

CLIENT EMPOWERMENT AND QUALITY ASSURANCE

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Abstract

Measurements of quality in social care services in the UK have generally been concerned with regularly measuring performance in terms of Quality Indicators or Best Value reports. Although these quality measures quite often involve user satisfaction surveys, the methodology does not allow for the user to give a holistic response about the service they have received nor is there any sense of client empowerment around measuring quality in this way.

What is not measured is the link between quality assurance, quality enhancement and client empowerment, nor whether empowerment is defined as a process, an intervention or an outcome. This paper utilises qualitative methodologies that enables users and carers to tell their own stories and suggests that client empowerment as a process is central to the future direction of quality assurance and quality enhancement policies in the UK and in an international context.

These studies of users' and carers' experiences of care in the UK and Eastern Europe involved over 500 individuals utilising an approach that allowed them to explain their experiences of the public care sector from their own perspective (Dowling 1997). In one follow up study, parents of children with disabilities designed the research tool and were involved in disseminating the findings from the research to social care organisations and the Social Care Institute for Excellence, (a government research organisation to promote innovative research that involves users and carers) (Dowling and Dolan 2001). The UNICEF research (2005) aims to utilise users and carers' experiences and views of their care to contribute to governments' policies concerning child disability and follow up qualitative research to this study is currently progressing in Bosnia, Bulgaria and Latvia.

Users of welfare services are the least powerful of groups in whichever country is being studied. In terms of age, gender, material resources, class, education, ethnicity and disability they are likely to be in the most excluded section of their society although professionals who work with them and the staff who organise and develop services are often under paid and have low status too.

The quality of social care services is considered in relation to three crucial issues: How can quality be measured? How can social service users and carers contribute to a quality service? How can the quality of services be improved so that innovative, participative and ongoing measurement of quality in social care organisations are developed through user and carer partnerships with social care managers and staff?

KEY WORDS : Quality assurance, quality enhancement, client empowerment, quality, social service users, carers.

Introduction - How can Quality be measured?

Quality...you know what it is, yet you don't know what it is. But that's self contradictory. But some things are better than others that is they have more quality. But when you try to say what the quality is, apart from the things that have it, it all goes poof! There's nothing to talk about. But if you can't say what Quality is, how do you know what it is or how do you know it even exists? If no one knows what it is then for all practical purposes it doesn't exist at all. But for all practical purposes it really does exist. What else are grades based on? Why else would people pay fortunes for some things and throw others in the trash pile? Obviously some things are better than others.....but what's the "betterness"?.....So round and round you go, spinning mental wheels and nowhere finding anyplace to get traction. What the hell is Quality? What is it?
(Pirsig, 1974).

Quality assurance is defined by Wikipedia as the activity of providing evidence needed to establish quality in work and that activities that require good quality are being performed effectively. In relation to social care services, 'fitness for purpose' encompasses a wide variety of services and organisations. For example it will be important to evaluate the ongoing attributes of a residential home, day care or a night sitting service, while outcomes such as whether social care recipients have a Care Plan or have been satisfied with the promptness of response to telephone enquiries are also important factors in the measurement of quality. Quality assurance in the latter example are well represented in quality indicator documentation and Best Value reports. However they measure facts and produce statistics that can never be the whole story in a social care environment where interaction and engagement are equally important.

Four approaches to Quality which have been imported from the commercial world highlight the way social care services in the UK have developed in the direction of 'Benchmarking' and Best Value.

- The Traditional Approach – an approach which conveys a definition of quality in the commercial world through establishing prestige and positional advantage for example 'status' names such as Rolls Royce or Harrods would maintain they offer better quality services and products than more 'run of the mill' companies. This approach is not easily transferable to social care services in that public welfare services are not regarded as high status in the first place. Two Acts of parliament (the NHS Act 2006 and the Local Government and Public Involvement in Health Act 2007) aim to put new duties on National Health Service (NHS) bodies to involve patients and the public in assuring and enhancing the quality of healthcare services while social care services which are targeted rather than the NHS universal services have less priority and resources.
- The 'Scientific' Approach – an approach which defines quality in terms a series of standards set by experts (for example in the business world ISO 9000/EN 29000). These quality measurements have been wholeheartedly applied to social care systems and developed through central government driven initiatives such as *Modernising Social Services* (Department of Health 1998), *Modernising Government* (Cabinet Office, 1999) and the *National Health Service Plan* (Department of Health 2000). However these standards are often seen as a bureaucratic nightmare by social care professionals and are not demonstrably transparent or understood by users, carers or social care workers.

- The ‘Managerial’ or Excellence Approach – an approach which stresses continuous improvement (for example Total Quality management – TQM in a commercial environment). This approach has been applied in a top down approach from Senior management in public welfare services in combination with the Scientific approach. However it is difficult to motivate welfare staff to improve in line with the social services ‘mission statement’ if there is low morale and 40% staff vacancies in some authorities. This approach also assumes commitment to improvement by staff whereas the commitment of users in working with public welfare officials cannot be guaranteed – especially if they are on probation or subject to compulsory mental health or child care legislation
- The Consumerist Approach – an approach which would evaluate quality through understanding the consumer perspective. Government policies are keen to apply this approach to users of public welfare services but the practice is not innovative or sensitive enough at present to have made a significant difference to social care services. John Hutton, Minister of State commented in a keynote conference speech (NISW 2000), ‘I want us to think about how quality can be defined ..A good place to begin is with users’ and carers’ experiences of social services. Their knowledge is key to what constitutes good social services. I want us to listen, and then apply the lessons learned from them...Users’ views are a crucial way of testing and assessing for quality in services’.

How can Quality be Measured from a User and Carer Perspective?

For the purposes of this paper “Users” are defined as individuals receiving social care services. “Carers” are defined as individuals who have, are or will provide family and community care for individual users whether paid or unpaid (Barnes et al, 1996). These definitions are necessarily broad because users and carers are not a static population. Birth, accidents, illness and the ageing process will mean that family members may suddenly or gradually require care. Death, recovery from illness and teenagers growing older may mean that social care services are no longer needed. This paper is mainly concerned with the establishment of a “voice” (Hirschman cited Pfeffer and Coote, 1991) for social service users and carers in concepts of quality. The market option of “exit” in relation to welfare services is only available to:

- users and carers with resources,
- those who are carers paid by the local authority (for example foster parents)
- users and carers who are so dissatisfied they would rather do without social care services altogether.

The first important issue in terms of measuring quality concerns how users and carers are listened to and observed. Users and carers have stories to tell which often do not fit into a questionnaire or quality standards format. Two classic studies used participant and non participant observation to examine the interactions between professional workers, the management hierarchy and social service users and carers in residential settings. John and Elisabeth Newsom in the 1960’s observed and filmed children’s reactions to being placed in residential care when their mothers were in hospital. The trauma that the children suffered had a significant effect on child development theory and policies for residential and NHS childcare in the following decades but evaluation studies of this sort are not generally part of the current quality assurance methods. A further classic study in Sweden conducted a participant observation study of an older people’s home which compared the glowing reports and observed positive interactions of users and carers with staff with the negative quality standards report that caused

the home to be closed. Such methods can explain why particular processes are unsatisfactory for users and carers, professionals and management by analysing prevailing attitudes and actions, the culture of the organisation and the wider social policy environment (Satyamurti, 1981; Dowling, 1999). As a method of evaluating quality in social services, it is useful from a managerial and consumerist perspective because it allows purchasers and providers of services to understand how the organisation operates at different hierarchical levels (Whyte, 1984).

In depth interviews and group discussions with users and carers as an evaluative method are part of a larger tradition of emancipatory qualitative research (Rogers and Pilgrim, 1996). They aim to give individuals power to define their own research agendas and to have a say in the research process. Such research is now commonly connected with the idea of empowerment. Whether such research is ever really empowering for users and carers is a difficult question to answer. However users and carers particularly those who had a poor experience of community care or child protection policies did often thank the interviewers for their help and in talking through the experience appeared to regain some personal power (Dowling 1997).

Mrs Q: I am quite pleased that you came to see me because I feel I know a little bit more of what I should be asking for and that you have reinforced me to say it. Because I think I don't know how much I should really be saying because I feel helpless.

Int: *Please be assured that you have every right to express your ongoing concern as Keith's parent and to be critical of the services and demanding of them to ensure that he comes out of this sorted out. You don't want to lose your son in care for years and find that at the end of it he is no better, or worse than when he went in.*

Each user and carer interviewed in the research programme (Dowling 1997) was provided with a copy of the report for their client group. This allowed them to see that their views were part of a wider agenda and would promote discussion with other users and carers who were not part of the research process. User and carer research monitoring groups were developed with active members of user and carer groups. The principal aim of the groups was to discuss with the activists whether and in what ways the social care issues presented to them from individual interviews were illustrative of the wider concerns of users and carers in their client group. In the ten research monitoring groups - one for users and one for carers in each of the five client groups (older people, people with physical disabilities, mental health service users, people with learning disabilities and children and young people) - the process of discussing issues concerned with social care and feeding back comments on drafts of each report appeared empowering. For example users and carers in the groups would feedback information on further steps they had taken to regain power in the social care arena. Users on the mental health service monitoring group formed themselves into a consortium to offer training on user issues to social services departments and to develop research as user academics. One of the users on the older people's research monitoring group who is a resident in a home succeeded in being appointed as an assessor of residential homes after his participation in the group and his attendance as a guest speaker at a Social Service User conference.

Consumerist Approaches to Quality Assurance

The consumerist perspective would tend to organise user and carer feedback to benefit the care organisation but also to improve the efficiency of the service provided for users and carers. This could be in the form of a survey with questions such as "how many times did the phone ring before it was

answered when you phoned social services?” Asking these sort of questions *appears* to promote action. For example if the results of the survey show that the average response from users and carers was 20 rings then staff can be told that they must answer the phone before it rings 10 times. While having a beneficial approach for the consumer, many users interviewed using a qualitative approach found these sort of questions not relevant to their everyday lives nor to what they wanted from social services. For example one lady of 75 who had rung social services when she had fallen over, had been hospitalised and was now back at home. She said she had no idea when asked the question of how many times the phone had rung when she first contacted them four months previously. On the other hand some mental health service users were happy that a quality standard existed that meant that they were able to get through to someone when they needed to in an emergency. They had had experiences where the telephone was not answered at all. Thus such a standard can be effective in promoting quality but it is not a complete answer to the question – what is quality?

Complaints procedures are also part of the consumerist approach in that they are able to give individual users and carers a voice. However welfare organisations do not necessarily respond effectively to the complaints nor can such individual complaints generally make a difference to the policies and practices of the organisation. The consumerist approach is seen as tokenistic as although it consults with users and carers there is no real attempt to share power with them.

Empowerment Approaches to Quality Assurance

The empowerment approach is consistent with the dictionary definition of “empower” -to authorise or enable. It has a fundamental aim of ensuring that users and carers not only have more say but more power in the policy making process. As Michael Turner from the user led network ‘Shaping our Lives’ notes, ‘ service users and their organisations are encouraged by the new emphasis on quality and the stated (government) aim to ensure that users play a central role in defining quality. Their reservations are about the current gap between this rhetoric and the realities of life for user groups.’(NISW,2000)

Participants who take part in any research or evaluative process can only be empowered if they are given power so that their perspectives are acted upon both at the local welfare practice and policy level and at national and international policy and practice debates with governments and NGO’s.

Users and carers understand the concept of quality and what could be defined as a quality service. However this parent does not at present have the power to organise a social care network for his learning disabled son as he would wish.

Mr E: *To educate the parents, to give sufficient facts for them to then be able to start asking sensible questions about the child’s options, the parent’s options, what is part of the infra structure. If there are charitable trusts which you should get in touch with now who may provide a house which can transfer to the local authority, who they are, what they are. Have you made a will? You have a child with problems, may we respectfully suggest you look in our direction. So you cover two things, your child and possible extra funding for Social Services. OK this will be directed at your child but so what? If it means buying a house and your child is one of four in that house, well.....We want Edward to have as fuller life as possible, and we want him to get out there and start doing it as quickly as possible. We don't want the situation of him living at home with us when he is still 30 as he won't have any social life, - he'll be lost in this house.*

Nevertheless client empowerment as an ongoing process to ensure quality cannot succeed, if the resources for the core services and recruitment of staff are poor, as this parent points out.

Mr RG: My opinion is that the Health Service should have a requirement to contact Social Services when anybody is diagnosed with whatever. Our experience was that our daughter was diagnosed

as autistic at two years old, we went away, my wife was suicidal, and it's one of the worst things that can happen to you. We wrote to Social Services they didn't even bother to reply to the letter. The reason was they didn't have a case manager in the Frankam area. That is totally inexcusable, if there is not a case manager in Frankam, those letters should be sent somewhere else for a reply. They are understaffed, these Managers keep changing from one office to another there is no continuity - nobody is taking responsibility. We were very upset with social services. We had no help at all.

How can the Quality of Services be improved within a Social Care framework?

Defining a quality service and then improving it from a user and carer perspective will depend on the service required and the type of care provided. For example children and young people in residential care had different perspectives regarding a quality service to those receiving mental health services (Dowling 1997, UNICEF 2005).

A user member of the research monitoring group for mental health service users and carers felt that the quality of social care services for mental health service users was about providing a safety net for those discharged from hospital.

Mr C: *I think still largely with mental health the problem is loneliness and isolation. They're in their bedsits, they don't see anybody, they've got no money to go anywhere and in some ways it's quite nice for them, usually it's the social worker, then they lowered the salary and called it Community Support Worker. They would come along and knock on their door and say 'Put the kettle on ' or 'I'll put the kettle on, you sit down and we'll have a chat for a minute'. To some extent that's what a lot of them wanted. It's almost buying company, the government paying for their company. There probably is a better way of doing it than that but that's what they see the social worker as I think.*

Improvement in the service would have meant employing a larger number of community support workers preferably ex-users to support individuals with mental health difficulties in the community.

For the UNICEF research over 170 children with physical disabilities and their parents were interviewed in Bulgaria, Russia and Latvia regarding their experiences of medical and social care and their views on better services. Parents and children who lived together at home were in the minority with the majority of children living in residential care. The majority of children and parents thought that children with disabilities should be cared for at home and integrated into schools with other children. The children who identified themselves or were identified by parents and providers as most at risk were: children in institutions who had no contact with their families; severely disabled children of all ages and teenagers leaving institutions. Parents who lived at home with their children, lived on a very small allowance from the State and worked less because of their childcare responsibilities. The principal recommendations from children and their parents for improvements in medical and social included avoiding family dislocation where children and parents are split up by:

- providing counseling, information and training
- organizing respite care and family programmes
- giving economic support for parents including adequate disability benefits and/or tax credits and developing flexible employment possibilities and incentives for businesses
- Involving parents in professional services including collaboration and communication with service providers and financial and professional support for active caregivers and for self-help groups
- Combating disabling public attitudes and improving the physical environment such as access to buildings and transportation to school

Conclusion

How can quality of services be improved so that innovative, participative and ongoing measurement of quality in social care organisations are developed through user and carer partnerships? Client empowerment will have different meanings for different user and carer groups and quality services in a developed country will be understood and may have progressed differently from quality services in developing countries. Bearing these variations in mind, three key issues could ensure improvements in the measurement of quality from an empowerment perspective:

- For user and carer organisations to be able to produce the evidence sought on their perspectives and work in partnership alongside managers and social care workers, they need to be supported with adequate resources. Without this support, the infrastructure for user involvement at a local and national level either does not exist or cannot function effectively
- User and carer involvement and user and carer evidence needs to be valued. Valuing this input as an essential component in ensuring quality services means appreciating user and carers who work with social care organisations and supporting user led research and qualitative and ethnographic research. Furthermore as recipients of social care services, they are able to monitor the effects of improvements in the quality of the social care system over time.
- Welfare services need to be resourced and staffed at a level at which it is possible to measure quality and offer partnership working. If funding and staffing are insufficient, then whatever measure of quality is utilised, the results will be disappointing.

As Alan Walker noted in 1993 (p221/2), ‘..the user centred or empowerment approach would aim to involve users in the development, management and operation of services as well as in the assessment of need. The intention would be to provide users and potential users with a range of realisable opportunities to define their own needs and the sorts of services they require to meet them. Both carers and cared for would be regarded as potential service users. Services would be organised to respect user’s rights to self determination and dignitythus user involvement must be built into the structure and operation of Social Services Departments and not bolted on.’

There is in the United Kingdom a drive for audit processes that assume: statistical standards are the only measure of quality; that there is no other way of measuring quality; that the standards produced are understandable to the general public and what they want; and that they are achievable by the workforce at the current resource level.

This final story illustrates by taking the orchestra as the welfare world – which includes users and carers, social care workers and their management, government organisations and elected officials - the danger of trying to achieve and measure quality from one (business) perspective rather than from a number of different perspectives that combine to create a unique whole.

Schubert’s Productivity

A company Chairman was given a ticket for a performance of Schubert’s unfinished symphony. Since he was unable to go, he passed the invitation to the company’s Quality Assurance Manager. The next morning, the Chairman asked him how he enjoyed it, and instead of a few plausible observations, he was handed a memorandum, which read as follows:

- 1) For a considerable period, the oboe players had nothing to do. Their number should be reduced, and their work spread over the whole orchestra. Thus avoiding peaks of inactivity.
- 2) All twelve violins were playing identical notes. This seems unnecessary duplication, and the staff of this section should be drastically cut. If a large volume of sound is really required, this could be obtained through the use of an amplifier.

- 3) Much effort was involved in playing the demi- semi quavers. This seems an excessive refinement and it is recommended that all notes should be rounded up to the nearest semiquaver. If this were done, it would be possible to use trainees instead of craftsmen.
- 4) No useful purpose is served by repeating with horns the passage that has already been handled by strings. If all such redundant passages were eliminated, the concert could be reduced from two hours to twenty minutes.

In the light of the above, one can only conclude that had Schubert given attention to these matters, he would have had time to finish his symphony (Roseland, 2000).

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