

Ensuring quality in the new culture

Ensuring Quality in the New Culture

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If ever a subject was shrouded in mystery, fantasy and unreal goals it is quality in the personal social services. It is even more difficult to define than quality within the health service or education where there are at least a few yardsticks which may be reasonably reliable pointers.

I suppose if the wrong leg is removed by a surgeon he will have failed the quality test. A school producing a 99 per cent pass rate of three 'A' levels per pupil at the age of 16 might be seen in some eyes at any rate to produce a quality product. For the personal social services there may be similar quality goals, possibly an admission to a residential home, possibly the provision of an aid, but in general the quality indicators for services are really quite tricky to identify and always have been.

The point I am making is that the attention to quality in the new culture is no different than the attempts to achieve quality in the old culture. The question that must be asked is whether the new culture in itself will ease first the identification of quality measures and secondly the process of measurement, thereby creating yardsticks and quality indicators which can be reliable and valid in their own function.

At the present time I believe the new culture will help only if the purchaser/provider divide is driven firmly through and this only to concentrate the mind. The identification of measures of quality have always been fraught with problems: social work intervention particularly so. That is probably because social work itself is such a quasi-professional activity with no formally determined edges to its role, thus making comparative studies of effectiveness extremely difficult.

Other areas of social service provision may indeed be easier to measure for quality purposes, although this may be only at a superficial level. One is tempted to assume that quality measures associated with the Home Care Service, occupational therapy and residential placements might be easier to identify. The analogy with a psychopath comes to mind, which is that nobody can describe the characteristics of such a person yet, when met, we all know one. For example, we can probably identify a good residential placement simply by our subjective responses to the state of the home, to the way individual residents relate to each other and to the home, and the way the staff relate to each other and to residents. Yet to analyse the ingredients of those quality measures becomes very difficult indeed.

One major issue which seems to beg many questions is why no academic institution, in particular social work training courses, have ever attempted to research quality questions within social service agencies. I find this quite astonishing. No other professional group fails to bed practice firmly within research development and constant and regular studies of performance. Even in education much research takes place, some of it controversial but all of it stimulating. Where, for the social services, is a similar driving activity?

Some work has been done by management consultants, but this appears to be related more to perception of management or organisational quality rather than to quality of service. Thus indicators such as the number of children boarded out compared with the number of children in care, or, in relation to a family centre, the number of children taken into care from the centre's case list, the number of re-referrals, the number of cases dealt with which subsequently require legal intervention are helpful, but at best they are surrogate indices of quality and demonstrate the frailty of our knowledge base.

So what is going to change in the new culture given that there is now an intensive spotlight on quality and, in theory at least, an intensive mobilisation of activity to identify quality measures throughout the organisation? I fear much is directed at managerial quality rather than output quality, yet the potential which arises from the definitions of individual care plans for the measurement of quality is considerable if we apply the best research tools to that point. There is, however, part of me which is quite cynical about the present attention to quality. I fear that the whole movement is political rather than care based: primarily a method of finding issues which will keep

the personal social services on the wrong foot. This will be particularly so if the government do not find ways of funding academic research into quality irrespective of the model of organisation. We must not forget that the new culture is quite simply a reorganisation of the way we provide services.

There is nothing special in the changes which create more opportunities for quality control. We must, however, look positively at those opportunities if we are going to do justice to the very people it is our task to help. At the end of the day, directors of social services have one objective, which is to provide the best quality service to those for whom we have a statutory responsibility. What cannot be denied is the incredible proliferation of the number of quality mechanisms which will be available to us in the future. The list is impressive:

- Community care plans will be published and subject to public scrutiny.
- Arm's length inspection and registration units.
- Formal complaints procedures with the probability of advocate support.
- Parental participation in child protection.
- User and carer involvement in assessment and service provision.
- Statements of assessment under the Disabled Persons Act.
- Case management, individual care plans and key worker control.
- Changes in the member role emphasising performance.
- The move to identify outputs rather than inputs.
- Contracting services which will identify measures of quantity and quality.

More arguably one could add the purchaser/provider split, the purchasing power of the case manager, the political commitment to targeting and prioritising, the client service objectives and the independent registration of social service employees. It is not appropriate to go into all these quality control assessments, but they are there and, if departments mobilise their potential clearly, much benefit could arise. They will be less successful, however, without the basic quality research to which I referred earlier.

I would like to generate some ideas about quality which may help to bridge the gap between the process opportunities listed above and the state of the quality which I emphasise is the desired goal. First I put forward some quality definitions.

I suggest customer quality should be perceived as fitness for use and should pass the test 'does it meet need to the customer's satisfaction?' There is a second internal quality definition which might be called process quality, which reflects where the service meets the specifications of a contract whilst being controlled to eliminate error and waste and keep costs down. Thus there are internal and external definitions of quality which are equally important.

There are some themes around quality which may help senior management steer the issue forward:

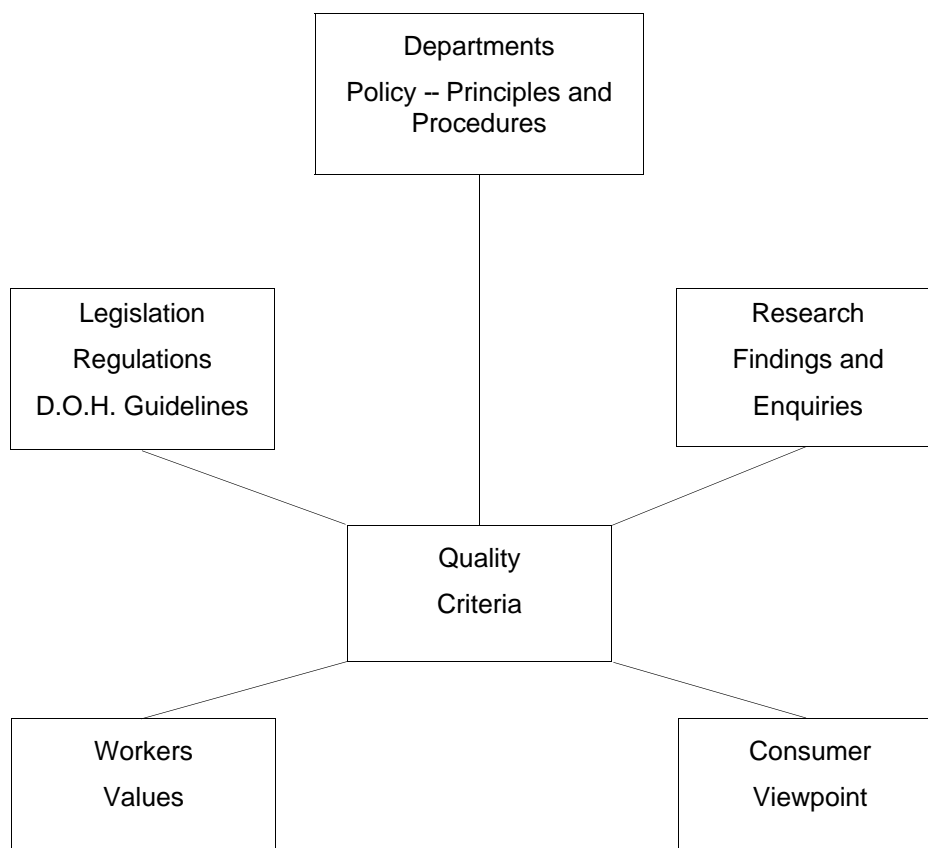
- Quality is a central responsibility of managers.
- Quality problems are much more likely to be caused by management not carrying out responsibilities than by poor work by staff.
- Managers must lead on quality improvements and prove to staff their commitment.
- Quality improvement should lead both to meeting need and improving efficiency.
- Attention to quality should give each person in the organisation the opportunity to get job satisfaction by doing a good job.
- Quality ideas and methods must be simple and everyday within the department.

The next question which has to be addressed is 'how do we know that quality is being achieved?' I suggest there are six tests: of accessibility; of relevance; of equity; of effectiveness; of social acceptability and of efficiency. The test of accessibility is that the service is timely and geographically available. The test of relevance is that the service should meet the needs of an individual client or carer. The test of equity is that services are available to people irrespective of location, race, sex, creed and independent of the ability to pay. The test of effectiveness is difficult to measure, but indicators could be consumer satisfaction with service given or establishing that distress or difficulty has been reduced. Social acceptability needs to be tested in various ways so as to establish that services provided reasonably

Drawing the line

satisfy the expectations of consumers, providers and tax-payers. Efficiency may be viewed as the process of not using more resources than needed to achieve the stated aims of an individual care plan. What needs to be heavily underlined is that a case manager who is inefficient in the use of resources deprives others of a service.

Quality is established in a social services department by pressure points which influence ultimate criteria. These may be demonstrated in the following diagram:



The establishment of quality, taking account of all the preceding comments, requires a step by step approach. I suggest that best results are achieved by very small gradations of improvement rather than giant steps. What is essential is that the operators of services establish their own quality measures and are released to achieve these by management. Thus each individual, each team and each organisation goes through the following steps whether dealing with an individual

care plan, a care plan, service specification or business plan. A quality circle approach seems a must.

Essentially, the first ingredient is to start with a definition of need or objective. The second is to specify the processes and standards which will be achieved in providing a service to meet that need. The third link in the chain is the delivery of the service. The fourth step is to monitor and measure the service product and consumer satisfaction. Following that step there is a link back to the definition of need or objective. The whole process is driven by the underlying values in any organisation. It should be noted that no single quality standard can be established; rather we should attempt to set what might be called a comfort zone within which good enough quality is supplied.

To achieve more than the top line is to exceed expectations. Not to hit minimum quality standard is to fail, and whilst there should be constant movement to improve quality, individual staff or groups of staff should be rewarded for product achieved within the comfort zone.

My conclusion is that quality, although much talked about, is an elusive concept. We should make haste slowly, taking staff and consumer with us so that there is full participation in the setting of standards, both for services to individuals and in planning overall services.