

Kent Academic Repository

Full text document (pdf)

Citation for published version

Towers, Ann-Marie and Holder, Jacquetta and Smith, Nick and Netten, Ann and Welch, Elizabeth and Crowther, Tanya and Collins, Grace and Bass, Rosalyn (2015) Adapting the adult social care outcomes toolkit (ASCOT) for use in care home quality monitoring: conceptual development and testing. *BMC Health Services Research* (15:304).

DOI

<https://doi.org/10.1186/s12913-015-0942-9>

Link to record in KAR

<https://kar.kent.ac.uk/44856/>

Document Version

Pre-print

Copyright & reuse

Content in the Kent Academic Repository is made available for research purposes. Unless otherwise stated all content is protected by copyright and in the absence of an open licence (eg Creative Commons), permissions for further reuse of content should be sought from the publisher, author or other copyright holder.

Versions of research

The version in the Kent Academic Repository may differ from the final published version.

Users are advised to check <http://kar.kent.ac.uk> for the status of the paper. **Users should always cite the published version of record.**

Enquiries

For any further enquiries regarding the licence status of this document, please contact:

researchsupport@kent.ac.uk

If you believe this document infringes copyright then please contact the KAR admin team with the take-down information provided at <http://kar.kent.ac.uk/contact.html>

1 Adapting the Adult Social Care Outcomes Toolkit (ASCOT) for use in
2 quality monitoring: conceptual development and testing.

3

4 Ann-Marie Towers*, Jacquetta Holder, Nick Smith, Tanya Crowther, Ann Netten, Elizabeth Welch
5 and Grace Collins.

6 *Corresponding author: Personal Social Services Research Unit (PSSRU) George Allen Wing,
7 Cornwallis Building, University of Kent, Canterbury, Kent, CT2 7NF. All authors can be reached at the
8 address.

9 Ann-Marie Towers, Research Fellow, PSSRU, University of Kent (A.Towers@kent.ac.uk)

10 Dr Jacquetta Holder (former Research Fellow at the PSSRU, University of Kent)

11 Nick Smith, Research Officer, PSSRU, University of Kent (N.J.Smith@kent.ac.uk)

12 Tanya Crowther (former research assistant at the PSSRU, University of Kent)

13 Professor Ann Netten (former Director of the PSSRU, University of Kent)

14 Elizabeth Welch, Research Officer, PSSRU, University of Kent (E.Welch@kent.ac.uk)

15 Grace Collins, Research Assistant, PSSRU, University of Kent (G.Collins@kent.ac.uk)

16 Abstract

17 **Background:** Alongside an increased policy and practice emphasis on outcomes in social care, English
18 councils are now obliged to review quality at a service level to help in their new role of ensuring the
19 development of diverse and high-quality care markets to meet the needs of all local people,
20 including self-funders [1, 2]. The Adult Social Care Outcomes Toolkit (ASCOT) has been developed to
21 measure the outcomes of social care for individuals in a variety of care settings. Local councils have
22 expressed an interest in exploring how the toolkit might be used for their own purposes, including
23 quality monitoring. This study aimed to explore how the care homes version of the ASCOT toolkit
24 might be adapted for use as a care home quality indicator and carry out some preliminary testing in
25 two care homes for older adults. **Methods:** Consultations were carried out with professional and
26 lay stakeholders, with an interest in using the tool or the ratings it would produce. These explored
27 demand and potential uses for the measure and fed into the conceptual development. A draft
28 toolkit and method for collecting the data was developed and the feasibility of using it for quality
29 monitoring was tested with one local authority quality monitoring team in two homes for older
30 adults. **Results:** Stakeholders expressed an interest in care home quality ratings based on residents'
31 outcomes but there were tensions around who might collect the data and how it might be shared.
32 Feasibility testing suggested the measure had potential for use in quality monitoring but highlighted
33 the importance of training in observational techniques and interviewing skills. The quality
34 monitoring officers involved in the piloting recommended that relatives' views be collected in
35 advance of visits, through surveys not interviews. **Conclusions:** Following interest from another local
36 council, a larger evaluation of the measure for use in routine quality monitoring is planned. As part
37 of this, the ratings made using this measure will be validated against the outcomes of individual
38 residents and compared with the quality ratings of the regulator, the Care Quality Commission.

39 **Key words:** Quality monitoring, care homes, outcomes, ASCOT, quality indicators.

40 Background

41 In England, as in many other countries, there has been increasing emphasis on the importance of
42 considering the impact of services on outcomes and quality of life in health and social care policy,
43 practice and research [3-6]. Despite the move towards community care, care homes remain the
44 largest and most expensive provision of long-term care for frail older people in England [7], with
45 local authorities spending £4,960 million on care homes for adults over the age of 65 in 2013-14 [7].
46 Ensuring that these services are providing good quality care is therefore high on the agenda of
47 commissioners. As part of an ambitious government agenda to change and improve adult social
48 care, the 2014 Care Act [8] places responsibility on local authorities to ensure the quality of services
49 they are commissioning. Historically, local councils have only focused on monitoring the care
50 provided to publicly-funded residents. However, in a significant change of emphasis, councils are
51 now obliged to ensure the development of diverse and high-quality care markets to meet the needs
52 of all local people, including self-funders [1, 2]. This wider remit lends itself to a more inclusive,
53 home-level view of quality monitoring and may mean councils take a closer look at homes who care
54 predominantly for self-funding residents.

55 There is very little literature providing a national picture of English council's quality assurance
56 systems and audits. Think Local Act Personal (TLAP) surveyed local authorities to try and find out
57 more about their systems and the way in which their quality data is used, however, they only
58 received 12 responses, representing 22 authorities; 11 individual councils and one consortium of a
59 further 11 [9]. Even with the consortium, given there are 152 councils with social services
60 responsibilities in England, this represents only 1.6% of councils. In total, seven reported conducting
61 monitoring visits to assess care home quality, which included some observation of practice [9] and
62 five maintain an online directory of some kind to provide information to the public about the
63 services they accredit. Beyond the information made available by the regulator, historically,
64 relatively little information about the quality of individual care homes in England has been made
65 available to the public [see for a review 10]. Providers are generally considered opposed to the

66 publication of individual provider performance data [11]. Although some councils have used
67 information gathered during quality audits to indicate 'preferred providers' and used their own
68 ratings or those of the regulator to incentivise providers through 'payments by results' [12, 13], this
69 quality information is rarely shared with the public and so has typically not been able to support user
70 choice.

71 There are an increasing number of 'care ratings websites' being provided by a variety of
72 organisations, including the Social Care Institute for Excellence [14] and a care home sector led
73 voluntary compact [15]. To aid choices about care and incentivise quality improvement through the
74 provision of comparative information at provider level, the government launched a portal
75 (www.nhs.uk) [4], which aims to draw together 'high-quality' information on the quality and
76 effectiveness of individual care homes. Existing and planned quality marks, such as those of My
77 Home Life [16], the Dementia Care and Support Compact [17] and NICE (National Institute for
78 Clinical Excellence) quality standards [18] are intended to be included, along with the views of
79 service users and their families, and specific information from providers on issues such as falls, staff
80 training and turnover, medication errors and pressure sores [19].

81 A key source of information about the quality of health and social care is the regulator. Until 2010,
82 star ratings (poor to excellent) were awarded to care homes by the then health and social care
83 regulator, the Commission for Social Care inspection (CSCI). However, when CSCI was replaced by
84 the Care Quality Commission (CQC), it withdrew the quality ratings and began a system of
85 monitoring compliance against essential standards instead. This decision was met with anger and
86 disappointment within the care home sector because the star ratings were seen by providers as
87 supportive of high quality care [20, 21]. Following the recommendations of reports into high profile
88 abuse scandals [22, 23], a review of the value of quality ratings [24] and an independent review of
89 how they carry out inspections [25], CQC carried out consultations on a new strategy for inspection
90 [26]. This was followed six months later by another report, A Fresh Start [27], which outlined the

91 feedback from the consultations and the proposed changes to the regulatory approach to collecting
92 evidence, conducting inspections and judging quality, including the re-introduction of a quality
93 ratings system (outstanding, good, requires improvement, inadequate).

94 In line with the Nuffield review of the value of quality ratings [24], CQC will now ask whether
95 services are; safe, caring, effective, responsive and well-led and rated accordingly, with a view to;
96 increasing accountability, aiding choice, improving performance, spotting failure, and reassuring the
97 public [4, 24, 28]. CQC will gather evidence relating to these key areas through ‘intelligent
98 monitoring’ [29], including evidence gathered by providers and others about the service. However,
99 there is currently no way for providers, commissioners or researchers to reliably measure, evaluate
100 and report quality of life outcomes at the provider/organisation level. As well providing helpful
101 information for CQC, recent research suggests such an indicator would be valued by the public, with
102 relatives and carers identifying a measure of residents’ quality of life among their top three most
103 useful indicators of care home quality [30].

104 The adult social care outcomes toolkit (ASCOT) currently offers a multi-method approach to
105 establishing outcomes for individual care home residents based on eight domains of social care
106 related quality of life (SCRQoL) (www.pssru.ac.uk/ascot). ASCOT was derived through a series of
107 studies [31] and to date is the only measure focusing specifically on the areas of quality of life that
108 can reasonably be attributed to social care services. The domains cover the basic (personal,
109 cleanliness and comfort, accommodation cleanliness and comfort, food and drink, and feeling safe)
110 and higher order (social participation, occupation and control over daily life) aspects of SCRQoL, and
111 there is also a domain to measure how the way the care and support is delivered impacts on service
112 user’s self-esteem (dignity). ASCOT includes a care homes tool (CH3) which uses a multi-method
113 approach (observation and individual interviews) to score the social care related quality of life
114 (SCRQoL) of individual care home residents based on these domains (www.pssru.ac.uk/ascot).

115 The multi-method approach was developed due to the challenges of gathering self-report
116 information from care home residents. Around two-thirds of care home residents in the UK have
117 dementia [32] and engaging people with cognitive impairment through surveys poses many
118 challenges [33]. Observations have long been used as an ethnographic method of research in care
119 homes [34] and can be particularly helpful when researchers are interested in the daily routines and
120 interpersonal communications of residents and staff [35, 36]. As noted by Luff et al [34], “while self-
121 report scales and questionnaires are traditionally ‘quick and easy’ forms of data collection, this may
122 not be the case when working with people living in care homes” (p.25), owing to the high levels of
123 physical and cognitive frailty [37]. Furthermore, there is evidence that it is inappropriate to rely
124 solely on the kind of self-report information collected through surveys/questionnaires when making
125 judgements about the quality of a service [31, 38, 39].

126 The ASCOT toolkit, and in particular the care home interview and observation instruments, are cited
127 as data sources for local data collection about quality measures identified by NICE for care homes for
128 older people [40]. However, mixed-methods approaches to data collection are more time-
129 consuming and resource intensive than self-completion surveys or interviews alone. This is justified
130 and indeed appropriate when the goal is to measure the outcomes of individuals lacking the capacity
131 to participate in other ways but does not lend itself to a ‘whole home’ approach. At the home level,
132 individual ratings would need to be aggregated to either an average score for the home or reported
133 at the domain level, indicating the distribution of outcomes in each. This kind of information is highly
134 sensitive to changes in the current population of residents, however, and as such may be better used
135 by providers to profile residents and identify unmet needs and potential training issues. It is also a
136 resource-intensive method of collecting data that relatively few, if any, people outside of the homes
137 would be able to undertake as part of their routine quality monitoring activities, let alone keep up to
138 date. An ASCOT style care home level measure may be able to fill the gap for a reliable outcomes-
139 based approach to quality monitoring, assurance and improvement at the care home level [41], and
140 if made available to the public has potential to help people compare and choose an individual care

141 home. However, before a new measure is developed it is important that the purposes are clear and
142 the measure viewed as useful to potential users.

143 This paper presents the results of an exploratory study that sought to develop a new measure of
144 care home quality, based on residents' quality of life outcomes. We describe the consultations with
145 stakeholders, outline how these fed into the conceptual development of the measure and end by
146 reviewing the feedback from the feasibility testing in one local authority quality monitoring team.

147 [Methods](#)

148 Three broad interlinked activities were carried out: consultations with stakeholders, tool
149 development and feasibility testing with a quality monitoring team.

150 Key professional and lay stakeholders' views were sought through a variety of methods: a one-day
151 workshop, face-to-face interviews and focus groups. Each set out to identify views about potential
152 use of the measure and associated methodological issues and to gather feedback on how the ASCOT
153 domains and definitions might be adapted to work at a whole home level.

154 Professionals were invited to the workshop using opportunistic sampling of those who were already
155 aware of and interested in ASCOT and had signed up to the ASCOT mailing list. This included; local
156 authorities, care providers and their representatives, academics and voluntary organisations. We
157 also purposively invited stakeholders that did not attend the workshop to take part in face-to-face
158 meetings. During the workshop, small group consultation sessions, led by different members of the
159 research team, were tape recorded and transcribed for later analysis. During the face-to-face
160 meetings, participants did not wish to be tape recorded, so the research team took detailed notes
161 instead.

162 Potential lay users of care home quality information were invited to take part in focus groups to
163 complement the consultations with professionals. Ethical approval for this phase of the study was
164 granted by the national Social Care Research Ethics Committee (SCREC) in June 2013. The lay groups

165 aimed to include (1) relatives and carers of older people living in care homes, (2) relatives and carers
166 of older people who have experience of social care services and support and (3) adults aged
167 between 45 and 75 who may have to help arrange residential care for an older relative in future, but
168 as yet have no experience of choosing a care home. They were recruited through existing local
169 groups in one council area. Three local voluntary sector carer organisations agreed to help recruit
170 groups 1 and 2. A University run database of members of the public willing to be research
171 participants was accessed to recruit participants for group 3, however to address low response rates
172 an advertisement was also posted on an online University website.

173 Following the consultation phase, the research team undertook a review of the findings and drew
174 out the main messages for the development of the draft measure. Sometimes different stakeholders
175 had different priorities and views of the proposed measure and these were discussed and reviewed
176 on an iterative basis throughout the conceptual development phase. Using the ASCOT care homes
177 toolkit as a starting point, and drawing on previous work undertaken for one council's quality
178 monitoring team, we began the conceptual and descriptive adaptation of the quality of life domain
179 headings, descriptions and ratings system. We also drafted some provisional guidance and wrote
180 training materials for the final phase.

181 In the final phase we explored the feasibility of quality monitoring (QM) officers using the new tool
182 as part of their monitoring visits. This stage of the research was granted ethical approval from the
183 national Social Care Research Ethics Committee (SCREC) in November 2013. We sent an email via the
184 ASCOT mailing list asking for one local authority to pilot the draft measure in two homes for older
185 people. Three local authorities expressed an interest and we recruited the one able to work within
186 the time frames of the project. QM officers were trained to use the draft measure and then, working
187 in pairs, they spent a day in each home collecting outcomes-focused data through: a 2-hour period
188 of structured observation in communal areas (including lunch) and semi-structured interviews with
189 staff, residents and family members, if available. The day after the visit, they each individually rated

190 the home they had visited drawing on the evidence collected and the guidance and training we had
191 given them. A face-to-face debrief meeting was held within a week of the visits to gather feedback
192 on the data collection processes and ratings-system and explore whether they had disagreed about
193 any of the ratings, and if so, why? We also explored the face-validity of the measure by asking the
194 team to reflect on whether their final ratings gave an accurate depiction of their own views of the
195 homes, drawing on their professional experience as quality monitoring officers.

196 Results

197 Consultation phase

198 Sample

199 17 adults (13 women and 4 men) with and without current caring responsibilities took part in the
200 focus groups in 2013. 16 provided further demographic information. Of those, all stated their
201 ethnicity as White. Two participants were in the 45-54 age bracket, eight were aged 55-64, five
202 were aged 65-75 and one participant was in the bracket of 75-84 years. 12 were married/living in a
203 civil partnership, one was widowed, two were cohabiting/living as married and one was divorced. 11
204 identified themselves as carers and 15 had experience of knowing/helping someone move into a
205 care home. Despite our attempts to recruit people who might potentially use care home quality
206 information in the future but who currently had no experience of doing so, all but two of the
207 participants had experience of helping a parent, parent-in-law or spouse choose a care home. Most
208 reported experiences of choosing permanent placements, although two had looked for a short-term
209 placement.

210 The workshop attendees (N=28) included care home providers, local authority staff, representatives
211 from membership body for the voluntary care sector, Skills for Care, HealthWatch, NICE, SCIE and
212 professionals involved in education and training in the sector (e.g. around end of life care). We
213 interviewed representatives from a membership body for the nursing home sector (N=2), a local
214 authority (N=1) and the regulator (CQC) (N=2).

215 It was clear from the consultation phase that who collects the data entirely affects how the data
216 might be used and in particular, whether or not it would be helpful for the public. Focus group
217 participants said they would find the information helpful when choosing a home for themselves or
218 their family members and believed it would serve to drive up quality by focusing homes on
219 outcomes for residents. However, they also noted that they would only consider the ratings
220 trustworthy if provided by an independent organisation or if they represented the views of relatives
221 and those who had stayed in the home. Ratings based on first-hand experience were considered
222 more reliable than judgements made by health and social care professionals, who they felt might
223 have ‘an agenda’ based on making cost-savings. There are currently other mechanisms in place for
224 gaining the views of residents and their families, including; user satisfaction surveys carried out by
225 providers and local authorities and the Your Care Rating survey developed by Ipsos MORI with the
226 National Care Forum and Care England [42]. Indeed, the ASCOT is included in the user experience
227 surveys sent out by local authorities each year. However, there is evidence to suggest that online
228 quality information might not be that well utilised when choosing homes [30] and that surveys do
229 not usually represent the views and experiences of the most impaired, often relying on the views of
230 representatives or ‘proxies’, which are known to be different from the service users themselves [43,
231 44].

232 Professional stakeholders suggested that consumer champion, Health Watch, might be able to
233 collect the data and make the ratings available to the public. Healthwatch is made up of local
234 organisations based in each of the 152 local authorities in England (www.healthwatch.co.uk) and is
235 commissioned by, but independent to, those local authorities. Healthwatch has statutory powers,
236 including being able to enter health and social care services to conduct quality reviews but relies
237 heavily on volunteers to operationalise its objectives. Nevertheless, at the time of writing, some
238 authorities have already commissioned local Healthwatch organisations to carry out their own ‘enter
239 and view’ visits from a quality monitoring perspective (e.g. Healthwatch Kent
240 <http://www.healthwatchkent.co.uk/projects>). However, the success of this approach not only

241 depends upon the skills, training and capacity of Healthwatch staff and volunteers but also the
242 number of homes they inspect and their ability to keep ratings up-to-date. Recency of ratings and
243 frequency of data collection were themes that arose during the focus groups with members of the
244 public, with participants agreeing that ratings should be updated every six months to be considered
245 reliable. Unless ratings are available on all homes their potential to aid user choice is limited. Homes
246 without ratings, as well as those who have been rated poorly or as requiring improvement, may
247 justifiably feel they are at a disadvantage and users may experience frustration when they cannot
248 directly compare across short-listed homes.

249 Unsurprisingly, given that this project was prompted by interest from local authorities, a key use of
250 the measure was for quality monitoring and improvement and workshop participants noted that its
251 focus on residents' outcomes fitted well with wider regulatory and policy changes. Compared with
252 Healthwatch, local authority quality monitoring teams are likely to have greater coverage in terms of
253 the number of homes they audit. At the very least they should collect information about the homes
254 they fund placements in. However, much like the lay stakeholders, they said their ratings should not
255 be made publicly available. There seemed to be two interrelated reasons for this: firstly, many
256 councils wanted to work in partnership with providers to improve quality and publishing ratings was
257 seen as potentially damaging to positive relationships (echoing the view that providers are generally
258 against the publication of what is considered 'performance data'); and secondly, there were
259 concerns about local authorities' capacity to keep ratings up-to-date (which is one of the reasons
260 providers are against such ratings being published). This raises the question of who, other than the
261 providers themselves, would have the resources to keep ratings up to date in a way that would be
262 considered fair to providers and helpful to the public. This is also a challenge for CQC [45], especially
263 in the current financial climate.

264 Development of the draft measure

265 Background information

266 ASCOT has eight domains of social care-related quality of life (see box 1), with one item per domain
267 [31]. Domain descriptions are purposively broad so as to be relevant to all adults using social care
268 services, including younger adults, those living in the community and those in paid or voluntary
269 work. The full toolkit and associated guidance and scoring systems can be viewed here
270 www.pssru.ac.uk/ascot. Self-completion and interview versions of ASCOT have four response
271 options per item. In these versions, the top two states make a distinction between no needs and the
272 ideal situation and are phrased in the language of capabilities [46]: whether or not people are able
273 to achieve their desired situation [31].

274 The existing care homes toolkit for individual residents (CH3) has three response options per item
275 worded in the language of 'functionings' (no needs, some needs and high needs), based on the
276 principle that nobody should maintain such a poor level of functioning in any domain that there are
277 health implications if their needs are not met [46]. As outcomes in the care homes toolkit are 'rated'
278 by observers to enable the inclusion of people with cognitive impairment, a domain rating of no
279 needs is the best outcome that can be given. No needs indicates that the person has no unmet
280 needs in that area of their life; some needs means that they have some unmet needs and it is having
281 a negative effect on their quality of life and high needs are distinguished from some needs by being
282 severe or numerous enough to have physical or mental health implications. For example, in the case
283 of food and drink, people who do not have meals at times they would like or choice over what to eat
284 would have some needs; those who were getting an inadequate diet or insufficient liquids would
285 have high needs.

286 The measure

287 It was clear from the consultation phase and the interest from local authorities that potential users
288 wanted this measure to operate as a driver for continuous quality improvement. As such, the home

289 level toolkit needed to go beyond simply recognising when residents' needs are met. ASCOT has
290 potential to do this at the home-level through an adaptation of the capabilities approach and by
291 extending the existing three-level ratings system to four, in line with the self-completion and
292 interview tools. As homes are increasingly striving to deliver person-centred care [47, 48] we
293 decided to conceptualise the top level in these terms. Each domain will be rated according to one of
294 four possible outcomes states, shown in Table 2. The best outcome is conceptualised in terms of the
295 delivery of personalised care and support.

296 How these outcomes states are described will depend on how the measure is used and by whom
297 and will require further work and testing than was possible in this study. Initial plans had been to
298 label them outstanding, good, inadequate and poor but during the consultation phase some local
299 authorities and providers indicated that these labels were not helpful and were laden with negative
300 connotations. For quality improvement purposes, some preferred 'grades' (A, B, C, D) and others
301 suggested a traffic light system (green through to red), although how this might be conceptualised at
302 four levels requires further testing. CQC have adopted a traffic light system in their new quality
303 ratings, with the top two quality ratings both being green but being distinguished by shape;
304 outstanding is a green star and good is a green circle (<http://www.cqc.org.uk/content/care-homes>).

305 A similar approach might work well for these ratings but some professional consultees felt that this
306 toolkit needed to be very different to any approach taken by the regulator, to avoid confusion.

307 Currently, ratings are made at the domain level and although they could be arbitrarily assigned a
308 value, which could be summed to create a raw 'score', the validity of such a score would also require
309 further testing. As the aim of this study was to create a draft toolkit and explore its feasibility as a
310 care home quality indicator, not develop a final toolkit, this was considered acceptable.

311 Unlike the individual level outcomes states, the definitions of the new home-level states need to
312 account for variation in quality of life between residents in a home. To do this, we included
313 quantifiers such as 'all' and 'some' in the top level definitions and provided additional guidance for

314 those planning to use the toolkit to rate homes. For example, if any residents are experiencing poor
315 or inadequate quality of life for a particular domain, the home cannot be rated as outstanding in that
316 domain. For quality improvement purposes, homes would receive a rating, contextualised with
317 evidence collected from observation and interviews. Workshop attendees wanted the wording of
318 this measure to be written from the perspective of the person using the service and be tailored
319 specifically for residential care. To avoid losing comparability with the original ASCOT measures, we
320 accommodated this by introducing subheadings for each domain. Stakeholders also expressed a
321 preference for the measure to avoid passive language (e.g. *residents receive*).

322 The domains themselves were considered relevant to a care home quality indicator, with lay
323 stakeholders spontaneously mentioning control over daily life, food and drink, occupation, social
324 participation, safety and accommodation when asked what the proposed measure should include.
325 There was considerable discussion amongst all stakeholders around the meaning and focus of the
326 safety domain and what it added to the judgements made by CQC and other safeguarding systems.
327 As ASCOT is rooted in the measurement of quality of life, it seemed appropriate for CH4-HL to focus
328 primarily on how residents' *feel* and be worded accordingly. Lay stakeholders also discussed
329 including an indicator of staff compassion and empathy, linking well to the outcome referred to as
330 'dignity' in ASCOT, which is conceptualised in terms of the impact of the way staff treat you on your
331 self-esteem. This domain also offers an explicit opportunity to evaluate relationships between staff
332 and residents, with evidence of good outcomes coming from the nature, tone and warmth of
333 communication in the home and feeding into final ratings. As relationship-centred care is being
334 increasingly advocated in terms of best-practice in care homes [49], this is an important
335 consideration of care home quality.

336 [Draft methodology and guidance](#)

337 CH4-HL has been adapted from the existing care homes toolkit, CH3, which used a mixed-methods
338 approach to data collection, including; structured observations and interviews with residents, staff

339 and family members, where possible. It takes approximately one day to collect CH3 data for every
340 five care home residents [50], which is very resource-intensive, especially in large homes. Feedback
341 from local authorities was that for CH4-HL to fit with existing quality monitoring visits and activities,
342 raters should be able to collect all the information required to make the ratings in one day.

343 Primarily the toolkit is based on the 'enter and view' model [51] and as such places emphasis on
344 structured observation of residents in communal areas. However, it is also important that residents,
345 staff and family members have the opportunity to give their opinions as much as possible.

346 Consequently, the draft guidance recommended that raters work in pairs and between them:

- 347 • Conduct a 2 hour structured observation
- 348 • Interview at least five residents (2-3 each)
- 349 • Interview up to five staff members (2-3 each)
- 350 • Speak to family member and visitors, if available
- 351 • Interview the home manager

352 CH4-HL interviews were semi-structured around the eight domains to gather evidence on what life is
353 like for residents in those domains. Ideally, residents would be interviewed first, followed by a
354 period of observation, including the midday meal. This would then raise issues or queries that could
355 be followed up with staff and the home manager in the afternoon. As recruitment of family
356 members was likely to be opportunistic, our guidance recommended trying to speak to family
357 members and visitors when the opportunity arose, rather than being prescriptive. The feasibility
358 testing aimed to examine whether it was possible to collect all of this information in one day and
359 whether teams felt it provided them with enough details to be able to make the ratings.

360 [Feasibility testing](#)

361 Five quality monitoring (QM) officers in one local authority were trained to use the measure as part
362 of a routine visit. Working in pairs, four used the draft measure in two care homes for older adults.

363 The characteristics of these homes are shown in table 4. After their visits, each QM officer made

364 their own independent ratings of the home they had visited before talking through their ratings with
365 their colleague and identifying differences in opinion and why these might have occurred. In
366 accordance with their preferences, the team piloted a grading system for ratings, with A being the
367 best and D being the worst. Care homes were given a grade for each domain and a written
368 explanation for that rating alongside. These were discussed with the home managers with a view to
369 agreeing action points for quality improvement. The research team returned to the local authority
370 approximately two weeks later to discuss their experiences and the feasibility of using the toolkit as
371 a care home quality indicator in the future.

372 [Feedback from the quality monitoring team](#)

373 Overall, the team felt that *“the day went well”* (QM2) but they reported struggling to achieve the
374 desired number of interviews with staff and were unable to interview any relatives. Table 5 provides
375 information about the homes and summarises how many interviews the teams managed to
376 complete during their day. There were two main barriers to completing more interviews: interview
377 length and the availability (or lack thereof) of staff and relatives. Upon discussion, it became clear
378 that a more feasible approach would be to use the observations and resident interviews as a
379 foundation for follow-up questions with staff, rather than complete interviews, and to target these
380 around the issues identified. There was also discussion about sending ASCOT questionnaires to
381 family members in advance of the visits, asking for their view of their relative’s quality of life that
382 way. Training in observational methods and interviewing was highlighted as being particularly key.
383 Teams found they sometimes struggled to stand out of the way (but in positions from which they
384 could easily see what was happening) and found that some residents found their presence a concern
385 because they were not clear (or lacked the capacity to understand) why they were there:

386 *“There was a particular lady who said, “Oh, are you writing about me?” And she was saying, “Is that*
387 *a bad report?””(QM2)*

388 This highlights the skilled nature of the work and suggests the measure should only be used by those
389 who have the necessary training and expertise. Although many quality monitoring officers have
390 experience of 'enter and view' visits, some authorities still rely on paper-based monitoring and
391 would require greater input to ensure staff are competent and confident in this approach.

392 In terms of coverage, feedback about the domains was very positive: *"the domains cover the*
393 *elements of what's important for a home"* (QM1). Despite some anxiety about making the ratings
394 without looking at care plans, they recognised that there was an intention to move away from
395 paper-based monitoring and that spending all their time on care plans and policies was not the
396 answer either:

397 *"you can have the documentation that's brilliant but what you see in practice doesn't reflect that...
398 and what makes a difference to them [residents] on a day to day basis is the interaction and that
399 experience."* (QM2)

400 In a sense, their concerns echoed what had already been picked up in the workshop and survey, in
401 that much of their anxiety was around culpability and reliability. To collect all the data, the team had
402 divided the interviews between them and sometimes seen or heard different things during their
403 observations. Consequently, they found it essential to discuss the evidence before making their
404 ratings. In terms of feasibility, this is important, suggesting that teams need to collect the data in
405 pairs and then share information or allow one person two days to conduct a visit. Despite these
406 challenges, however, they felt that the guidance led them to rate the home in a way that reflected
407 their own feelings of what life was like for residents:

408 *"I felt that if I'd have gone in that home and done a quality monitoring visit, the normal visit, I'd
409 have said, "That's a good home," which is where that came out with the toolkit"* (QM3)

410 Feedback from the homes

411 The QM team asked homes for their views on the data collection process and final ratings.

412 Unfortunately, in one home the manager was called away from the home during the pilot testing
413 and then felt unable to comment on the process and ratings. In the second home, staff felt the day
414 was not disrupted in any way by their visit and the home manager said that the:

415 “assessment/ report is fair and [it] will help me to address areas that raise some concerns so
416 improvements can be made to the service we deliver to our residents” (Home Manager 1)

417 After the visit, the home manager drew on the evidence gathered by the QM team to respond to the
418 ratings in each domain. Although the home manager and the QM team did not always agree, having
419 the evidence to support the ratings allowed them to enter into a dialogue about this and understand
420 why those ratings had been given and agree actions for improvement, which is key for quality
421 improvement and mutual respect and understanding between professionals in the sector.

422 Discussion

423 This paper has explored the demand for a new care home quality measure based on residents’
424 outcomes and presented early development and feasibility testing. Feedback from the consultations
425 with stakeholders and preliminary testing in one local authority indicates that there is a use for this
426 measure, especially in local authority quality monitoring teams, and that the ASCOT domains work at
427 the care home level. However, it also highlighted the skilled nature of collecting data about quality
428 of life through structured observations and interviews and the importance of thorough information
429 gathering to inform ratings. The observational element of the draft toolkit worked well but training
430 would be required to ensure a consistent approach. If used in quality monitoring, the interviews
431 require further work to fit with the time constraints of those collecting the data and ensure
432 adequate information is collected from a variety of sources. Alternative modes of engagement,
433 including postal questionnaires for family members, should be explored.

434 The potential for this measure to aid user choice arose several times during the consultation phase
435 and reflects a wider political and cultural shift towards encouraging the public to adopt a consumer-
436 approach to long-term care [52, 53]. Certainly previous research and the result of our own
437 consultation indicates that the public would value a quality indicator based on residents' outcomes
438 [30] but this raises the issue of who would be responsible for collecting the data and making it
439 public. Professional stakeholders suggested Healthwatch might be best placed to fulfil this role.
440 However, for such information to be truly of use to prospective residents and their families, ratings
441 would need to be available on all homes in their area. With around 10, 087 homes for older people
442 in England [54], this is not a small task and would require substantial resources, even with the use of
443 trained volunteers. Furthermore, research evidence suggests the information may not be widely
444 used by the public. The decision to move into a care home is often made at a time of crisis and
445 constrained by the availability of places [55] and greater weight is often given to 'word of mouth' or
446 the reviews of people who know the services [13, 56]. The previous regulator, the Commission for
447 Social Care Inspection (CSCI), found that less than 1% of social care users said they used the previous
448 star ratings when making a decision about which home to move to [13].

449 Our own consultations with members of the public suggested a preference for information about
450 the quality of homes to be grounded in the views of residents and their families. This is in line with
451 the recent increase in 'care ratings websites' [see 30 for a review]. On its website, Your Care Rating
452 states that it aims to: give care home residents a voice; promote continuous quality improvement
453 and provide an "authoritative source of information for existing and prospective customers"
454 (<http://www.yourcarerating.org/about-us/>). However, providers have to opt-in to the survey and in
455 2013 it was only sent out to 1, 123 homes, or approximately 11% of care homes for older adults in
456 England [42]. Thus, it is unlikely that the data held on this website will be used to help prospective
457 users find a home. Furthermore, although participants are asked about important aspects of their
458 quality of life (e.g. having visitors when they want, having their own possessions around them, taking

459 part in activities), unlike ASCOT, the survey does not measure the outcomes of social care, which
460 was something the public said they would find relevant and helpful.

461 Clearly a measure of care home quality based on ASCOT has the potential to be used in different
462 ways by different stakeholders. However, without better information sharing between
463 organisations, it might not be possible for the measure to do all of the things highlighted by
464 stakeholders in this study. As Warmington [57] notes, there needs to be a collective accountability
465 for the quality of care and better information sharing is a key part of this. For example, a key tension
466 for this measure is whether, and how, ratings are made available to the public to aid user choice. For
467 good coverage, consistency and authority, local authorities appear best placed and most interested
468 in using the toolkit to carry out 'enter and view' visits. However, feasibility testing indicated they
469 may not have the resources required to collect the experiences of relatives and visitors, which the
470 public seem to value particularly highly. Perhaps there is scope for partnership work between local
471 Healthwatch and quality monitoring teams, with Healthwatch collecting information about relatives'
472 views of the CH4-HL domains and the local authority conducting the monitoring visits? To avoid
473 compromising the relationship between local authorities and providers, only the results of the
474 potential survey of relatives need be made publicly available. Under the Care Act (2014) authorities
475 are required to provide prospective users, including self-funders, with information about the homes
476 in their area. Information such as this could be shared upon such enquiries being made, thus
477 avoiding the need for relatives and frail older people to 'data mine' themselves for reliable, relevant
478 and current information.

479 Conclusions

480 This study came about because local authorities expressed an interest in using the Adult Social Care
481 Outcomes Toolkit in quality monitoring. Our aim was to explore the wider demand for such a
482 measure and examine how it might be used and by whom. Since carrying out the feasibility testing,
483 another local authority has approached us with a view to piloting the draft measure in their routine

484 quality monitoring visits. We plan to evaluate this and examine how it relates to the ratings given by
485 the CQC and the outcomes of individual residents living in the homes, with a view to validating the
486 measure and scoring system and making it available for use by researchers, providers and local
487 authorities in the future.

488 **List of abbreviations used (written in full on first occurrence in text)**

489 ASCOT – adult social care outcomes toolkit

490 CSCI – commission for social care inspection

491 CQC – care quality commission

492 NICE - National Institute for Clinical Excellence

493 QM - quality monitoring

494 SCIE – Social Care Institute of Excellence

495 SCRQoL – Social care related quality of life

496 TLAP - Think Local Act Personal

497 **Competing interests**

498 None.

499 **Author's Contributions**

500 AT – conceived of the study and new measure, led on design, ethical submissions and manuscript
501 drafting. Contributed to data collection and analysis of workshops with professionals; trained QM
502 team and gathered their feedback after piloting.

503 JH – contributed to conception and design of the study, the ethical submissions and design, data
504 collection and analysis of the workshops with professionals. She designed and carried out the focus

505 groups, reviewed the literature and contributed to the development of the new measure and
506 manuscript drafting.

507 NS – contributed to the conception and design of the study and measure. Contributed to data
508 collection and analysis of workshops with professionals; trained QM team and gathered their
509 feedback after piloting. Contributed to revisions of manuscript drafts.

510 TC - recruited participants for and assisted with running of two focus groups. Conducted the analysis
511 of all three focus groups, wrote up the analysis and contributed to revisions of manuscript drafts.

512 AN – contributed to conceptual development of new measure and rating levels, assisted with
513 consultations with professionals and critically revised the content of the manuscript.

514 EW - Contributed to the ethical submission for the focus groups and assisted with the design of
515 research materials. Recruited focus group participants and assisted with the running of one group.
516 Contributed to revisions of manuscript.

517 Grace Collins – assisted with the collection of professional stakeholder views and contributed to
518 revisions of manuscript.

519 **Acknowledgements**

520 We would like to thank Amanda Burns for helping with the administration of the project and
521 consultations with stakeholders, the professionals and members of the public who took part in the
522 consultations and focus groups and the agencies that helped us recruit people to the study.

523 The research on which this paper is based was funded by the NIHR School for Social Care Research.

524 The views expressed in this presentation are those of the authors and not necessarily those of the
525 NIHR School for Social Care Research or the Department of Health/NIHR.

526

Table 1 – The ASCOT domains	
Control over daily life	The service user can choose what to do and when to do it, having control over his/her daily life and activities
Personal cleanliness and comfort	The service user feels he/she is personally clean and comfortable and looks presentable or, at best, is dressed and groomed in a way that reflects his/her personal preferences
Food and drink	The service user feels he/she has a nutritious, varied and culturally appropriate diet with enough food and drink he/she enjoys at regular and timely intervals
Personal safety	The service user feels safe and secure. This means being free from fear of abuse, falling or other physical harm and fear of being attacked or robbed
Social participation and involvement	The service user is content with their social situation, where social situation is taken to mean the sustenance of meaningful relationships with friends and family, and feeling involved or part of a community, should this be important to the service user
Occupation	The service user is sufficiently occupied in a range of meaningful activities whether it be formal employment, unpaid work, caring for others or leisure activities
Accommodation cleanliness and comfort	The service user feels their home environment, including all the rooms, is clean and comfortable
Dignity	The negative and positive psychological impact of support and care on the service user's personal sense of significance

529 Table 2: CH4-HL ratings states from best to worst

Best outcome	Residents have outstanding quality of life in this area. All residents are being cared for and supported in a consistently personalised way with their wishes and feelings being taken into account.
	Residents have good quality of life in this area. All residents are cared for and supported in a way that meets their needs.
	Residents have an inadequate quality of life in this area. Some residents are not having their needs met and there are enough issues to affect their quality of life although there is no immediate risk to their health.
Worst outcome	Residents have a poor quality of life in this area. Residents' needs are not being met and their physical or psychological health is being put at risk because there are so many issues or because the issues are so serious.

530 Table 3 Domain titles, subheadings and definitions for draft measure CH4-HL

CH4-Qualii Domains	Definitions
Accommodation Living in a clean and comfortable home	Residents live in a clean and comfortable home and like how it looks and feels. Bedrooms and shared areas are well designed, easy to get around and meet residents' health and social care needs.
Personal cleanliness and comfort Being clean and presentable	Residents are clean and comfortable. They are dressed in ways that meet their individual needs and wishes.
Food and drink Eating and drinking well	Residents eat and drink well. They get a balanced and varied diet, including food they like and need.
Personal safety Feeling safe and free from fear	Residents feel safe and free from fear of physical and psychological harm and are supported to manage risks.
Being sociable	Residents spend time socialising with people they like and taking part in social activities. Close relationships with family, friends (from inside

Spending time with people, being sociable.	and outside the home), carers and people from the wider community are supported.
Being occupied Having things to do, being occupied	Residents spend time doing things they like, value and enjoy on their own or with others. They are supported in continuing activities that they have been involved in the past.
Choice and control over daily life Having choices, feeling in control	Residents have choice and control over their daily life. They feel they 'have a say' in their care, daily routine and activities and that their views are respected.
Dignity Being treated with dignity and respect by staff	Residents are treated with compassion, dignity and respect. Staff think about what they say and how they say it and consider the feelings of residents when giving care and support.

531 Table 4: Characteristics of homes involved in feasibility testing

	Home 1	Home 2
Type of home	Older adults without nursing	Older adults without nursing
Including dementia?	Yes	Yes
Capacity	28	29
Occupancy	27	27

532 Table 5: Summary of data collected during the visits

	Home 1	Home 2
Manager present?	Yes	No – called away urgently
No. QM officers	2	2
Staff interviews *	2	1
Resident interviews*	4	4
Relative interviews*	0	0

533 *Aiming for 5 staff and *at least* 5 resident interviews per home. We included relative interviews but knew

534 these were going to be opportunistic and difficult to achieve.

535 **References**

- 536 1. Department of Health, *The Care Bill explained*. 2013, The Stationery Office: London.
- 537 2. Samual, M., *Care homes to be rated through survey of 50,000 residents*, in *Community Care*.
538 2012.
- 539 3. Department of Health, *Improving health and care. The role of the outcomes frameworks*.
540 2012, Department of Health: London.
- 541 4. Department of Health, *Caring for our future: reforming care and support. White Paper. Cm*
542 *8378*. 2012, The Stationery Office Limited on behalf of the Controlloe of Her Majesty's
543 Stationery Office: London.
- 544 5. Department of Health, *Our health, our care, our say: a new direction for community services*.
545 *Cm 6737*. 2006, The Stationery Office: London.
- 546 6. Department of Health, *Healthy Lives, Healthy People: our strategy for public health in*
547 *England. Cm 7985*. 2010, The Stationery Office: London.
- 548 7. National Audit Office, *Adult Social Care in England: Overview*, in *Report by the Controller and*
549 *Auditor General*,. 2014, National Audit Office: London.
- 550 8. *Care Act*. 2014: England.
- 551 9. Think Local Act Personal, *Quality assurance survey of Local Authorities*. 2012.
- 552 10. Malley, J., et al., *Regulating the quality and safety of long-term care in England in Challenges*
553 *in Regulating the Quality of Long-term Care: An International Comparison*, V. Mor, T. Leone,
554 and A. Maresso, Editors. 2014, University Press: Cambridge.
- 555 11. Health Committee, *2012 accountability hearing with the Care Quality Commission*. 2012,
556 House of Commons: London.
- 557 12. Allan, S. and J. Forder, *Care Markets in England: Lessons from Research. PSSRU Discussion*
558 *Paper 2815* 2012, Personal Social Services Research Unit and the Economics of Social and
559 Health Care Research Unit at the University of Kent: Canterbury.
- 560 13. Commission for Social Care Inspection, *Quality Ratings. Market Research Report*. 2009.

- 561 14. Social Care Institute for Excellence. *Find Me Good Care* 2012 10/10/2012]; Available from:
562 <http://www.findmegoodcare.co.uk/>.
- 563 15. Your Care Rating. *Have your say*. 2012 12/09/2012]; Available from:
564 www.yourcarerating.org/index.html.
- 565 16. Owen, T., National Care Homes Research and Development Forum, and H.t. Aged, *My Home*
566 *Life: Quality of Life in Care Homes*. 2006, Help the Aged London.
- 567 17. Department of Health, *Prime Minister's Challenge on Dementia: Delivering major*
568 *improvements in dementia care and research by 2015*. 2012, Department of Health: London.
- 569 18. National Institute for Clinical Excellence. *NICE quality standards in social care*. 2011
570 10/10/2012]; Available from:
571 <http://www.nice.org.uk/guidance/qualitystandards/socialcare/home.jsp>.
- 572 19. Cabinet Office, *Open Data White Paper: Unleashing the Potential*. Cm 8353. 2012, HM
573 Government: London.
- 574 20. Brindle, D., *Why social care providers want their stars back*, in *The Guardian*. *Joe Public*
575 *Blog*. 2011.
- 576 21. Pitt, V., *Anger over CQC decision to end star ratings*, in *Community Care*. 2010.
- 577 22. Department of Health, *Transforming care: a national response to Winterbourne View*
578 *Hospital: Department of Health Review Final Report*. 2012, Department of Health: London.
- 579 23. Francis, R., *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. 2013, The
580 Stationery Office: London.
- 581 24. Nuffield Trust, *Rating providers for quality: a policy worth pursuing? A report for the*
582 *Secretary of State for Health*. 2013, Nuffield Trust: London.
- 583 25. Deloitte, *Care Quality Commission: Third party review of CQC's regulatory approach: Final*
584 *report*. 2013, Deloitte LLP: Manchester.
- 585 26. Care Quality Commission, *A new start. Responses to our consultation on changes to the way*
586 *CQC regulates, inspects and monitors care services*. 2013, Care Quality Commission: London.

- 587 27. Care Quality Commission, *A fresh start for the regulation and inspection of adult social care.*
588 *Working together to change how we inspect and regulate adult social care services.* 2013,
589 Care Quality Commission: London.
- 590 28. Department of Health, *Transparency in outcomes: A framework for quality in adult social*
591 *care. The 2011/12 Adult Social Care Outcomes Framework.* 2011, Department of Health:
592 London.
- 593 29. Care Quality Commission, *Residential adult social care. Appendices to provider handbook.*
594 *Consultation.* 2014, Care Quality Commission: London.
- 595 30. Trigg, L., S. Kumpunen, and J. Holder, *Results from the England Study, Annex A of Activity 3.1*
596 *User Choice: Using information to choose residential care for older people: a European study,*
597 *in European Union Cross-border Care Collaboration (2013), Measuring and Reporting Quality*
598 *of Long-term Care; Work Package 6.* . 2013, Prepared for the European Commission.
- 599 31. Netten, A., et al., *Outcomes of social care for adults: developing a preference-weighted*
600 *measure.* Health Technology Assessment, 2012. **16**(00).
- 601 32. Alzheimer's Society, *Dementia UK: a report to Alzheimer's Society by King's College London*
602 *and the London School of Economics.* 2007, Alzheimer's Society: London.
- 603 33. Beadle-Brown, J., et al., *Engagement of people with long term conditions in health and social*
604 *care research: Barriers and facilitators to capturing the views of seldom-heard populations.*
605 2012, Quality and Outcomes of Person-Centred Care Policy Research Unit, University of
606 Kent: Canterbury.
- 607 34. Luff, R., Z. Ferreira, and J. Meyer, *Care Homes: Methods Review 8.* 2011, NIHR School for
608 Social Care Research: London.
- 609 35. Bowling, A., *Research methods in health: investigating health and health services.* 3rd Edition
610 ed. 2009, Maidenhead: Open University Press.

- 611 36. Brown-wilson, C., S. Davies, and M. Nolan, *Developing personal relationships in care homes: realising the contributions of staff, residents and family members*. Ageing and Society, 2009. 612 *29*(7): p. 1041-1063. 613
- 614 37. Malley, J., et al., *A report on the development studies for the National Adult Social Care User Experience Survey*. PSSRU Discussion Paper 2721. 2010, University of Kent: Canterbury. 615
- 616 38. Clark, P. and A. Bowling, *Observational study of quality of life in NHS nursing homes and long-stay wards for the elderly*. Ageing and Society, 1989. **9**: p. 123-148. 617
- 618 39. Mays, N. and C. Pope, *Qualitative research: Observational methods in health care settings*. 619 British Medical Journal, 1995. **311**(6998): p. 182-184.
- 620 40. National Institute for Health and Clinical Excellence, *Mental wellbeing of older people in care homes*. NICE Quality standard 50. . 2013, National Institute for Health and Clinical 621 Excellence: London. 622
- 623 41. Matenda, J. and L. Maurice, *ASCOT and East Sussex Quality Monitoring Audits*. 2014, Annual 624 ASCOT Workshop: London.
- 625 42. Ipsos MORI, *Your Care Rating*, I. MORI, Editor. 2014, Ipsos MORI: London.
- 626 43. Sands, L.P., et al., *What Explains Differences Between Dementia Patients' and Their 627 Caregivers' Ratings of Patients' Quality of Life?* The American Journal of Geriatric Psychiatry, 628 2004. **12**(3): p. 272-280.
- 629 44. Schölzel-Dorenbos, C.J.M., P.F.M. Krabbe, and M.G.M. Olde Rikkert, *Quality of Life in 630 Dementia Patients and Their Proxies: A Narrative Review of the Concept and Measurement Scales*, in *Handbook of Disease Burdens and Quality of Life Measures*, V. Preedy and R. 631 Watson, Editors. 2010, Springer New York. p. 3671-3689. 632
- 633 45. Care Quality Commission, *Overview to the provider handbooks for adult social care. For 634 consultation* 2014, Care Quality Commission: London.
- 635 46. Sen, A., *The possibility of social choice*. The American Economic Review, 1999. **89**(3): p. 349- 636 378.

- 637 47. Burke, S., *A personal service: residential care and personalisation*, in *Residential care: a*
638 *positive future*, T. Philpot, Editor. 2008, Residential Forum: London.
- 639 48. Carr, S., *SCIE report 20: Personalisation: A rough guide*. London: SCIE, 2008.
- 640 49. Owen, T. and J. Meyer, *My Home Life: Promoting Quality of life in care homes*. 2012, Joseph
641 Rowntree Foundation and Age UK.
- 642 50. Beadle-Brown, J., et al., *Adult Social Care Outcomes Toolkit: Additional Care Home Guidance*
643 *v2.1*. 2011, Personal Social Services Research Unit, University of Kent: Canterbury.
- 644 51. Healthwatch England, *Annual Report 2013/14*. 2014, Healthwatch England: London.
- 645 52. Clarke, J., et al., *Creating Citizen-Consumers: Changing Publics and Changing Public Services*.
646 2007, London: SAGE Publications Ltd.
- 647 53. Glendinning, C., *The consumer in social care*, in *The consumer in public services: Choice,*
648 *values and difference*, R. Simmons, M. Powell, and I. Greener, Editors. 2009, The Policy Press:
649 Bristol. p. 177-196.
- 650 54. Laing, W. and Buisson, *Care of older people: UK market report 26th Edition 2013/2014*. 2014:
651 London.
- 652 55. Netten, A., et al., *Self-funded admissions to care homes. Research Report No.159*. 2001,
653 Department of Work and Pensions: Leeds.
- 654 56. Trigg, L., *Using online reviews in social care*. *Social Policy and Administration*, 2013. **48**(3): p.
655 361-378.
- 656 57. Warmington, J., A. Afridi, and W. Foreman, *Is excessive paperwork in care homes*
657 *undermining care for older people?* 2014, Joseph Rowntree Foundation

658