

**DEFINING AND MEASURING QUALITY IN
THE CONTEXT OF COMMUNITY CARE AND
BEST VALUE**

SUMMARY

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NOVEMBER 2000

ABOUT THE STUDY

A literature review was carried out in early 2000. This covered the development of managerialism in the public sector, quality in the commercial sector and in public services, the Scottish best value literature, community care policy and discussions of statutory: voluntary relationships.

The case studies, pairing a council with an external provider of community care services active in its area, were primarily identified through Community Care Providers Scotland, a national network of large voluntary organisations. A private provider was a later addition.

Interviews took place in June 2000, separately with senior officers from each of the four councils and senior officers from each of the paired external providers. Three of the latter were voluntary organisations, one private.

It is acknowledged that the study was of a small scale and important areas, such as the conclusions of best value reviews, could not be included.

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INTRODUCTION

This research project was carried out as part of a MSc. in Social and Public Policy at the University of Edinburgh. It examined the approaches to service quality in use by voluntary and private sector providers of community care and Scottish councils. It is based on four case studies, which pair a local council in Scotland with a voluntary or private sector organisation providing community care services within their area. The context is the implementation [in Scotland] of Best Value reviews.

Quality is both a simple and a difficult concept. It offers private business the promise of customer-focus and elimination of waste thereby creating a better product, which sells more at less cost to produce. Quality can also be adopted as a determined approach to make bureaucratic, professionally dominated public services much more responsive and accountable to their users, in line with the emerging consumerist trend of post-war society. It can be used by organisations in every sector to improve their internal processes, their service delivery and the outcomes of user-satisfaction. It can generate higher expectations and increased demand.

Best Value [COSLA /Scottish Office/Accounts Commission, 1999] is a New Labour addition to the continuing agenda of change for publicly funded services that began in the 1970s. Essentially, this has involved seeking value for taxpayers' money, in a period of relative economic decline for the UK

during which increasing taxes and public spending were viewed as an inappropriate response as well as an electoral liability by first the Conservative government and then 'New' Labour. Best Value seeks to balance judgements about cost *and* quality in determining how public services should be delivered.

Further, community care, as a human service, is much more complex and value-laden than some other services where tight technical specifications are more easily measured. The research tried to identify how this problem is being addressed.

The evidence from an initial survey of Community Care Provider Scotland' members showed that the majority have adopted, or are adopting, quality approaches and systems. One-third of those in that study had achieved some type of independent, external accreditation. These may only relate to one part of the organisation, or cover particular organisational processes. The research tried to examine what these systems collect and measure.

Service quality is difficult to define and measure therefore achieving a balance between cost and quality, as the government expects, is difficult. Cost measures are more readily available. The research tried to identify what definitions of service-quality exist in councils, what measures councils are using, what is gathered, and then used, to inform the quality element of the Best Value judgement.

Best Value is applied across a whole range of services. It is not a "regime" insofar as this implies a single model of compliance across Scotland. Rather, the Scottish Executive expects variation between councils in how they interpret and

implement. An aim of the research was to identify the main variations in assessing service-quality.

SERVICE QUALITY

A generic system to deliver service quality would have these basic elements:

1. methods to understand the outcomes desired by customers, linked to
2. methods to understand which interventions and activities [predominantly of staff] are effective in creating these outcomes, linked to
3. service specifications or standards about how those actions [processes] and outcomes will be realised, linked to
4. periodic measurement or evaluation of processes and outcomes from the customers' perspective, linked to
5. planned, continuing improvements [to close gaps between expectation and performance and/or to move to higher standards], linking back to customers.

Such an organisational system has its own internal processes to define and measure quality and these are essential to the *delivery* of service quality. However, the wider field of community care has different requirements within it for definition and measurement, generated by multiple interests each bringing their own perspective to bear.

In such a system as described above, definitions of quality are to be found in the referents, against which measurements of quality are also made. Referents may take the form of

specifications or standards. The emphases may lie with inputs, processes, outputs or outcomes, depending on whose perspective prevails. Financial concerns may focus on inputs and outputs, professional practice concerns on processes, and customers/users on outcomes. In the commercial sector, and increasingly in public services, expert or professional definitions and measures of quality are being replaced by customer definitions. In services with few tangible characteristics, such as community care, the perceptions of customers/users are particularly important.

KEY POINTS FROM THE RESEARCH

- Council Social Work departments in the study did not have distinct policies or systems to help them define or measure quality. Best value was filling a vacuum.
- Community care assessments, care management and reviews were not being used to develop measures of quality around individual service users or in any way being aggregated to inform strategy and policy on quality.
- Arms length Registration and Inspection, where it applied, was not acknowledged as an important source of information on quality by either councils or providers.
- Councils recognised multiple stakeholders - users, potential users, the public, and central government - as required by

best value, whereas providers focused on their staff and users.

- There was no evidence that councils or providers saw national policies as defining quality.
- Quality systems were evident in the providers. These focused on processes, especially those directing staff behaviour and attitudes. Providers were seeking new ways to measure outcomes from users' perspectives, but little practice was evident.
- Best value reviews showed a commitment to user consultation and some effort to establish criteria for quality based on users' views. Timetables had slipped, benchmarking was difficult in practice, and results were inconclusive therefore it was not possible to tell what weight was finally given to this.
- Council staff wanted to control the measurement of quality and were reluctant to use information on quality from other sources. The preferred approach was through contract compliance. Providers perceived this as focused on cost and volume, not quality.
- The definitions and methods of measurement that were in use had little focus on outcomes. All respondents, in different ways, acknowledged the need to do much more in this respect.

- Different quality systems were in use or being considered for use. There are significant differences, for example, whether they focus on users or multiple stakeholders, processes or outcomes, on service delivery or external comparisons, whether partial or total in their application. There is a risk of confusion amongst professionals and users, and a risk of 'quality fatigue'.
- The effort to find a suitable professional and/or bureaucratic approach to defining service quality may be overtaken by the extension of 'direct payments'. These begin to replicate the conditions of the commercial sector, [where it is claimed only customers judge quality], by giving the user the purchasing power. It then becomes possible for the user of community care services to make their own judgement about the balance between quality and cost.

THE POLICY BACKGROUND

The U.K. public sector has been through major change in the last 30 years. Publicly funded services have been increasingly delivered through markets or quasi-markets in which choice exists insofar as there are a variety of providers or suppliers. Competition between providers is used to reduce costs and improve services. The same period has seen an increase in the power of individuals, as consumers, to challenge professional and bureaucratic decision-making and control.

Community care policy supports the enabling of a diversity of provision through market mechanisms. [The liberalisation of

supply.] It also supports the enabling of choice by individual users of community care services. More recently, direct payments extend individual power and choice by giving users the money to purchase their services. This completes the liberalisation of the demand-side of the market.

Quality in the commercial sector represents a continuous effort by all parts of an organisation, and its suppliers, to produce a product or service with the right mix of characteristics or features to satisfy the customers. This is expected to increase sales while eliminating waste and reducing the costs of producing or delivering the goods or services. Like competition, quality can be used to reduce costs and improve services.

Quality is also used politically within the broad themes of transforming, improving or modernising public services.

Best value asks councils to determine what will be done, how, and by which agency, having given equal consideration to quality of service as well as cost.

Community care is value-laden. Each individual experiences the services with a unique perception of quality. The service intervention is often long term and intensive. Such service quality is particularly difficult to define and measure. The expectation that equal consideration can be given to quality as well as cost will be very hard to meet. The former is much more difficult to define and measure relative to the latter.

THE RESEARCH FINDINGS

SIMILARITIES AND DIFFERENCES BETWEEN COUNCILS

The broad overview would be that Councils are much more similar than different in their general approach to 'quality' and that this is due to best value. When certain things are expected, required and inspected upon, as is best value, it will follow that those things are, eventually, implemented to some degree.

Outside of what happened with best value, there was no evidence of any existing systems for quality or simple, accessible definitions. In C1, a quality assurance system had fallen into disuse, the respondent describing it as "very bureaucratic, time-consuming, [and] not sure if it supported quality". Best Value was filling a vacuum. All Councils were progressing it and two were particularly enthusiastic for more guidance and direction from the Accounts Commission, C3 stating that things "would become much more focused – really sharpen things up". The practice of Councils reflected the concept of multiple stakeholders and interests. There were signs that too many systems were being introduced and that this was confusing, not illuminating. C2a said, "lots of people don't understand the links between different systems, only a few of us do."

No Council responded in a way that saw independent, external Registration & Inspection reporting as a significant guide to quality. It was not recognised that comprehensive standards existed, and the use made of inspection reports was

minimal. Councils were more interested in using contracts and contract compliance as a way to measure activity and quality.

All Councils were committed to extending user-consultation, making use of surveys, meetings and focus groups. In C2, user-consultation defined the performance criteria against which the service was measured. But the big question then is what use is made of the results of consultation. Weaknesses in user-consultation were pointed out by Council and provider respondents as being narrow in representation and exclusive of people who had significant difficulties with communication. Provider 3 noted the absence of local advocacy services, which could assist with this problem.

No Council had in place a system to measure the quality of service interventions at individual level through assessment and care management. One had a very limited system connected to their charging policy. All Council respondents felt that more should be done. Providers were generally critical of care management, it being frequently remarked that designated care managers “probably do not know what the individual looks like” and that the care management process “hasn’t measured anything”. [Anonymous, by request.]

Little significance was given to information that might relate to service-quality that came from providers. In different ways, to different levels of sophistication, each provider had a system in place to set standards for, and measure, human resource processes which each would claim as a sound indicator for quality of outcomes. Similarly, each had in place, to some degree, systems for individual planning and review. The overriding impression from talking to Council staff was that they

needed to feel they were in control and finding things out for themselves. On one occasion it was indicated that information from providers might be biased, or that expressions of user-satisfaction might be based on misplaced loyalty.

Councils used various methods to ascertain the views of other professionals with links to the service under review. Respondent C3a acknowledged that this could be “unfair” to providers and each provider questioned the validity of these opinions and in P1 and P2 there was a strong feeling that professional opinions ended up carrying more weight than user-consultation. Although carrying out a comparatively sophisticated approach to a best value review, respondent C3a still remarked that they “used people rather than processes”, implying that conclusions were still formed by professional opinions despite the gathering of evidence.

SIMILARITIES AND DIFFERENCES BETWEEN PROVIDERS

Providers were less likely than councils to recognise a range of stakeholders and interests in their approach to quality. They were predominantly focused on the users of the service. One provider regarded the purchaser as the secondary customer, but overall there was no expressed concern with the public or government as stakeholders. Respondents indicated little influence from central or local government on their approach to quality, whether best value or community care related. Predominantly, they had chosen a quality-related system that involved some form of external accreditation. Essentially, the systems in use defined and measured quality in relation to processes, and in particular human resource processes.

Where Registration and Inspection applied, and this meant that their standards had to be met in service delivery, no provider saw this as defining quality. There was too much emphasis by R&I on the “establishment” and on procedures and not enough on the individual users. One respondent, P4b, reported positive experience from inspection visits when time was taken to speak to service-users but this was not typical.

All providers emphasised a growing commitment to user-consultation and a search for better ways for users to define quality in their own terms. One provider already used person-centred planning and measured goal achievement. Another had bought into an U.S. based model for personal outcome measures.

Some service-users had no contact with Social Work and it seemed few had regular involvement. Providers all had a similar negative view of assessment and care management. Provider 3 and 4 stressed the importance of knowing people well in order to understand their limited communication.

Where contracts existed, the impression given by all providers was that compliance measured cost and volume, not quality.

BEST VALUE REVIEWS

The difficulty here is that reviews were either incomplete or at least not fully written up and available. It was possible to see the approach being used, but not the conclusions and therefore what weight was given to different information, or whether information gathered was then discarded. This also made it difficult to see how information was being synthesised

and what conclusions were drawn in regard to improvement or change.

In Council 2 and 3 the work underway seemed to be comprehensive. Multiple stakeholders were identified and consulted, with particular emphasis on users and carers. In C2 this process identified “critical success factors” of “customer care, availability, flexibility, involvement and quality of life” which were then used in a user-satisfaction survey. An effort was then made, by measuring service activity types and levels, to link levels of outcome satisfaction to particular processes and to their costs.

In the above example, only one service was under review and the difficulties would be multiplied in a review of bigger scale. These difficulties of measurement and comparison lead into the problems with benchmarking. Firstly, where information was supplied by providers it seemed that Council staff had difficulty in making anything of it that could be seen as a valid comparison. Secondly, other Councils that were benchmarking partners were reported as finding it difficult to supply useful information. Without that, it was difficult, especially for a small Council, to identify from its own locality suitable services with which to compare. Thirdly, other providers were reported as reluctant to share cost information. Fourthly, it could be observed that many community care services were different in terms of users, service design, purpose and scale. More recent services do not share the similarities that exist in traditional home care services, or large residential or nursing home provision. The latter was the subject of an Accounts Commission study which respondents

in each Council cited as an important example of how to 'do' best value. ["Care in the Balance", Feb. 1999.]

HOW SERVICE QUALITY IS MEASURED

Service quality in community care services exists in the interaction of users and care staff and in the outcomes perceived by users from this interaction. It may have a few tangible characteristics, for example the physical environment, but it is predominantly about particular, individual perceptions of interpersonal relationships. What matters may exist in the process as well as in outcomes. How the service is delivered, how staff behave, is very important. From a user' perspective, processes and outcomes are not so distinct. That said, it was a deliberate feature of the interviews not to accept any easy attribution between quality assurance of processes and quality of outcomes for users. However, systems relating to staff behaviour, and their training and development, should be powerful in a human service such as community care. Processes can provide an essential foundation for an environment and culture that supports user satisfaction with outcomes. One independent study of residential and nursing homes concluded that, "The level and intensity of the staff: resident encounter is where attention needs to be focused for service quality to succeed", and "The stumbling blocks to service quality [are] communication and training." Examples of standards for staff practice can be found in the research through the use of Scottish Vocational Qualifications, Investors in People and are also covered by ISO 9002 [along with other processes.]

Within the case studies, there were parallel systems to set and control standards. Councils operated 'approved provider' systems that in essence set entry-level standards that, if met, allowed an organisation to operate. Local Registration and Inspection services used registration in a similar way to set and control entry to the areas for which they were responsible. Subsequently, inspections would be carried out by Registration and Inspection Officers or by Contracts Officers to measure what happened in practice. Where Councils tried to move beyond cost and volume in contract compliance monitoring, the same approach was envisaged. In either contract compliance monitoring or Registration and Inspection inspections, the critical issues were how far the personnel involved were able to spend time with service users to really understand their views. If this could be achieved, there was some possibility of measuring quality at the outcomes level. If not, as was more often the case, both approaches were measuring that which was easy to measure at the level of inputs, processes and outputs. There were issues of duplication between, essentially, local regulation by contract and local [but arms-length] regulation by Registration and Inspection Units. The proposed introduction of a new national level of regulation for community care services, and national standards for care, will not remove duplication. Local councils will still regulate external providers by contracts within which there will be efforts to define and measure quality.

The contract compliance work of Councils is variable. It definitely measures inputs and outputs [cost and volume] and may check that certain processes are in place. If it begins to

seek information on outcomes the staff are required [as with best value reviews or R&I visits] to spend a considerable amount of time with users and/or rely on information from providers' review systems.

Both councils and providers use user consultation methods and these can cover processes and outcomes. Much of Councils' user consultation takes place within best value reviews and relates to specific services and to planning. Again, sufficient time and knowledge of individuals was essential if this was to be meaningful to the many users who were either unable or unwilling to communicate within the methods used. The people most able to facilitate involvement would be front line staff who knew them well [or relatives, friends or advocates] and they were predominantly within service-provision not care management. In practice, Council staff showed evidence of consultation in planning, but very little in measuring outcomes for existing service-users. To do the latter, Council staff [care managers or contracts officers] and external regulators need to either rely on, or duplicate, the knowledge of staff in service delivery, whether within the statutory, voluntary or private sector.

Care management, in theory, has the potential to establish measures at individual level against past experience or agreed standards, over time. There was no evidence of this happening. The most obvious reported reasons were lack of time and pressure of other work. Each provider would have been able to contribute information at this level.

There was one example of a best value review seeking information on outcomes from users. Reviews have the

potential to gather information about quality at all stages, but there were no completed examples. Reviews could strengthen their content by making more use of other information, especially from Registration and Inspection and from providers.

There were three evidenced methods by which providers can measure outcomes. One is through independent and in-depth evaluation by an outside consultant. Another is through forms of planning with individuals [e.g. person-centred planning] and, crucially, measuring outcomes. The third is to find an accredited system for “personal outcomes measures”. [The example comes from the US-based Council on Quality and Leadership in Supports for People with Disabilities, 1997]

CONCLUSIONS

Service quality is to be found in the experiences and perceptions of individuals who use services. In an intensive human service such as community care the attitudes and behaviours of staff will be strong indicators of quality. Users will be concerned with processes and outcomes. The information needed to judge service quality would come from the service delivery interface. Methods of individual planning and review, however done and by whom can generate the necessary information. Purchasers and providers need to agree how this is to be done, especially to emphasise outcomes, and agree to trust the resultant information. This requires agreement about ‘referents’, [which may be in the form of standards.]

The measurement of performance for the purpose of comparison has a different emphasis to the use of measurement to improve service delivery. The latter places the

responsibility for quality with the service provider. In turn, the delivery of quality requires a systematic approach which builds in and manages all the necessary inputs and processes [or enablers.] Quality is not achieved by inspection but by a systematic and disciplined approach within the provider. The systems to deliver quality do also need to satisfy the information requirements for comparison. However, looked at from the opposite direction, systems designed for measurement and comparison are not necessarily helpful to the delivery of service quality, especially if the referents for comparison are different from those in operational use.

Ideally, and conceivable as practical, would be an agreed system of standards, shaped by users and agreed by other stakeholders, then operationalised by providers within a quality system, and generating performance measurements that satisfy different requirements, including those for comparison.

The evidence of the case studies showed that there were not agreed definitions of quality within or between agencies. Although there was a shared view about the importance of users' definitions and experiences of quality, there were no agreed methods to use the richness of material that could be gathered from individuals' experiences.

Where standards existed, as with local registration and inspection, there was a shared view that there was insufficient emphasis on users and outcomes but no shared view about improving a common set of standards to address this imbalance. [This may be achieved by the national standards.] Providers were developing their own systems to deliver service quality, councils were developing their own methods to

measure quality within the best value framework and The Scottish Executive is developing national standards for the regulation of care services.

In respect of achieving a balance between cost and quality, it appears that there is no common quality 'currency' and within different agencies, and around different purposes, different currencies are in use without the means to convert one to the other. At this stage it is not apparent how the measurement of quality can be given equal consideration alongside the measurement of cost.
