



Improving the quality of residential care
for older people:

A study of government approaches in
England and Australia

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The information in this summary is from the author's PhD thesis. More information on the research methods and interview participants, as well as more detailed results, can be found at <http://etheses.lse.ac.uk/3772>

1 About the study

The purpose of this study was to find out what governments can do to encourage care providers to improve their quality. To do this, I compared the approaches of England and Australia to improving quality in residential care for older people.

The main activity by each government to improve quality is through the inspection of care homes. The government in England has created the Care Quality Commission (CQC) to inspect care homes, and in Australia, the Australian Aged Care Quality Agency (AACQA)* has been set up to review and accredit homes. In both countries, the governments also say that care homes will improve if people can choose which one to move to, and a lot of importance is attached to making it easier for people to choose the homes they prefer.

What did I do?

I conducted interviews in England and Australia to look at the differences in how things work. I interviewed politicians and people in government, charities representing residents and carers, bodies representing care home organisations, and senior managers from the CQC in England and AACQA in Australia. I also conducted interviews at five different care home organisations in each country – ten organisations in total.

*AACQA was merged with the Aged Care Complaints Commissioner on 1 January 2019 to form the Aged Care Quality and Safety Commission.

2 Key findings

The main differences between the two countries' approaches to quality in residential care are summarised in Table 1 at the end of this section

Comparing England and Australia showed that there were lessons which could be applied in other countries.

1. Governments and people making policy should think about provider quality in three different ways

It is very difficult to define 'quality' in residential care, and this makes it difficult for governments to put things in place to address quality. For people living in residential care, quality will be made up of many different parts, from the standard or size of the accommodation to how safe and secure they feel.

For my study I came up with a new way of explaining the different types of quality for care home organisations. These categories draw from both existing studies (1–4) and from what I heard in my interviews. The three types of quality are:

■ **Organisation-focused quality** is where providers are most interested in making sure that their residents are safe and that they all receive the same standard of clinical care. This type of quality is important for all residents, but for some providers, it is as far as they go.

■ **Consumer-directed quality** is where providers treat residents and their families like customers or 'consumers' and focus on things that help them to attract new residents and their families, like the design of accommodation or the type of activities on offer. One author has referred to this as 'cruise ship living'(5)

■ **Relationship-centred quality** is the best type of quality and is where every resident is treated as an individual with her or his own personality, regardless of how unwell she or he is. The most important priority for these care homes is to help all their staff and residents and families form good relationships so that everyone feels that they matter.

2. Different policies will influence what type of quality providers will focus on.

- Inspection and accreditation tend to focus providers on organisation-focused quality in the form of basic standards of safety and good processes. Some ways of funding care, for example, the Aged Care Financing Instrument in Australia, can also result in providers focusing on this type of quality.
- Promoting consumer choice as a way of improving quality can result in providers focusing on the visible aspects of care, or consumer-directed quality.
- Providers who deliver relationship-centred quality tend to do it because they are motivated to do so, regardless of what the government might do. But something that seems to be useful is to provide a rating of quality, as in England, so that providers know who to copy.

3. The best strategy for improving quality is to have a mix of policy approaches and provide checks and balances.

- Having different groups involved with quality, for example, the CQC in England and local safeguarding teams, means that there might be less chance of poor quality slipping through the net. However, this only works if these groups communicate effectively.

- Having different programmes running alongside inspection and accreditation can also help to provide checks and balances. Examples include the Community Visitors Scheme and National Aged Care Advocacy Program in Australia, although recently they have not been used effectively to support quality as they were originally intended.
- Being aware of the imbalances between different policies and strategies is important. For example, the way providers are paid might motivate them to concentrate on one type of quality regardless of what is required by activities like inspection.

4. Governments need to communicate what good quality looks like. Without a vision for good quality, it is impossible to know how to encourage care homes to deliver it.

- Governments should play a role in making sure that information is available about the quality of each provider.
- The government in England has put a lot of effort into making sure people can tell the difference between good and poor providers. The information includes ratings where providers are scored outstanding, good, requires improvement or inadequate. The inspection reports produced by the CQC also try to describe what it's really like to live in the care home. The CQC also publishes reports on the state of care in England and talks freely about where it sees poor care.
- In Australia, there is much less information available, although this is changing, starting with the introduction of Consumer Experience reports in 2017.
- Governments need to make sure that not all the attention is on 'input' standards like how big the rooms are, or on 'process' standards like how medication is managed, as these can distract care homes from delivering high quality, relationship-centred quality and cause them to focus on the wrong priorities.

5. The reasons why governments approach quality differently can be due to bigger historical reasons.

- In England, even though there is a lot of emphasis on consumer choice, there is still a 'welfarist' flavour to how the government treats quality. This is because local government in England was, for nearly two centuries, very involved in the delivery of care. Social workers and local authorities play a central part in organising care and quality is informed by a human rights-based approach (6).
- In Australia, there is a more 'consumerist' approach which in part stems from the fact that care has always been delivered by other organisations, such as faith-based organisations. The federal government takes the lead in contracting with providers, and quality is linked to consumer protection and choice.
- In the past in England, there has been a greater tendency for the government to react to scandals and crises in both health and social care – often called 'never again' events because of the way politicians often say things like 'we will make sure this never happens again'. Until recently in Australia this would have been unusual and there was much more 'bipartisan' support where the parties agreed with each other. This changed recently with the impact of the Oakden scandal* in Australia.
- A number of individuals have been very influential in driving certain approaches in both countries. In England, there have been individuals behind the human rights approach in quality over nearly 20 years. In Australia certain individuals have pushed hard to give choice to consumers with the aim of improving quality.
- Provider organisations in Australia have also been better at working together than in England. This is one reason why providers in Australia seem to have had more influence over how regulation has been designed and carried out.

*The Oakden scandal refers to the uncovering of mistreatment and neglect at a unit for people with dementia in South Australia in 2016 (7).'

Table 1: Quality in residential care in England and Australia

	ENGLAND	AUSTRALIA
QUALITY AND INSPECTION/ ACCREDITATION		
What do the standards look at?	Try to consider the experience of the person	Look at how good the processes are for running the home
What is most important?	The right of the individual to live a good life	The need for consumer protection and good internal processes
How is quality scored?	Using ratings (Outstanding/Good/Requires Improvement/Inadequate) The 'Mum Test'	Pass or fail
INFORMATION ABOUT QUALITY		
What information does the regulator publish?	Inspection reports which try to describe what it's like to live in the home Ratings for every home Reports on the quality of care is across all providers	Accreditation reports based on the provider's processes Information on what the resident's experience is like (since April 2017)
What do care homes publish?	CQC ratings at the home and on their website – this is compulsory	Prices on MyAgedCare website (compulsory)
How are resident ratings and reviews used?	Some ratings and reviews are available on NHS Choices and the CQC website but there are very low numbers of reviews	Under development
What part does information on quality play?	CQC aims to use ratings to encourage providers to improve quality to protect their reputations, as well as helping people choose homes	Emphasis is on publishing information to help people choose homes
WHAT AFFECTS QUALITY AND HOW?		
Organisation-focused quality	CQC inspections include making sure the residents are safe	Accreditation reviews make sure the providers have safe, standard processes The way the government pays providers (through the ACFI) can mean that providers focus too much on organisation-focused quality
Consumer-directed quality	Half of residents pay for their own care and companies improve consumer-directed quality to attract them	Many residents pay deposits and accommodation payments and companies improve consumer-directed quality to attract them
Relationship-centred quality	The best providers improve relationship-centred quality independently, but it helps that the CQC highlights examples of outstanding care for providers to copy	The best providers improve relationship-centred quality on their own, without government involvement

3 Introduction

Many countries around the world are trying to find ways of making sure that older people receive good care and support when they need it. However, for many years, there has been coverage in the news about neglect and abuse in residential care (8). England and Australia are no exception. Both countries have had several scandals in residential care. The latest of these are the problems at the Oakden mental health facility in South Australia in 2016, where a number of older people living with dementia had been neglected and badly treated.

Even though there are many problems in residential care, there are also many good providers. But it is not clear why some care home providers are motivated to provide very good care while others continue to provide poor care. The aim of this study was to try to understand what governments can do to encourage more providers to go the extra mile and deliver good or excellent care for their residents.

How I did the study

To find out about what happens in residential care for older people, I compared what happens in England and Australia. I chose these two countries because they are very similar in how and when residential care is used and they both use external inspections to review the quality of care. I interviewed two different groups of people in each country, and asked each group slightly different questions:

Group 1: In these interviews I tried to find out about how each country's care system had developed and how it works now. I interviewed different types of experts in residential care, including politicians and people working in the government, people from groups representing providers and older people, staff from AACQA and the CQC, and consultants and academics.

I interviewed 32 people in England and 47 people in Australia.

Group 2: I then interviewed staff from 10 different care homes to find out what really happens on the ground. In total I interviewed 9 people from 5 care home organisations in England and 15 people from 5 organisations in Australia. I visited at least one care home from each of these organisations.

The term 'care home' from England is used throughout the report as a catch-all to refer to all residential homes in both countries, including homes that offer both personal or nursing care or both.

Background to residential care

People only go into residential care when they need a lot of support and help

Most countries try to help people to stay in their own homes as long as possible. What this means is that, when older people finally need residential care, they are often very unwell and need a lot of support. In England and Australia, at least half of the older people in residential care are also living with dementia (9, 10).

People in residential care need different types of support

Many residents need help with 'personal' care, for example, getting dressed or going to the toilet. Many residents will also need clinical care which can range from the simple administration of regular medication to more complicated care. The high number of people living with dementia means that many older people in residential care need specialist dementia support. Also, many of the older people will spend the rest of their lives in residential care, so end-of-life care is also very important.

People can spend long periods of time in residential care

Once they move into residential care, older people will often live there permanently. This means that everyday things like accommodation and food are also important, in the same way they would be in the person's own home.

Background to residential care in England and Australia

Comparing countries is often helpful as it allows us to see how governments have tried to solve similar problems in different ways. This is not as straightforward as it sounds. Sometimes governments do things differently because of complicated and longstanding reasons to do with the history and culture of the country.

Previous researchers have written about the differences between residential care in England and Australia (11–14), and also between the way inspections are carried out in each country (15). These differences are important because they help to explain some of the findings of this current study.

One important difference between England and Australia is the way the country is governed. In England, there is a central government in London, which collects most of the taxes and passes all of the laws. In Australia, these responsibilities are split between the central (called 'federal') government and the six state governments.

Some of the main differences in how the care systems work are outlined in Table 2:

Table 2: Differences in how care is organised in England and Australia

	ENGLAND	AUSTRALIA
Who pays for care?	About half of people in care homes pay for themselves. The other half are paid for by their local council or by the National Health Service (if they are very unwell).	The government pays something towards the care of everyone in residential care. For the less well-off, called 'low means' residents, the government also helps to pay for accommodation.
Who organises the care paid for by the government?	There are 152 councils (called local authorities) who liaise with the care home companies to organise care for people who are paid for by the government.	All of the care is organised through the federal government, rather than through the governments of each state and territory, as is the case for health care.
Who delivers care?	Most of the companies that deliver care are private companies that make profits for their owners and shareholders.	More of the companies that deliver care are voluntary and religious organisations that put their profits back into their organisations.
How is care inspected in each country?	The CQC inspects care providers and gives each home a rating of outstanding, good, requires improvement or inadequate. The CQC has the ability to close down a provider or even bring criminal charges if it finds a provider has provided very poor care.	AACQA reviews each home and simply passes or fails the home. The Agency hardly ever fails homes, but where it does, it must send the report and recommendations to the Department of Health for them to take action. AACQA cannot take further action without the permission of the Government, through the Department of Health.

There are roughly the same number of care home residents in England as in Australia, when compared to the population of older people. In England, about 410,000 people were using residential care as at December 2016 (16), which works out at about 4.1% of people aged 65 and over (17). In Australia, the total number of people in residential care was about 184,000 in June 2017 (18), or about 4.8% of people aged 65 and over (19). One difference is that homes in Australia tend to be bigger – care homes in Australia have an average of 70 places, compared to around 40 in England (16,18).

History of inspection and accreditation

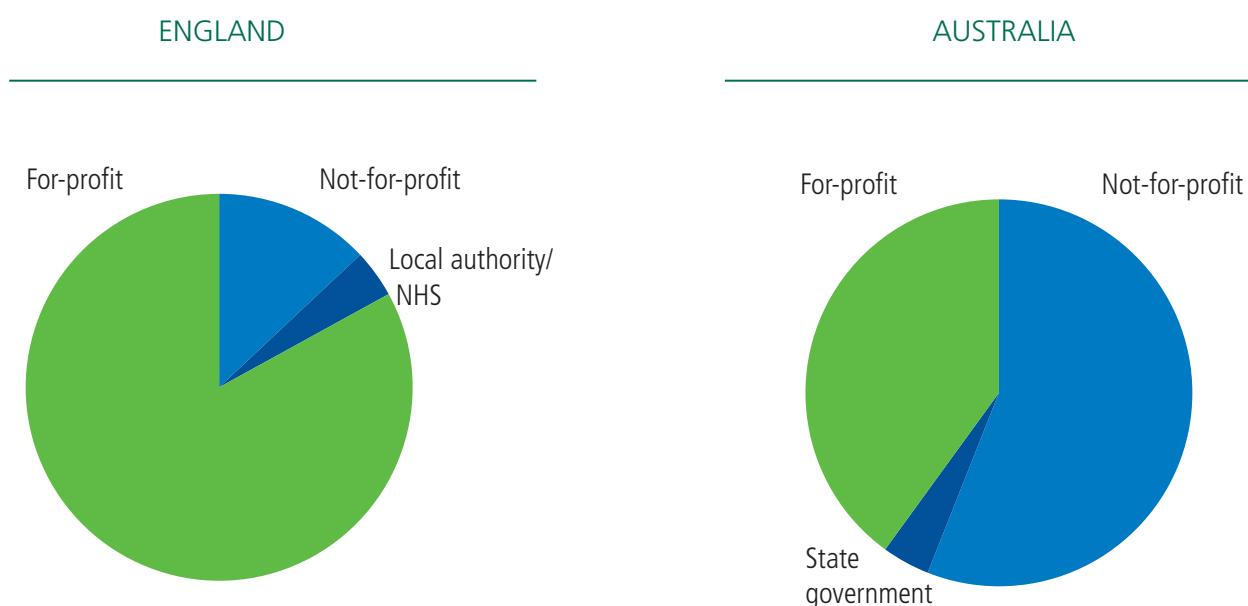
In England, inspection in residential care has been increasing since the 1990s. Following the NHS and Community Care Act 1990, councils started to use external companies for delivering most residential care, instead of providing it themselves. This meant that the government and councils needed a system where they could keep an eye on what was happening in care homes that they were not involved in running. Across the board, and not just in social care, the amount of regulation increased from the 1980s and a report in 2005 (20) observed that there

was too much regulation and ‘red tape’ for businesses. Because of this, in 2006, the government announced that the inspection bodies which were in place at the time for all different types of care (including health care, and residential and home care) would be merged into a new body, the CQC.

In Australia, the reasons why inspections increased were initially different to England. The Australian government has always used private companies to deliver most of its residential care. Most of the private companies who deliver care in Australia are ‘not-for-profit’ voluntary organisations, usually run by religious organisations. This is different from England where most companies are in the business of residential care to make money. The split between for-profit and not-for-profit care in each country is shown in Figure 1.

The Australian government introduced inspection in the 1980s after an inquiry known as the Giles Report discovered horrible cases of abuse and neglect in nursing homes (21). The introduction of regulation was in line with the priorities of the Australian Labor Party government of the time, which wanted to make sure there was a fairer and better system of residential care. When the Liberal government came to power in 1997, the rules were relaxed,

Figure 1: Ownership of residential care places [16, 18]

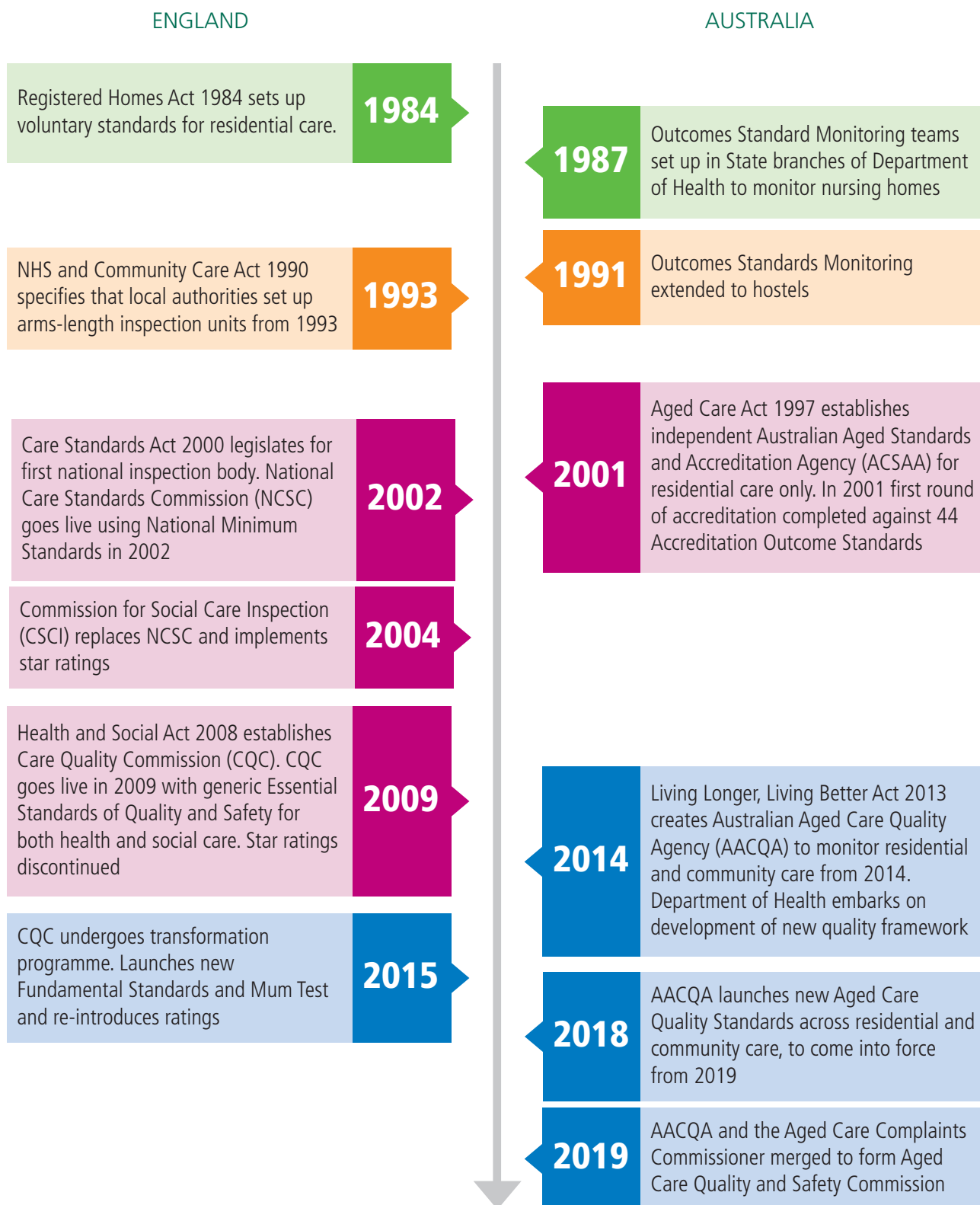


* The Liberal Party in Australia is most similar to the Conservative Party in England

and a system of accreditation was introduced. The government set up a body called the Australian Aged Care Accreditation Standards Agency to look after residential care. This Agency was in place until 2014, when it was

relaunched as the Australian Aged Care Quality Agency (AACQA) and given the responsibility for care delivered in people's homes and in the community. The history of regulation in each country can be seen in Figure 2.

Figure 2: Legislative and organisational milestones in quality regulation



What do governments do now to encourage good care?

It can be difficult for governments to encourage good care because now they usually rely on private care companies to deliver care. These companies can be set up to make a profit for their owners or shareholders, or can be not-for-profit, where they spend any extra money they make on improving their homes and services.

Governments have tried three main ways to encourage these care companies to improve their care:

1. Inspection

A common way of encouraging providers to improve their care is to do regular inspections. Governments often set up separate organisations to carry these out. These organisations decide how well providers are meeting specific standards. These standards come in three different types (22):

Structural standards about things like the number of staff in the home, or how big the rooms are.

Process standards about things like how the care company goes about keeping track of people's medication, or whether they have processes for handling complaints from families.

Outcome standards about things like whether the care company is good at helping residents to enjoy life or to feel safe and secure.

2. Markets and competition

Many governments have tried to encourage providers to improve quality by having 'markets' in residential care. This means that people get to choose which care provider they use. What is supposed to happen is that providers will go out of their way to show they are better so that they get chosen (23). The problem with this is that choosing a residential care place is not as simple as other decisions in life, like buying a fridge or choosing a hotel, because:

- The older person may not be well enough to be able to find out about different care homes and make good choices.

- The person living in the care home has often not decided they need residential care or thought much about which care home to use. These decisions are frequently made by the individual's family or by a person such as a doctor or a social worker.
- It can be difficult to work out which are the best care homes by just visiting them and without actually going to live in them.
- People often go into residential care when a crisis happens, for example, the death of their partner or because of a health problem, such as a broken hip. This means there is often not much time to look around at different care homes. Sometimes people just have to choose the first home which has a place available.
- Once the person is in the care home, they may be too ill to move or even to tell people that the care they are receiving is poor.
- When things are not going well in residential care, their families and friends of residents maybe worried about complaining in case it affects the way the resident is treated.

3. Quality information

When governments try to use markets to improve quality, they often make information available on how good the provider is. This can come in many forms, for example, ratings from residents (like the ones for hotels on websites like TripAdvisor), or scores from inspectors for how well they do certain things. However, there is lots of research to say that people do not make use of this information because they are unwell or the decision has to be made very quickly (24–26). But this does not mean that having ratings is pointless – for example, in health care ratings work because providers can be worried about their reputation or about losing business if they get a bad rating (27, 28).

Conclusion

Researchers have already found that inspections and reviews have helped to raise the most basic standards of care, even though there are still examples of very poor care. But inspections are not so helpful for encouraging care companies to deliver really good quality care. Giving people

choice of care home is another way of encouraging care homes to improve, but this also has its problems, because people are often too unwell or stressed to make good decisions, or because there are not many options available.

4 Understanding quality

There are many challenges to understanding quality in residential care. Some of the reasons for this include:

- Quality means different things to different people. An example is that one person might like to have privacy and their own space, while another may prefer to have the company of other people. To complicate things, people can have different preferences at different times.
- Quality is made up of many different things. Quality in a care home can include things as varied as how good the nursing care is, whether the home is clean and tidy, how safe someone feels, how good the food is, and whether people feel there is enough to do that they enjoy.
- Quality in care can vary depending on who is delivering it and when. The quality of care can be different from each care worker, from the same person from day to day, or even from hour to hour. The quality of care can also be affected by how well the resident and the care worker get on together.

Because of these challenges, an important part of this study was to find a new way of talking about provider quality. I developed three different ways of talking about quality: organisation-focused quality, consumer-directed quality and relationship-centred quality. I did this partly by looking at what had already been written about quality in general (29–31), and specifically about quality in care homes (1–4), and also by thinking about what people told me in their interviews. The three types of quality are:

Organisation-focused quality is where providers are most interested in making sure that their residents are safe and that they all receive the same standard of clinical care.

There is less emphasis on making sure people feel part of a community. People living in these homes are treated as if they are patients, and the accommodation often has the look and feel of a hospital.

Consumer-directed quality is where providers treat residents and their families like customers or 'consumers' and focus on things that help to attract new residents and their families.

The sorts of things these providers might concentrate on might be the appearance of the home or making sure there is a formal schedule of activities laid on. These care homes may look and feel like hotels, with entertainment and activities organised like they might be in a hotel – something which has been called 'cruise ship living' (5).

Something often said is that families can feel guilty about placing their relative in a home, but they often feel better when they can see a high standard of accommodation or lots of activities for their relative to do.

Relationship-centred quality is the best type of quality and is where every resident is treated as an individual with her or his own personality, regardless of how unwell she or he is.



The most important priority for relationship-centred care homes is to help all their staff and residents and families form good relationships so that everyone feels that they are important. These care homes are as focused on the quality of life of their residents as they are on the quality of the care they provide. These care homes try to be as homelike as possible, which can mean they are often not the tidiest or best presented of care homes.

The term 'person-centred' is often used to refer to this type of care but this term means many different things to different people, ranging

from giving people control of their care budget or writing down information about the person such as what time they would like to get up in the morning, right through to care being about relationships and connections (32, 33). For this

reason, I use the term 'relationship-centred' to describe the best quality care, a term originally coined by health care researchers in the US (34) and adapted for use in residential care by Davies and Nolan in the UK (35).

Table 3: Different quality orientations

	PROVIDER QUALITY ORIENTATION		
	 Organisation-focused	 Consumer-directed	 Relationship-centred
What does the provider focus on?	Internal processes	Consumer preferences and choice	Quality of life of residents, families and staff
What is important to the provider?	Patient safety and quality of care	Consumer rights and choice	Human rights and quality of life
What does 'care' mean?	Care is a process	Care is a service	Care is a relationship
How is work organised?	Task-centred and routine	Customer-centred and individual	Person-centred and relational
What does 'resident' mean?	Passive patient	Empowered consumer	Individual with 'personhood'
Who has the power?	Resident is dependent on the care worker	Resident is superior to the care worker	Resident and care worker in equal, two-way, meaningful relationship
What is the accommodation like?	Hospital-like	Hotel-like	Home-like

How each country defines quality in its standards

The CQC and AACQA have different powers, responsibilities and reporting lines. In England, the CQC can bring criminal charges against individuals and providers, including for manslaughter, where the AACQA has to refer decisions and issues to the Department of Health in Australia.

The standards each country uses are also different. In England, the standards look at what the experience is like for the person living in the home. Called the *Fundamental Standards* and launched in 2015, the standards are based on five questions as shown in Table 4.

Table 4: The five questions in the CQC’s Fundamental Standards (41)

KEY QUESTION
Is it safe?
Is it effective? (Does it give good results?)
Is it caring?
Is it responsive? (Does it meet people’s changing needs?)
Is it well-led? (Is it managed well?)

The CQC gives each home a rating or score for each of these questions, either ‘Outstanding’, ‘Good’, ‘Requires Improvement’ or ‘Inadequate’. The CQC then uses a set of ‘key lines of enquiry’ (KLOEs) to direct the focus of the inspection (37).

When the CQC launched the standards, the Chief Inspector of Social Care, Andrea Sutcliffe, also introduced the idea of the ‘Mum Test’, which she explains here:

“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.” (38)

In Australia, a set of 44 Accreditation Standards split into four themes (see Table 5) were introduced in 1997. The Standards focus mainly on whether care homes have good processes, for example, whether they record medication properly for each individual.

In Australia, there are only two outcomes to accreditation reviews. Providers can either pass or fail. If they fail, the Agency refers the provider to the Department of Health so that they can deal with the provider. There are several things the Department of Health can do, including sending in a team to sort things out (something

Table 5: Accreditation Standards in Australia (39)

STANDARD	PRINCIPLE
1. Management systems, staffing and organisational development	Does the way the home is run help to meet the needs of the people who live there, their families and friends, and all the people involved in running the home? Does the way it is run help it to adapt to change?
2. Health and personal care	The physical and mental health of the resident will be looked after in partnership with the person themselves, their families and friends and the health care team.
3. Care recipient lifestyle	The resident keeps all their rights and is helped to take control of their own lives, both in the home and outside in the community.
4. Physical environment and safe systems	The home is safe and comfortable to help the residents, visitors and the people who work there to have good quality lives and wellbeing.

which the provider has to pay for), or they can also close the provider down if they need to. However, very few providers are flagged up as having problems by the Quality Agency (40, 41) and 98% of providers pass accreditation overall (42). Because of this, at first sight it looks like everything is much better in Australian aged care than in England, but this did not turn out to be the case. People I interviewed told me that care homes had become very good at knowing what to do to pass accreditation, even though they might not really be providing good care for their residents. This is made easier because the accreditation standards have been the same since 1997 and so providers are very familiar with them.

Australia's Accreditation Standards are different from the CQC's Fundamental Standards in two main ways:

1. Even though they are called outcomes standards, the Accreditation Standards are mainly concerned with making sure that providers have good processes in place for internal quality improvement. AACQA does not specify what these processes should look like. Reviewers in Australia could be more interested in whether a care home had a good way of making sure that they gave the correct medication out to residents as their doctors had prescribed, rather than whether residents had been prescribed the right amount of medication in the first place. In England, while

some of the KLOEs explore the quality of provider processes, the overall approach to inspection is to make sure the provider is delivering care which is person-centred and passes the 'Mum Test'.

2. Providers can only pass or fail the Standards and there is no way of knowing whether they just scraped through. This means that all the system can tell is whether providers achieved the minimum standards of quality (43, 44). In England, the CQC replaced its pass/fail compliance approach with the ratings system in 2015. It is not good enough that the provider simply passes the inspection – the CQC uses the 'Mum Test' to make sure that inspectors would be happy for a loved one of theirs to live in the home.

While I was conducting this study, the Australian Government was in the process of developing new Consumer Outcome Standards to replace the Accreditation Standards, to cover residential care and home care. These standards were introduced in 2018 and will be rolled out in 2019 (45). These new standards are more interested in what life is like for the people who live in the home, but they are still based on a system of pass or fail and stop short of stating what good quality looks like. However, the Australian Government is planning the roll-out of ratings, as recommended by the Carnell-Paterson review into the events at Oakden (46).

5 How does each government use information to improve quality?

One of the ideas for improving care homes is to make information available about how good or bad they are. By making information available, governments hope that one of two things will happen to make providers improve their quality. Either people will use information to choose the best providers and other providers will get better to attract and keep new residents, or providers will run their businesses well simply because they want to make sure they keep up a good public reputation.

Publishing quality information sounds simple, but there are lots of issues tied up with it. As explained earlier, quality is not easy to define or explain, so it is very difficult to find straightforward ways of saying how good a provider is. One answer is to give numbers for unwanted types of incidents in the home, for example, did a lot of residents have falls? But this is much less straightforward than it sounds. It may be that there were a lot of falls because the home had the most unwell residents, or because the home believes that it is better for people to get up and move around and risk falling, rather than use things like bed rails or medication to restrain them or keep them safe from falls. Researchers have also found that providers might do unwanted things to keep looking good. So, for example, to keep the number of falls low, care homes might refuse to take very frail residents, or they might give residents drugs to make them less likely to move around and fall over.

There is also the issue of how information on quality is collected. Residents and their families may not be able to comment on care and anyway, it is not like in a hotel where you have lots of people coming and going so a lot more people can leave reviews (47). Residents can also

be worried that staff may treat their relatives badly if they know they have published information that is critical. Governments can ask providers to collect and publish quality information, but researchers have found that it is difficult to make sure that all providers publish the same amount of information (48).

What are the differences between England and Australia?

The way governments in England and Australia write and talk about quality is different. It is easier to get an idea of which care homes are better in England than in Australia. I found this out in the interviews, and also because of the problems I had in finding good care homes to talk to for my research. In Australia, even a senior participant from an industry organisation admitted it was 'breathlessly impossible' to work out which were the better care homes.

There were three features about information that are different in each country:

1. Each country has different types of information available to the public

One of the biggest differences between the two countries is how easy it is to tell the difference between good homes and bad homes. In England, the CQC uses ratings to show how good a provider is, and then the provider must display this rating at their location and also on their website. The ratings are Outstanding, Good, Requires Improvement or Inadequate. This means that it is possible to see what the CQC inspectors thought of a provider's quality.

At the same time, there are some problems with ratings. One is that the inspector is making up

her or his mind based on spending only one or two days at the home, and the management of the care home might go out of their way to make sure there are more staff working on that day and that things are running much more smoothly than normal. Another problem is that, when care homes receive a poor rating things can quickly deteriorate. Staff begin to leave, which makes things worse, and the care home is then even less likely to attract new residents. With less money coming in, the care home can struggle to address the problems the inspector spotted in the first place.

There are currently no ratings in Australia, although it is now planned to introduce them in the future because of the problems at Oakden. During the study, people told me about two Australian government activities to help with showing how good or bad providers were. One project was to ask providers to voluntarily report how well they were doing in four specific areas*. The four areas were the number of restraints, the number of pressure sores, and whether residents were losing weight unexpectedly. These are all important measures, but previous research shows that focusing on specific, clinical measures can mean that other things get neglected – particularly around the quality of life of residents (49).

The other plan in Australia was to ask residents and their families to leave reviews on websites and, at the time of the study, the government was looking at different systems for doing this. In Australia, many people spoke about how the ‘baby boomers’ born after the second world war would be much more demanding than the people in care homes now, and so they would be more likely to leave reviews. Some people told me that this would be so successful that it

would mean that the government could stop inspecting care homes at all.

Previous research says that relying on reviews from residents and their families might not be a good strategy (47). In England, the government introduced these types of reviews in 2011, but this has not been successful, mainly because so few people have written reviews. One person in the government in England told me this is partly because there are too few people going in and out of care homes to post enough reviews on the internet, when compared to how many people visit GPs and hospitals.

2. Finding out what is it like to live in the home

The goal of the CQC in England is to help people understand what it’s like to live in the home. It uses three ways to do this:

- The inspectors talk to residents and their families. Where residents are unable to communicate, the inspectors spend time watching what is going on to see how the residents are involved in the home.
- The inspectors take people with them who either have personal experiences of living in a care home or, more commonly, have been close to someone who has lived in a care home, for example, their husband or mother. These people are referred to as ‘experts by experience’.
- When the inspectors write their reports, they try to include examples of things they saw in the home to help bring it to life. To help see the difference between the inspection reports in England and the accreditation reports in Australia, Table 6 shows examples from reports in each country:

* This project was known as the National Aged Care Quality Indicator Program, launched in 2016. More information is available at <https://agedcare.health.gov.au/ensuring-quality/quality-indicators/about-the-national-aged-care-quality-indicator-programme>

Table 6: Selections from inspection and accreditation reports (54, 55)

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>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>
<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>	

3. Talking about bad provision

One of the biggest differences between the two countries is whether it is legal to share information about bad providers.

In Australia, the law which applies to residential care (the Aged Care Act 1997) says that the government cannot draw attention to specific problems in care homes. It is not possible for AACQA to publish reports with information which might make it easy for people to work out which providers they are talking about.

It is different in England. Not only can inspectors put negative information in specific inspection reports about providers, but the CQC also publishes information about problems in both health and social care. These reports include a report every year on the state of care and also special reports about specific problems such as how difficult it is when older people move between hospitals and residential care (52).

6 What difference do the governments make to the quality of residential care?

So far, this report has focused on what I learned in the interviews about the regulatory systems in each country. Another important part of the study involved visiting residential care providers in each country to see what happens in practice.

I interviewed people from five residential care providers in England and five in Australia. The details of these organisations are given in the table below. Each person agreed to participate anonymously, so I have changed their job titles and the names of each organisation to make sure they cannot be identified. The providers were a mix of for-profit and not-for-profit in both countries.

At the start of the study, I only planned to do interviews with care providers who were going the extra mile and delivering really good care. However, this was difficult in Australia because of the lack of information to help identify the good providers. While the CQC's system of ratings is not perfect, the ratings system gave a good sense of which providers in England are good. In Australia, nearly all providers pass accreditation, but there is no information other than whether they pass or fail, so it is hard to separate the ones who are going the extra mile from the ones who are just scraping through. In the end, I asked people at AACQA and the Department of Health to help me identify good organisations. There was only limited information they could share with me and this meant that the group of five providers I

interviewed in Australia was much more mixed in terms of quality than the group in England.

In both countries there were different standards of accommodation depending on whether the resident was paid for by public money or not.

Four of the providers in England have stopped accepting residents who are paid for by their local authorities. This has been happening frequently recently because the rates paid by councils have been falling or have stayed the same for some time, and providers say they can no longer afford to take new residents at the rates paid by the local authorities.

In Australia, the situation is slightly different. All providers approved by the government take publicly-funded residents, otherwise the government pays them lower rates for care.

At the providers I visited this meant that there were two standards of accommodation: one for wealthier residents, and a different standard for residents whose accommodation is paid for by the government – referred to as 'low means' residents. The differences in accommodation were striking. At three of the provider organisations (two for-profit and one not-for-profit), RAD/DAP-paying* residents generally lived in single rooms while many low means residents shared rooms of up to four people. These shared rooms were more like small hospital wards than homelike bedrooms. In England, there are now very few shared rooms,

*A RAD (Refundable Accommodation Deposit) is where the accommodation part of care home fees is paid for upfront as a lump sum. Residents can opt instead for a DAP (Daily Accommodation Payment) which is like a regular rental payment. The level of payments is determined by the quality, location and features of the accommodation and is capped by the government. More information on how people pay for residential care in Australia is available at www.myagedcare.gov.au/costs/aged-care-homes-costs-explained/paying-accommodation-aged-care-home

Table 7: 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	Operations Director Care Home Manager	Care Home Manager	Chief Executive Operations Director Senior Manager (shared services)	Care Home Manager	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	Chief Executive Operations Director Quality Manager & Senior Manager (shared services)	Chief Executive Senior Manager (shared services) Care Home Manager	Senior Manager (shared services) Quality Manager Care Home Manager	Chief Executive Care Home Manager Operations Director	Operations Director

and usually only for couples. The guidelines in Australia are that providers can have an average of 1.5 low means residents per room (53).

One provider in Australia thought that low means residents probably do not expect the best accommodation and it was like being able to afford different classes on an airline:

“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)

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

In both countries, some of the providers were running homes which looked and felt like hotels. They had smart reception desks, expensive decoration and furnishings, waiter service and menus in the dining rooms and fresh flowers.

What difference do the governments make?

The following section looks at how and if quality improvement is linked to what the governments in each country do. It finds that some government actions can influence quality improvement, but this is mainly the type of quality linked to organisation-focused or consumer-directed quality. There are not such strong links between government actions and relationship-centred quality, because this type of quality depends on the ‘intrinsic’ motivation of providers, motivation which comes from doing things because they are personally rewarding (54). Even so, there are ways governments can influence relationship-centred quality, for example, by identifying outstanding providers as role models for other providers to copy.

Regulation and quality improvement

All the people I interviewed said that inspection and accreditation in each country have generally improved the basic level of quality. Otherwise,

they did not think that inspection and accreditation had made much difference to higher levels of quality. In both countries, the standards can unfortunately lead to an unnecessary focus on paperwork and bureaucracy.

One of the problems in Australia is that the Accreditation Standards have been much more concerned with how things are done, rather than what difference they make, as mentioned above.

In the case of an Accreditation Standard called ‘continuous improvement’, one problem I found in two of the providers was that they were more concerned with making sure they had written down what improvements they were doing, than whether they actually made any difference.

Some Australian researchers have looked at nursing homes in the past and called what these providers were doing ‘continuous improvement ritualism’ (15). What they mean is that care providers are more concerned about the ‘ritual’ of improving quality, rather than really making a difference to the lives of their residents.

For these two providers, the improvements were mostly simple things like changing the type of trays they used at mealtimes or for organising for homes to be redecorated. Other improvements were to help to run the homes more smoothly. So, for example, one home talked about improving handovers between shifts. This definitely is helpful for residents and for better quality care (55), but the provider was much more focused on how much more efficient it made their home.

“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.”
(Care Home Manager, Waratah, Australia)

One Australian provider explained how the priority is often on recording things rather than what is needed for a feeling of ‘normal’ life. She gave the example of how people need to write down whether people prefer tea or coffee:

“ ... 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)

So, while ‘continuous improvement’ is an important standard in Australia, there was nothing to suggest that this really had an impact on the best, relationship-centred, quality.

There were care providers in both countries who looked like they were delivering relationship-centred care. The attitude of these providers was that they had to pass inspection or accreditation, but this was just business as usual and not the be-all and end-all. Instead, ‘real’ quality improvements were happening day-in, day-out. A participant in Australia (Hibiscus, Operations Director) explained that the key to passing accreditation was ‘to know the regulations better than the regulator’ but making sure their residents were happy with their lives was much more important.

Money and quality improvement

A special feature of the care system in Australia is the use of the Aged Care Funding Instrument (ACFI)*. The government uses the ACFI to decide how much it pays providers for each resident’s care. One of the problems with the ACFI is that it means providers can be very focused on making sure that the resident receives specific types of care, like certain types of pain treatment, rather than thinking about how to help the resident to get back on their feet or become more independent. This is something that was talked about by many of the people I interviewed in Group 1. The providers I talked to did not say directly that the ACFI affected the way they worked, but at the same

time said other things which suggested that making sure providers got as much money from the government as possible could take a higher priority than whether their residents had a higher quality of life.

Choice and quality improvement

One of the goals for letting people choose their care home is to encourage homes to improve their quality to attract more residents. Talking to providers confirmed something the other participants told me, that having a ‘market’ in care led to a focus on consumer-directed quality. The ‘consumer’ was not necessarily the resident, but often their families or friends who were choosing the home. The large amounts of money involved meant that appealing to new, wealthy, residents could outweigh what the inspector or accreditation reviewer were looking for. Quality improvement was often focused on the visible features of the home, rather than relationship-centred quality, for example:

- Appearance of the home

Homes focused on consumer-directed quality often looked and felt like upmarket hotels. Often the design of the building was to appeal to the family of residents, rather than the residents themselves. This provider in England was about to start renovating their home, even though the residents liked the ‘shabby chic’ look of the home:

LT: So, you were telling me about [your] refurbishment...why did that become a priority here?

“ ... 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)

In fact, some of the homes were decorated in unsuitable ways for people living with dementia for example, isolated rooms, bright white bathrooms and softly-lit dining rooms. The high-

* More information on how the ACFI works can be found at <https://agedcare.health.gov.au/funding/aged-care-subsidies-and-supplements/residential-care-subsidy/basic-subsidy-amount-aged-care-funding-instrument/aged-care-funding-instrument-acfi-user-guide>

end homes had features such as printed menus and silver service in their dining rooms. Participants said that the quality of the home and the quality of life of the residents did not go hand in hand:

“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)

- Cruise ship living

One of the ways homes try to attract consumers is by showing that they have plenty of activities for residents. All the providers in the studies offered activities and therapies for residents, for example, music therapy and pet therapy.

But for the providers who treated residents as consumers, the emphasis was on having formal timetables of activities rather than just letting things happen when residents wanted them to – like living on a cruise ship. Other providers gave examples of how things like ‘Snoezelen rooms’* and the ‘Namaste Care’** programme were used to stimulate or comfort people living with dementia. For the best providers, stimulating and comforting residents was just part of day-to-day living, and did not rely on formal programmes.

- Sales and marketing

All the homes were interested in knowing what residents and families thought about the home and the way it delivered care. However, the reason for being interested in what they thought varied from provider to provider. For homes focused on consumer-directed quality, asking residents and relatives was much more about making sure the homes knew how to attract residents in the future. For relationship-centred providers, understanding the feelings of residents and their families was part of day-to-day living. These providers talked about the best ideas for quality improvement coming from their own residents on a day-to-day basis.

How do the ratings help?

The CQC introduced the ratings in England so that providers would want to improve their quality to get a ‘good’ or ‘outstanding’ rating. From my conversations with providers, it looks like the ratings might be having an effect. For one provider in England, even the possibility of relatives looking at the CQC ratings meant that the ratings were important. But for another provider, being outstanding was something they would do even if ratings did not exist and being outstanding was all about wanting their residents to have the best quality of life possible.

The CQC ratings might be helpful for providers to know who they can look to for inspiration, but this requires further research. One person told me that it can be hard for providers who are not ‘Outstanding’ to understand quite what is involved with being ‘Outstanding’ – another person told me this even applied to some inspectors.

What can governments do to encourage relationship-centred quality?

The use inspections and reviews in England and Australia have had some success in raising the basic levels of quality in each country. But past research also shows that there is less governments can do to encourage providers to deliver relationship-centred quality and in fact, things like inspection can hinder this type of quality improvement.

Sometimes, the rules and regulations involved with inspections can be a problem for relationship-centred quality (58–60). This is because it is difficult to make rules for the types of things managers do to deliver relationship-centred quality, for example, around leadership and how they support staff to develop meaningful relationships with residents and their families. An example is how the managers at the relationship-centred providers in the study were relaxed about what happens in the home and

* ‘Snoezelen’ rooms are specially designed for people living with dementia to stimulate them with things like lighting and tactile surfaces (56).

** ‘Namaste Care’ is for people living with the advanced stages of dementia who might otherwise be left out of other activities (57).

were not worried about strict timetables and rules. They were creative about managing risks to the health and safety of their residents (for example, having kettles available or keeping pets and animals) and accepted messiness and untidiness where it helped to create a cosy and homelike environment.

Providers in both countries agreed that there were things about inspection and regulation which could make providing relationship-centred quality more difficult. However, providers in England thought that the new CQC standards were better than the old standards because they were more focused on outcomes than the previous regulations.

In both countries, providers commented how they sometimes 'went into battle' with inspectors and reviewers where they felt that what the inspector wanted was not best for the resident. The best providers felt that their staff should be able to make decisions even though they might do things which the inspector might not like. 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 might have triggered concerns about the level of physical contact:

"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)

Respect for the resident's wishes came up more often in the interviews in England than in Australia. One provider said the Mental Capacity Act in England was a big influence as it meant a shift from 'the nurse knows best' to giving more control to residents.

On my visits, it was clear that there were care homes in both countries that were trying to deliver relationship-centred quality. This suggests that relationship-centred care is not connected

to regulation but is something which providers decide to do by choice. Unfortunately it is not possible to say whether there is more relationship-centred quality in one country than the other as I only spoke to five providers.

So, if providers decide to deliver relationship-centred quality independently of regulation, the question is what can governments do to encourage relationship-centred quality. The interviews with the providers came up with five things to assist managers in improving quality. This help seemed to be more important to small and medium organisations, which had fewer people available within their organisations to work on quality.

1. Learning and development

The managers in the study who were most positive about quality also looked out for information and inspiring ideas. They did their own research for new ideas, including reading, attending conferences and training programmes and visiting other provider organisations. While learning and information was helpful for improving their knowledge, they were not the source of motivation for improving quality.

2. Getting to know other managers

Managers in England talked about the benefits of getting together with other care home managers, either within the same company, or in external groups. One manager described a local network of about 25 managers where guests presented different aspects of running care homes. This network was seen as highly valuable by the participants, in part for the moral support it provided:

"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, managers had particular praise for the *My Home Life* programme (for more information see <http://myhomelife.org.uk>), which promotes relationship-centred quality by bringing managers together for training events

and support (61). This was also mentioned in other interviews and some people thought the programme should be funded by government.

There is lots of debate in previous research about whether not-for-profit providers deliver better quality than for-profit providers. My study did not have enough providers in it to be able to settle this question but one thing that came up is that not-for-profit providers seemed more likely to collaborate with and support each other than the for-profit providers in the study.

3. Models of care

Providers in England thought that the government could play a bigger part in advising what models of care to adopt, for example, the best way to look after people living with dementia. A participant from one of the industry associations which represented smaller providers talked about a bigger role for government to test specific models, rather than just issue general guidance about quality. The participant commented on how the sector needed a body like the NHS Improvement Agency to test approaches and come up with practical help to implement them.

4. Practical interventions

In both countries, provider organisations mentioned hands-on projects as being very helpful. In England, an example was regular district nurse and pharmacist visits set up by a local authority and the local Clinical Commissioning Group (CCG). In Australia, managers and staff talked about the Dementia Behaviour Management Advisory Service (DBMAS). DBMAS is a service funded by the Australian government and is staffed by teams of professionals who provide support by telephone. 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. Hands-on interventions like the CCG project and DBMAS were viewed by providers as more helpful than traditional training.

5. Prizes and awards

Some providers thought that prizes and awards were good for motivating staff. Awards were all about rewarding individuals:

“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 and connected with industry magazines and consulting services. In Australia, AACQA itself organises better practice conferences, training, education and state-based awards to recognise examples of innovative and leading quality practices. It was unclear whether these awards helped to improve poorer providers or whether awards simply served as a showcase for high-quality providers.

Conclusion

Providers cannot be focused on only one type of quality or on one type of quality improvement. All providers must make sure they deliver organisation-focused quality because the safety of residents and the quality of clinical processes is so important. Providers can also focus on relationship-centred quality and consumer-directed quality at the same time. Wealthier residents might expect luxury accommodation if this is what they have been used to, but it is important that homes do not just focus on consumer-directed quality while neglecting relationship-centred quality.

At the end of all the interviews, I asked what governments could do to help improve quality. More money was frequently mentioned, especially in England. Several people in England commented on the difference between how much money is spent on training in the NHS compared to social care.

In both countries, many saw the main responsibility of government was to make sure there were enough skilled workers, through making sure immigration policies were effective and providing training and education. Both countries are facing chronic shortages of skilled workers, particularly of qualified nurses (62–65). There is a need for further research on what governments can do to support making sure there are enough workers.

7 Why are the systems in England and Australia different?

This report has identified several differences between the systems in England and Australia. This final section looks at possible explanations for why the two systems are different.

One of the biggest differences is whether responsibilities are mainly held in central government (as in Australia), or whether there is a mixture in who holds responsibility for different parts of the system (as in England). In England, many different bodies are involved directly or indirectly in quality, for example, the CQC, local authorities, HealthWatch and safeguarding boards. This means that there is more 'noise' and checks and balances in the system than there seem to be in Australia.

There has also been more change in the system in England, with three different regulators since 2000 and different approaches to standards and ratings. In Australia, there was virtually no change in the system between 1997 and 2014.

One benefit of the amount of change in England is that it can avoid the issue of 'regulatory capture', where providers work out how they can game the system. In Australia there is evidence of this 'regulatory capture' and also of 'corrosive capture' (66), where providers argue that the regulator is not making any difference. My interviews suggested that both forms of capture have also been easier because providers can lobby the government in Australia about many different aspects of the system, where providers in England have to work with both the central government and local authorities – and the local authorities pay the bills.

There have been some previous studies into why governments do regulation differently (67–69). I looked at these studies to see whether they

could help me explain why the systems in England and Australia are different.

I found three main explanations for why regulation looks different in each country.

1. Politics and 'never again' events

There are lots of examples of where governments have put regulation in place after problems have been covered in the news. These examples are not just in residential care, but in sectors including nuclear power, the airlines and other forms of transport. One of the most famous international examples is where security regulations for flying were stepped up after the 9/11 attacks in New York in 2001 (68). Sometimes these regulations are more about making the public feel safe than about whether they really make any difference.

In England, there have been many changes to the inspection system for residential care since it was first introduced in 2000. My study found that these changes have often been because of 'scandals'. Problems in health and care for older people tend to get called 'scandals' once they are covered in the news (70). Otherwise problems which are just as bad can happen without attracting much attention.

In England (but not in Australia), the changes have been caused by scandals which have not even been in residential care for older people. The first scandal which was mentioned in the interviews in England was at Longcare in the 1990s, where adults with learning disabilities experienced awful abuse, including sexual abuse. More recently, the biggest influence on how inspection works in England was a scandal at Mid Staffordshire hospital, often referred to

as the 'Mid Staffs' scandal. An enquiry into problems at the hospital found many examples of poor care and people dying unnecessarily (71). Because the CQC is responsible for inspecting all types of care, including general practice doctors, hospitals, dentists, residential care and care provided in people's homes, this enquiry had a major effect on what the CQC does in other areas, including residential care for older people.

People I interviewed said that these scandals were a big influence on regulation in England and that this led to 'fads' in how inspection worked. One participant told me that politicians tended to get too involved:

"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)

The situation was very different in Australia, at least until very recently. There has been an absence of major scandals in the news in Australia since the Giles Report. An exception was the 'Kerosene Baths' incident, where a home in Victoria was closed down in 2000 after older people in the home had been given baths of diluted kerosene to treat scabies, and one of these people had died (72, 73). But even this scandal did not lead to any major changes in the accreditation system in Australia. This situation changed dramatically recently (after I finished the interviews for this study) when problems were uncovered at the Oakden Older Persons Mental Health Service in South Australia (7). This triggered the Carnell-Paterson Review of the regulation of quality in aged care in Australia (46). This was followed by an exposé into aged care by the Four Corners TV programme (similar to Panorama in the UK) and in response the government announced a Royal Commission into aged care (74).

When compared to England, there has also been more cooperation (or 'bipartisan support') between the political parties in Australia about making changes to residential care. This is because both the parties are afraid of what can go wrong in residential care, something which is seen as a continuous risk:

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. [...] Why is that?

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

2. The power of organisations

Researchers who have studied regulation before say that the biggest influence on how regulation works is the power that businesses have over government (75, 76). Some researchers have described how this has also happened in residential care (15, 77–79).

In England and Australia, the businesses who run care homes have different levels of influence over the government, with businesses in Australia seeming to hold more sway than businesses in England.

One of the reasons for this is that in Australia, the federal government in Canberra looks after everything to do with residential care, from deciding who can open care homes, to paying for residents' care, to inspecting the care homes. This means that it is easier for businesses to 'lobby', or try to influence, politicians and the Department of Health because everything happens in one place. And because the Department of Health is the part of government which pays for the care of residents, care companies have very strong reasons to try to influence it.

In England, it is much more complicated to influence the government about what happens in residential care because responsibilities are so spread out. The central Department of Health looks after policy and the CQC looks after regulation but everything else is looked after by 152 local councils. This makes it very difficult for businesses to have influence over every part of what the government does in residential care.

There is also a difference in how well companies work together to influence the governments in each country. Residential care businesses in Australia are much better organised as a group than in England and more companies appear to belong to industry associations. There are three

main associations which represent care companies in Australia, as well as associations that look specifically after the interests of religious organisations. It was not possible to find out how many care providers were part of these groups, but it seemed to be much more common than in England. In England there are four national associations that represent care providers, but membership is thought to be much lower than in Australia. There are many local associations in England because many businesses have either one or a very small number of homes often based in just one or two council areas.

In Australia, another important group is the National Age Care Alliance, referred to as 'NACA'. NACA was set up following the Kerosene Baths incident to have more influence over government policy. In 2018 it has 50 members*. All the members are national organisations which in turn look after other groups, for example, providers, residents and different types of care professionals. The government gives money to NACA and asks for help from its members on developing policies about residential care.

In England, the closest thing to NACA is the Care Provider Alliance (CPA). This was set up in 2009 to represent residential care providers. It has eleven members, all of which look after the interests of different groups of providers**. However, it does not have much money or any permanent staff and this means the CPA cannot influence the government in England in the way NACA can in Australia.

Another difference between the two countries is the type of organisation speaking up for older people. In England there are many organisations which say they represent older people and which offer practical advice. There are also several organisations in Australia, but the most influential one is the Council for the Ageing or 'COTA', an organisation which tends to represent wealthier individuals, rather than the whole cross-section of older people, and particularly 'low means' residents.

The lack of representation of the voices of all residents might be partially due to reforms put in place under the Howard Government, for example, through the defunding of the Combined Pensioners and Superannuants Association (CPSA), an organisation which represents less wealthy pensioners. Also, 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.

3. The influence of individuals

So far, this chapter has looked at the role of 'never again events' and the influence of interest groups in how regulation is designed. However, these factors do not explain the main differences between the two systems, namely the role of human rights-based approaches in England, and the importance of the consumer and markets in Australia.

England has taken a human rights-based approach to quality with a high level of state involvement, while Australia sees quality as something which can be tackled by creating 'consumers', by giving people choice and creating a market for care.

Human rights have not always received a lack of attention in aged care in Australia. In the 1980s, a human rights lawyer, Chris Ronalds, was asked to look at resident rights in the sector (80). Her report led to the drawing up of a Charter of Residents' Rights and Responsibilities and 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. However, my interviews and visits suggested that the Charter, along with the Aged Care Advocacy Program and Community Visitors Scheme, appear to have lost influence.

* www.naca.asn.au/about.html

** www.careprovideralliance.org.uk/list-of-members.html

Another explanation for this difference is that there are individual people or 'policy entrepreneurs' who have had a strong influence. Previous studies have looked at the importance of specific people in influencing how regulation works, referring to them as 'policy entrepreneurs' (81, 82). In England, interviewees spoke frequently of the influence of two individuals, Denise Platt (the Chairman of CSCI) and David Behan (the Chief Executive of CSCI and eventually the CQC), in making the rights of the individual the most important part of quality.

One possible explanation for how the system is designed in Australia could be the turnover in

public servants in Canberra (83). One former policymaker commented on how Australian departments tend to look to consultants for advice and problem-solving. Current staff in the government commented on how little time they had to conduct research and prepare policy positions. Stepping into the gap are the CEOs of provider organisations in Australia who have taken on leadership roles in many of the groups looking after policy for the government. In Australia, virtually all the participants in the study highlighted the influence of Ian Yates, the Chief Executive of COTA, in all areas of aged care policy and particularly in the 2012 reforms in aged care.

References

1. Wærness K. On the rationality of caring. In: Sassoon AS, ed. *Women and the state: the shifting boundaries of public and private*. London: Routledge 1987. 207–34.
2. Wærness K. Caring as women's work in the welfare state. In: Holter H, ed. *Patriarchy in a welfare society*. Oslo: Universitetsforlaget 1984:67–87.
3. Bowers BJ, Fibich B, Jacobson N. Care-as-service, care-as-relating, care-as-comfort: understanding nursing home residents' definitions of quality. *Gerontologist* 2001;41(4):539–45.
4. Davies S. Creating community: the basis for caring partnerships in nursing homes. In: Nolan M, Lundh U, Grant G, et al., eds. *Partnerships in Family Care*. Maidenhead: Open University Press 2003:218–37.
5. McCann M. A Culture of life enrichment: Beyond 'cruise ship living' 2013. Available from www.leadingage.org/magazine/septemberoctober-2013/culture-life-enrichment-beyond-%E2%80%9Ccruise-ship-living%E2%80%9D [Accessed 21 July 2017].
6. CQC. *Human rights approach for our regulation of health and social care services*. London: Care Quality Commission 2014.
7. Groves A, Thomson D, McKellar D, et al. *The Oakden Report*. Adelaide, South Australia: SA Health, Department for Health and Ageing 2017.
8. Lloyd L, Banerjee A, Harrington C, et al. It's a scandal! Comparing the causes and consequences of nursing home media scandals in five countries. *International Journal of Sociology and Social Policy* 2014;34(1/2):2–18.
9. Alzheimer's Society. *Low expectations. Attitudes on choice, care and community for people with dementia in care homes*. London: Alzheimer's Society 2013.
10. Department of Health. *Report on the Operation of the Aged Care Act 1997. 2015–16*. Canberra: Commonwealth of Australia 2016.
11. Parker RA. *The elderly and residential care: Australian lessons for Britain*. Aldershot: Gower 1987.
12. Gibson D, Means R. Policy convergence: restructuring long-term care in Australia and the UK. *Policy and Politics* 2000;29(1):43–58.
13. Healy J. The care of older people: Australia and the United Kingdom. *Social Policy & Administration* 2002;36(1):1–19.
14. Wiener JM, Tilly J, Howe A, et al. *Quality assurance for long-term care: the experiences of England, Australia, Germany and Japan*. Washington, DC: AARP 2007.
15. Braithwaite J, Makkai T, Braithwaite VA. *Regulating aged care: Ritualism and the new pyramid*. Cheltenham; Northampton, MA: Edward Elgar Publishing 2007.
16. CMA. *Care Homes Market Study. Final report*. 2017. Available from: <https://assets.publishing.service.gov.uk/media/5a1fdf30e5274a750b82533a/care-homes-market-study-final-report.pdf> [Accessed 30 November 2017].

17. Office for National Statistics. Estimates of the population for the UK, England and Wales, Scotland and Northern Ireland 2018 [updated 28 June 2018]. Available from: www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/datasets/populationestimatesforukenglandandwalesscotlandandnorthernireland [Accessed 13 January 2019].
18. Aged Care Financing Authority. Sixth Report on the Funding and Financing of the Aged Care Sector: Australian Government 2018.
19. Australian Institute of Health and Welfare. Older Australia at a glance 2018 [updated 20 September 2018]. Available from: www.aihw.gov.au/reports/older-people/older-australia-at-a-glance/contents/demographics-of-older-australians/australia-changing-age-and-gender-profile [Accessed 13 January 2019].
20. Hampton P. Reducing administrative burdens. Effective inspection and enforcement. London: HM Treasury 2005.
21. Senate Select Committee on Private Hospitals and Nursing Homes. Private nursing homes in Australia: their conduct, administration and ownership (the 'Giles Report'). Canberra: Parliament of the Commonwealth of Australia 1984.
22. Donabedian A. Evaluating the quality of medical care. *Milbank Quarterly* 1966;44(3):Suppl:166–206.
23. Hirschman A. Exit, Voice, and Loyalty: Responses to Decline in Firms, Organizations, and States. Cambridge, London: Harvard University Press 1970.
24. Bebbington A, Darton R, Netten A. Care Homes for Older People. Vol. 2: Admissions, needs and outcomes. Canterbury: Personal Social Services Research Unit 2001.
25. Davies S, Nolan M. 'Making the move': relatives' experiences of the transition to a care home. *Health & Social Care in the Community* 2004;12(6):517–26.
26. Trigg L, Maarse H, Sole M, et al. Choice and the selection of residential care provider for older people: a comparative study in England, The Netherlands and Spain. *Ageing and Society* 2018;38(6):1121–47.
27. Hibbard JH, Stockard J, Tusler M. Hospital performance reports: impact on quality, market share, and reputation. *Health Affairs (Millwood)* 2005;24(4):1150–60.
28. Kolstad JT. Information and Quality When Motivation Is Intrinsic: Evidence from Surgeon Report Cards. *American Economic Review* 2013;103(7):2875–910.
29. Garvin DA. What Does Product Quality Really Mean? *Sloan Management Review* 1984;26(1):25–43.
30. Ghobadian A, Speller S, Jones M. Service Quality. *International Journal of Quality & Reliability Management* 1994;11(9):43–66.
31. Moullin M. Delivering excellence in health and social care: quality, excellence, and performance measurement. Buckingham: Open University Press 2002.
32. Manthorpe J, Samsi K. Person-centered dementia care: current perspectives. *Clinical Interventions in Aging* 2016;11:1733–40.
33. Wilberforce M, Challis D, Davies L, et al. Person-centredness in the community care of older people: A literature-based concept synthesis. *International Journal of Social Welfare* 2016;26(1):86–98.
34. Tresolini CP, the Pew-Fetzer TaskForce. Health Professions Education and Relationship-centered Care: A Report of the Pew-Fetzer Task Force on Advancing Psychosocial Education. San Francisco: Pew Health Professions Commission 1994.
35. Nolan MR, Brown J, Davies S, et al. The Senses Framework: improving care for older people through a relationship-centred approach. Getting Research into Practice (GRiP) Report No 2. Sheffield: University of Sheffield; 2006. Available from: http://shura.shu.ac.uk/280/1/PDF_Senses_Framework_Report.pdf

36. Care Quality Commission. About CQC. What we do and how we do it. (Easy read version of 'About us: What we do and how we do it') 2017, Available from: www.cqc.org.uk/sites/default/files/20170629_CQC_About_us_easyread_0.pdf [Accessed 13 October 2018].
37. Care Quality Commission. How CQC regulates. Residential adult social care services. Provider handbook. April 2016. Available from: www.cqc.org.uk/sites/default/files/20160422_ASC_residential_provider_handbook%20April_2016_update.pdf [Accessed 26 November 2017].
38. CQC. Making the 'Mum Test' real: CQC sets out its new model for inspecting adult social care 2014. Available from: www.cqc.org.uk/content/making-mum-test-real-cqc-sets-out-its-new-model-inspecting-adult-social-care [Accessed 30 October 2016].
39. Australian Aged Care Quality Agency. Assessor Handbook: Australian Government 2014.
40. Baldwin R, Chenoweth L, dela Rama M, et al. Quality failures in residential aged care in Australia: The relationship between structural factors and regulation imposed sanctions. *Australasian Journal on Ageing* 2014;34(4):E7–12.
41. Ellis JM, Howe A. The role of sanctions in Australia's residential aged care quality assurance system. *International Journal for Quality in Health Care* 2010;22(6):452–60.
42. Australian Aged Care Quality Agency. Let's talk about quality. Developing a shared understanding of quality in aged care services. 2015. Available from: www.aacqa.gov.au/for-providers/promoting-quality/lets-talk-about-quality-updated-1-september-2015 [Accessed 14 May 2016].
43. Commonwealth of Australia. Evaluation of the impact of accreditation on the delivery of quality of care and quality of life to residents in Australian Government subsidised residential aged care homes - Final Report. Canberra: Department of Health and Ageing 2007.
44. O'Reilly M, Courtney M, Edwards H. How is quality being monitored in Australian residential aged care facilities? A narrative review. *International Journal for Quality in Health Care* 2007;19(3):177–82.
45. Australian Aged Care Quality Agency. The Quality Standard Monthly Newsletter February 2018. Available from: www.aacqa.gov.au/providers/education/the-standard/february-2018/providers/education/the-standard/february-2018/piloting-new-standards [Accessed 4 March 2018].
46. Carnell K, Paterson R. Review of National Aged Care Quality Regulatory Processes 2017. Available from: https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/10_2017/review_report_final_23_october_2017.pdf [Accessed 10 December 2017].
47. Trigg L. Using Online Reviews in Social Care. *Social Policy & Administration* 2014;48(3):361–78.
48. Dranove D, Jin GZ. Quality disclosure and certification: Theory and practice. *Journal of Economic Literature* 2010;48(4):935–63.
49. Werner RM, Konetzka RT, Stuart EA, et al. Impact of public reporting on quality of postacute care. *Health Services Research* 2009;44(4):1169–87.
50. Care Quality Commission. Prince of Wales House Inspection report: CQC; 2015 [updated 7 January 2015]. Available from: www.cqc.org.uk/sites/default/files/new_reports/AAAA2076.pdf [Accessed 25 August 2017].
51. Australian Aged Care Quality Agency. Montgomery Nursing Home 2014 [updated May 2014]. Available from: www.aacqa.gov.au/publications/reports/local-montgomerynursinghome6-1400626864.pdf/@@display-file/file/local-montgomerynursinghome6-1400626864.pdf [Accessed 18 August 2017].
52. Care Quality Commission. Cracks in the Pathway. People's experiences of dementia care as they move between care homes and hospitals. London: Care Quality Commission 2014.

53. Productivity Commission. Caring for Older Australians. Productivity Commission Inquiry Report. No. 53, 28 June 2011. Volume 1. Canberra: Australian Government 2011.
54. Ryan RM, Deci EL. Self-determination theory and the facilitation of intrinsic motivation, social development, and well-being. *American Psychologist* 2000;55(1):68–78.
55. Moriarty JO, Lipman V, Norrie C, et al. Handovers in care homes for older people – their type, timing and usefulness. Findings from a scoping review. *Ageing and Society* 2017:1–21. [Published online 27 November 2017].
56. Chung JCC, Lai CKY. Snoezelen for dementia. *Cochrane Database of Systematic Reviews* 2002;Art. No.: CD003152(4).
57. Simard J. The end-of-life namaste care program for people with dementia. Baltimore: Health Professions Press 2007.
58. Banerjee A, Armstrong P. Centring Care: Explaining Regulatory Tensions in Residential Care for Older Persons. *Studies in Political Economy* 2015;95:7.
59. Lathlean J, Goodship J, Jacks K. Modernising Adult Social Care for Vulnerable Adults: The Process and Impact of Regulation. Regulation of Adult Social Care Research Project. Final Report: School of Nursing and Midwifery, University of Southampton 2006.
60. Miller SC, Miller EA, Jung HY, et al. Nursing home organizational change: The “culture change” movement as viewed by long-term care specialists. *Medical Care Research and Review* 2010;67(4 suppl):65S–81S.
61. Owen T, Meyer J, Cornell M, et al. My Home Life: Promoting quality of life in care homes. York: Joseph Rowntree Foundation 2012.
62. Cavendish C. The Cavendish Review. An Independent Review into Healthcare Assistants and Support Workers in the NHS and social care settings 2013. Available from: www.gov.uk/government/uploads/system/uploads/attachment_data/file/236212/Cavendish_Review.pdf [Accessed 30 December 2015].
63. Kingsmill BD. The Kingsmill Review: An independent report into working conditions in the Care Sector 2013. Available from: www.yourbritain.org.uk/uploads/editor/files/The_Kingsmill_Review_-_Taking_Care_-_Final_2.pdf [Accessed 30 December 2015].
64. Senate Community Affairs References Committee. Future of Australia’s aged care sector workforce. Commonwealth of Australia 2017.
65. Health Committee. The nursing workforce. Second Report of Session 2017–19. HC353. www.parliament.uk/healthcom: House of Commons 2018.
66. Carpenter D, Moss DA. Introduction. In: Carpenter D, Moss DA, eds. Preventing Regulatory Capture: Cambridge University Press 2013:1–22.
67. Hood C, Rothstein H, Baldwin R. The government of risk: Understanding risk regulation regimes. Oxford: Oxford University Press 2001.
68. Haines F. The paradox of regulation: what regulation can achieve and what it cannot. Cheltenham; Northampton, MA: Edward Elgar 2011.
69. Prosser T. The regulatory enterprise: government, regulation, and legitimacy. Oxford, New York: Oxford University Press 2010.
70. Butler I, Drakeford M. Scandal, social policy and social welfare. 2nd ed. Bristol: Policy Press 2005.
71. Francis R. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery Office 2013.
72. Reynolds F. Parliament hears kerosene bath led to death. *ABC Radio National* 2000 8 March 2000.
73. Cauchi S. Kerosene bath nurses banned. *The Age* 2002 29 March 2002. Available from: www.theage.com.au/articles/2002/03/28/1017206136360.html [Accessed 5 March 2016].

74. Hutchens G. Scott Morrison announces royal commission into aged care after string of scandals. *The Guardian* 16 September 2018. Available from www.theguardian.com/australia-news/2018/sep/16/morrison-to-announce-royal-commission-into-aged-care-after-string-of-scandals [Accessed 17 November 2018]
75. Wilson JQ. *Politics of regulation*. New York: Basic 1980.
76. Baldwin R, Cave M, Lodge M, editors. *Understanding regulation: theory, strategy, and practice*. 2nd ed. Oxford: Oxford University Press, 2012.
77. Hawes C. Regulation and the politics of long-term care. *Generations* 1997;21(4):5–9.
78. Edelman TS. The politics of long-term care at the federal level and implications for quality. *Generations* 1997;21(4):37–41.
79. Weisskopf M, Weisskopf M. The good provider (Reprinted from *Time*, 10 February 1997, p. 32). *Generations* 1997;21(4):42–3.
81. Mintrom M, Norman P. Policy Entrepreneurship and Policy Change. *Policy Studies Journal* 2009;37(4):649–67.
80. Ronalds C, Godwin P, Fiebig J. Residents' rights in nursing homes and hostels: final report. Canberra: Australian Government Publishing Service 1989.
82. Béland D, Cox RH. Ideas as coalition magnets: coalition building, policy entrepreneurs, and power relations. *Journal of European Public Policy* 2016;23(3):428–45.
83. Tingle L. Quarterly Essay 60. *Political Amnesia: How We Forgot How To Govern*. Collingwood, VIC: Black Inc. 2015.