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**Article (Accepted version)  
(Refereed)**

**Original citation:**

Malley, Juliette and Fernández, José-Luis (2010) *Measuring quality in social care services: theory and practice*. [Annals of public and cooperative economics](#), 81 (4). pp. 559-582. ISSN 1370-4788

DOI: [10.1111/j.1467-8292.2010.00422.x](http://dx.doi.org/10.1111/j.1467-8292.2010.00422.x)

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Available in LSE Research Online: May 2012

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# **Measuring quality in social care services: theory and practice**

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## **ABSTRACT**

Measuring and assessing service quality in the social care sector presents distinct challenges. The ‘experience’ good properties of social care, for instance, and the large influence played by subjective judgements about the quality of personal relationships between carer and user and of process-related service characteristics make it difficult to develop indicators of service quality, including those of service impact on final outcomes. Using some of the key features of the ‘Production of Welfare’ approach, the paper discusses recent developments in the UK of the theoretical and practical frameworks used for assessing quality in social care and for understanding the final impact of services on the wellbeing of their recipients. Key current and future challenges to the development of such frameworks include difficulties in disentangling the impact of social care services on final outcomes from the often dominating effects of other, non-service related factors, and the generalisation of consumer-directed care models and of the ‘personalisation’ of care services. These challenges are discussed in the context of the different possible applications of quality indicators, including their role as supporting the service commissioning process and their use for assessing the performance of service providers.

# 1 INTRODUCTION

Governments across the world have introduced reforms to social care services to diversify provider markets, for example allowing (and in some cases exhorting) authorities with responsibility for provision of social care to purchase services from independent for-profit and not for-profit firms (Forder et al., 1996, Ikegami and Campbell, 2003). Alongside these provider-side reforms there have also been attempts to diversify purchaser markets and give service users more choice and control over their care, through the introduction of consumer-directed care reforms (Glasby and Littlechild, 2002). The resulting increased separation between service commissioners and providers has led to information problems, notably around the ability of service commissioners to judge the quality of services. Quality measures are required by purchasers to aid them in their commissioning decisions and to contribute to the monitoring of aspects of performance, such as efficiency and effectiveness. In times of fiscal austerity and retrenchment in public services it is all the more important to measure quality to ensure that quality does not suffer unduly at the expense of initiatives to save costs. The present article discusses the particular theoretical and practical challenges presented by the measurement of service quality in social care.

We first provide a discussion of the conceptual issues and analytical problems involved in the measurement and operationalisation of the concept of service quality in social care. In particular we consider the specific characteristics of social care which make quality difficult to define and to measure and argue that the focus of quality measurement should be on measuring outcomes. We discuss some of the analytical problems inherent in this choice of focus and illustrate, using key features of the ‘Production of Welfare’ approach, how some of these difficulties could be conceptualised and overcome. Finally, we review some of the challenges for quality measurement likely to emerge in the future, given the evolving nature and context of the social care system. Although the paper is framed around English examples, its central messages are relevant to policy discussions in the majority of developed countries.

## 2 MEASURING THE QUALITY OF SOCIAL CARE SERVICES

Measuring the quality of social care presents distinct conceptual and analytical challenges, not least because of its complex multi-dimensionality and the different meanings attached to the quality by alternative social care stakeholders. Overall, users of social care services have tended to perceive service quality in terms of either aspects of ‘quality of care’ or of ‘quality of life’ (Reed, 2007, Osborne, 1992). Frequently cited aspects of *quality of care* include service accessibility, accountability, attitudes and behaviour of staff, continuity of care workers, fluid communication of changes in care, flexibility of the service to meet changing needs, privacy and dignity, reliability and responsiveness of care workers, and skills, knowledge and trustworthiness of staff (Qureshi and Henwood, 2000, Edebalk et al., 1995, Harding and Beresford, 1996, Qureshi et al., 1998, Henwood et al., 1998, Sinclair et al., 2000, Francis and Netten, 2004, Malley et al., 2006, Raynes et al., 2001). Aspects of *quality of life* associated with services include the extent to which they help improve users' health and physical functioning, they meet basic physical needs with activities of daily living, they guarantee personal safety and security, ensure a clean and tidy environment, help users stay alert and active, provide access to social contact, ensure users are in control of their life, maximise autonomy, skills, morale and self confidence, and assist users coming to terms with impairment (Bamford et al., 1999, Qureshi et al., 1998, Miller et al., 2008). In addition to these items, service managers and policy makers frequently include additional aspects such as efficiency and equity as essential components of a high quality service (Donabedian, 1980).

Social care services provide help with intimate tasks such as washing and dressing, which require the ‘consumer’ of care to act as a co-producer of their own care and to interact closely with the service provider. Understanding this collaborative aspect of social care, and the central role of the carer-service user relationship in defining the unit of production and consumption of care is therefore fundamental to assessing effectively service quality (Donabedian, 1988). By focusing on this relationship as the object of

quality measurement, we ensure that assessments of quality are not divorced from the practice of caring, which has been a critique of some early quality assessment systems for social care (National Institute for Social Work, 1988). This focus also excludes from quality assessment aspects such as equity, efficiency and accessibility which are perhaps better considered as indicators of 'aggregate' performance of the support system in general, rather than defining the quality of the care worker-service user relationship (Reerink, 1990). These service-related aspects can be used therefore to *evaluate* the service rather than *assess the quality* of social care (Arah et al., 2006, Schallock, 2004, Donabedian, 1980).

## **2.1 Identifying indicators of quality: structure, process or outcomes?**

The assessment in practice of quality requires the identification of indicators which are sufficiently sensitive to variations in the key aspects of quality outlined above. In this context, it is useful to distinguish between indicators that focuss on structure, process and outcomes. Structural indicators refer to the “*relatively stable characteristics of the providers of care, of the tools and resources they have at their disposal, and of the physical and organizational settings in which they work*” (Donabedian, 1980, p. 81); process indicators refer to the activities that go on within and between care workers and service users; and outcome indicators to the desired (and undesired) results of the care activity.

Identifying good quality indicators (QIs) in social care pertaining to any of the three groups is a complex task. Like all service goods, social care services possess three characteristics which make quality difficult to assess (Parasuraman et al., 1985). First, services are best described as 'performances', so their products are intangible and cannot be easily measured, counted, tested or verified; rather they are 'experienced' goods, which require first-hand contact to establish some of its most valued characteristics. Second, social care services are labour intensive, which can lead to a high degree of service heterogeneity. As a result, service performance can vary significantly from producer to

producer, by producer from day to day, and by producer from consumer to consumer. Third, consumption and production of service goods is simultaneous and inseparable, and it is therefore difficult to disentangle the providers' influence on the quality of the service from that of users (Baldock, 1997). Overall, these features of the social care 'good' mean that social care services have few 'search' properties identifying core aspects of quality that can be easily observed, measured and therefore known ex ante.

Available search properties tend to be associated with structural quality indicators. Relevant examples include for instance whether residential care homes offer single-occupancy rooms, the size of rooms and the range of facilities available in a care home. Where the service does not have physical attributes, for instance in the case of home care support with activities of daily living such as dressing, feeding and going to the toilet within the person's own home, it is very difficult to identify search properties. In this case, potentially searchable properties relate to relatively stable characteristics of the care worker that can be known prior to purchase, such as their qualifications and employment experience. These characteristics, however, are often poor predictors of overall satisfaction with services.

Structural quality indicators present a series of limitations. Because they concentrate on relatively stable properties of the service, they are relatively insensitive to changes in quality through time. They are also, by definition, removed from the core focus of quality assessment – the care worker-service user relationship. In this respect, structural indicators are only indirect measures of quality; they are a necessary but not sufficient condition for quality. Although, there is some evidence from the US to suggest that certain structural features of nursing homes (such as the nurse-patient ratio) are highly associated with good quality care (Sangl et al., 2005), evidence from England has found that features such as care worker qualifications and hours of training have a complex and not unequivocally positive relationship with user's perceptions of home care service

quality (Netten et al., 2007). The appropriateness of structural indicators as QIs remains therefore questionable, with further research required to establish the detailed nature of their link to the concept of social care quality.

In contrast with 'search' properties, 'experience' properties relate directly to the care performance, and can only be determined subsequent to purchasing the good or during consumption (Parasuraman et al., 1985). For social care, examples would include many of the aspects of quality of care as stated by service users, such as flexibility, the degree of empathetic behaviour displayed by the care worker, the way the care worker communicates to the care consumer and other 'softer' caring abilities. Experience properties would also include aspects of quality of life, such as feelings of safety, control over daily life, and improvements in physical functioning. 'Credence' properties differ from *search* and *experience* properties in that consumers are likely to find them difficult to evaluate even after purchase. These properties are largely associated with the technical aspects of services, where the consumer does not have the knowledge to assess the skill with which the activities are carried out. Although social care does have a 'technical' component (for example, the skill and knowledge required to lift and transfer frail older people), in general it requires a relatively low level of technical know-how to administer social care interventions (c.f. Donabedian, 1988). Most formal social care is provided by para-professionals, such as home care assistants, rather than professionals like social care workers and nurses. A very large amount of care is also provided by often untrained family, friends and volunteers. In England, for instance, it is estimated that approximately 85 per cent of older people with functional disabilities living in private households receive 'informal' care (Pickard et al., 2007). Experience properties therefore dominate the assessment of social care service quality, and are the basis for the construction of process and outcome quality indicators.

There is some debate as to the relative merits of focussing on process or outcome indicators of quality. Although both are direct measures of the care performance, process indicators focus on the way the service is delivered and outcome indicators focus on the result of care activity. In part, the choice between process and outcome indicators depends on the purpose of measurement. Process quality indicators, for instance, are often used by service managers as tools for service improvement, as they are more amenable to direct managerial intervention (Steel et al., 2004).

The continuous and long term nature of much social care service use means that the way care is delivered, the process aspects, become an integral part of the service user's life. For this reason, and despite not being directly related to the purpose of the intervention, process indicators may be of interest in their own right. For instance, "process" characteristics such as having a say in what is provided, when and how service are delivered, being valued and treated with respect, and being treated as an individual have been identified as key determinants of social care quality (Qureshi and Nicholas, 2001, Bamford et al., 1999, Sangl et al., 2005). Health economists in the UK have begun to incorporate aspects of process into health care valuation tools in an attempt to recognise that intrinsic value associated with the way care is delivered (Kelly, 2005). Similar steps have been made in measures designed specifically to value social care services (Netten et al., 2009).

Outcome indicators, as direct indicators of the final impact of the service, are preferable for the purpose of comparing quality across different types of services (process related quality indicators, in contrast, tend to be highly service-specific). However, some commentators have doubted the feasibility of the systematic measurement of final outcomes in a timely and accurate manner – and in particular our ability to identify the specific contribution of services to outcomes (Donabedian, 1988). Whilst recognising these difficulties, a growing consensus is emerging which views outcomes as the ultimate measures of quality due to their direct relationship with the final aims of the care activity, and the problems in establishing an unequivocal link between service process indicators and service quality (Mor et al., 2003, Reed, 2007).

## 2.2 Measuring social care outcomes

From an economic perspective, outcomes are not just defined in terms of the positive (or negative) effect of services, but also in terms of the value of the effect. They are therefore indicative of the benefit accrued from the intervention (Smith, 1996). In social care assessing, benefit (and indeed effect) is complicated by the co-production and co-consumption of care and by the presence of caring externalities. Since care is co-produced and co-consumed by both care worker and service user, benefits (and disbenefits) from care can accrue to either party. In addition, formal services can have positive (as well as negative) externalities. Social care, particularly when it is community-based, is often provided by a mixture of formal services and informal help from a wider care network composed of family members, neighbours and friends. Formal support can enhance the well-being of the wider care network, by giving them a ‘break’ from the often very significant demands of caring. Poor social care, in contrast, can also harm the well-being of the same network when poorly organised or ineffective.

Ideally, the assessment of service quality should capture outcomes for everyone involved either directly or indirectly in the care intervention. However, in spite of emerging research in the area (see for instance Bobinac et al., 2010), it is rarely possible to measure outcomes for the entire care network. As a result, in the public sector, recent efforts for measuring service outcomes have focused on user outcomes for the purpose of service quality assessment (Heinrich, 2002, Heinrich, 2003, Department of Health, 2006). In the English context, for instance, recent government policy has promoted the following user-related outcomes for social care services: “improved health and emotional well-being”; “improved quality of life”; “making a positive contribution”; “choice and control”; “freedom from discrimination”; “economic well-being”; “personal dignity” (Department of Health, 2006). This focus on care recipients implicitly assumes that the impact of the intervention on the wider care network and care staff is of lesser consequence. Too sharp

a focus on recipients clearly has the potential to ‘miss’ important impacts of social care and provide a one-sided view (Challis, 1981).

Social care services attempt to maximise the quality of life of individuals who are not fully capable of long-term self-care. Importantly, their aim is generally not to improve or remediate the underlying impairment (as is often the aim of medical care) but to compensate the person for the impact of their impairments on their physical and mental functioning. As suggested by Qureshi and Nicholas (2001), social care is therefore low in “change” outcomes, which aim to lessen the person’s underlying level of impairment, and high in “maintenance” outcomes, where the aim is to maintain the person’s quality of life or physical and mental functioning.

It is relatively straightforward, in theory at least, to assess the outcomes of interventions aiming to produce *change* outcomes. Typically, these interventions (such as rehabilitation services) are provided for a defined period of time, and outcomes can be measured in terms of changes in quality of life (or physical functioning state) before and after the intervention. However, services producing *maintenance* outcomes are much more difficult to assess. First, such services tend to be provided continuously, often on a daily basis until a person dies, in the context of an unavoidable deterioration in the physical and mental functioning of the service user. As a result service inputs may actually increase over time, as the service has to do more to compensate the person for the effect their worsening impairments have on their quality of life. Second, the capacity of the service to compensate a person for their impairment may also decline over time, as it may become harder to maintain some aspects of quality of life. The assessment of the impact of the service on quality of life or functioning is therefore hampered by a natural deterioration through time in the state of most social care users. For example, as a person moves from moderate to severe cognitive impairment it may be more difficult to maintain

aspects of quality of life related to self-determination, as the person simply no longer has capability in this dimension.

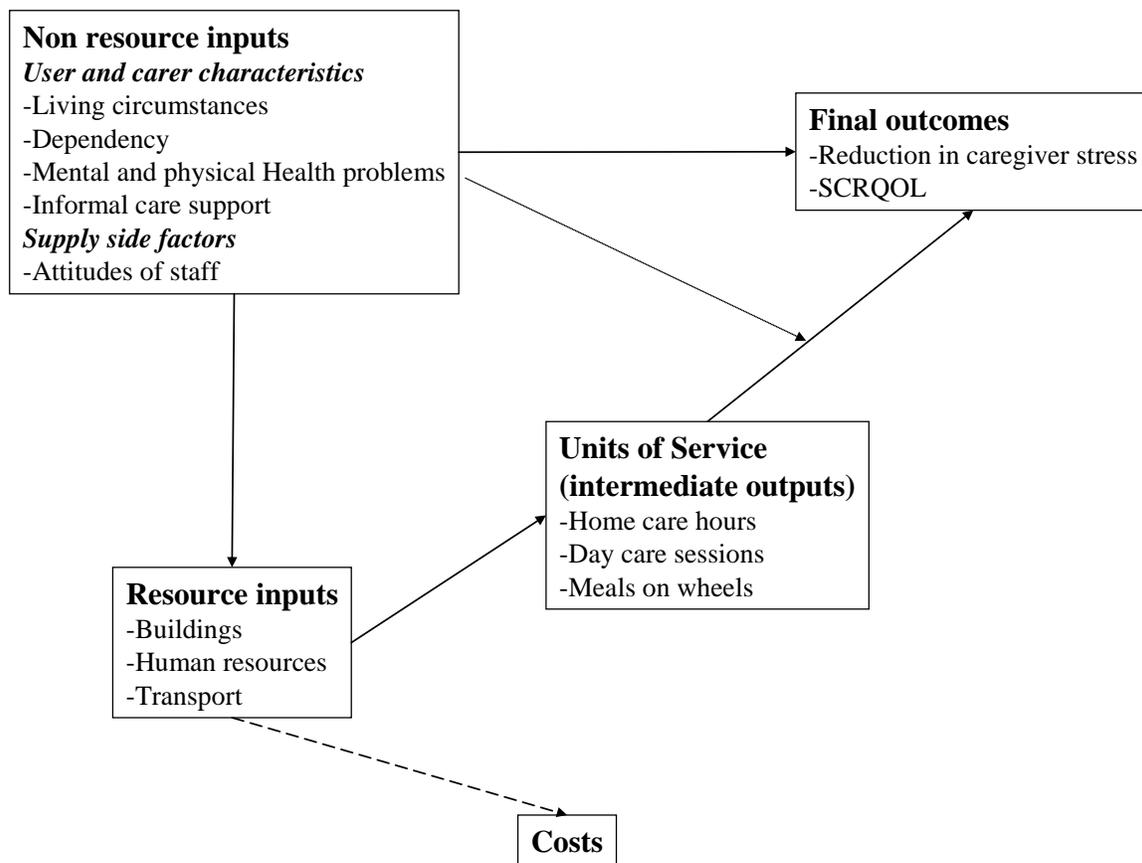
### **2.3 Attribution and the ‘Production of Welfare’ framework**

Regardless of the particular quality indicator chosen, observed outcome levels will be product of the joint influence of service related factors, and of factors outside of the influence of the service, such as the level of need of the service user (Goldberg, 1970). In fact, decades of research in human services – for instance, in education, health and social care – confirm that variations in the quantities of a service (e.g. class size in schools, or hours of home care) have a smaller impact on outcomes than the personal circumstances of the individuals involved, including material, psychological, social and cultural influences (Davies and Verry, 1976, Davies and Challis, 1986, Wolff, 2000, Benzeval and Judge, 2001, Blane, 1995, Goldstein et al., 2007, Knapp, 1978a, Knapp, 1978b, Davies et al., 2000b, Fernandez et al., 2007, Fernandez and Forder, 2006). Measuring service quality requires being able to apportion the relative contributions to outcomes of services and non-service factors. To this we refer as the 'attribution problem'.

To address the attribution problem we draw on an analytical framework known as the ‘Production of Welfare’ (POW) approach, which has been applied in English academic studies to the analysis of equity and efficiency in social care services and provides a framework with which to isolate the contribution of the service to the outcome state of individuals (Davies and Knapp, 1981, Davies, 1985, Knapp, 1984). Figure 1, adapted from Knapp (1984, p. 26), summarises the set of factors relevant to the production of welfare in social care, together with the main relationships between them, as postulated by the POW approach. Inputs comprise all the resource (such as staffing), and non-resource factors (such as characteristics of users, type of building) which go to make up a service. Outputs comprise the actual service (such as the number of hours of care). Final outcomes are the longer-term impacts upon the wellbeing of service users (and of their

care network). It follows from this framework that in order to develop a good understanding of the contribution of services to users' outcomes, one needs to gather comprehensive information about a wide range of variables.

**Figure 1 The production of welfare framework**



Studies that use the POW approach have used regression models to specify the nature of the relationships outlined in Figure 1 and to estimate outcomes after 'controlling' for the effect of factors that are not related to the service, such as service user and carer characteristics (Davies et al., 2000a). An accurate estimation of the contribution of social care services to final outcomes relies on the capacity of the model used to capture all of the non-service-related factors that have an influence over outcomes. The measurement problem can have important implications for the statistical techniques used in the

estimation of the contribution of services to outcomes. The difficulties involved in controlling for all the relevant non-service related factors influencing outcomes can lead to unobserved heterogeneity and to biases in the estimates of quality. The fact that higher levels of services are provided to individuals with greater needs (and thus with the worst raw outcomes), for instance, means that failing to control fully for differences in need in the analysis will lead to a positive bias in the estimates of the social care quality (c.f. Davies et al., 2000a).

### **3 THE ENGLISH QUALITY ASSESSMENT SYSTEM: CURRENT DEVELOPMENTS AND KEY CHALLENGES**

The discussion above has outlined a theoretical framework to aid the measurement of social care quality and described some of the difficulties that are involved in this process due to the special and complex nature of social care. In this section we examine the English approach to quality measurement in more detail. We consider the extent to which the measures used address the challenges to measurement raised and also their suitability for performance management, quality assurance activities and commissioning, particularly in light of current policies to create more personalised services.

#### **3.1 Recent developments in England in quality measurement**

In the last ten to 15 years there have been great advances in England in terms of quality measurement (Boyne, 2002). Prior to 1997, few attempts were made to measure directly quality in social care; measurement tended to focus on activity, expenditure and costs (Challis et al., 2006). Under the Labour government a new data collection, the Performance Assessment Framework (PAF), was introduced and a concerted effort was made to increase the number of QIs. Around the same time a mandatory annual user experience survey (UES) was introduced to collect information on state funded social care users' experiences of and satisfaction with their care.

The QIs introduced under PAF have focussed on care structures and processes. Hence, the indicators introduced related to issues such as the time taken to set-up the care package, and to aspects relating to the infrastructure and adherence to procedures (e.g. percentage of people going into nursing and residential care who are allocated single rooms; adult and older clients receiving a review as a percentage). The QIs based on questions from the User Experience Survey questions have tended to focus on aspects associated with the quality of care, such as whether care workers come at suitable times or overall satisfaction with services, rather than with quality of life per se.

Over time, the focus of the assessment of quality in public social care has become more outcomes-focused, with ministers stating that the objective of services is to provide “better outcomes for all” (Office of the Deputy Prime Minister, 2005, Communities and Local Government, 2007). As a result, the PAF framework was criticised for focusing on what was easily measurable, and for providing a very limited picture of quality and of whether people’s lives were actually improved as a result of service intervention (Department for Health, 2009). In the last few years, policy-makers have therefore developed a revised, outcomes-focussed, QI data collection system for social care. Much effort has been invested in the development of patient-reported outcome measures. The User Experience Survey has been redeveloped specifically for this purpose (Malley et al., 2010, Department for Health, 2009). This direction of travel towards outcomes focussed quality indicators looks set to continue under the new Conservative-Liberal Democrat Coalition government.

However, the increased emphasis on the use of user surveys for assessing service quality advocated in England poses considerable practical challenges, not least of which is the expense and burden on the bodies in charge of carrying out and analysing the survey. There are also difficulties associated with conducting surveys with social care clients, many of whom require help to answer questionnaires due to their impairments. This may lead to high rates of non response among certain sub-sections of the population, which could lead to bias in the results obtained. So far, analyses in England have tended to be relatively simple, and to involve the reporting of raw percentages with little detailed analysis of the effect of non response (see e.g. Information Centre, 2007). Detailed

analysis requires good data on the population characteristics of service users in each commissioning area. Improving the availability of such data will be a major challenge for improving future survey-based QIs.

### **3.2 Uses of quality measures for assessing service commissioners**

In England the QIs described above have mainly been used for monitoring the performance of commissioning organisations and assuring the quality of the services purchased by these organisations (Department of Health, 1998). Since the focus has been on the commissioning organisations, QIs have generally been reported at the level of the organisation, by aggregating the individual-level quality measures. The QIs therefore measure the average quality of social care purchased by an authority, which, to the extent that commissioners have control over the quality of social care, reflects the performance of the organisation. The QI is also a good indicator of the quality of care that people living in that area could expect to receive if they were ever to need social care<sup>1</sup>. Importantly, the QI is not a complete measure of the quality of the commissioning organisation, since other factors such as accessibility and equity are likely to be important to such an assessment.

The use of QIs for assessing the commissioning organisation is subject to the attribution problem highlighted above. Typically, service use is found to be negatively related to raw outcomes states, because people with higher levels of need tend to require more services but to show worse outcomes overall (in spite of higher service contributions to their outcomes) (Davies et al., 2000a). Not controlling for differences in local case-mix is therefore likely to bias the assessment of local performance.

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<sup>1</sup> Although this does depend on the variance associated with each point estimate. If the measure has a large variance then the average quality may not be a terribly good indicator of the quality of social care people in the area can expect.

Overall, deciding which factors should be controlled for during the assessment process is not always straightforward. In addition to need related factors, aspects such as local service supply can constrain the ability of local commissioners to achieve improvements in outcomes for their local population, other things equal. Overall, the analysis should attempt to control for those factors which lie outside the control of services, in this case the commissioning organisation (c.f. Heinrich and Lynn, 2000).

Deciding which factors are beyond the control of service commissioners is often not easy (Wilson and Piebalga, 2008). Deprivation, for instance, has been argued to undermine the capacity of local authorities to achieve good outcomes. As a result, the English resource allocation system in charge of transferring tax-payers money to local government makes an adjustment for deprivation so that more deprived areas receive additional resources.

Further work is being carried out to identify the range of non-service-related factors affecting social care outcomes (Malley and Netten, 2009, Malley and Netten, 2008). Collecting the data required to adequately and accurately ‘control’ for factors beyond the control of commissioning organisation, however, is a resource intensive task. It seems unlikely in the current fiscal climate that organisations will be mandated to collect more information. Furthermore, the need for sophisticated analytical techniques to determine the contribution of social care services to local outcomes puts a further burden on the process of performance assessment, and can delay the production of national adjusted scores.

### **3.3 Measuring the quality of provider organisations**

In England, the QIs are not reported at the level of providers, so these measures are not routinely used to inform commissioning decisions<sup>2</sup>. A different measurement system has been developed to assess the quality of providers by the social care regulator. As part of its role as regulator, the Commission for Social Care Inspection developed a ‘star rating’ system for commissioners, which it later extended to providers, as a ‘quality rating’ system. These ratings are composite measures ‘calculated’ by combining data from a variety of sources, including inspection fieldwork data, data from ongoing performance management meetings, data from the PAF and any other sources including complaints. In line with the policy focus on outcomes described above, much of the data gathered by the regulator is used to assess user outcomes. The regulator also gathers data about the management of the service and includes aspects which focus on staff, such as investment in staff training. The information from all of these areas is organised following guidance and combined together using rules to form a single composite measure of provider quality on a zero (poor) to three (excellent) scale (Commission for Social Care Inspection, 2007).

The quality rating is designed to be easy to understand. Star ratings were initially introduced as a response to the perception that the QIs in the PAF were complex to interpret, so limiting their usefulness as tools for public accountability. Star ratings were designed to be more user-friendly versions of the QIs (Social Services Inspectorate, 2002, Cutler and Waine, 2003). The move towards developing provider-level ratings arose from a desire to help commissioners make good purchasing choices, in part driven by findings that some local authorities were purchasing services from unregistered providers. In recent times, provider quality ratings have been promoted as tools to

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<sup>2</sup> There are, however, some examples of commissioners investing resources to collect and report, in particular, the UES data at the level of provider organisations to inform their commissioning decisions.

improve market efficiency and correct information asymmetries, by providing commissioning organisations and prospective users of services with straightforward information about the quality of care providers (HM Government, 2010). The regulator has developed various tools to help commissioners and prospective users make use of the quality ratings and other inspection information, including a care provider directory on its website which is searchable by quality rating.

Whether the quality ratings system is perceived as valuable in helping potential service users to choose the best provider for them, and help commissioners to make good purchasing decisions, depends on the accuracy and reliability of the ratings. There has been quite a lot of criticism of composite measures; a variety of evidence has been presented to demonstrate that such measures are sensitive to the interpretation of guidance (Cutler and Waine, 2003, Jacobs and Goddard, 2007). The lack of sufficient resources to continuously monitor all services providers also has consequences for the reliability of ratings. To minimise the administrative burden associated with inspections and reduce the cost, the ratings are not updated annually for the best performing organisations; rather resources are focused on those with the poorest ratings. This system relies on stability. However, work in other areas of the public sector has demonstrated that service quality has the potential to change rapidly (Bevan and Cornwell, 2006). In England, provider organisations in the social care sector are in a constant state of flux, with frequent mergers and changes in management that are likely to have an impact on quality. Very recent work looking specifically at the care home providers seems to support these concerns, with researchers able to demonstrate that provider quality ratings were relatively insensitive to variations in quality as measured using an observational outcome tool (Netten et al., 2010). The future of the quality ratings system is uncertain. It is currently being revised and it remains to be seen whether its successor will be able to address any of the criticisms made of the current ratings.

### **3.4 Personalised services and consumer-directed support**

The current developments in quality measurement come at a time of profound change in the delivery of social care services, with the introduction of new forms of consumer-directed support and the transformation of adult social care around the personalisation agenda (Ministers et al., 2007, Department of Health, 2008, Department of Health, 2006). Despite a relatively low take-up currently, consumer-directed care continues to receive support from policy-makers and is expected to become the main mechanism for commissioning services in the coming years.

In a world of consumer-directed care, QIs are also needed to inform service users in their role as purchasers, by providing evidence about the quality of the different services available. And yet, presenting the information in a format that makes sense to prospective users and is at the same time accurate and sensitive to variations in quality is not straightforward. Providing information for many QIs is arguably more accurate, but more complicated to absorb. In contrast, composite measures of quality are easy to understand, but have limited sensitivity to variations in quality. Survey-based indicators have not been explored as measures of provider quality, but could be useful measures for this purpose. In as far as they are based on the views of other service users, they resonate with and be more easily understood by prospective service users.

A policy emphasis on consumer-directed care creates further difficulties for quality measurement. The notion of provider quality developed for the regulator's quality rating system seems inappropriate for this type of care. Consumer-directed care forms blur our understanding of the concept of the service, since many of the functions of the service, in particular those related to the organisation of care and responsibilities for employee welfare, are taken on by the service user. Consequently, where people have consumer-directed support any attempts by the regulator to judge the care these people receive by,

for example, examining the way they treat their staff or organise their care are likely to be treated with suspicion.

## **4 CONCLUSION**

There are many challenges associated with measuring the quality of social care. However, significant advances have been made in recent years, particularly in the development of instruments and frameworks, such as POW to aid measurement. In England, political will has resulted in significant investment in quality measurement with tangible results. There are now a variety of social care quality measures, both at the level of provider and commissioning organisations. There are still important measurement issues that need to be addressed to improve the current set of quality measures, particularly around the attribution of variations in outcomes to service and non service related factors. It is likely that over the next few years, tighter public spending budgets will encourage the further development of quality measures both in England and in other countries, as governments are challenged to prove to tax-payers that they can do more with fewer resources.

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