interlinks

Health systems and long-term care for older people in Europe
Modelling the interfaces and links between
prevention, rehabilitation, quality of services and informal care

Quality in Long Term Care

United Kingdom (England)

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Contents

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1 Introduction

This report focuses on quality measurement and management in England. In the UK each of the devolved governments of Scotland, Northern Ireland and Wales have control over their health and social care systems which operate independently and under different policies. We therefore report on how quality policy and delivery is organised in England only.

It is important to recognise that policy and systems in England are currently changing. The Healthcare Commission, Commission for Social Care Inspection and the Mental Health Act Commission were merged in April 2009 into the Care Quality Commission (CQC). The merging of these three inspectorates better reflects the overlaps between these sectors and is intended to help reduce problems of incompatibility in the quality criteria that apply to integrated services. The establishment of the CQC brings regulation of health and social care together under one regulatory body. Regulation is moving away from national minimum standards towards outcomes based assessments. This transition began in April and will continue through November 2010 (CQC, 2009a). We present what is currently happening and what is known at this time about the future of quality assurance and management. Many of the existing quality measures are being changed or abandoned entirely as part of this process and therefore some specific details about the assessment of quality are missing from this report.

1.1 Structure of Health and Social Care Services in England

Health care in England is organised through trusts, namely Primary Care Trusts (PCTs) [1] and NHS trusts. PCTs both commission and provide health services and they account for 80% of the NHS budget (NHS Choices, n.d.). GPs, opticians, pharmacists and dentists fall under their commissioning remit, but they may also commission hospitals to provide services. NHS trusts, which include acute, mental health and ambulance services, provide secondary care services. Within the next five years NHS trusts must become NHS Foundation trusts, which mean the public and local community have greater control over the decision-making for the trust rather than central government.

Local councils commission adult social services from various providers (CQC, 2009b). The majority of residential and home care services are provided by private (for profit and non-profit) organisations. Private health and social care providers can be commissioned by PCTs or councils to provide services.

Up until April of this year, quality in health and social care was assessed and measured separately, using different methods and by different regulating bodies. The CQC has merged together the regulating bodies of health and social care thus greatly reducing the boundary lines between these two sectors. Services are now evaluated based on whether they *commission* services, or whether they *provide* services.

1.2 Funding for Health and Social Care in England

In England health and social care are funded differently. Funding for health care comes from central government; whereas social care funding comes from a combination of money from

central government, local council taxes and user charges and is controlled by the local council. From the point of view of the service user, health care is free at the point of delivery whereas social care is means tested. If you qualify to receive funding from social services you can either have your care managed by social services, receive a direct payment to manage and pay for your own care, or receive an individual budget[2] which is like a direct payment but combines the funds received from social services with funding from other streams, such as the Independent Living Fund. Variations in funding can create tension from the service user perspective as some needs will be met at no cost whereas other needs incur a cost. Integrated (or intermediate) care is funded jointly by social services and PCTs and is provided free of charge, but for usually only the first six to twelve weeks depending on the locality.

2 Quality Assurance, Assessment and Management in England

2.1 By what mechanisms is quality in the components of LTC assessed and ensured in your country?

Quality assurance in England happens at two levels: a service or organisational level and a local level. At a service level health and social care services are registered and inspected by the Care Quality Commission (CQC). At a local level, local governments are assessed on how well they maintain the quality of life of the local population through the Comprehensive Area Assessment (CAA)[3] (Audit Commission *et al*, 2009). Information gathered by the CQC as part of their assessments are used as part of the CAA. We present the mechanisms at each level separately.

2.1.1 Service Level

As mentioned in the previous section, the regulation of providers and commissioners differs, therefore we will discuss them separately.

Commissioners

Beginning next year, commissioners of health and social care services will undergo a periodic review which will assess how well they commission services for their local population. PCTs must show that they are commissioning within the guidance of the World Class Commissioning (WCC) framework[4] (DH/Commissioning, 2007). The WCC framework outlines eleven organisational competencies that PCTs must work towards and includes steps for how to implement improvements to the system (DH/Commissioning, 2007; DH, 2008a).

In the periodic reviews the performance of councils will be graded based on outcomes for the population served[5] (CQC, 2009a). Their performance is graded against seven outcome areas which are: improved health and wellbeing, improved quality of life, making a positive contribution, increased choice and control, freedom from discrimination and harassment, economic wellbeing, and maintaining personal dignity and respect (CQC, 2009b).

Providers

The first step in ensuring quality is for health and social care service providers to register with the CQC (CQC, 2009a). Registration ensures that they meet a number of common quality standards. In 2009/2010 NHS trusts are being registered based on their infection control rates. Independent health care providers must also be registered. Social care services must register with the CQC and undergo a registration assessment. The CQC registers and inspects care homes that provide personal or nursing care, adult placement schemes, domiciliary care agencies (also known as home care agencies), and nurse agencies.

After providers have been registered, they must show that they continue to meet the common quality standards. This happens through periodic reviews, inspection, collecting information to monitor their service, and by self-assessment. The purpose of the periodic review[6] is to ensure that services (CQC, n.d. b, pg. 15):

- are safe
- provide the right outcomes for people
- provide a good experience of care and meet peoples' expectations of personalised and individualised care
- support people to live healthy independent lives, improving their quality of life
- promote appropriate, fair and timely access to services; and
- provide value for money.

Independent health care providers will have to carry out an annual self-assessment. The self-assessment is used to determine whether the CQC needs to carry out an inspection.

There are three types of inspections for social care service providers plus an annual review7 (CQC, n.d. d). Social care services are not always notified in advance of when key inspections are taking place. Key inspections check: current info about a service (e.g. previous complaints, incidents, inspections), service user and professional feedback, and observations during the inspection. The frequency of inspections for a service relates to the level of quality they achieved on the previous inspection, i.e. higher quality services are inspected less often. Random and thematic inspections are also conducted in social care services which are usually shorter and focus on following up an outstanding issue or investigate a specific issue or complaint. Services are graded with stars as poor (0 stars), adequate (1), good (2), and excellent (3)8 (CQC, n.d. d).

Social care service providers must also complete an Annual Quality Assurance Assessment (AQAA) for CQC (CQC, n.d. a). The AQAA requires services to complete two parts. The first is a self-assessment on how well the service feels it is meeting service users' needs. The second requires them to submit a data set to the CQC on basic facts and figures, such as number of people who have dementia and residents' funding sources. The CQC may also send a survey to service users for their feedback.

2.1.2 Local level

The Comprehensive Area Assessment (CAA) combines information from the service assessment discussed above and an area assessment (Audit Commission *et al*, 2009). The CAA is important for ensuring that services work in partnership to meet the needs of the service user at a local level. There are 198 national indicators which are meant to be adapted

by local areas to create their own indicators that meet the needs of the local population. Provision by multiple services can be used to meet a requirement. For example the indicator 'End of life access to palliative care enabling people to choose to die at home', can be met by partnership working between the local PCT and social services. The CAA is generic and covers all factors relating to quality of life in an area, from health to crime. The Audit Commission acts as the gatekeeper for the following inspectorates which feed into the CAA: Care Quality Commission, HMI Constabulary, HMI Prisons, HMI Probation and Ofsted.

2.1.3 Research

Research and evaluation of services also plays a part in ensuring quality in care. The CQC carries out special reviews[9] and studies in order to provide guidance on best practice and drive improvement (CQC, 2009a). Also, the NHS Institute for Innovation and Improvement was set up to improve quality through research (Darzi, 2008).

2.2 What is assessed?

To better reflect the government's move towards integrating health and social care, the CQC has outlined six quality domains which apply equally to health and social care (CQC, 2009a). Table 1 outlines these six domains.[10]

Table 1 Assessing Quality in Health and Adult Social Care

Quality domain	Dimension characteristics
Safe care	Making sure people are not put at unnecessary risk of harm when receiving care. Safeguarding people when they are vulnerable.
Improving outcomes for people	Ensuring care has the right outcomes for people, including clinical outcomes. Making sure care is integrated in meeting individual needs.
A good experience for people	Ensuring dignity and respect. Empowering people who use services, and their families and carers, in shaping services to ensure that they are built around people's needs and what is important to them.
Focus on health, independent living and quality of life	Helping people achieve the best possible health and quality of life. Ensuring independence.
Access to services	Available to those who need it when they need it – ensuring appropriate, fair and timely access to services in relation to individual needs. Planning and organising services so that they reflect the needs of the whole community.
Value for money	Offering good value for money.

Source: Care Quality Commission (2009a) *Reviews in 2009/10*: 8

The six quality domains are very broad and are not long term care specific, though long term care services would have to work within this framework. At both service and local levels there are no specific provisions for long term care, except for guidance relating to care homes.

2.2.1 Service level

Commissioners

PCTs as commissioners of healthcare will be rated on their 14 existing commitment indicators (such as delayed transfers of care to be maintained at a minimal level) and 24 national priorities in tiers 1 and 2 of the Vital Signs Framework (which outline national requirements and national priorities for local delivery) (CQC, 2009a; DH/NHS Finance, 2008). PCTs will receive an aggregate score based on their performance in these commitments and priorities (calculation of this score is yet to be determined). PCTs will also be assessed on their competencies in the World Class Commissioning framework and on how well they manage their finances. Views of service users and the public will also be used to assess their performance.

Councils as commissioners of social care will receive an aggregate grade based on the outcomes of people who use their services (CQC, 2009a). These outcomes are based on the seven grades in the existing performance framework (see pg. 3, Commissioners).

Providers

NHS trusts and PCTs as providers of health care must show that they are compliant with core standards outlined in Standards for Better Health (DH, 2004; HC, 2008). They are ranked as: fully met, almost met, partly met and not met (HC, 2008). There is a maximum of 44 core standards on which trusts can be assessed. The core standards are quite general, for example:

> "Core Standard C13a: Healthcare organisations have systems in place to ensure that staff treat patients, their relatives and carers with dignity and respect." (HC, 2008, pg. 29)

Trusts at the highest risk for breaching these core standards will undergo more rigorous scrutiny. They must also show their performance against the government's national priorities and existing commitments and show proof of their financial management (CQC, 2009a; HC, 2009).

There will also be a new form of regulation for independent health and social care providers from October 2010. However it has not yet been decided if the periodic review previously mentioned in section 1 will extend to independent providers.

For care homes there are national minimum standards for: choice of home, health and personal care, daily life and social activities, complaints and protection, environment, staffing, and management and administration (DH, 2001a). These ensure that the care home maintains a standard national level of quality. In addition care homes must monitor their own quality based on service user feedback:

> "Standard 33: Effective quality assurance and quality monitoring systems, based on seeking the views of service users, are in place to measure success in meeting the aims, objectives and statement of purpose of the home." (DH, 2001a, pg. 33)

For domiciliary care there are also national minimum standards on: user focused services, personal care, protection, managers and staff, and organisation and running of the business (DH, 2003). Inspections are carried out by having discussions with service users, their family and friends, observing daily life at home and in the office, and by scrutinising written policies, procedures and records.

Service users of social services funded by the council receive satisfaction surveys to complete.

2.2.2 Local level

Though not specifically targeted at long-term care, the CAA is meant to be more outcomes based and focuses on the experience and perspective of the service user than on the individual institution. The CAA is based on 198 performance indicators, 21 of which relate to adult health and wellbeing. Of those 21 indicators, the following relate most closely to long-term care (DCLG, 2007):

124: People with a long-term condition supported to be independent and in control of their condition.
125: Achieving independence for older people through rehabilitation/intermediate care.
127: Self reported experience of social care users.
129: End of life access to palliative care enabling people to choose to die at home.
130: Social Care clients receiving Self Directed Support (Direct Payments and Individual Budgets)
131: Delayed transfers of care from hospitals.
132: Timeliness of social care assessment.
133: Timeliness of social care packages.
135: Carers receiving needs assessment or review and a specific carer's service, or advice and information.
136: People supported to live independently through social services (all ages).
139: People over 65 who say they receive the information, assistance and support needed to exercise choice and control to live independently.

2.3 What are the incentives/sanctions to measure, ensure and/or improve quality in everyday practice; what are the barriers? How successful have they been?

Commissioning tends to be mainly incentive driven with good commissioning being rewarded with additional money and greater freedom in setting priorities (e.g. if a GP provides flexible hours for patients then they are given additional remuneration). Traditionally the inspection/audit system for providers is sanction led, whereby if a service falls below a certain level then there are punitive repercussions.

Commissioners

The practice of commissioning services means that services should compete with each other to be commissioned by the PCT or council. A competitive environment should drive up standards. PCTs that are high performers will achieve World Class PCT status and will receive

incentives, such as having greater freedom to set their own priorities (status, financial) (DH, 2008). Where PCTs fall below standards they will be assigned criteria based thresholds in a performance framework for improvement. Where they fail to improve in accordance with this framework they will publicly be labelled as 'challenged' which threatens their position in the public view (status and legitimacy).

The Commissioning for Quality and Innovation scheme (CQUIN) will increase payments to NHS organisations that commission using a framework that encourages quality improvement and innovation (financial) (DH, 2008b).

Providers

There are a number of new incentives for healthcare agencies to improve the delivery of their care. The following is a list of some incentives (Darzi, 2008):

- Incentives for General Practice (family doctors, practice nurses and other primary and community clinicians) for prevention of long term illnesses (financial).
- Healthcare providers will need to publish 'Quality Accounts' for public viewing which will report on a service's performance in safety, experience and outcomes (professional).
- Results from audits are published for the public to view (professional, status and legitimacy)

These incentives have not yet been fully implemented and therefore their success and effectiveness is unknown. However with the third point on audits, there is considerable pressure not to have an unfavourable review. In previous inspection systems, poor outcomes have been made very public in the press and have led to high profile job losses, and loss of confidence on the part of the users in quality of care.

If providers do not meet quality standards then the CQC can take action against them. The CQC can impose a fine, issue a public warning, suspend a service until it is brought up to standard, or take it off the register entirely (status, financial).

An apparent constant lack of resources in social care seems to place a greater emphasis on the punitive aspect of regulation. Upon inspection, if a social care provider is found to have an unsatisfactory performance in an area, there are four steps for the enforcement of improvement[11] (CQC, n.d. e):

1. A requirement to change is issued.
2. The service must draw up an improvement plan.
3. If improvements have not been made within a certain amount of time then a warning letter is sent.
4. If still no improvements have been made, then the CQC can take enforcement action and can do one of the following: issue a statutory requirement, issue a formal caution, change the conditions of the service's registration or cancel a registration (i.e. close it down).

These steps are followed if national minimum standards are not met. However, if a service works above the minimums, then their additional effort is reflected by a higher star rating

and therefore would potentially be more attractive to prospective clients (status and legitimacy, financial).

Service users are increasingly being given power to exercise choice over services. The introduction of direct payments and individual budgets means people can choose to spend their money where they want, thus creating competition in an effort to drive up standards. There are some websites that allow patients to rate a service, GP or specialist. The website 'NHS Choices' is not easy to navigate for the purposes of leaving feedback. In order to leave feedback you must give a considerable amount of personal information and it is not clear how confidential your feedback is.

2.4 Is there a quality-policy for informal care/volunteers? If so, what are the general principles and measures?

There does not appear to be any policy that dictates the quality of care that informal carers must provide. However, if the person they are caring for does not have the capacity to make their own decisions, then the informal carer and any other care provider must follow the Mental Capacity Act. The Act is meant to help guide them in making decisions on behalf of the person.

There is policy to help carers receive support so that they can lead more normal lives and better perform their caring duties. The Carers (Equal Opportunities) Act 2004, has two aims: to identify carers and inform them of their rights, and to ensure that their needs for education, training, employment, and leisure are recognised and supported (Cass, 2005). Carers can access the equipment they need for caring through a community care assessment of the person they care for. However, this act does not make provisions to ensure the quality of care that informal carers provide.

2.5 Are there quality indicators (or will they be developed shortly) to monitor patient pathways across services?

As of yet there are not any specific quality indicators for the movement of patients between services. The CAA assesses how well care is integrated in an area, though this is presented more as a framework for services rather than indicators of quality. Quality indicators for both health and social care are being developed currently at a national level (Archer, 2009), though it is unclear if and how they will monitor the interaction of different services. We will first discuss how patient pathways are monitored, and then discuss the development of quality indicators more generally.

2.5.1 Monitoring patient pathways

As part of the changes being implemented by the CQC, special reviews will be undertaken that can look at patient pathways across health and social care. Topics for the special reviews will be chosen each year in response to identified gaps in provision. One of the first potential topics is 'How well the health and social care pathway is working for people who have had a stroke and their carers.' The outcomes of these reviews could be scored assessments or recommendations for practice (CQC, 2009a).

The current National Service Framework for Older People (DH, 2001) outlines 8 standards for integrated health and social care. These are: rooting out age discrimination, person-centred care, intermediate care, general hospital care, stroke, falls, mental health and the promotion

of health and active life in older age. Each standard has milestones which services are expected to meet by certain dates to ensure that services are being improved equally across the board. However, these are standards which must be met and not mechanisms for monitoring pathways.

As mentioned previously, the CAA has 21 indicators related to adult health and well-being which looks at the integration of services (Audit Commission et al, 2009). However, area assessments are presented as narratives rather than with rating scales which makes comparing different areas difficult.

2.5.2 Quality Indicators

There are 198 national indicators as discussed in section 2, though they span all areas of public services (DCLG, 2007). These indicators are how central government will monitor local government. The indicators apply to local government, PCTs, the police and other local bodies as they monitor quality geographically rather than by service.

In healthcare national metrics, or quality indicators, are currently being developed. Quality indicators for acute settings have been published, and indicators for community services will be developed over the next year[12] (Darzi, 2008). NHS organisations will be asked to develop their own additional indicators to meet their local needs.

From 2010 NHS will have to publish 'Quality Accounts' which will reflect the 3 themes of patient safety, experience and outcomes (Darzi, 2008). The comparative information will be available on the NHS Choices website. It is unclear though whether these indicators monitor across services or just measure the performance of a singular service.

The formation of a new National Quality Board will bring together people with an interest in improving quality in order to establish NHS quality goals (DH, n.d.). The purpose of the board is to align the quality system, oversee the work on quality indicator development, and push forward the quality agenda. Members of the board come from the Department of Health, Care Quality Commission, Monitor, National Institute for Clinical Excellence (NICE), National Patient Safety Agency and expert and lay members. The board will make its first report in June 2009.

The national minimum standards for care homes (DH, 2001a) and domiciliary care (DH, 2003) that have been set outline the minimum quality of care that must given by a service. The minimum standards do not encompass the pathways across services, but care homes and domiciliary care agencies would be expected to contribute towards the CAA and national indicators.

2.6 Is cultural diversity a subject in quality management?

Cultural diversity appears in performance indicators of the Comprehensive Area Assessment (CAA) for quality of life in an area, such as in the indicator '% of people who believe people from different backgrounds get on well together in their local area' (DCLG, 2007). These indicators may not be picked up within long-term care settings though.

In addition the CQC conducts an Equality Impact Assessment (CQC, n.d. b) to assess the impact of the periodic reviews on race, gender, disability, sexual orientation, religion, and

age. It ensures that the periodic reviews do not negatively impact on equality among these groups.

2.7 Who uses quality indicators and for which purposes?

Existing (and future) quality indicators are used at three levels: on a national level by the CQC for evaluating service performance, by the service to evaluate its own performance, and by the service user to help make informed choices for care.

2.7.1 National Level

The CQC ranks both health and social care services based on their performance as discussed in previous sections. These rankings usually have implications for funding with better performers getting more money and worse performing services getting less. The national indicator set is used by central government to manage the performance of local government (DCLG, 2007).

2.7.2 Service Level

PCTs are meant to develop their own quality indicators in line with the three national quality domains: patient safety, effectiveness of care, and patient experience (Darzi, 2008). They use the quality indicators to determine how well they are meeting the quality domains and government targets. A range of quality measures including Patient Reported Outcome Measures (PROMs) will be used to determine payments available to hospitals (Darzi, 2008).

Care homes are not required to use any specific quality indicators, apart from meeting the national minimum standards (DH, 2001a) as previously discussed. They are required to use an assessment tool, some of which may produce quality indicators, such as the MDS-RAI. However, the validity and reliability of these tools is not regulated, only the content.

2.7.3 Service User Level

The ratings given by the CQC to health and social care providers are available as public information. Service users can thus make decisions about where they wish to receive care based on these ratings. Ratings are available for viewing via websites such as NHS Choices and the CQC website.

In addition, the 'Quality Accounts' which are to be published by healthcare providers will also inform the public on a service's performance in safety, experience and outcomes (Darzi, 2008).

The narratives produced by the CAA will also be available for public viewing to see how services are performing in their local area.

2.8 How financially sustainable are the approaches being adopted?

In both health and social care the government issues national guidance which then must be translated by local health authorities and individual care providers into practical guidance which meets local needs. This may lead to implementations being patchy, with those who have more resources to spend on development better able to provide a higher quality of service.

Quality assessment is also increasingly being based on self-assessment, such as with the AQAA (CQC, n.d. a). While this may save the regulating body money, it increases the

workload on care providers and commissioners. This paperwork burden is an increasingly common complaint among professionals who feel it takes them away from providing hands on care.

3 Critical overview

3.1 An evaluation of quality management in England and an appraisal of where it is heading

There is a lack of practical guidance on how care providers should interface in order to maximise quality of care for older people. Long-term care must be a marriage of health and social care to maintain people at home, or move into the care home if needed. As services operate autonomously, it is difficult to evaluate the linkage between these systems. The Comprehensive Area Assessment (CAA) looks at the integration of services, but the evaluation is a narrative which makes it difficult to make objective comparisons of areas. There appear to be standards for health and social care, but none specific for long term care which bridges both sectors. The formation of the CQC is a step towards bringing health and social care closer together, though does not make special provisions for long term care.

Current quality indicators which are specific to long term care are presented as minimum standards with either a service meeting it or not. Only for World Class Commissioning is guidance presented as best practice rather than bare minimums, but again this is not long term care specific. In the past standards have tended to focus on the process and system, rather than on the outcome for the person, they do not ask a service to consider itself through the eyes of the person. Services are asked to provide evidence of their care through document checks and paperwork. This process is bureaucratic and not always linked to outcomes. Newer quality indicators are meant to be more outcomes focussed and person-centred. Patient feedback is increasingly being relied upon as a measure of quality, however, it is unclear how this feedback is meant to be translated into changes in practice.

The implementation systems allow health and social care organisations to develop local standards for local needs and this in turn can create variability and lack of comparability in quality of care nationally. As mentioned, the public humiliation resulting from poor inspections is something that NHS organisations are under considerable pressure to avoid and this could act as an incentive to 'massage figures' or promote progress in a more favourable light than is the case. The self-assessment procedures could also inadvertently encourage such a situation especially as more favourable self-assessments would lead to fewer inspections. The extent to which this has happened in the past is unknown, and current new systems do not seem to have put extra monitoring in place.

Social care is moving towards personalisation with direct payments and individual budgets. Under these schemes service users buy in their own services and therefore they must judge the quality provided. If service users buy from a registered provider then that provider would be assessed as outlined in this paper. However individual budgets mean that service users can employ who they want, including family members, who may not fall under the remit of regulatory bodies.

Commissioning of services creates an environment of pseudo-competition with services competing with each other to be commissioned by the PCT or council. However, while this may improve services on one level, it takes the decision-making role away from the service user as they will only have access to services commissioned by the PCT or council unless they have the means to go privately. In theory only the best services should be commissioned, but commissioned services are often the cheapest and not necessarily the best. Also there is often a reluctance to let services fail as this may reflect badly on the commissioning body.

As stated previously England is currently undergoing a change in the measurement and management of quality through the establishment of the Care Quality Commission, National Quality Board, national metrics and other measures that were outlined in this paper. As these organisations and systems are in their infancy it is too early to assess their effect, but their impact will come to light over the next few years.

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References

Archer, B. (2009) *Clinical Quality Indicators Development: Indicators Survey Report.* Available online from the NHS Information Centre.

Audit Commission, Care Quality Commission, HM Inspectorate of Constabulary, HM Inspectorate of Prisons, HM Inspectorate of Probation and Ofsted. (2009) *Comprehensive Area Assessment: Framework document.* London: Audit Commission.

Care Quality Commission. (n.d. a) *Annual Quality Assurance Assessment* [online]. http://www.cqc.org.uk/guidanceforprofessionals/socialcare/careproviders/inspection/annualqualityassuranceassessmentaqaa.cfm (accessed on 21/7/2009).

Care Quality Commission. (n.d. b) Equality impact assessment of proposals for periodic reviews of health and adult social care providers for 2009/10. Available online: http://www.cqc.org.uk/_db/_documents/EIA_of_proposals_for_periodic_reviews_of_care_providers.pdf (accessed on 21/7/2009).

Care Quality Commission. (n.d. c) How we inspect [online]. http://www.cqc.org.uk/guidanceforprofessionals/socialcare/careproviders/inspection/howweinspect.cfm (accessed on 23/7/2009).

Care Quality Commission. (n.d. d) Quality ratings for care services [online]. http://www.cqc.org.uk/guidanceforprofessionals/socialcare/careproviders/inspection/ratingsandreports/qualityratingsforcareservices.cfm (accessed on 23/7/2009).

Care Quality Commission. (n.d. e) Enforcement [online]. http://www.cqc.org.uk/guidanceforprofessionals/socialcare/careproviders/enforcement.cfm (accessed on 24/7/09)

Care Quality Commission. (2009a) *Reviews in 2009/10.* London: Care Quality Commission.

Care Quality Commission. (2009b) *Inspection for Adult Social Care: An Introduction for Councils*. London: Care Quality Commission.

Cass, E. (2005) *Implementing the Carers (Equal Opportunities) Act 2004*. London: Social Care Institute for Excellence.

Darzi, A. (2008) *High Quality Care for All – NHS Next Stage Review Final Report.*

Department for Communities and Local Government. (2007) *The New Performance Framework for Local Authorities and Local Authority Partnerships: Single Set of National Indicators*. London: Department for Communities and Local Government.

Department of Health. (2001) *Care homes for older people: national minimum and care homes regulations.* London: TSO.

Department of Health. (2001) *National Service Framework for Older People.* London: Department of Health.

Department of Health. (2003) *Domiciliary care: national minimum and regulations.* London: TSO.

Department of Health. (2004) *Standards for Better Health*. Available online: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4086665 (accessed on 21/7/2009).

Department of Health. (2008a) *World Class Commissioning Assurance Handbook.* London: Department of Health.

Department of Health. (2008b) *Commissioning for Quality and Innovation (CQUIN) Payment Framework*. London: Department of Health.

Department of Health (n.d.) National Quality Board [online]. http://www.dh.gov.uk/en/Healthcare/Highqualitycareforall/NationalQualityBoard/DH_095234 (accessed on 24/7/2009).

Department of Health/NHS Finance, Performance and Operations. (2008) *The operating framework for 2009/10 for the NHS in England*. London: Department of Health.

Department of Health/Commissioning. (2007) *World Class Commissioning: Vision.* London:

Healthcare Commission. (2008) *Criteria for assessing core standards in 2008/09: Primary care trusts (as providers and commissioners).* Healthcare Commission.

Healthcare Commission. (2009) *2008/09 scoring rules for quality of services and quality of financial management*. Healthcare Commission.

NHS Choices. (n.d.) *NHS Authorities and Trusts in England.* [online] http://www.nhs.uk/NHSEngland/aboutnhs/Pages/authoritiesandtrusts.aspx (accessed on 21/7/2009).

Appendix A

Barriers to interagency collaboration:

- **Structural** (fragmentation of service responsibilities across agency boundaries, within and between sectors).
- **Procedural** (differences in planning horizons and cycles; differences in budgetary cycles and procedures; differences in information systems and protocols regarding confidentiality and access).
- **Financial** (differences in funding mechanisms and bases; differences in the stocks and flows of financial resources).
- **Professional** (professional self-interest and autonomy and inter-professional competition for domains; competitive ideologies and values; threats to job security; conflicting views about clients/consumers interests and roles).
- **Status and legitimacy** (organisational self-interest and autonomy and inter-organisational competition for domains; differences in legitimacy between elected and appointed agencies).

UPDATE - March 2011

Since publishing the original version of this paper in July 2009 there have been a number of new developments which will be summarised briefly here. The new coalition Government issued an NHS White paper, 'Equity and excellence: Liberating the NHS' in July 2010 which will radically change the structure of the NHS. This has had a knock on effect to the regulation of quality standards and management and may affect parts of this report in ways that are not yet known. In general, quality assurance is moving towards continuous monitoring focussed on the individual patient experience rather than systems and processes and past performance. Presented here are updates on what is so far known and are linked to relevant sections in the text through numbered superscripts.

1 PCTs are in the process of being dismantled and will be replaced by GP consortiums which will be responsible for guiding the direction of health services. The details and structure are still being developed.

2 Individual budgets were piloted and are not likely to be implemented at a national level due to the complexity of organising funding from different streams.

3 The Comprehensive Area Assessment was abolished by the new government in May 2010: http://www.audit-commission.gov.uk/localgov/audit/caa/Pages/default.aspx

4 The CQC will not assess PCTs as commissioners in 2010/2011; this will be overseen by the new NHS Commissioning Board.
http://www.cqc.org.uk/newsandevents/newsstories.cfm?FaArea1=customwidgets.content_view_1&cit_id=36599

5 As announced by the Government in November 2010, the CQC will no longer conduct annual performance assessments of councils as commissioners

6 Changes in legislation in October 2010 has meant that the CQC is moving away from periodic assessments and quality ratings towards continuous monitoring of compliance with the essential standards.
http://caredirectory.cqc.org.uk/caredirectory/whathaschanged.cfm

7 The CQC will not conduct annual reviews of adult social care providers in addition to the registration assessment in 2010/2011.

8 The CQC will no longer be using the star rating scale for care providers. A new scheme is being developed which will be rolled out in April 2012.

9 The CQC is revisiting its plans for special reviews and studies for 2010/2011 in response to the NHS white paper.

10 A new law came into effect from 1 October 2010 about the regulation of health and adult social care services. Services will be registered if they meet the following five essential standards and they must continue to meet those standards:

1. You can expect to be involved and told what's happening at every stage of your care.
2. You can expect care, treatment and support that meets your needs.
3. You can expect to be safe.
4. You can expect to be cared for by qualified staff.
5. You can expect your care provider to constantly check the quality of its services.

http://www.cqc.org.uk/usingcareservices/essentialstandardsofqualityandsafety.cfm

11 CQC's enforcement policy has changed as a result of a public consultation and new guidance was published in October 2010. The following are enforcement actions that CQC can take depending on the severity of noncompliance:

- Issue a warning notice.
- Impose, vary or remove conditions.
- Issue a penalty notice instead of prosecution.
- Prosecute for specified offences.
- Suspend registration.
- Cancel registration.

http://www.cqc.org.uk/_db/_documents/CQC_enforcement_policy_Oct_2010.pdf

12 Over 70 potential quality indicators for community services have been identified and will be further refined and piloted.
http://www.ic.nhs.uk/services/measuring-for-quality-improvement/indicators-for-community-services