# Measuring social care quality: key concepts and applications

Fernandez, J-L. Malley, J. Zigante, V. Srivastava, D.

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# Aims and structure of the slide pack

- This set of slides describes key definitions and features of the concept of “quality” when applied in the social care sector. It then discusses the different ways in which evidence about social care quality is used in the English social care system.
- Detailed information about the quality information collected across the English social care system is presented in a separate slide deck entitled “Sources of evidence on social care quality in England”.
- The material is structured in the following broad sections:
  - Section 1: The concept of quality in social care.
  - Section 2: Measuring social care quality.
  - Section 3: Using quality indicators in the social care system.
- Overall, these slides concentrate on the concept of quality as an indicator of the extent services improve service users’ and carers’ well-being, and on the use of quality indicators for system-wide governance. They do not discuss issues of quality in terms of the assessment of unmet need for care or provide an assessment of the overall quality of the care system in England.

# The concept of social care quality

# The meaning of quality in social care

- In social care, the term "quality" is used to refer to different concepts. Its definition will depend on the level at which it is assessed and the function of the care system under consideration (see Figure 1).
- At the ***individual level***, care quality centres on the care user-caregiver relationship and is generally used to refer to the extent to which the package of support that a service user/carer receives improves their wellbeing and is suited to their characteristics. The **care package quality** will therefore reflect the extent to which both (1) the amount of support and (2) the service mix provided reflect the individual's characteristics and preferences.
- At the **provider-level**, quality relates to the quality of the service per unit of support, reflecting the extent to which a unit of service from a given provider (e.g. an hour of home care or a care home bed) improves the wellbeing of service users and carers. Differences in service quality between providers can be linked to factors such as the personal traits of the formal carers (e.g. their empathy, their knowledge), the physical environment of a care home, and aspects related to the way care is organised and managed (e.g. reliability of carers).
- At the ***system level***, the concept of social care quality can be associated with different aspects of aggregate performance (in the broadest sense), such as:
  - **Equity of access**: the extent to which more support is provided to individuals in greater need, and people with similar needs receive similar levels of support.
  - **Targeting efficiency**: the extent to which resources are concentrated on people who are likely to benefit most from them, and on the services that generate the greatest levels of outcomes given their cost.
  - **Market management outcomes**: the extent to which adequate supply of good quality services is available and that "bad" providers are driven away from the market.

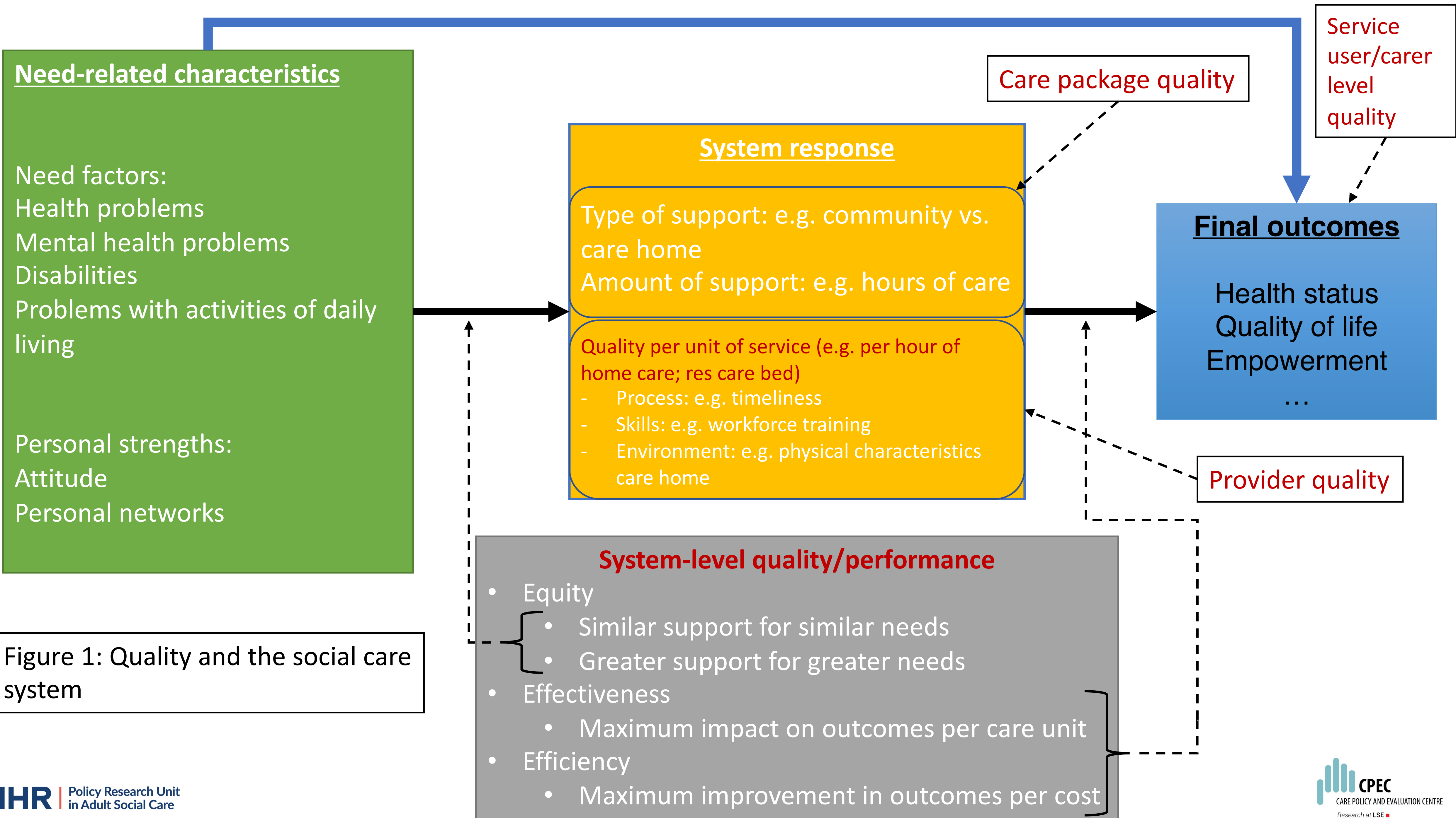



Figure 1: Quality and the social care system

# Final outcomes and social care quality

- As reflected for instance in the 2014 Care Act, supporting individuals' wellbeing is the ultimate purpose of social care provision. At the individual-level, social care quality indicators should therefore reflect the extent to which service recipients' wellbeing is improved by the support they receive. The different ways services impact upon wellbeing constitute the ***final outcomes*** of social care services, and include the following dimensions:
  - Reducing the ***risk of harm*** (safeguarding): protecting people's right to live in safety, free from abuse or neglect. Local authorities have a duty of care towards people at risk of abuse or neglect.
  - Supporting individuals with their daily lives: social care services often support individuals with their ***activities of daily living***, with the aim to support personal cleanliness and comfort, helping with the preparation and consumption of food and drink, with cleaning of the accommodation, and improving social participation.
  - Supporting independence and preventing **functional decline.** Services such as reablement, for instance, aim to improve the physical and mental health of the person with social care needs and/or reduce the risk of further deterioration.
  - Maximising ***autonomy*** and sense of control over daily living
- Outcome indicators attempting to capture the impact of social care services on final outcomes therefore tend to include a range of indicators to capture the multitude of dimensions of well-being of the person (e.g. ASCOT, ICECAP).
- Improvements in certain outcome dimensions can be at the expense of reductions in others. For instance, increasing independence and sense of control can be at the expense of increases in risks of harm. Improving outcomes for carers can lead to reductions in the outcomes for the service user. Judging outcomes overall therefore requires weighting improvements in different dimensions of wellbeing and across different individuals.

# Quality and the delivery of social care support

- The importance of the ***care process***: social care support is often provided over long periods of time, and sometimes for life. The way in which care is provided (the nature of the ***care process***) is therefore intrinsically important to the experience that a person has of the care received, and therefore of the quality of the service[2]. Key process-related factors for service quality include: the quality of the relationship between the caregiver and the cared for person, aspects of continuity of care, and good coordination between different services (e.g. between health and social care).
- The ***personal nature of social care*** and the importance of individuals' preferences: social care services address shortfalls in highly personal areas of people's lives (e.g. support with key activities of daily living, support with opportunities for socialising, support with autonomy and sense of control). Whether a service is perceived to be good or bad will therefore depend on the individual preferences of service users and carers. The emphasis on personal preferences is reflected in the emphasis on the ***personalisation*** of care in the English social care system.
- The personal nature of social care support means that the "best" care package for two individuals with similar needs might be different, because they might have different personal preferences over what support they want or how that support should be delivered.

# The social care *system* and quality

- As noted above, aggregate/system level social care quality is associated with the nature of the distribution of public social care support and with concerns about the availability of good quality supply to meet local needs.
- ***Localism and the quality*** of the social care system
  - In England, the organisation of statutory social care support is the responsibility of local authorities (LAs). Within the limits set out by the eligibility criteria introduced by the 2014 Care Act, LAs have ***significant flexibility*** to decide the types of support that they provide (e.g. the balance between community and institutional services) and the coverage of this support (how much support to provide to people in different circumstances).
  - ***Judging the quality*** of the local social care system, in terms of the extent to which it provides the right support to people with social care needs is therefore difficult because differences in local support are likely to reflect differences in the characteristics of the local population, differences in the costs of services and differences in local preferences over the role of the state in the support of people with social care needs[3].
- Local authorities have a responsibility ***to manage and oversee the market*** and ensure the availability of good quality services locally. This requires achieving:
  - A good balance of suppliers to ensure an efficient market (e.g. a good balance between prices and quality) and sufficient service capacity to meet the needs of the population.
  - A good balance between different types of services (e.g. between community and institutional services).
  - Judging the quality of the local market is challenging, because exogenous factors such as local wages and costs of capital and the socio-economic characteristics of the local population are likely to affect the capacity of LAs to shape the market as well as the 'optimum shape' of the local care market .

# Measuring social care quality

# Measuring social care quality (1/2)

- Translating the different aspects of social care quality into measurable indicators is challenging. Reflecting the different levels at which it can be defined (e.g. individual/provider/system) and its different purposes (discussed in detail in the next section) a myriad of quality proxies have been developed. We summarise some of the main groups of indicators below.
- Quality indicators collected at the individual service user/carer level
  - Quality measured using **final outcomes** (Person Reported Outcome Measures, **PROMs**): These are self-reported indicators (collected from service users/carers) which measure final outcomes, typically in order to assess the impact of services on their quality of life. Key examples for social care include ASCOT and ICECAP.
  - **Quality of process** (Person Reported Experience Measures, **PREMs):** These are self-reported indicators collected from service users/carers and include information about their experience of services, including aspects such as the continuity of care, attitude of caregiver, timeliness of the care etc.
  - **Administrative** records describing the nature of the care provided: these indicators are extracted from the administrative systems of local authorities and/or service providers, and describe aspects of the care process (e.g. length of wait before assessment; timeliness of carer) or combine information from administrative records to generate proxies of care outcomes (e.g. destinational outcomes such as care home mortality, proportion of service users admitted to care homes, or the proportion of care users with direct payments as a proxy for local emphasis on personalisation). The increasing use of digital systems for recording the care is accelerating the availability of this type of information.

# Measuring social care quality (2/2)

- In addition to quality measures collected from/about individual service users and carers, quality indicators can be defined around the characteristics of care providers. It is useful to distinguish between
  - Quality proxied by **“structural” provider characteristics**: for instance, care provider quality might be measured by staff/user ratios, staff qualifications, proportion of single occupancy rooms. These characteristics are more difficult to identify for services without physical attributes, for instance in the case of home care support people are cared for in their own homes so the care environment is not a fair indicator of the quality of provision in the same way as it is for a care home.
  - Quality proxied by indicators of how **well the organisation is managed** such as food hygiene ratings, staff retention rates, frequency of change of care home manager.
- Structured vs unstructured data:
  - **Structured** quality indicators (e.g. provider ratings, ASCOT) synthesise the concept of quality into measures which can be aggregated and used for quantitative analysis, for instance in order to compare quality across providers or areas. However, synthesising quality into structured measures involves some loss if information.
  - Examples of **unstructured** quality information include free-text in provider inspection reports, or in judgements by the Ombudsman about complaints against care providers. These provide richer descriptions of care quality than structured indicators, but are very difficult to aggregate or to use for comparison across providers/areas.
  - At the individual service user/carer level, there is significant free-text information describing key aspects of care quality in care management **case notes**. Their use for quality assessment is however challenging because of their unstructured nature, large volume and information governance constraints limiting access to them.

# Strengths and challenges of final outcomes as quality indicators

- Final outcome indicators provide a common measure of quality across social care services and users:
  - The social care system provides a wide range of support services (e.g. personal assistants, group activities, care homes, etc) to individuals with a wide range of characteristics (e.g. people with dementia, physical and sensory impairments, autism, mental health problems).
  - By focusing on the impact of services on the wellbeing of the person, final outcomes indicators such as ASCOT or ICECAP provide a way to **compare the quality of the support received across different services and groups of service users**. This is particularly attractive because of the volume of "non-standard support" commissioned through direct payments (e.g. one-off support, personal assistant support).
  - As discussed further in the next section, having a common metric to compare quality across services is crucial to understand the cost-effectiveness of different social care interventions.
- However, measuring the extent to which services improve final outcomes is challenging because:
  - **The effect of non-service factors on final outcomes**: Many of the indicators above are likely to be (most strongly) affected by factors other than the type and amount of services provided. For instance, a person's sense of control is likely to be determined primarily by their need-related characteristics (e.g. whether they are cognitively impaired, have mobility problems etc.). Figures 2 and 3 illustrate the need to control for the impact of needs when assessing the positive impact of services on final outcomes, because of the strong positive correlation between levels of social care support and individuals' needs, and the negative correlation between needs and outcomes.
  - **The natural deterioration of abilities**: through time, the abilities of most social care service users tend to deteriorate, and with them their wellbeing and the capacity of services to compensate for the deterioration in their abilities. Indicators of social care quality based on final outcomes therefore need to control for the natural deterioration of individuals' abilities through time in order to identify the beneficial effect of care services on wellbeing.
- Collecting PROM indicators is resource intensive and requires individual level data collections which can be difficult to implement. Because services tend to be delivered on a continuous basis and to address the measurement challenges above, ideally PROMs would be collected at regular intervals to track change over time.

Because service users with more needs receive more services, but needs have a direct negative effect on care outcomes, assessing the relationship between services and outcomes without controlling for needs is likely to produce biased (down) estimates of the effectiveness of care services.

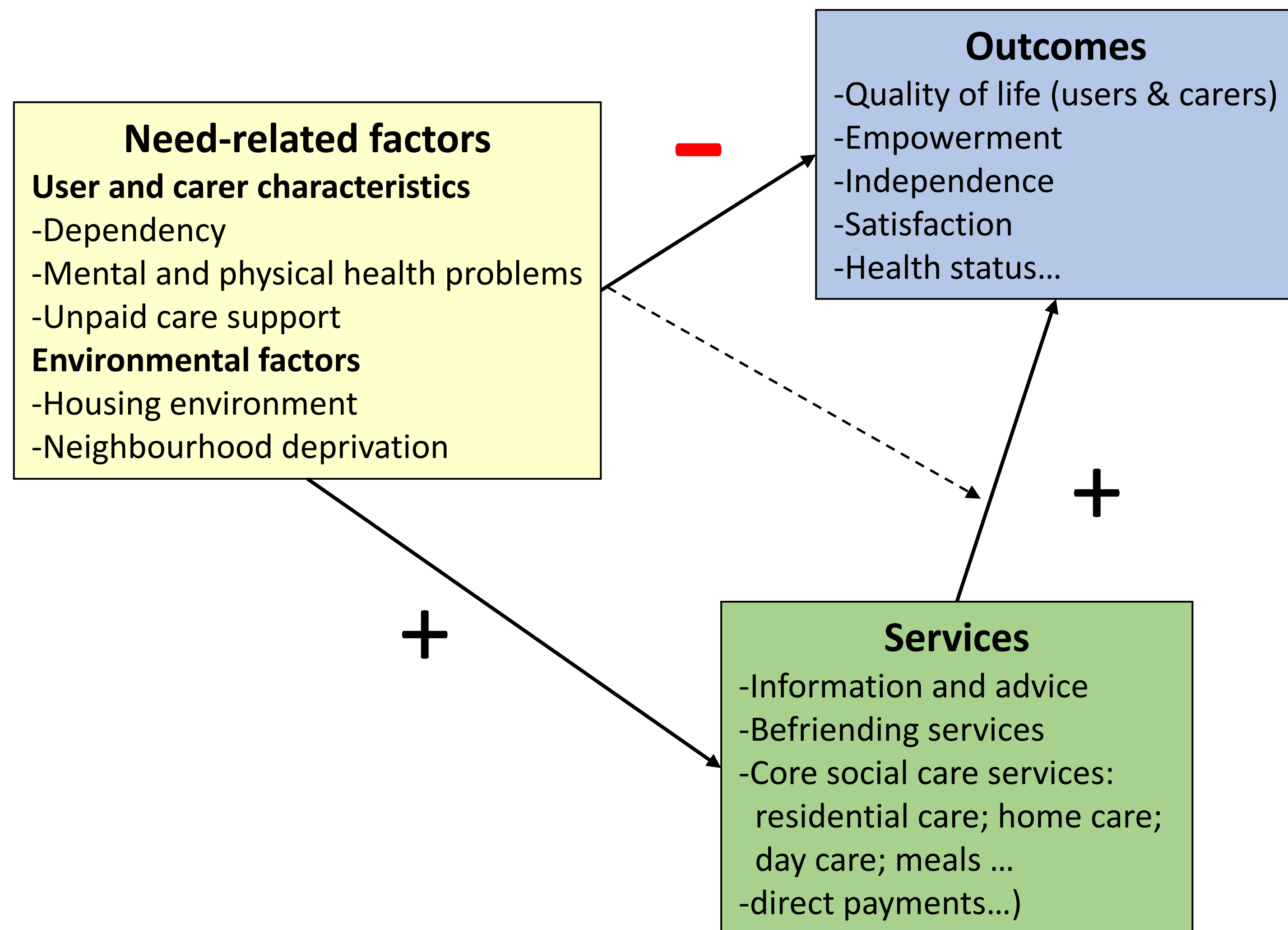
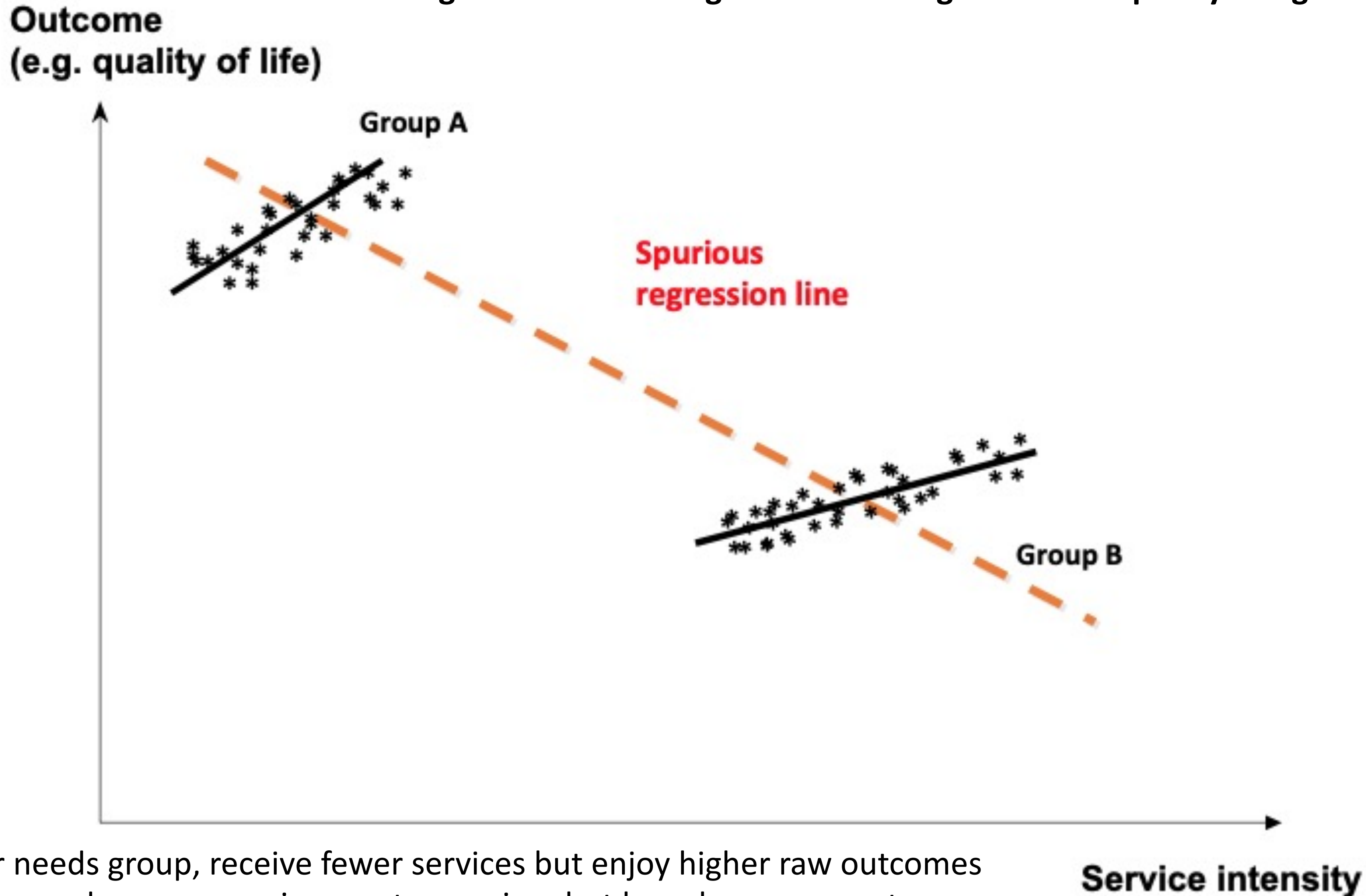



Figure 2 **The Production of Welfare**

**Figure 3 The challenges of measuring social care quality using final outcomes**




**Group A**: lower needs group, receive fewer services but enjoy higher raw outcomes
**Group B**: higher needs group, receive greater services but have lower raw outcomes

# Strengths and challenges of PREMs as quality indicators

- Relative to PROMs (which concentrate on measuring the quality of life of the person) PREMs focus on the perceptions of service users/carers of key aspects of the care process. In this sense, they provide a more detailed description than PROMs of specific shortfalls in care quality and how to redress them.
- As self-reported measures, process indicators describing the care experience of service users and carers require the implementation of potentially resource intensive surveys.
- Given the differences in the nature of support provided by different care services, many PREMs are service specific and therefore unsuitable for comparing quality across services. By corollary they require a different set of survey questions for each type of service.
- Research has shown that responses to PREMs are also affected by the needs of the service users/carers (e.g. their mental health). As in the case of final outcome indicators, their analysis therefore requires standardising for the need of care recipients.
- The psychometric properties of some PREMs are limited. In particular, satisfaction indicators tend to show high levels of satisfaction across service users even where there is evidence that the quality of care is not good.
- Research suggests that improvements in aspects of the care process are associated with improvements in the wellbeing of the care recipient[1]. Interpersonal aspects of care, such as the responsiveness and caring behaviour of staff, have a stronger relationship with wellbeing than those related to the organisation of care by the provider, such as timekeeping and continuity of care. However, the relationship between characteristics of the care process and final outcomes is limited, so focusing purely on process indicators is likely to give a limited picture of service quality.

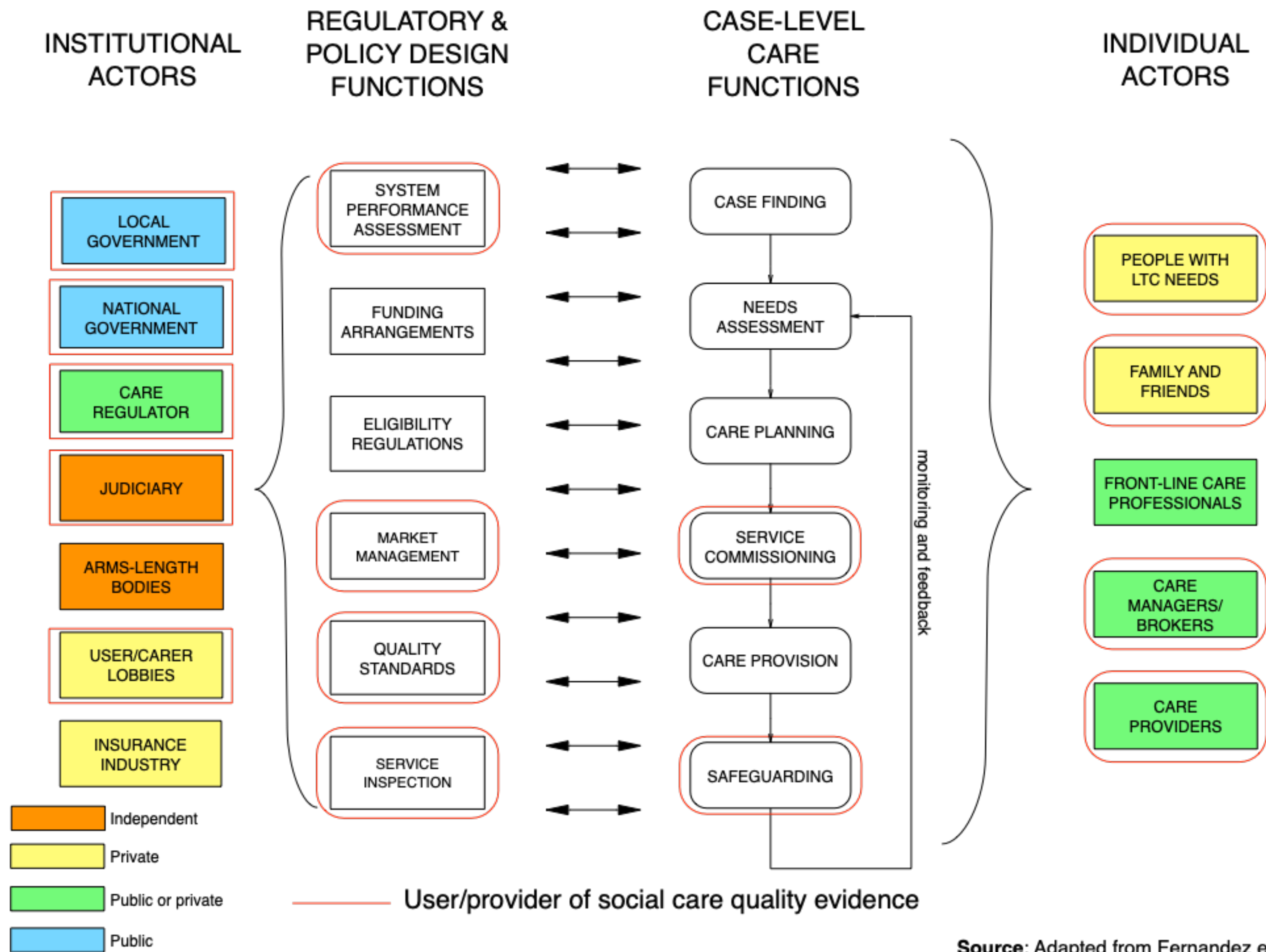
# Provider characteristics as quality indicators

- Structural quality indicators are associated with “search properties”, characteristics which can be used to advertise key features of service providers. Relevant examples include whether residential care homes offer single occupancy rooms, the size of rooms and the range of facilities available in a care home.
- Where the service does not have physical attributes, for instance in the case of home care support with activities of daily living such as dressing, feeding and going to the toilet within the person’s own home, it is very difficult to identify search properties. In this case, potentially searchable properties relate to relatively stable characteristics of the care worker that can be known prior to purchase, such as their qualifications and employment experience. These characteristics, however, are often poor predictors of the overall quality of services.
- Services are also labour intensive, which can lead to a high degree of variability. Service performance can vary significantly from producer to producer, by producer from day to day, and by producer from consumer to consumer. The last of these is partly driven by the inseparability of consumption and production of the social care process and by the fact that services are frequently ‘customised’ to meet the consumer’s preferences.
- Overall, social care services usually have few ‘search’ properties, or core aspects of quality that can be easily observed, measured and therefore known *ex ante*. This limits the use of structural indicators for measuring social care quality.

# The uses of social care quality evidence

This section discusses the range of decisions and processes underpinned by quality evidence in the social care system and what this implies for the desirable features of indicators. Figure 4 illustrates the range of actors and functions involved in the use and/or production of quality evidence.

Figure 4 - Key actors and functions in the social care system: the role of quality evidence



# The need for social care quality evidence

- Evidence about the quality of social care is needed by a range of different stakeholders for a range of purposes. The main users and uses are illustrated in the table below.

| **Users** of quality evidence | **Uses** of quality evidence |
|---|---|
| Purchasers of social care (individuals and local authorities) | Choosing a provider / caregiver<br>Monitoring contractual obligations around the quality of provision |
| Providers of social care | Marketing<br>Monitoring and improving quality as part of a quality management system |
| Government (central and local) and arms-length bodies | Accountability to the public and Parliament<br>To guide intervention and investment in the market to assure and improve the overall quality of provision*<br>Policy development to support intervention and investment in the market to assure and improve the overall quality of provision |
| Citizens | To hold (central and local) government to account |
| Research community | To support practice improvement by identifying what works best, for whom, how and why<br>To support policy development around market intervention and investment |

* Includes, for example, audit and inspection, public reporting of quality evidence about providers, strategic market management e.g. around the allocation of resources, investment in innovative models

# Quality evidence for care purchasers and providers (1)

- A concern frequently raised in relation to social care is that services are not responsive enough to the needs and preferences of the people who use them, resulting in poor quality provision. This issue is linked to both i) a lack of **information about the quality of providers' services**, meaning that people may not always be choosing the highest quality care given their budget and ii) a lack of **incentives for providers to develop services that attend to users' preferences** rather than are easy for providers to deliver.

**Public reporting of provider quality**

- Making evidence about the quality of care delivered by providers publicly available is important to the efficient functioning of social care markets. It should ensure that the best quality providers are in highest demand, by helping prospective users to make the right choices between providers and arming care brokers/care managers with impartial information to give to prospective users to help them choose the right provider for them. Public reporting may also help to improve quality through reputational effects, shaming poor quality providers to improve.
- It is recognised that for quality evidence to be useful i) the same information should be available for all providers, so choices can be made on the basis of the same information, ii) evidence should be reported in a simple to use format, iii) evidence should focus on the lived experience of existing users as this matters most to prospective users, and iv) people may need to be supported to make the best use of the available evidence[5].

**Contract monitoring**

- Contracts for care provision usually include a set of quality standards within the service specification. Local authorities often seek to base the quality standards on evidence about the features of a service that promote quality (e.g. as set out in NICE quality standards) and have a concern with care outcomes. They may also try to harmonise their quality standards with CQC requirements and neighbouring areas.
- Quality evidence is required to monitor compliance with contract standards. Since contract standards are often broad covering outcome, process and structural indicators, a mix of approaches is required to assess compliance. Approaches include auditing compliance with structural indicators (e.g. staffing ratios, training matrices) and observation, surveys and interviews to assess the effectiveness of care and the care experience. Although budget cuts have seen LAs scale back approaches to contract monitoring. some LAs have approaches that look very similar to a CQC inspection, but their assessments tend to be more frequent and can cover different aspects of provision e.g. focus in on dementia care for providers with many dementia clients.

# Quality evidence for care purchasers and providers (2)

**Signalling quality to the market**

- Providers can find it useful to collect and report evidence about the quality of their care as a way of signalling quality in a competitive market. Quality marks can attract more users, and they can attract staff – an important consideration given the undersupply of workers. Additionally quality evidence can support a business case for investment in the provider[6]. Enthusiasm for signalling quality is demonstrated by the many examples of providers participating in voluntary accreditation schemes, whereby a third party assesses whether the provider meets certain quality standards and awards a quality mark to those that do.
- Accreditation schemes usually require providers to collect evidence about the quality of their provision, and some schemes are linked to the use of a particular quality management system (e.g. ISO, E-Qalin). Quality management systems give providers the tools to continuously improve their services, and reflecting their commercial roots often put more emphasis on measuring customer satisfaction than effectiveness. They also tend to focus on process and structural indicators of quality, as these are closely linked to the way care is delivered and are therefore easy to act on to improve services.

**Lessons from research**

- Some research suggests that prospective users do not consult quality information, but this may be due to flaws in the presentation of evidence[5]. There is evidence that providers pay attention to their quality ratings, suggesting that quality may be improved via reputational effects rather than shifts in choices[6].
- The importance of making quality information available is illustrated by evidence showing that in competitive care markets there is downward pressure on both prices and quality, with the effect on quality working through prices. Providers are competing on price and this has a negative impact on quality[7].
- Variations in contractual requirements across local authorities creates significant inefficiencies for providers. Consistency around quality standards in service specifications would lower the costs of tendering for providers.

# Quality evidence for intervening and investing in markets (1)

- Scandals associated with the poor quality of social care provision and the concern that care markets are not responsive enough to the needs and preferences of the people who use them, provide the main rationale for government intervention and investment in social care markets to assure and improve quality. Quality evidence is required to support these decisions.

**Assuring services meet a minimum quality standard**

- Commonly countries use legislation to mandate providers to meet a set of quality standards. In England a range of quality standards are set out in legislation. Powers for monitoring and enforcing compliance with the standards are delegated to CQC. Since the quality standards are broad and include outcome, process and structural indicators, a mix of approaches is required to assess compliance. These include data returns based on information collected by providers' administrative systems to capture structural indicators, and observation and interviews to assess the effectiveness of care and the care experience.
- While the breadth of standards allows for a more rounded assessment of quality and can help to overcome the distortion and motivation problems associated with standards focused on structural indicators, the evidence suggests that process and outcome standards lead to higher surveillance costs and more variability in the assessment of compliance with standards[5].

**Evidence about what improves quality and its value for strategic investment**

- Evidence about the most effective practices and types of services for different groups of service users can help guide quality improvement and investment decisions by providers and improve the strategic investment and purchasing decisions of commissioners.
- In England NICE is charged with collating and distributing such evidence for the social care sector. Developing such an evidence base depends on partnerships between researchers and social care organisations, a culture of research within social care organisations and a well-funded and substantial community of researchers – none of which characterise the social care sector. There is an absence of this evidence at present. Critically researchers need to work with social care organisations to identify appropriate quality indicators that can be routinely collected to investigate effective practices and services. Investments that support these partnerships could be beneficial to the development of quality evidence.

# Quality evidence for intervening and investing in markets (2)

**Overseeing quality in local markets**

- Local authorities have responsibility to oversee the quality of local markets and step-in in instances of provider failure. Rather than letting poor quality providers fail, many local authorities prefer to support failing providers and help them to improve. This is less disruptive for users of the service and is often what users want. To effectively support providers, ideally LAs would be able to identify poor quality organisations or problem areas of practice before problems escalated. Such evidence could then guide either targeted support (e.g. training, turnaround teams), closer scrutiny, or inform the development of schemes to incentivise improvement (e.g. performance payments, accreditation).
- Continuously-updated evidence about the quality of care received by both self-funders and publicly-funded care users is clearly critical to identifying poor quality organisations and problem areas of practice. There are several challenges
  - LAs lack any levers to mandate providers to give them data where a contract for provision is not in place. For some providers LAs will therefore be reliant on publicly-available quality evidence, which may not be detailed enough to assess some aspects of quality, especially effectiveness and the care experience.
  - Provider groups are often regionally-located and providers work across LA boundaries so neighbouring areas may hold valuable information about the quality of a given provider (and/or parent organisation). A regional approach to oversight is likely to be preferable to make the best use of the quality data collected by each LA and to coordinate targeted support.
  - Assessing the quality of care practice where care is delivered by Personal Assistants for Direct Payment users or self-funders is likely to be extremely difficult for LAs, since these workers are not regulated and are largely unknown to them.

**Developing policies to guide intervention and investment in markets**

- In addition to guiding operational decisions, quality evidence can help to develop policy that supports the key actors to make the best decisions, for example by providing funding to stimulate investment in new service or practice models that have been shown to be effective.

# Quality evidence and the role of the research community

- The research community has an important role to play in supporting (central and local) government and arms-length bodies to make good decisions about how they intervene and invest in social care markets. They can also play a role in guiding practitioners about the best way to deliver services to optimize the quality of care provided to different groups of people.
- The availability of high quality, publicly-available evidence about social care quality is key if the research community is to play these roles effectively.
- **Understand the effectiveness** of different social care services: a key evidence shortfall in social care is the lack of estimates of the impact of different service and practice models on outcomes for people with social care needs. Without this evidence NICE cannot effectively perform its role in guiding decision-makers about investment in different types of services. Information on social care quality, and in particular on care outcomes, is crucial to address this shortfall.
- **Routine collection** of quality data: the need to collect outcomes data is increasingly being recognized by providers, especially where they are delivering more innovative services that have not yet become mainstream. As commissioners demand evidence about the effectiveness of such services in order to support decisions around the reallocation of budgets, providers have needed to respond. They have found that digitization has helped, as a raft of data is routinely collected and can be made available to researchers to investigate the effectiveness of services. Moving forward it will be important to work with providers of digital care planning software and other systems to ensure the most appropriate quality evidence is collected.

# Quality evidence for accountability

- Functioning democracies rely on governments being held accountable for the decisions they make. In the social care sector, government sets the policy and legal framework and steps in to fund care where people do not have the means to pay for it. These decisions shape the performance of the system.
- There are several dimensions to accountability
  - Local authorities to citizens in the local area: given that the publicly-funded social care provision is now majority funded via local taxation this relationship is of increasing importance.
  - Local authorities to central government: local authorities carry out their responsibilities as set out in legislation and articulated in guidance. Central government has an interest in their performance in discharging these functions. An important consideration is how this relationship has changed as the amount of money from central government to local authorities for funding social care has decreased and become tied to specific goals for the sector (e.g. around the Better Care Fund).
  - Central government to Parliament and citizens: here accountability is supported by oversight institutions, such as the Care Quality Commission and National Audit Office, who prepare overviews of system performance. The media and other actors have a key role in informing citizens.
- We refer to performance rather than quality when considering accountability, as it is the performance of the system (aspects such as effectiveness, efficiency, and equity) that is the critical consideration. Quality as viewed from the individual-level or provider-level perspective is too narrow a focus.
- Accountability and **performance assessment frameworks**: accountability is usually identified as a key reason for the development and implementation of performance assessment frameworks. Such frameworks provide central government with a consistent view of the performance of all local authorities with respect to key indicators and provide Parliament and citizens with information to judge the performance of the system at the national level. Accountability is an explicit goal of the current Adult Social Care Outcomes Framework (ASCOF) and its predecessors (Performance Assessment Framework, Citizen's Charter). A notable difference between ASCOF and its predecessors is that ASCOF focuses primarily on effectiveness, the care experience and outcomes related to specific policy objectives. Previous frameworks covered these aspects of quality very poorly (focusing too much on process and structural indicators) but had a broader view of performance.

# What social care quality evidence should be collected?

- The variety of uses for quality evidence means that **we need a range of types of quality evidence** in order to fulfil the needs of different stakeholders.
- It is likely to be better to have **multiple approaches for collecting quality evidence** rather than mandating a single set of indicators. Past sets of indicators that have been developed to serve multiple purposes have often been perceived as overly burdensome and due to compromises around content please no-one.
- There are clearly situations where consistency in the reporting of quality evidence is essential, including for market oversight, accountability purposes and to support user choice. Additionally, there seems to be much to be gained from some degree of rationalisation and coordination of quality standards, as this would facilitate market oversight, streamline tendering and minimise confusion among providers. A firmer evidence base would clearly help in this regard, but in the absence of that strong leadership to agree quality standards and develop a consistent set of quality indicators for each of the above functions is important.
- It is also useful to reflect on some of the key dimensions along which quality indicators need to vary according to the uses of quality evidence:
  - **simplicity v. complexity** of the quality indicators: where quality evidence is used for accountability purposes or to help individuals (and local authorities) make good decisions about purchasing social care the evidence needs to be simple to understand. By contrast the research community is likely to favour more complex sets of measures that enable detailed analysis to account for a range of factors that may influence quality.
  - **effectiveness v. care experience v. satisfaction**: the research community and those parts of government that are interested in informing the allocation of resources to promote quality and understanding what models of social care work best, will see outcomes and the effectiveness of services as critical. Conversely providers of care and purchasers are likely to be more interested in the experience of care delivery and adherence to standards related to the care process. Providers as business owners are also likely to be interested in satisfaction with care, since this is often seen as indicative of customer market behaviour.
  - **quality v. performance**: for accountability purposes performance is a more relevant concept than quality. For all other uses quality of providers and quality of care at the individual level is highly relevant.

# References

[1] Malley J, D'Amico F, Fernandez J-L. What is the relationship between the quality of care experience and quality of life outcomes? Some evidence from long-term home care in England. Soc Sci Med [Internet]. 2019 Oct 23 [cited 2019 Oct 30];112635. Available from: https://www.sciencedirect.com/science/article/abs/pii/S0277953619306306?via%3Dihub

[2] Donabedian A. The quality of care. How can it be assessed? JAMA [Internet]. 1988;260(12):1743–8. Available from: http://jama.ama-assn.org/cgi/content/abstract/260/12/1743

[3] Fernandez J-L, Forder J. Local Variability in Long-Term Care Services: Local Autonomy, Exogenous Influences and Policy Spillovers. Health Econ [Internet]. 2015 Mar [cited 2019 May 28];24:146–57. Available from: http://doi.wiley.com/10.1002/hec.3151

[4] Trigg, L., Kumpunen, S., Holder, J., Maarse, H., Solé Juvés, M., & Gil, J. (2018). Information and choice of residential care provider for older people: A comparative study in England, the Netherlands and Spain. *Ageing and Society, 38*(6), 1121-1147. doi:10.1017/S0144686X16001458,

[5] Malley, J., Trukeschitz, B., & Trigg, L. (2015). Policy instruments to promote good quality long-term care services. Long-term care reforms in OECD countries, 167-193.

[6] Forder J, Allan S. The impact of competition on quality and prices in the English care homes market. J Health Econ. 2014;34:73–83.

[7] Fernández, J. L., Trigg, L., Reinhard, H. J., & Micharikopoulos, D. European Long-Term Care Models And Compatibility With Social Investment Approaches.