most notably, a slightly different role for the inspections body (CQC/the Aged Care Quality Agency).

As I said in my letter/email, I've asked you for an interview due to..... (your current role/your previous role).

[AND/OR IF APPROPRIATE]: (Name) suggested that you would be a good person to interview because

Purpose of study

The period of time/experience I'm particularly interested in is However, with your experience there is every chance you will also have an opinion on recent/ historical developments.

I'm interested to know more about:

- What you can tell me about government attempts – both past and present – to improve quality in the sector – over and above minimum standards
- How effective these are
- How the current and previous systems came to be in place and why
- What are the opportunities to improve quality in the future

The interview should take about one hour.

At the end of the study I'll publish my findings – anonymously – and I hope that it will help to design better ways of doing things in the future.

The research is being funded by the National Institute of Health Research, which is in turn funded by the Department of Health [in England].

Consent

Did you receive a copy of this document that describes the study [show study information sheet]?

No- [Review the study information sheet in detail]

Yes- *Good* [Review the study information sheet briefly]

Do you have any questions about the study or the interview we're doing today?

Please can you sign this consent form for our records [show the consent form], it's a standard form used in research, to say that:

- you understand what the research will involve
- you are happy for our discussion to be audio recorded
- you know that you can change your mind about taking part and stop the interview anytime without saying why
- your name and role will be included in the list of participants
- your personal information such as your contact details will be kept private and your name will not be directly attributed to information and quotations in the study, and finally,
- you would like to consent to take part.

[Start recording]

1. Background

First I'd like to start by confirming some of the details I have about your role and experience.

[Refer to profile and confirm roles and dates if necessary].

2. Role for Government

What do you think are the responsibilities of the government in terms of best practice and excellent quality?

To what extent should the government be involved in improving quality in the sector? Why is this?

And what about improving quality over and above minimum standards? What is your rationale for this?

3. Current Interventions

Thinking about the broad range of government interventions which government interventions (if any) are an attempt to raise quality in the sector over and above minimum standards?

PROBE:

- Quality commissioning/allocation of aged care places or pay-for-performance
- Inspections and standard-setting
- Training and education
- Best practice information
- Professional qualifications
- Rules around pay and conditions

How much do you think the current approach influences provider quality in reality? Are any of these interventions likely to improve quality over and above minimum levels of quality?

What about previous approaches?

Which are the interventions have the best chance of success? Why do you think this is?

How does the current approach compare with previous approaches?

4. How the system is/has been designed?

You were involved with/around during the design of the current system (and/or one of the previous systems).

Could you talk me through how the design of the current (and/or previous) system came to be in place?

What were the main influences on how the system was designed? How were decisions made about different aspects of the system?

Probe:

- The different regulatory bodies
- What sort of standards would be set
- What is meant by quality
- What is meant by 'excellence' or 'best' or 'better practice'?

Who led the process? Who were the key players? Who had most influence over the process?

What was your role?

Was anyone (or any organisations) missing from the process? Who?

Was anyone (or any organisation) opposed to the current system?

What are the other factors which might have influenced the way the current system is designed in England (Australia)?

Probe:

- Political preferences or ideologies
- Economic or financial factors
- Social pressure e.g. scandals or lack of social pressure e.g. place of older people in society
- Technical (e.g. development of outcomes measurement, dissemination of best practice, dissemination of results)

What evidence was used to inform the design of the current system? [AND/OR] What evidence was used to inform the design of previous systems?

Probe:

- From other sectors
- From other countries

What were the alternatives to this approach (if any)?

5. The future

In your view, what responsibility should the government have for improving quality in the sector? Why?

What about quality over and above minimum standards? What should be the government's role in this?

What are the best interventions or initiatives for delivering this in the future?

What would improve the current system?

What are the main barriers to improving provider quality?

Closing

Is there anything you'd like to go back to – or anything else you would like to tell me?

And, do you have any questions for me before we finish?

Are there any specific individuals you would recommend I speak to?

Thank participant, explain what will happen next and check contact details for sharing results (if desired).

Interview Guide: Providers

[Information in square brackets is a note to the researcher. Where information will vary between each country, it is shown in italics.]

Thank you for agreeing to take part in my study and for agreeing to an interview. My name is Lisa Trigg, and I'm from the London School of Economics *in the UK*.

The research project I'm working on is looking at what governments should – or shouldn't – do to encourage or help care home providers deliver excellent care.

I'm interviewing managers from a number of *nursing homes and care homes/residential aged care facilities* to find out more about how you go about improving and making changes to the way you do things and how much this is influenced or supported by bodies like the *Care Quality Commission/the Aged Care Quality Agency* or the *local authority/Department of Social Services* and any other external organisations you deal with.

I'm interviewing managers here and I'm also talking to managers in *England/Australia* to see whether their experiences are different. This is interesting because the systems are a bit different...

For participants in England:

Here we have the Care Quality Commission doing inspections of homes, with local authorities often getting involved as well. In Australia they have a body called the Aged Care Quality Agency. It's similar to CQC in some ways, but they use different standards which haven't changed much since the late 1990s. Inspectors also spend a lot of time looking at how the homes go about improving care and what processes they have in place for this. And the Agency also holds training courses and conferences on 'better practice' and presents awards to providers.

For participants in Australia:

While here the Aged Care Quality Agency conducts quality reviews of homes, in England we have a body called the Care Quality Commission – CQC. It's similar to the Agency in some ways, but it uses different standards which have changed many times in the last 10 or 15 years – and have just changed again. Some of these standards cover the same things as in Australia but they don't refer to continuous improvement as much as here. And at the moment the CQC doesn't do extra things the Agency does, like hold conferences and training courses.

So I'm doing interviews in both countries to see if this makes any difference for *home/facility managers*. I'm also doing some interviews with other groups of people for example, from *CQC and also CSCI, some local authority staff and various other people/the Agency and also the Accreditation Agency, from the government and some other groups* involved in the industry. At the end of the study I'll publish my findings – anonymously – and I hope that it will help to design better ways of doing things in the future.

The research is being funded by the National Institute of Health Research, which is in turn funded by the Department of Health [in England]. I'm going to talk to around 10 managers of *homes/facilities* of various sizes in each country.

Purpose of study

I want to talk to you as someone who looks after a *care home/aged care facility*. The sorts of things I want to talk about are:

- What type of improvements you've made in the *home/facility* and how you go about making these improvements
- Where the ideas for improvements come from
- What are the reasons for making the changes?

The interview should take about one hour.

Consent

Did you receive a copy of this document that describes the study [show study information sheet]?

No- [Review the study information sheet in detail]

Yes- *Good* [Review the study information sheet briefly]

Do you have any questions about the study or the interview we're doing today?

Please can you sign this consent form for our records [show the consent form], it's a standard form used in research, to say that:

- you understand what the research will involve
- you are happy for our discussion to be audio recorded
- you know that you can change your mind about taking part and stop the interview anytime without saying why
- you know that the information we discuss will be kept private and your name will never be used in anything that is written about the study, and finally,
- you would like to consent to take part.

[Start recording]

1. Background

I'd like to start by confirming some of the details I have and finding out a bit more about the *home/facility*.

Can I confirm that this *home/facility* provides care for older people. Do you offer:

- Care with nursing/high care beds?
- Care without nursing/low level beds?
- Specialist dementia services?
- Do you provide any other specific or special services?

In terms of ownership, is the *home/facility* a voluntary or non-for-profit organisation or a private 'for profit' company? Is it part of a chain?

How many beds does the home have?

[England only]

At the moment, how many residents pay for their own care versus how many receive some or all of their funding from their local authority or the NHS?

[Australia only]

Do you have any residents who pay for their own care?

Are there other homes/facilities in the area? Is there much competition for new residents?

What are the main reasons people choose your home/facility?

And some background on you...

How long have you worked here? What did you do before you became the manager here?

And finally, could you give me an idea of how the home/facility is organised in terms of staff and who reports to who?

2. Changing the way things are done in the home

I'm interested in finding out more about some of the improvements you [or the managers before you] have made to the home or the way things are run.

Can you tell me what sort of improvements and positive changes have happened, over, say the last 5 years?

Probe:

- Physical environment
- How residents are cared for and live their lives
- Staffing and roles
- Specific processes which have been implemented – e.g. links with health providers, medications management, falls prevention
- Staff training and development
- Procedures and documentation
- Technology

Which have been the most major changes?

Thinking about (the change/ changes), how did you go about making it happen? Probe:

- Communication (with staff/residents/families and relatives/outside organisations)
- Training and development
- Changes to staffing and/or structure
- Use of technology

Did you get any help from outside? If so, who? How did you decide who to approach?

[If part of a chain]:

How much does head office get involved with these sorts of changes?

How do you know if the changes were successful or what effect they had?

3. Ideas

Thinking about some of those improvements, where do the ideas behind them come from?

So, for example, if we take the change you described, how did the idea for that come about?

[Repeat, depending on answers in previous section.]

In general, how do you find out about new ways of doing things?

Probe:

Talk to other home/facility managers (who and why?)

Had office [if part of chain]

Attend training courses (delivered by whom, who attends?)

Attend conferences (organised by whom, who attends?)

My own research

If you had to choose just one of these, which one would it be?

[Choose one of the following based on whether government organisations were mentioned]

You said you talk to (e.g. *CQC/Quality Agency*). Do you find this particularly helpful? If so, why? Can you give me an example of where you've done this?

[OR]

You didn't mention *CQC/the Quality Agency/your local authority*? Have you thought about asking them for help in the past? If not, why not?

[England only]

What about other organisations like the Social Care Institute for Excellence or NICE?

[If the manager has said they conduct their own research]

You said you do your own research? How do you go about this? Are there any sources you particularly trust?

Probe:

- Individuals
- Organisations
- Websites/magazines/publications

How do you decide who provides the best information?

4. Reasons/rationale for making changes

Thinking about some of the improvements you've made here, what are the main reasons they've happened?

What did you set out to achieve?

Possible probes:

- To make life better for the residents
- To make life better for the staff
- To comply with the *CQC/Quality Agency* standards

- To comply with *local authority/Commonwealth* requirements
- To save money
- To be more profitable
- To attract more residents
- To attract more local authority residents/allocated places from the government
- As part of an internal quality programme
- Changes are led by head office [for chains only]

If you had to choose one reason, which would it be?

How do you prioritise? Which changes come first?

If we think about improvement? Did it involve spending much? How did you go about justifying the extra money?

Are there changes you would like to make but can't? What stops you from making these changes?

5. Government Support

This final section of the interview is about your views on whether there are opportunities for the government to support you better in this area.

Do you think the government (and its agencies like CQC/Quality Agency) could do more to support you to improve the way you do things? DO you think it could do less? What could it do differently?

How much does the inspection/quality review process help you to deliver good care? Does it help you to deliver care which is better than the standards require?

Closing

Is there anything you'd like to go back to – or anything else you would like to tell me?

And, do you have any questions for me before we finish?

Thank participant, explain what will happen next and check contact details for sharing results (if desired).

Appendix 10: Fieldnotes Template

Interview with XXXX

Role	
Date and time of interview	
Location	
Environment/setting/ tone/atmosphere	
Key points and observations	
Areas which were difficult in any way	
Recommendations for additional participants during the interview	
Anything else to follow up?	
Actions agreed	
Broader themes or issues to think about	